

MENTAL HEALTH SERVICES DELIVERY SYSTEM

PROGRAM GUIDES

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**HEALTH CARE
SERVICES DIVISION**

**CALIFORNIA DEPARTMENT OF CORRECTIONS
PUBLIC SAFETY, PUBLIC SERVICE**

MENTAL HEALTH SERVICES DELIVERY SYSTEM

PROGRAM GUIDE

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SECTION 1: MENTAL HEALTH SERVICES DELIVERY SYSTEM

PROGRAM GUIDE OVERVIEW

The California Department of Corrections (CDC) is implementing the Mental Health Services Delivery System (MHSDS), which significantly improves inmate access to mental health services. The intent of the MHSDS is to advance the Department's mission to protect the public by providing timely, cost-effective mental health services that optimize the level of individual functioning of seriously mentally disordered inmates and parolees in the least restrictive environment.

The MHSDS supersedes and supplants the existing system of mental health services. Like the existing system, the MHSDS utilizes a variety of professional clinical and support staff to provide the best available quality of care to seriously mentally disordered inmates. There, however, the similarity ends. Building on and expanding from the existing inpatient and outpatient services provided in a few centralized locations, the MHSDS creates a new, short-term crisis inpatient care program and significantly expands outpatient care into a greater array of treatment levels and modalities. The MHSDS is a decentralized, system-wide concept using standardized evaluation and treatment, rather than a centralized program utilizing a few locations with measurable variations in treatment. The MHSDS provides universal screening and direct transfer from the Reception Center to the treatment facility to begin treatment, rather than screening only those with observable problems and then transferring them for secondary evaluation prior to confirmation for treatment. The MHSDS greatly accelerates the ongoing professional trend away from inpatient care towards outpatient care in a shorter, more open environment, rather than relying solely on inpatient or highly structured, long-term outpatient care. The MHSDS utilizes case management techniques to manage the majority of mentally disordered inmates in the general population while greatly increasing their access to care as needed, rather than relying on existing, non-caseload managing staff to detect and refer inmates who may need mental health services. Finally, the MHSDS utilizes a standardized, automated system of records management and case tracking, rather than the manual or semi-automated systems used previously.

The MHSDS is designed to provide an appropriate level of treatment and to promote individual functioning within the clinically least restrictive environment consistent with the safety and security needs of both the inmate and the institution.

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Some key concepts are inherent in the design and administration of these services. These concepts are:

1. To deliver services not only to promote mental health, but also to develop and reinforce individual responsibility, with the basic premises that mental disorder does not necessarily excuse individual responsibility and accountability, that achieving clinical goals is enhanced by a therapeutic emphasis on responsibility for one's own behavior.
2. To understand mental health treatment not only as a treatment expectation of inmates, but also as a sensible administrative approach when behavioral expressions of mental disorder or other disorders disrupt the inmate's ability to function and program during confinement.
3. To provide all services with strict observance of Utilization Management guidelines, as a reminder to fiscal responsibility regarding the use of taxpayer funds, which are a limited resource.

To achieve its treatment goals, the MHSDS will use a variety of therapeutic strategies. All such strategies will have as goals the need for adjustment to the realities of the prison environment and the optimalization of appropriate personal functioning, as well as the need for personal acceptance of responsibility for one's behavior. These goals are furthered by the operating premise that an inmate's offense and institutional behavior, rather than the need for treatment, determine the level of custody placement.

A. Primary Components

Crisis Intervention A crisis is defined as a sudden or rapid onset or exacerbation of psychiatric symptoms, including suicidality or other aberrant behavior which may or may not lack clarity of etiology, and which requires immediate intervention. Crisis intervention is provided at all institutions to inmates suffering from a situational crisis or an acute episode of mental disorder. The primary element in initial crisis intervention is training for all institution staff in: recognition of mental health crisis symptoms, procedures for immediate response and referral to clinical staff, and the role of custody/clinical staff cooperation to ensure that an inmate in a mental health crisis is seen by appropriate clinical staff as soon as possible. Such training will be developed and administered under the authority of the MHSDS.

Comprehensiveness The new system offers more comprehensive services and better continuity of treatment than were previously available. In addition to standardized screening and evaluation, all Levels of Care found in a county mental health system are represented in the new system.

Decentralized Services Mental health services are geographically decentralized by making basic services widely available. All levels of care except inpatient hospitalization will be

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available at all geographically-defined Service Areas (see below). Case management will be provided at all institutions.

Improved Clinical and Administrative Oversight In coordination with each institution, specialized units within the Health Care Services Division (HCSD) will facilitate program policy and development, operation and monitoring, and patient tracking. A system-wide automated tracking and records system is being developed to support administrative and clinical oversight.

Standardized Screening Earlier access to mental health services is enhanced for all inmates through standardized screening of all admissions at Reception Centers. Standardized screening assures that all inmates have equal and reliable access to services. The uniform types of data generated by standardized screening also provide the Department with improved methods of regularly assessing mental health service needs. If screening reveals such indicators for mental disorder as prior psychiatric hospitalization, current psychotropic medication, suicidality or seriously maladaptive behaviors, follow-up evaluation by a clinician will determine immediate treatment needs and the need for monitoring and tracking. Early identification of mental health needs will help to contain the higher costs of acute exacerbations of mental disorder.

Pre-Release Planning This component of service, in conjunction with custody staff, focuses on preparing the seriously mentally disordered inmate for parole. Its objective is to maximize the individual's potential for successful linkage and transition to the Parole Outpatient Clinic, or, if required, to inpatient services in the community or the Mentally Disordered Offender Program operated at the Department of Mental Health (DMH) facilities. This service includes assessment, determination of the type of living situation required in the community, life skills training, medication management and transition planning by the parole outpatient clinician from the region where the inmate will be paroled.

B. Treatment Criteria for the Levels of Care

Specific Treatment Criteria have been developed for the MHSDS. An inmate must meet these criteria in order to receive MHSDS treatment.

1. Treatment and continuous monitoring are provided to any inmate who has **current** symptoms and/or requires treatment for the DSM IV diagnosed (may be provisional) Axis I serious mental disorders listed below:

Schizophrenia (all subtypes)
Delusional Disorder
Schizophreniform Disorder
Schizoaffective Disorder
Brief Psychotic Disorder

Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)
Psychotic Disorder Due To A General Medical Condition
Psychotic Disorder Not Otherwise Specified
Major Depressive Disorders
Bipolar Disorders I and II

2. **Medical Necessity:** Crisis intervention will be provided as needed. Treatment is continued as needed, after review by a treatment review committee, for all cases in which:

Mental health intervention is necessary to protect life and/or treat significant disability/dysfunctionality in an individual diagnosed with or suspected of having a mental disorder. Treatment is continued for these cases only upon reassessment and determination by the treatment review committee that the significant or life threatening disability/dysfunctionality continues or regularly recurs.

There are four levels of care in the MHSDS:

1. **Inpatient Placement (Crisis Beds, DMH Acute Care)**

- a. Overall Treatment Criteria A (One of the serious mental disorders listed above) or B (Medical Necessity) with:
- b. Marked Impairment and Dysfunction in most areas (daily living activities, communication and social interaction) requiring 24 hour Nursing Care
- c. And/Or: Dangerousness to Others as a consequence of a serious mental disorder/Dangerousness to Self.
- d. These conditions usually result in a Global Assessment of Functioning (GAF) Score of 30 or less.

All inmates admitted to Mental Health Crisis Beds (MHCB) return to either outpatient care or the general population or are transferred to DMH inpatient care in 10 days or less. The MHCB also provides short-term inpatient care for seriously mentally disordered inmates awaiting transfer to a hospital program or being stabilized on medication prior to transfer to a less restrictive level of care. Access to the MHCB is available at the point of reception, and continues through institutional confinement until discharge. The MHCB will be a part of a licensed medical facility, a Correctional Treatment Center (CTC) offering 24-hour basic medical, nursing and other health services. A Central Health Services building which houses CTC services will house the MHCB beds, staff offices and therapy space. The MHCB will run its short-term crisis care program licensed as a CTC optional mental health treatment program.

2. **Enhanced Outpatient Program (EOP)** EOP provides care to mentally disordered inmates who would benefit from the structure of a therapeutic environment that is less restrictive than inpatient settings. This may include response to crisis symptoms which require extensive treatment, but can be managed as outpatient therapy with several psychotherapy sessions or medication adjustment with follow-up visits. The Treatment Criteria for the EOP are:

Overall Treatment Criteria A or B and:

- a. **Acute Onset or Significant Decompensation** of a serious mental disorder characterized by increased delusional thinking, hallucinatory experiences, marked changes in affect, and vegetative signs with definitive impairment of reality testing and/or judgment

And/OR Inability to Function in General Population Based Upon:

- a. **Inability to Program** in work or educational assignments, or other Correctional activities such as religious services, self-help programming, canteen, recreational activities, visiting, etc. as a consequence of a serious mental disorder; **OR,**
- b. **Dysfunctional or Disruptive Social Interaction** including withdrawal, bizarre or disruptive behavior, extreme argumentativeness, inability to respond to staff directions, provocative behavior toward others, inappropriate sexual behavior, etc., as a consequence of serious mental disorder; **OR,**
- c. **Impairment in Activities of Daily Living** including eating, grooming and personal hygiene, maintenance of housing area, and ambulation, as a consequence of serious mental disorder.

These conditions usually result in a Global Assessment of Functioning (GAF) Score of 50 or less.

These inmates do not require continuous nursing care. Often, they are transitioning from inpatient care in a DMH hospital or the MHCB. They may also be chronically mentally disordered with moderate to serious but persistent functional disabilities. The EOP's structured program of treatment and supportive activities will in many cases build on therapeutic improvements made in a hospital program or MHCB. EOP will release cases which have successfully completed treatment to Correctional Clinical Case Management Services (CCCMS). The EOP is located in a designated living unit at the hub institution.

3. **DMH Inpatient Hospital Care:** Referral to inpatient programs provided on contract with the DMH is available for inmates whose conditions cannot be successfully treated in the outpatient setting or in short term MHCB placements. Both acute and intermediate care programs are offered in facilities for both male and female inmates. Specific criteria are noted in Section V, Department of Mental Health Inpatient Program.

4. Correctional Clinical Case Management System CCCMS is located at all institutions to provide care, monitoring and follow-up services to inmates whose condition is relatively stable and whose symptoms are largely controlled. This may include a response to symptoms which require only a brief, such as a psychotherapy session or an adjustment in medications. While mentally disordered, these inmates can function in the general population and do not require a clinically structured, therapeutic environment. The Treatment Criteria for CCCMS are:
 - a. **Overall Treatment Criteria A or B and:**
 - b. **Stable functioning in the general population and**
 - c. **Criteria not met for higher levels of care**
 - d. **These conditions usually result in GAF scores above 50.**

C. Service Areas

The principal infrastructure for service delivery in the new system is the Service Area. A mental health Service Area assumes responsibility for mental health services; a medical Service Area, while it generally overlaps with that for mental health, is responsible for medical services. Several Service Areas report to a Regional Administrator.

Each Service Area consists of a group of two or more institutions in relative geographic proximity that share the full complement of services directly provided by CDC. These services include all levels of care except the Acute and Intermediate inpatient care provided through DMH. Each mental health Service Area will have from one to three MHCBs and one EOP located at its hub institution. CCCMS completes the delivery system within a Service Area. While CCCMS is coordinated at the hub institution, staff handling caseloads will be at every institution. CCCMS coordination is chiefly provided by a Case Management Supervisor in charge of the patient monitoring system who assigns and sends clinicians to other institutions as the need arises.

D. Clinical Program Guides

Clinical Program Guides have been developed for the MHCB, EOP and CCCMS levels of care. Each Guide is organized into the following sections: Program Objectives, Population Served, Treatment Modalities, Staffing, and Patient Assessment and Case Review Procedures. Although these Guides define essential program content and delineate systemwide policies, each Service Area is expected to have written policies and specific operational procedures derived from the Guides but articulated in ways that best address the unique needs of the specific Service Area and its institutions. Written policies and procedures are especially necessary for the MHCB to meet CTC licensing requirements.



MENTAL HEALTH SERVICES DELIVERY SYSTEM LEVELS OF CARE
CALIFORNIA DEPARTMENT OF CORRECTIONS

PARAMETERS	CORRECTIONAL TREATMENT CENTER MENTAL HEALTH CRISIS BED PROGRAM (MHCB)	DMH PSYCHIATRIC INPATIENT PROGRAMS (ACUTE OR INTERMEDIATE CARE)	ENHANCED OUTPATIENT PROGRAM (EOP)	CORRECTIONAL CLINICAL CASE MANAGEMENT (CCCMS)
1. Main Program Objective	Provide crisis evaluation and stabilize condition of crisis cases for placement in appropriate level of care; provide alternative to hospitalization for inmates who can be stabilized within ten days or less.	Stabilize acute and persistently severe symptoms; improve functioning to enable less restrictive placement.	Provide focused evaluation and treatment of mental health conditions which limit ability to adjust to General Population (GP) placement; return inmate to least restrictive clinical and custodial environment.	Maintain or improve functioning for continued placement in general population or segregated housing units; prompt access to evaluation, diagnosis and treatment; continuity of care; and linkage to institution programs, prerelease, and Parole Outpatient Clinic (POC).
a. Activities of Daily Living	Markedly impaired ability to take care of self, direct assistance necessary; continuous supervision for most.	Many with impaired ability to care for themselves, others need supervision continuously.	Impaired ability in self-care skills ranges from unacceptable, requiring supervision, to erratic or sloppy requiring prompting.	Usually able to care for self, occasional reminders or prompting needed.
2. Admission Criteria a. Overall level of functioning	One of the DSM-IV AXIS I serious mental disorders or medical necessity <u>with</u> marked impairment and dysfunction <u>and/or</u> dangerousness to others as a consequence of SMD/ dangerousness to self requiring 24-hour nursing care; usually results in GAF score of 30 or less.	One of the DSM-IV AXIS I serious mental disorders or medical necessity, <u>and/or</u> dangerousness to others as a consequence of SMD/ dangerousness to self requiring 24-hour intermittent or continuous nursing care; usually results in GAF score of 30 or less.	One of the DSM-IV AXIS I serious mental disorders or medical necessity, and acute onset or significant decompensation, and/or inability to function in general population; usually results in GAF score of 50 or less.	One of the DSM-IV AXIS I serious mental disorders or medical necessity with symptoms well-controlled or at least in partial remission as a result of treatment and inmate able to function in general population or segregated housing unit.
b. Social Interaction	Withdrawn, sometimes extremely; often grossly inappropriate; too impaired to participate in institutional programs.	Acute very often quite withdrawn and grossly inappropriate; subacute often inappropriate but may be able to interact and participate in modified education and work programs.	Some withdrawn, some grossly inappropriate in social and sexual behaviors; may be extremely argumentative and unable to follow staff directions; often unable to participate in institutional programs.	GP inmates able to socialize, communicate needs, comply with treatment, and participate in institutional programs.

PARAMETERS	CORRECTIONAL TREATMENT CENTER MENTAL HEALTH CRISIS BED PROGRAM (MHCB)	DMH PSYCHIATRIC INPATIENT PROGRAMS (ACUTE OR INTERMEDIATE CARE)	ENHANCED OUTPATIENT PROGRAM (EOP)	CORRECTIONAL CLINICAL CASE MANAGEMENT (CCCMS)
c. Dangerousness	Many overtly suicidal or assaultive, often in immediate danger.	Acute often overtly suicidal/assaultive with some in immediate danger; subacute sometimes suicidal/assaultive but no immediate danger.	May have suicidal ideation or be assaultive and require observation and control.	Often minimal problems with suicide or assaultiveness but can be very angry and, depressed.
d. Former Category Classification	New concept; infirmiry admissions.	Category I.	Category J (Usually Intensive and Transitional, sometimes Maintenance).	Category J (Partial and Maintenance); Category U; no category but may be on psychotropics.
3. Services a. Assessment/ Individualized Treatment Planning	Initial treatment plan within 72 hours: comprehensive assessment (history, physical and mental health) within 24 hours; plan includes at least a provisional diagnosis; identifies main presenting problems, measurable objectives, frequencies and providers of prescribed therapies including medications, aftercare plans.	Initial treatment plan completed within 72 hours, master plan within ten days based on comprehensive psychiatric, psychological, and social evaluations; screen for medical problems.	Within 14 days, conduct a review of mental status, psychological and social, criminal history, primary diagnosis, main presenting problems, etc; develop treatment plan with activities, duration, and outcome expectations.	Within five days, conduct Clinical Intake Assessment including mental status, level of functioning, diagnosis; within seven days, develop treatment plan including treatment goals/ objectives and appropriate institutional activities/programs as part of support services.
b. Medication Monitoring	Emergency medication, usually required by crisis cases, when necessary followed by proper legal procedures for involuntary medication (Keyhea).	Direct supervision and monitoring of voluntary and involuntary medications, per DMH procedures.	Medication management provided to improve compliance and responsibility for taking medication.	Usually compliant, regular monitoring provided per established medication monitoring protocols.

PARAMETERS	CORRECTIONAL TREATMENT CENTER MENTAL HEALTH CRISIS BED PROGRAM (MHCB)	DMH PSYCHIATRIC INPATIENT PROGRAMS (ACUTE OR INTERMEDIATE CARE)	ENHANCED OUTPATIENT PROGRAM (EOP)	CORRECTIONAL CLINICAL CASE MANAGEMENT (CCCMS)
c. Nursing	Continuous 24-hour care and/or observation often initially quite intensive.	Continuous, initially intensive, 24-hour care and/or observation of acute; intermittent care for subacute.	Administering medications, routine nursing procedures, and help with managing activities of daily living; prompt access to crisis care, as needed.	Psychiatric nursing care not generally needed.
d. Psychotherapy i. Patient Response	I/Ms in crisis state are usually too unstable; may participate in brief intensive programs when sufficiently stabilized.	Acute often unable to program, need frequent one-to-one and structure; may participate in groups, individual therapy and other treatment programs when sufficiently stabilized.	Some need frequent one to one, structure and limit-setting; may participate in variety of treatment activities including institution programs.	Capable of actively participating in group therapy, individual therapy, self-help activities and institution programs.
ii. Treatment Modalities	Medication and nursing assistance for activities of daily living are needed most; one-to-one brief intensive therapies with focus on issues that precipitated crisis.	In addition to medication and continuous nursing assistance, one to one problem-oriented counseling, recreation and rehabilitation therapies; also therapeutic community, some social skills training, cognitive behavior therapy, some family therapy, limited insight therapy for subacute.	Ten hours per week structured therapy including social skills training, problem-solving skills, substance abuse counseling, offense-specific issues, recreation and rehabilitation therapies, group therapies (anger management, relapse prevention, medication and symptom management, etc.)	Crisis intervention, individual therapy including problem-solving skills and offense-specific issues, some cognitive behavior therapy such as anger management and relapse prevention, family counseling, social skills training, substance abuse treatment will be available
e. Adjunct Services	Too unstable to participate in institution-based adjunct services. Supervised activities shall be provided as clinical needs dictate.	In acute stage, often too unstable to participate; higher functioning I/M-patients may be involved in outside groups (socials, AA/NA, work, education, etc.).	Institutional programs available to GP inmates are available to EOP I/Ms.	Institutional activities such as work, school, religious and library services, self-study are available.

PARAMETERS	CORRECTIONAL TREATMENT CENTER MENTAL HEALTH CRISIS BED PROGRAM (MHCB)	DMH PSYCHIATRIC INPATIENT PROGRAMS (ACUTE OR INTERMEDIATE CARE)	ENHANCED OUTPATIENT PROGRAM (EOP)	CORRECTIONAL CLINICAL CASE MANAGEMENT (CCCMS)
4. Patient Movement a. Referral Sources	Reception center, EOP, CCCMS, GP including staff referral and I/M self referral, segregated housing units.	Institutions with EOP or Mental Health Crisis Beds, via designated DMH hub institution for intermediate care, and directly to CMF for acute care.(Direct referral to CMF from CCCMS approved on a case by case basis).	Mental Health Crisis Beds, Reception Center, DMH inpatient program, and CCCMS.	Reception center, EOP, Mental Health Crisis Beds, DMH, and GP including staff referral and I/M self referral.
b. Clinical Discharge/ Transfer Criteria	Sufficient resolution of symptoms with crisis behavior stabilized to allow continuing treatment in lower level of care; continuing need for inpatient care (more than 10 days) requires transfer to DMH programs.	Sufficient resolution of symptoms to allow placement in outpatient treatment.	Optimal treatment benefit reached and ability to function in GP with or without outpatient care; marked decompensation, dangerousness to self/others leads to more intensive level of care.	Remission for one year without treatment, including medication, leads to clinical discharge to nonpatient status; deterioration in clinical status results in transfer to a higher level of care for more intensive services.
c. Aftercare	Usually, EOP or DMH inpatient; occasionally Correctional Clinical Case Management for a long-term or short-term.	Often, DMH acute to intermediate care; usually, DMH to EOP; occasionally, CCCMS or POC when paroled directly.	Usually Correctional Clinical Case Management when improved or I/M is returned to Mental Health Crisis Beds or DMH inpatient; direct parole release with POC follow-up.	Usually clinical discharge to nonpatient status; may return to EOP or Mental Health Crisis Beds or parole with POC follow-up.
d. Length of Stay	Ten days or less or stabilize for transfer; if needed, immediate transfer to DMH.	Up to 60 days for acute, nine months for subacute.	Usually four to six months; may be indefinite for stable, low-functioning chronic cases.	Clinical discharge to nonpatient after one year of stable remission without treatment; indefinite while on medication.

PARAMETERS	CORRECTIONAL TREATMENT CENTER MENTAL HEALTH CRISIS BED PROGRAM (MHCB)	DMH PSYCHIATRIC INPATIENT PROGRAMS (ACUTE OR INTERMEDIATE CARE)	ENHANCED OUTPATIENT PROGRAM (EOP)	CORRECTIONAL CLINICAL CASE MANAGEMENT (CCCMS)
5. Quality Management System	Medication emphasis requires M.D.; nursing assistance and monitoring essential; RT support for supervised leisure activities.	M.D., RN for acute; Ph.D., PSW for subacute with RT and M.D. support.	Treatment focus best served by Ph.D., PSW and Recreation/ Rehabilitation Therapists (RTs); psychiatric support by MD's.	Usually, P SW. and Ph.D for case management; with M.D. support.
a. Primary Treatment Responsibility				
b. Staffing Ratio	One mental health staff for every patient; staffing set by regulations.	One mental health staff for every patient; staffing set by regulations.	About one mental health service provider for every 5-10 patients, depending on program size.	One case manager for every 100 cases plus support from psychiatrist; staff enhancements for SHU.
c. Clinical Contacts	Daily monitoring and assessment.	Daily to weekly.	Daily for new inpatient releases; weekly for stable and chronic cases.	At least quarterly face-to-face contacts with case manager; daily to weekly, as needed.
d. Clinical Case Reviews	Ongoing evaluation for first 24 to 72 hours; thereafter, twice weekly review for stable cases or as needed.	Monthly for acute; quarterly for subacute.	At least quarterly.	At least annually; before transfer to higher level of care or when clinical discharge is imminent.
e. Suggested Performance Indicators	LOS, admission/discharge measure of functionality.	Indicators from Utilization Management process including LOS.	Length of stay (LOS), functionality measure (e.g., GAF), medication compliance.	LOS to nonpatient status; percentage returned to inpatient or EOP; LOS to return date; annual measure of functionality.



SECTION 3: RECEPTION CENTER MENTAL HEALTH ASSESSMENT

A. Program Overview

The program to improve the reception center assessment of inmates for mental health needs is the first step in a multi-year plan to improve clinical services for seriously mentally disordered inmates under commitment to the California Department of Corrections (CDC).

By enhancing and standardizing screening and evaluation efforts at the entry point into the prison system, the Department can best assure that all inmates in need of mental health treatment are identified and provided necessary services at the earliest possible time. Early and easy access to care has been shown to have both therapeutic as well as fiscal benefits in managing mental illness at its lowest level of acuity. This is particularly true in the high stress environment of a prison setting.

This project utilizes the \$1.9 million in budget allocations for 30 additional clinical and clerical positions to achieve the following objectives:

1. Provide a standardized system for universal screening of all inmates received in the CDC for possible symptoms of mental disorder or suicide risk.
2. Conduct in-depth clinical evaluations of individuals identified in the screening process for diagnosis of serious mental disorder, level of functioning, and necessary level of care.
3. Develop an automated data processing system to track inmates through the screening and evaluation process and provide a clinical profile of the identified treatment population to be utilized in program planning.

It is important to emphasize that the population in this program seeks to identify is defined as those inmates who are dysfunctional in the prison environment as a result of a serious mental disorder. Specifically, these are inmates with a Diagnostic and Statistical Manual Axis I diagnosis, with current symptoms, or evidence of medical necessity. Inmates with this diagnosis who are able to function at higher levels as a result of the use of psychotropic medications are also included. Inmates suffering suicidal ideation may also receive crisis care to protect life. Mental health intervention is also provided to treat significant disability/dysfunctionality in an individual diagnosed with or suspected of having a mental disorder.

Commonly regarded mental health issues which may be identified in the screening process, but which are not included in the treatment services provided by the Department's mental health treatment programs are sexual and substance abuse disorders, personality disorders, and developmental disorders, unless these conditions are also accompanied by an Axis I serious mental disorder.

Due to the priority of need for this project, the Director of Corrections has indicated that the staff additions are authorized to be filled during the later quarter of Fiscal Year (FY) 1993/94. The new policies and procedures with the preliminary phase of the data processing system will be implemented during the first quarter of FY 1994/95. The full system, including the ability to begin direct placement of inmates into new programs for crisis care and clinical case management at general population institutions should be implemented by the close of the second quarter of FY 1994/95.

An overview of the new reception center screening and evaluation process is presented on the following page. Full descriptions of all of the program elements is presented in succeeding pages.

B. Policies And Procedures For Assessment Of Mental Health Needs

Goal and Target Population: To identify and assign an appropriate level of care to inmates who are suicidal or are experiencing impaired functioning as a result of serious mental disorder.

Policies To Achieve Goal:

1. All inmates will be screened within 24 hours of arrival for need for continuation of currently prescribed and used psychotropic medications or need for crisis psychiatric care.
2. All inmates will receive a Mental Health screening within the first seven calendar days of arrival to identify mental health concerns which may indicate a need for treatment.
3. All inmates with possible mental health treatment needs will receive a standardized psychological evaluation within 18 calendar days of arrival, and prior to any placement decision.
4. All inmates who request a clinical interview will receive one.
5. Any Reception Center Staff may refer any inmate for clinical interview at any time.
6. All mental health screening and evaluation interviews shall be conducted in a private setting.

7. All Psychological evaluations will conclude with a provisional diagnosis, level of functioning, and recommended level of care placement, if required.
8. Basic treatment will be provided to inmates while awaiting transfer.
9. In order to facilitate long range planning, each reception center will accumulate and regularly report data on all inmates screened, evaluated, and determined to be in need of particular levels of treatment.

Procedures To Implement Policies

1. Bus Screening of Inmates at Receiving and Release.

Upon arrival at the Reception Center, Medical Technical Assistants, or equivalent staff, who have been trained in the procedures for mental health referrals, will review available documentation from committing jurisdictions regarding mental health treatment, including medications, provided at County facilities, or observed behavior which may be indicative of a need for such treatment. All inmates will be interviewed, utilizing a standard set of questions (Attachment #1 with instructions on Attachment 1A) regarding their medication needs or need for immediate referral for crisis care. This interview shall be conducted in an environment which is sufficiently private to encourage honest responses. Where such a need for emergency or urgent psychiatric review is identified, a direct referral will take place, utilizing a standard referral 128B chrono (Attachment #2; original to psychiatrist with copy to mental health office for data entry and filing). These Chronos should be "flagged" or in some appropriate manner designated for urgent attention. Emergency or urgent reviews will be conducted immediately (within 24 hours) and facilitated telephonically, if necessary. Observation of possible mental health symptoms not requiring emergency attention may also be documented on a staff referral chrono forwarded to the mental health office for future reference and clinical evaluation. Information from committing counties relating to a need for mental health care or assessment are to be placed in the inmate Unit Health Record for the same purpose.

2. Physical Exam

Within three working days of arrival, all inmates undergo a physical examination and evaluation of medical history. Any mental health issues which become apparent in the interviews of the physician or medical technical assistant conducting these reviews, will be documented on staff referral Chronos (Attachment #2) for subsequent mental health evaluation. Emergency or urgent cases requiring crisis care or medication review will be immediately referred for psychiatric evaluation, also utilizing "flagged" staff referral Chronos directed to the institutional psychiatrist with copies to the mental health office. Evaluations in these emergency or urgent cases shall be conducted within 24 hours.

3. Mental Health Screening

Within seven calendar days of arrival at the reception center, all inmates (new commitments and parole violators) will receive a screening for possible mental health needs. They will be individually interviewed by a psychologist (or other master's level mental health clinician trained on the screening instrument), who will explain the purpose of the screening process, and assess the inmate's ability to complete the interview. Inmates who are unable to speak English will be provided with necessary interpreters. Inmates who refuse to participate in the mental health screening interview shall be referred for a psychological evaluation to determine if they have a mental disorder. Individuals who are unable to participate in the screening interview due to possible acute psychiatric distress will be immediately referred for crisis care. This will normally include a referral for an emergency psychiatric evaluation (see section E).

Following completion of the screening interview, the completed screening form will be forwarded to the mental health data processing station for analysis. The results of this computer assessment will be documented on a 128C chrono (Attachment #3). Refusals to participate and any need for an interpreter will also be documented on this chrono. Each case will be cleared for general population placement, scheduled for a full Psychological evaluation within 18 calendar days, or immediately referred for crisis care, as needed.

Information from the Screening Form will be retained in the automated system for future reference and data compilation.

4. Psychological Evaluations

Inmates referred for psychological evaluation who have been identified in the initial mental health screening as having a possible mental health need or who refused the screening will be scheduled for a full psychological evaluation to be completed by the 18th calendar day after arrival. Preparatory to the evaluation, the inmate's Unit Health Record and Central Files will be made available for review by the clinician. The results of the clinical screening assessment, including working diagnosis, will be reviewed, as will any information generated from staff or self-referrals to that point. If the inmate states that he or she had significant prior treatment or the file review indicates history of such treatment, the clinician shall request that the inmate sign a Release of Information in an attempt to obtain previous records.

The psychologist will conduct an individual interview with the inmate in a private setting. Where possible, the psychologist will utilize a computer terminal for reference and input in completing the evaluation. Identifying information already available in the computer will be verified in the file review and inmate interview.

The Psychological evaluation will be recorded on the form presented in Attachment #4, and explained in Attachment 4A. The psychologist will obtain and input a brief narrative of the presenting problem and historical information of relevance from the files and interview. A mental status examination and assessment of level of functioning will be completed, with the results directly entered into the computer on pre-programmed screens (or hard copy forms, where automated systems are not yet available). A provisional diagnosis will be noted and, where this includes a Diagnostic and Statistical Manual (DSM) Axis I condition, a level of functioning assessment will also be provided.

After arriving at a diagnosis and functioning assessment, the psychologist will determine need for treatment and recommend a level of care, based upon the level of acuity and treatment program criteria set forth on Attachment #6. Where possible needs for psychotropic medication are present, and no current prescription has been made, a referral to the psychiatrist will be made. A copy of the completed evaluation with a request for medication assessment will be provided to the psychiatrist, whose decision regarding the medication needs will be entered into the completed case summary and inmate Unit Health Record. An initial treatment plan pending transfer to an appropriate level of care will also be provided by the psychologist and, where medication or crisis care is necessary, the psychiatrist. Once determined by mental health clinician, inmates who are acutely psychotic or suicidal shall be referred for placement in crisis beds or emergency transfer to the Department of Mental Health facility at the California Medical Facility.

Inmates who have no diagnosed mental illness, or whose current level of functioning is adequate without need for treatment (including psychotropic medications) will be cleared for general population placement.

Inmates who are seen by the psychologist as a result of a staff or self-referral after the completed evaluation will be assessed for necessary adjustments to the original evaluation or treatment plan. Where such adjustments are indicated, new documentation will be generated.

Following entry of all elements of the psychological evaluation into the automated system, a "hard copy" report will be generated for the inmate Unit Health Record.- A brief summation of this report in CDC 128C format (Attachment #7 with instructions on Attachment #7A) will be provided for the Central File, with copies to the correctional counselor and inmate. These will be completed whether the inmate requires treatment or is cleared for general population placement. The original document will be signed by the clinician completing the evaluation.

If an inmate refuses to participate in the psychological evaluation interview, the clinician shall review the Central File, Unit Health Record, and reports from housing officers and/or other staff, and make clinical observation of the inmate. Clinicians shall make an effort to resolve refusal cases by the end of the 18 calendar day evaluation period. In those rare

situations where these cases cannot be resolved during the 18 calendar day evaluation period, the clinician shall document this in the placement chrono. The clinician shall include a description of what efforts were made to complete the evaluation (e.g., review Central File and Unit Health Record, consult with housing officers, etc.) and a recommendation of how to proceed with the case. The Chief Psychiatrist at the institution reviews all refusals and approves the clinician's recommendations for placement.

5. Psychiatric Evaluations

Psychiatric Evaluations will primarily address the issues of need for acute care and initiation or continuation of psychotropic medications. Review of need for continuation of medications prescribed prior to commitment to prison will normally occur within 24 hours of intake. A medication specific informed consent with signatures of psychiatrist and inmate will be completed in each case. Documentation of psychiatric evaluations will be provided in a standard format (Attachment #9), which will be placed in the inmate Unit Health Record, and completion of a 128C Psychiatric Evaluation Chrono (Attachment #5) for entry into the central file. Inmates requiring follow-up psychiatric care while awaiting transfer will be scheduled for that purpose, with documentation of clinical contacts recorded in the inmate Unit Health Record progress notes. Changes in mental status which impact placement decisions will also be documented on 128C Psychiatric Evaluation Chronos.

6. Staff and Self Referrals

At any time during the Reception Center process, an inmate may refer himself or herself, or be referred by any staff member for a review by a mental health clinician. Referrals will be made on standardized forms (Attachments #2 and #8), and forwarded to the mental health office. All referrals will be entered into the data system to assure responses, and facilitate scheduling.

Crisis cases and medication issues identified by medical staff will be immediately referred to the psychiatrist. Referrals from other staff and all inmate self referrals will be reviewed by psychologists by the next working day. A clinical interview will be scheduled and initiated in a timeframe clinically determined appropriate. Results of interviews will be documented (Attachment #3). Copies of staff referral forms and responses shall be placed in both the Central File and Unit Health Record for future reference. Staff members initiating referrals may be contacted directly, as necessary. Inmate self referral forms shall be kept confidential, and the results of these interviews documented as deemed appropriate by the clinician.

7. Classification File Review

A comprehensive review of the central file of all inmates returned to prison for violation of parole (with or without a new term) will be conducted by correctional counselors, when such files are obtained from parole authorities. This file review will include a review of any past mental health issues (suicide attempts, placement in treatment programs, reports of behavior possibly indicative of mental health problems). Prior criminal histories and current commitment offense records on all inmates will also be reviewed for indications of mental health needs. A face to face interview will also be conducted, in which any indications of a need for assessment will be noted. Specific issues which require current evaluations will be noted on staff referral forms (Attachment #2), which will be forwarded to the mental health unit. Completed psychological evaluations will be reviewed to assure prior mental health issues have been addressed in the current assessment. Clinical recommendations for treatment will be utilized in determining recommendations for specific institutional placements.

8. Placement Decisions

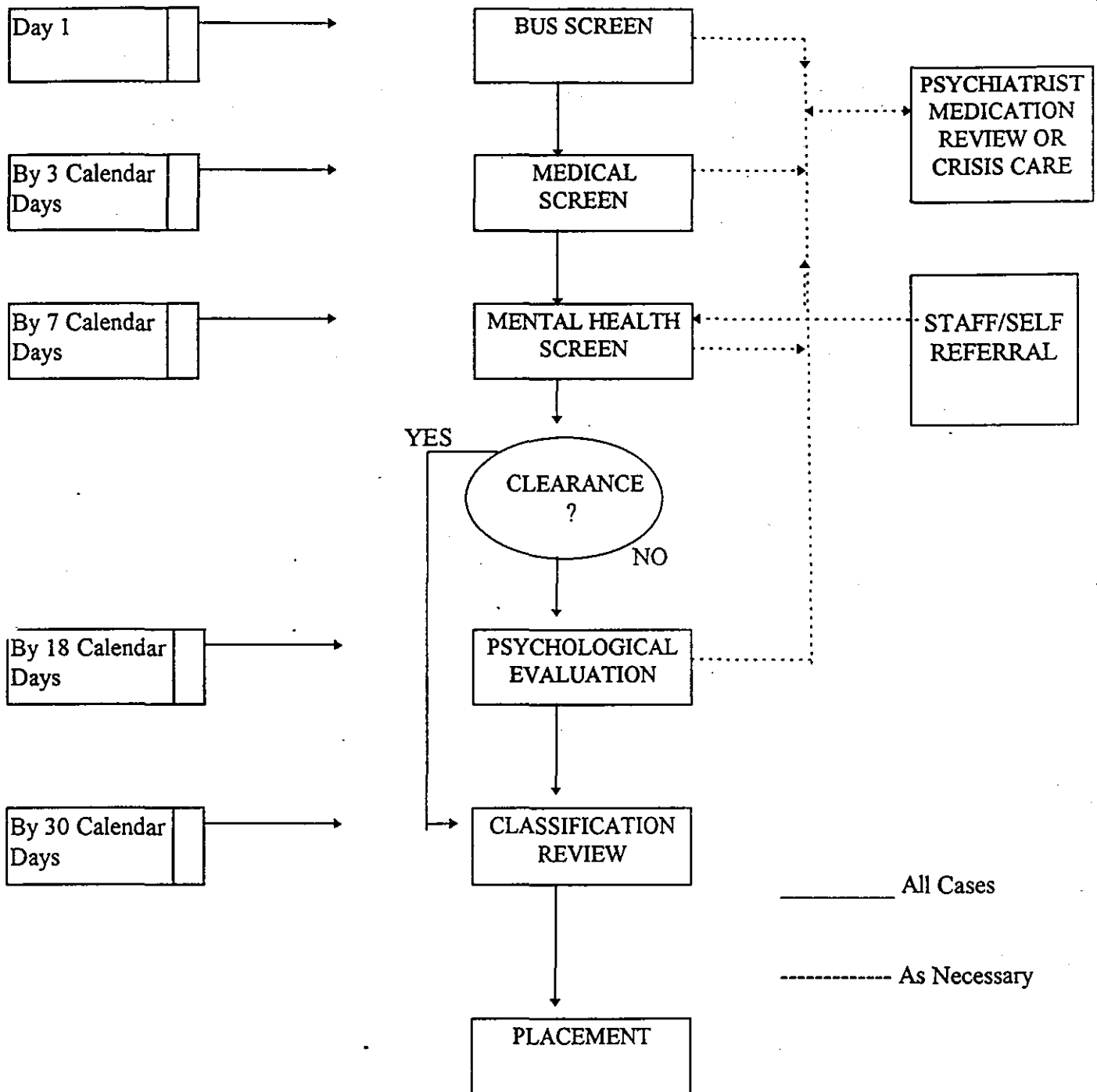
The completed case file with results of mental health evaluations will be reviewed by Classification Staff Representatives for final placement decisions. Where treatment is required, the decision will necessitate placement in an institution with the availability of the recommended level of care (inpatient, crisis care, enhanced outpatient, or clinical case management).

9. Data Processing

A data processing station within mental health services at each Reception Center will process screening assessments, receive all referrals for evaluation, schedule clinicians to conduct evaluations, process (type, record, distribute) completed evaluations, track inmates through the stages of assessment, and submit periodic summaries of required data to institutional administrative staff and headquarters. It is important to emphasize that, in order to ensure the accurate collection of data, the system will be utilized by appropriately trained CDC staff and will provide adequate safeguards to protect the security and confidentiality of the data.

C. Attachments

RECEPTION CENTER MENTAL HEALTH PROCESS



STANDARDIZED BUS SCREENING FORM (All Institutions)

Form _____

Inmate Name: _____ CDC Number: _____ Date of Birth ____/____/____

Receiving Institution: _____ Sending Institution: _____ Arrival Date: ____/____/____

Questions To Be Answered By The Inmate:**CIRCLE ONE**

1. Are you currently under a doctor's care for medical, dental or psychiatric reasons? Yes No
If yes, for what? _____
2. Are you taking any medications? Yes No
If yes, what are the medications? _____
3. Do you have any special health care needs? Yes No
Please describe them. _____
4. Do you have any of the following: (Indicate with a check) Yes No
Cough ☐ Fever ☐ Night Sweats ☐ Unexplained weight loss ☐
5. Do you have any physical deformity or disability? Yes No
Please describe. _____
6. Do you have any allergies? Yes No
Explain _____
7. Have you ever been treated for mental illness? Yes No
8. Are you thinking of committing suicide now or have you ever attempted suicide? Yes No
Do you have a current desire to hurt yourself or others? Yes No
10. Do you have a current mental health problem? Yes No

Questions To Be Answered By Female Inmates Only:

11. Are you pregnant? Yes No
Specify _____ Weeks _____ Months
12. Are you on methadone now? Yes No
13. Date of your last menstrual period? _____
14. Are you taking hormones or birth control pills? Yes No

RN, LVN or MTA Observation:

15. Does the inmate have visible signs of withdrawal, physical or mental illness? Yes No
16. Are there visible signs of lice or crabs? Yes No
17. Does inmate behavior suggest a danger to self or others? Yes No
18. Does the inmate appear disoriented to time, place, or person? Yes No

If the inmate answered yes to any question, contact an RN for an assessment and disposition.**LVN/MTA Disposition:** Release to Custody ☐**RN Disposition:** Referral: ☐ Immediate ☐ Within 24 hours ☐ Within 72 hours to: __________
RN, LVN or MTA Signature_____
Date

HEALTH RECORD REVIEW FORM (Intradepartmental Inmate Transfers Only)

JC Form _____

Inmate Name: _____ CDC Number: _____ Date of Birth ____/____/____.

Receiving Institution: _____ Sending Institution: _____ Arrival Date: ____/____/____.

To be completed by health care staff following the health record review

Review of Chronos (CDC Form 128C-1)

Yes

☐

No

☐

TB Code: _____

Special Needs (Refer to appropriate health care provider):

☐ Housing

Refer to: _____

☐ Dental

Refer to: _____

☐ Medical

Refer to: _____

Mental Health

Refer to: _____

☐ Other

Refer to: _____

Disposition:

Release to Custody ☐

Referral:

☐

Immediate

☐

Within 24 hours

☐

Within 72 hours

to: _____

Health Record Review (Check One):

☐ MTA☐ RN☐ MD/DO

Print Name

Signature

Date

STANDARDIZED BUS SCREENING

POLICY:

All inmates committed to a California Department of Corrections (CDC) institution or transferred from one institution to another shall be screened by a Registered Nurse (RN), Licensed Vocational Nurse (LVN) or a Medical Technical Assistant (MTA) for health care needs. The RN, LVN or MTA shall initiate the inmate screening within one hour of Receiving and Release (R&R) notification of the inmate's availability. The attached Standardized Screening Form shall be used by each institution and shall not be modified.

PURPOSE:

To identify inmates with health care needs in a timely manner. To ensure uniformity and standardization in screening inmates for health care needs. The attached Standardized Bus Screening Form shall combine, update and replace the CDC Form 7277 (Health Screening for New Commitment Inmates) and the CDC Form 7278 (Health Screening for Inmate Intradepartmental Transfers).

PROCEDURE:

1. The Standardized Screening Form shall be completed for all newly committed or returned inmates and inmates transferred between institutions.
2. All inmates in the receiving R&R shall be requested by a RN, LVN, or MTA to individually respond to Questions 1 through 10 (or Questions 1 through 14 for female inmates) on the Standardized Bus Screening Form. The RN, LVN, or MTA may discuss each question with each inmate, or discuss each question with the inmates in a group setting. If the screening is conducted in a group setting, the RN, LVN or MTA shall provide each inmate with a copy of the Standardized Bus Screening Form and request each inmate to circle yes or no after each question. The inmate's response to the bus screening shall be kept confidential. If any inmate does not read, write or understand English, the RN, LVN or MTA shall provide assistance or arrange to have an interpreter explain each question and the inmate's response on the Standardized Bus Screening Form.
3. If the inmate answered yes to any question on the Standardized Screening Form, an RN shall conduct an assessment to determine if a physician should be contacted immediately. A physician may conduct the assessment in the absence of an RN.
4. The RN, LVN or MTA conducting the standardized screening shall complete the bottom portion of the Standardized Screening Form, sign and date each form. A physician may sign for the RN, LVN or MTA.
5. The completed Standardized Screening Form shall be placed in the inmate's health record.
6. All inmates in need of prescription medications shall be referred to a physician for medication orders.
7. Inmates with chronic health care needs shall be referred to an appropriate health care provider within twenty-four (24) hours.
8. Mainline institutions screening intradepartmental inmate transfers shall also review the health record and complete the Health Record Review Form within twenty-four (24) hours.

1/24/96

REQUEST FOR MENTAL HEALTH SERVICES
STAFF REFERRAL

NAME: _____ CDC#: _____ HOUSING: _____
LAST FIRST MI

REASON FOR REFERRAL: (Please check the primary reason(s) and give an example or comment on the lines below)

- | | |
|--|---|
| ☐ History of Psychiatric care needs re-assessment | ☐ Need Psychotropic medication review |
| ☐ Expresses suicidal ideation or recent attempts | ☐ Exhibits bizarre behavior (describe below) |
| ☐ Incapable / unwilling to care for self | ☐ Poor appetite / sad / fearful / nervous |
| ☐ Confused / disoriented / withdrawn | ☐ Poor self control / unpredictable / bothers others |
| ☐ Unprovoked hostility / assaultiveness | ☐ Hears thing / sees things / imagines things |

Describe: _____

REFERRED BY: _____ TITLE: _____ SIGNATURE _____ PHONE: _____ DATE _____

Referral received at Mental Health by: _____ Date: _____ Action: _____

DC 128B

REQUEST FOR MENTAL HEALTH SERVICES
STAFF REFERRAL

NAME: _____ CDC#: _____ HOUSING: _____
LAST FIRST MI

REASON FOR REFERRAL: (Please check the primary reason(s) and give an example or comment on the lines below)

- | | |
|--|---|
| ☐ History of Psychiatric care needs re-assessment | ☐ Need Psychotropic medication review |
| ☐ Expresses suicidal ideation or recent attempts | ☐ Exhibits bizarre behavior (describe below) |
| ☐ Incapable / unwilling to care for self | ☐ Poor appetite / sad / fearful / nervous |
| ☐ Confused / disoriented / withdrawn | ☐ Poor self control / unpredictable / bothers others |
| ☐ Unprovoked hostility / assaultiveness | ☐ Hears thing / sees things / imagines things |

Describe: _____

REFERRED BY: _____ TITLE: _____ SIGNATURE _____ PHONE: _____ DATE _____

Referral received at Mental Health by: _____ Date: _____ Action: _____

DC 128B

REQUEST FOR MENTAL HEALTH SERVICES
STAFF REFERRAL

NAME: _____ CDC#: _____ HOUSING: _____
LAST FIRST MI

REASON FOR REFERRAL: (Please check the primary reason(s) and give an example or comment on the lines below)

- | | |
|--|---|
| ☐ History of Psychiatric care needs re-assessment | ☐ Need Psychotropic medication review |
| ☐ Expresses suicidal ideation or recent attempts | ☐ Exhibits bizarre behavior (describe below) |
| ☐ Incapable / unwilling to care for self | ☐ Poor appetite / sad / fearful / nervous |
| ☐ Confused / disoriented / withdrawn | ☐ Poor self control / unpredictable / bothers others |
| ☐ Unprovoked hostility / assaultiveness | ☐ Hears thing / sees things / imagines things |

Describe: _____

REFERRED BY: _____ TITLE: _____ SIGNATURE _____ PHONE: _____ DATE _____

Referral received at Mental Health by: _____ Date: _____ Action: _____

DC 128B

Reception Center: _____

MENTAL HEALTH SCREENING

CDC#: _____ HOUSING: _____

This inmate has completed a routine mental health screening and is:

- ☐ Cleared for general population (no restrictions). ☐ Referred for further evaluation. ☐ Referred for crisis care.
☐ Able, but unwilling to participate in clinical assessment.

☐ This inmate was interviewed after ☐ staff ☐ self referral on ____/____/____, and the following action was taken:

- ☐ Cleared for continued programming. ☐ Referred for further evaluation.
☐ Other: _____

☐ This inmate is non English speaking. Primary language: _____

Clinician's Name (Print) _____ Phone / Extension _____ Clinician's Signature _____ Date _____

DC 129C

Reception Center: _____

MENTAL HEALTH SCREENING

NAME: _____ CDC#: _____ HOUSING: _____

☐ This inmate has completed a routine mental health screening and is:

- ☐ Cleared for general population (no restrictions). ☐ Referred for further evaluation. ☐ Referred for crisis care.
☐ Able, but unwilling to participate in clinical assessment.

☐ This inmate was interviewed after ☐ staff ☐ self referral on ____/____/____, and the following action was taken:

- ☐ Cleared for continued programming. ☐ Referred for further evaluation.
☐ Other: _____

☐ This inmate is non English speaking. Primary language: _____

Clinician's Name (Print) _____ Phone / Extension _____ Clinician's Signature _____ Date _____

DC 129C

Reception Center: _____

MENTAL HEALTH SCREENING

NAME: _____ CDC#: _____ HOUSING: _____

☐ This inmate has completed a routine mental health screening and is:

- ☐ Cleared for general population (no restrictions). ☐ Referred for further evaluation. ☐ Referred for crisis care.
☐ Able, but unwilling to participate in clinical assessment.

☐ This inmate was interviewed after ☐ staff ☐ self referral on ____/____/____, and the following action was taken:

- ☐ Cleared for continued programming. ☐ Referred for further evaluation.
☐ Other: _____

☐ This inmate is non English speaking. Primary language: _____

Clinician's Name (Print) _____ Phone / Extension _____ Clinician's Signature _____ Date _____

DC 129C

RECEPTION CENTER MENTAL HEALTH EVALUATION: Page 1 of 3; Date ____/____/____ Critical Issue ☒

I. IDENTIFYING INFORMATION

Arrival date this RC: ____/____/____ Ethnicity: ☐ Non-English ☐ English ☐

Data Source (s): ☐ Interview ☐ Central File ☐ Unit Health Record ☐ Outside _____

II. BASIS OF REFERRAL/PRESENTING PROBLEM

Screening Report: ☐ Possible Thought Disorder ☐ Possible Mood Disorder ☐ Possible Major Depression

☐ Possible Suicidality ☐

Staff Referral: ☐ History of Mental Illness ☐ Medication Review ☐ Danger to self ☐

Self Referral: ☐ (State reason) _____

☐ Other Behavioral Signs or issues. Describe (include self referral detail): _____

_____ ☐

III. MENTAL HEALTH HISTORY: (If it is normal, check normal or none, if a deviation, check yes and explain.)

A. Developmental Problem ☐ Normal ☐ Abnormal _____ ☐

B. Marital: circle: S / M / D / W _____ ☐

C. Work History: ☐ None ☐ Some ☐ Erratic ☐ Extensive _____ ☐

D. Mental Health History: ☐ None known ☐ Yes _____ ☐

E. Issues and Problems _____ ☐

1. Psychiatric Hospitalizations..... ☐ None OR ☐ Yes _____

2. Psychotropic Medication _____

in the last 2 years ☐ None OR ☐ Yes _____

3. Outpatient Treatment ☐ None OR ☐ Yes _____

4. MH Treatment while _____

incarcerated/paroled:... ☐ None OR ☐ Yes _____

5. History of Substance Abuse..... ☐ None OR ☐ Yes _____

6. Release of information requested..... ☐ Yes _____ ☐ No

F. Suicidal Behavior..... ☐ None ☐ Present

1. History ☐ None ☐ Present

☐ Describe _____ ☐

G. Violent Behavior ☐ None ☐ Present

1. History ☐ None ☐ Present

☐ Describe _____ ☐

**MENTAL HEALTH ASSESSMENT:
RECEPTION CENTER
MENTAL HEALTH EVALUATION**

MH 7 [3/22/96]

Page 1 of 3

Use Insert-a-Page of MH 1
Confidential Client/Patient Information
See W & I Code, Section 5328

**LEVEL OF
CARE**

Inpatient

Outpatient

Last Name: _____ First Name: _____ MI: _____

CDC # _____ DOB ____/____/____

IV. CURRENT MENTAL STATUS: ("Within- Normal-Limits" = WNL; Describe Deviations)		Critical ☒
A. Appearance..... ☐ WNL	☐	
B. Behavior ☐ WNL	Speech ☐ WNL	☐
C.. Mood ☐ WNL	☐	
1. Sleep..... ☐ WNL		
2. Appetite..... ☐ WNL		
3. Affect ☐ WNL		
D. Cognition:	☐	
1. Fund of Information..... ☐ WNL		
2. Intellectual Functioning ... ☐ WNL		
3. Organization of Thought.. ☐ WNL		
4. Association of Thought.... ☐ WNL		
5. Reality Contact..... ☐ WNL		
6 Thought Quality ☐ WNL		
E. Perception Disturbance (Hallucination) ☐ None	☐	
F. Thought Content (Delusions, Preoccupation) .. ☐ None	☐	
G. Sensorium (Orientation, Memory, Attention, Concentration)..... ☐ WNL	☐	
H. Insight and Judgment ☐ WNL	☐	
I. Interview Attitude..... ☐ WNL	☐	
J. Current Suicidality..... ☐ None	☐	
K. Current Violence Risk..... ☐ None	☐	
Discussion:		
Is Substance Abuse an issue? ☐ No ☐ Yes		
☐		

MENTAL HEALTH ASSESSMENT: RECEPTION CENTER MENTAL HEALTH EVALUATION MH 7 [3/22/96] Page 2 of 3 Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	<table style="width: 100%;"> <tr> <td style="width: 33%;">Last Name:</td> <td style="width: 33%;">First Name:</td> <td style="width: 33%;">MI:</td> </tr> <tr> <td colspan="3" style="height: 40px;"></td> </tr> <tr> <td colspan="3"> CDC # _____ DOB ____/____/____ </td> </tr> </table>	Last Name:	First Name:	MI:				CDC # _____ DOB ____/____/____		
Last Name:	First Name:	MI:									
CDC # _____ DOB ____/____/____											

V. DSM IV Numerical - (Diagnosis, including provisional diagnosis and degree of uncertainty.)		
Axis I.	#	
	#	
	#	
Axis II.	#	
	#	
Axis III.		
Axis IV.	(current)	
VI. NEED FOR TREATMENT/LEVEL OF CARE:		
Axis V.	GAF= _____ Score based on: ☐	
Treatment Motivation: _____		
☐ DOES NOT MEET CRITERIA FOR INCLUSION IN THE MH TREATMENT POPULATION		☐ MEETS CRITERIA FOR INCLUSION IN THE MH TREATMENT POPULATION (SEE LOC BELOW)
Evaluations: ☐ Crisis Eval. ☐ Medication Eval. ☐ Psychological Testing ☐ Other, describe below		
Recommended CDC Setting: ☐ GP ☐ CCCMS ☐ EOP ☐ MHCB ☐ DMH DDPS # _____		
Rationale: _____		
Initial Treatment Plan (Include medication(s) target symptom & dose prescribed):		
Evaluation Follow up: (Who and When)		
Medication Follow up: (Who and When)		
Reception Center Mental Health Evaluation Completed by:		Date: _____
Clinician Name: _____		Clinician Title: _____
Clinician Signature: _____		Telephone: () Ext.: _____

MENTAL HEALTH ASSESSMENT: RECEPTION CENTER MENTAL HEALTH EVALUATION MH 7 [3/22/96] Page 3 of 3 Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	<table style="width: 100%;"> <tr> <td style="width: 33%;">Last Name:</td> <td style="width: 33%;">First Name:</td> <td style="width: 33%;">MI:</td> </tr> <tr> <td colspan="3" style="height: 40px;"></td> </tr> <tr> <td>CDC # _____</td> <td colspan="2">DOB ____/____/____</td> </tr> </table>	Last Name:	First Name:	MI:				CDC # _____	DOB ____/____/____	
Last Name:	First Name:	MI:									
CDC # _____	DOB ____/____/____										

FORM NAME: RECEPTION CENTER MENTAL HEALTH EVALUATION

I. Identifying Information:

Enter arrival date to this Reception Center, followed by the ethnicity of the inmate and the ability to speak English and understand English. On the next line enter the source(s) of data for the evaluation by check (✓).

II. Basis of Referral / Presenting Problem:

Check the appropriate box from the routine reception center screening. Check (✓) one or more of the basic issues: Thought disorder, mood disorder, major depression, possible suicidality.

Next, indicate the nature of any staff referral, if present, by a check (✓): History of mental illness, need for a medication review, the inmate appears to be a danger to self, other behavioral sign that justifies a referral for a Reception Center Mental Health Evaluation. On cases in which an evaluation is being conducted on the basis of an inmate request (self referral), the specific inmate complaint should be noted.

III. Mental Health History:

This list of six history areas (A through G) are each self explanatory. At the end of any line, check (✓) if that line contains a critical issue that leads to a referral to a mental health level of care. If more space is needed use the Insert-a-page of the MH 1 Form set. In the lower right hand corner, if an address-o-graph plate system is not available, print all data requested.

IV. Current Mental Status:

The Mental Status items are arranged to be consistent with the other CDC mental health forms that contain Mental Status Examinations. In this Reception Center form, check (✓) items that are within normal limits, otherwise explain deviations of the item. On the right hand margin do a critical item check (✓) if the item is a deciding factor in a referral to a Mental Health Treatment Setting. At the end of the Mental Status Evaluation give a brief discussion of the findings/conclusions. In addition, note if there is a Substance Abuse issue present and if the Criminal Justice Substance Abuse programs may have application.

V. DSM IV:

Three lines are available for listing an Axis I, two lines for an Axis II, and one line for an Axis III and Axis IV (current). The Reception Center is at the beginning of a potentially lengthy diagnostic process. **Provisional diagnosis is often preferred over a definitive diagnosis unless the degree of diagnostic certainty is high.** A provisional Axis I sets the stage for a treatment setting transfer in conjunction with the GAF score.

VI. Need for Treatment / Level of Care:

In determining the GAF score, make note what the individual's overall level of functioning is based. GAF is useful in determining what level of treatment is warranted, planning the treatment, measuring its impact, and predicting the outcome. Make note of the **treatment motivation** of the inmate. The next item forces the selection by check (✓) whether the inmate "Does NOT meet the criteria for inclusion in the Mental Health Population" or the inmate/patient "MEETS the criteria for inclusion in the Mental Health Treatment Population." Following the above, check any special evaluation items, and describe if additional detail is needed. Then recommend the CDC Treatment Setting Level of Care by check (✓). Space is

FORM NAME: RECEPTION CENTER MENTAL HEALTH EVALUATION

provided for defining this Treatment Level by a DDPS Code. Such recommendations must be noted in a 128 C. At this stage, the inmate either moves on to the General Population or is transferred to a Mental Health Treatment Setting. In the case of the latter the remainder of the form is completed by giving a brief rational for an Interim Treatment Plan, detailing the Treatment Plan and noting specific Evaluation (Treatment) and Medication Follow Up Plans. (This includes a referral to the psychiatrist for possible medication needs, if not previously reviewed, or for a second clinical opinion.) The interim treatment plan is one that is carried out while the inmate/patient waits for transfer from the Reception Center to the specified Mental Health Treatment Setting. Close the MH 7 with a completion date, the clinician's name and a telephone contact.

Revised 3/22/96 c:\mhi-mh7.doc/eal

RECEPTION CENTER PSYCHIATRIC EVALUATION

NAME: _____ CDC#: _____ INST: _____ HOUSING: _____
 LAST FIRST MI

This inmate received an assessment for need for psychiatric medication on ____/____/____. The result of this assessment is:

- ☐ Placed on medication (specify): _____
☐ No medication required.

☐ This inmate was assessed for need for crisis psychiatric care on ____/____/____. The result of this assessment is:

1. ☐ Placed in crisis bed for emergency care.
2. ☐ Referred for emergency inpatient placement in the Department of Mental Health (DMH) where #1 is not available.
(NOTE: Carbon CMO and read DOM Section 62080.18)
3. ☐ Return to Reception Center Psychological Evaluation process.

Psychiatrist's Name (Print)	Phone / Extension	Psychiatrist's Signature	Date
-----------------------------	-------------------	--------------------------	------

RECEPTION CENTER PSYCHIATRIC EVALUATION

NAME: _____ CDC#: _____ INST: _____ HOUSING: _____
LAST FIRST MI

☐ This inmate received an assessment for need for psychiatric medication on ____/____/____. The result of this assessment is:

- ☐ Placed on medication (specify): _____
☐ No medication required.

This inmate was assessed for need for crisis psychiatric care on ____/____/____. The result of this assessment is:

1. ☐ Placed in crisis bed for emergency care.
2. ☐ Referred for emergency inpatient placement in the Department of Mental Health (DMH) where #1 is not available.
(NOTE: Carbon CMO and read DOM Section 62080.18)
3. ☐ Return to Reception Center Psychological Evaluation process.

Psychiatrist's Name (Print) Phone / Extension Psychiatrist's Signature Date

RECEPTION CENTER PSYCHIATRIC EVALUATION

NAME: _____ CDC#: _____ INST: _____ HOUSING: _____
LAST FIRST MI

☐ This inmate received an assessment for need for psychiatric medication on ____/____/____. The result of this assessment is:

- ☐ Placed on medication (specify): _____
☐ No medication required.

☐ This inmate was assessed for need for crisis psychiatric care on ____/____/____. The result of this assessment is:

1. ☐ Placed in crisis bed for emergency care.
2. ☐ Referred for emergency inpatient placement in the Department of Mental Health (DMH) where #1 is not available.
(NOTE: Carbon CMO and read DOM Section 62080.18)
3. ☐ Return to Reception Center Psychological Evaluation process.

Psychiatrist's Name (Print) Phone / Extension Psychiatrist's Signature Date

Conditions Requiring Mental Health Care

Mental health treatment is provided, according to the level of care required, for the psychiatric conditions listed below, defined as Medically Necessary.

Overall Treatment Criteria

- A. Treatment and continuous monitoring are provided to any inmate who has ***current*** symptoms and/or requires treatment for the DSM IV diagnosed (may be provisional) Axis I serious mental disorders listed below:

Schizophrenia (all subtypes)
Delusional Disorder
Schizophreniform Disorder
Schizoaffective Disorder
Brief Psychotic Disorder
Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)
Psychotic Disorder Due To A General Medical Condition
Psychotic Disorder Not Otherwise Specified
Major Depressive Disorders
Bipolar Disorders I and II

- B. Medical Necessity: Crisis intervention will be provided as needed. Treatment is continued as needed, after review by a treatment review committee, for all cases in which:

Mental health intervention is necessary to protect life and/or treat significant disability/dysfunctionality in an individual diagnosed with or suspected of having a mental disorder. Treatment is continued for these cases only upon reassessment and determination by the treatment review committee that the significant or life threatening disability/dysfunctionality continues or regularly recurs.

I. Inpatient Placement (Crisis Beds, DMH Acute Care)

Overall Treatment Criteria A (One of the serious mental disorders listed above) or B (Medical Necessity) with:

Marked Impairment and Dysfunction in most areas (daily living activities, communication and social interaction) requiring 24 hour Nursing Care

And/Or: Dangerousness to others as a consequence of a serious mental disorder/Dangerousness to self.

These conditions usually result in a Global Assessment of Functioning (GAF) Score of 30 or less.

II. Enhanced Outpatient Care (Designated Housing Unit)

Overall Treatment Criteria A or B and:

Acute Onset or Significant Decompensation of a serious mental disorder characterized by increased delusional thinking, hallucinatory experiences, marked changes in affect, and vegetative signs with definitive impairment of reality testing and/or judgment

And/Or Inability to Function in General Population Based Upon:

Inability to Program in work or educational assignments, or other correctional activities such as religious services, self-help programming, canteen, recreational activities, visiting, etc. as a consequence of a serious mental disorder; **Or:**

Dysfunctional or Disruptive Social Interaction including withdrawal, bizarre or disruptive behavior, extreme argumentativeness, inability to respond to staff directions, provocative behavior toward others, inappropriate sexual behavior, etc., as a consequence of a serious mental disorder; **Or:**

Impairment in Activities of Daily Living including eating, grooming and personal hygiene, maintenance of housing area, and ambulation, as a consequence of a serious mental disorder

These conditions usually result in GAF Scores of 50 or Less.

III. Correctional Clinical Case Management

Overall Treatment Criteria A or B and:

Stable functioning in the general population and

Criteria not met for higher levels of care

These conditions usually result in GAF scores above 50.

MENTAL HEALTH PLACEMENT

NAME: _____ CDC#: _____ INST: _____ HOUSING: _____
LAST FIRST MI

This inmate has completed a mental health evaluation with the following results:

☐ Does Not Meet Criteria For Inclusion in the MH Treatment Population

☐ Meets Criteria For Inclusion in the
MH Treatment Population (See LOC Below)

Level of Functioning Assessment (GAF score or equivalent): _____ **Psychotropic Medication:** ☐ Yes ☐ No

Behavioral Alerts: _____

Level of Care Recommendation (LOC):

☐ Inpatient DMH ☐ Crisis Bed (MHCB) ☐ Enhanced Out Patient (EOP) ☐ Clinical Case Management (CCCMS)

CLINICIAN'S NAME (PRINT) _____ PHONE/EXTENSION _____ CLINICIAN'S SIGNATURE _____ DATE _____

CDC 128C

MENTAL HEALTH PLACEMENT

NAME: _____ CDC#: _____ INST: _____ HOUSING: _____

This inmate has completed a mental health evaluation with the following results:

☐ **Does Not Meet Criteria For Inclusion in the MH Treatment Population**

☐ Meets Criteria For Inclusion in the
MH Treatment Population (See LOC Below)

Level of Functioning Assessment (GAF score or equivalent): _____ **Psychotropic Medication:** ☐ Yes ☐ No

Violational Alerts: _____

Level of Care Recommendation (LOC):

☐ Inpatient DMH ☐ Crisis Bed (MHCB) ☐ Enhanced Out Patient (EOP) ☐ Clinical Case Management (CCCMS)

CLINICIAN'S NAME (PRINT) _____ PHONE/EXTENSION _____ CLINICIAN'S SIGNATURE _____ DATE _____

CDC 128C

MENTAL HEALTH PLACEMENT

NAME: _____ CDC#: _____ INST: _____ HOUSING: _____
LAST FIRST MI

This inmate has completed a mental health evaluation with the following results:

☐ **Does Not Meet Criteria For Inclusion in the MH Treatment Population**

☐ Meets Criteria For Inclusion in the
MII Treatment Population (See LOC Below)

Level of Functioning Assessment (GAF score or equivalent): _____ **Psychotropic Medication:** ☐ Yes ☐ No

Behavioral Alerts:

Level of Care Recommendation (LOC):

☐ Inpatient DMH ☐ Crisis Bed (MHCB) ☐ Enhanced Out Patient (EOP) ☐ Clinical Case Management (CCCMS)

CLINICIAN'S NAME (PRINT) _____ PHONE / EXTENSION _____ CLINICIAN'S SIGNATURE _____ DATE _____

CLINICIAN'S NAME (PRINT) _____ PHONE / EXTENSION _____ CLINICIAN'S SIGNATURE _____ DATE _____

Mental Health Placement Chrono Form Instructions

This form is to be completed by the clinician who has performed the Psychological Evaluation which provides the basis for mental health placement. Please write legibly.

<u>Item</u>	<u>Institution</u>
1) Identifiers (top line)	Self-explanatory
2) ☐ Does not meet criteria for inclusion in the mental health treatment population.	Check this box if inmate does not meet criteria displayed in I in the attached Level of Care Placement Decision Criteria.
3) ☐ Meets criteria for inclusion in the mental health treatment population.	Check this box if inmate meets criteria displayed in I in the attached Level of Care Placement Decision Criteria. If checked, one of the LOC boxes must be checked.
4) ☐ Level of Functioning	Please indicate current GAF score.
5) Psychotropic Medication	Check yes if the inmate is currently on psychotropic medication; no if not.
6) Behavioral Alerts	Indicate any behavior of importance to custody or clinical staff e.g., unpredictability; physically aggressive; suicidal. If none known, so indicate.
7) Level of Care Recommendation (LOC)	One of the four LOC boxes must be checked. See II, III, IV in the attached Level of Care Placement Decision Criteria.
8) Signature Block	Self-explanatory.
9) Distribution	C-File; Medical File; clinician; inmate

a:

INMATE REQUEST FOR INTERVIEW

DATE	TO	FROM (LAST NAME)	CDC NUMBER
USING	BED NUMBER	WORK ASSIGNMENT	JOB HOURS FROM TO
OTHER ASSIGNMENT (SCHOOL, THERAPY, ETC.)			ASSIGNMENT HOURS FROM TO

Clearly state your reason for requesting this interview.
You will be called in for interview in the near future if the matter cannot be handled by correspondence.

Do NOT write below this line. If more space is required, write on back.	
INTERVIEWED BY	DATE
DISPOSITION	

[illegible]

MENTAL HEALTH INTERDISCIPLINARY PROGRESS NOTES	LEVEL OF CARE	Last Name: _____ First Name: _____ Mi: _____
MH 3 [3/21/96]		
Confidential Client/Patient Information See W & I Code, Section 5328	Inpatient	
	Outpatient	CDC # ____-____-____ DOB ____/____/____

D. Staffing

Psychologists

The primary position for identifying inmates in need of mental health treatment is the Staff Psychologist. Responsibilities include preliminary screening of all inmates for possible symptoms of mental illness; completion of mental status examinations of individuals with possible treatment needs; arriving at clinical diagnoses, including level of functioning assessments; recommending level of care placements; and, in conjunction with psychiatrist, developing an initial treatment plan for the inmate while awaiting transfer. Twenty-five additional psychologist positions have been added to current staffing in the initial implementation of the program to accomplish these responsibilities.

Psychiatrists

The role of psychiatrists at reception centers is to review the need for prescription of psychotropic medication, and the related responsibility of providing emergency crisis care for acutely disturbed or suicidal inmates. These psychiatric reviews and interventions will be incorporated into both interim and long term treatment planning.

Medical Technical Assistants

Medical technical assistants play collateral roles in referring inmates for medication review, crisis care, or psychological evaluation who are identified at initial intake or physical examination. They also may carry out collateral treatment responsibilities, such as dispensing psychotropic medication, during the course of their regular medical assignments.

Medical Transcribers

Each reception center will require at least one full time clerical position, usually in the medical transcriber classification, to carry out responsibilities of acquiring and entering data into medical files and entering information into the institutional data processing system. Five additional medical transcriber positions have been allocated in the initial implementation of this program to augment existing staff for this purpose.

Allocation of Positions

The attached documents present the rationale for allocations of additional staff at the time of implementation of this program. A formula (one staff psychologist for each .0054 inmates received per month) was arrived at, based upon workload projects in which are also outlined. This provides the opportunity to adjust staffing in a consistent manner with future population increases.

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.0054 FTE per each Reception Center case received per month.

2.5 Psychiatrist positions now conducting intake evaluations and 1.0 psychologist currently completing Z-case evaluations (50% or 57 per month received are screened out) added to psychological pool.

3 Psychiatrist positions currently budgeted for reception center plus 2 psychologist positions now budgeted for Z-case evaluations added to psychological pool.

Figures for North Kern are not actual. The institution processed 5434 inmates in the first eight months of operation in 1993. The figure (1154) is added to bring the average projected total system-wide to 9000, which is a projection used throughout this study. Actual intake at North Kern is currently below the projected figure (707 in January), but will exceed this during Fiscal Year 1994-95, as this center absorbs much of the short term projected increase system-wide. Totals should then approximate WASCO numbers. Staffing allocations shall be phased in to reflect these changes.

.5 Psychiatrist is currently doing Z-case evaluations at CCWF. One half psychologist position added will free this full time psychiatrist position for intake evaluation.

Although the staffing formula calls for reduction of .8 of one position at CIW, this will not be ecommended. Instead, the allocation of additional staff for SQ was reduced from 5.9 to 4.9. The total additional staff required will therefore be 25 positions.

Computation Of Staff Requirements

1993 Reception Center Intake

<i>New</i>	<i>Parole Violators</i>	<i>Total</i>
<i>Commitments</i>		
43,150	54,681	97,831
(3,696 mo.)	(4,557 mo.)	(8,153 mo)

1994 Projected Intake=+10% (Planning Purposes)

<i>New</i>	<i>Parole Violators</i>	<i>Total</i>
<i>Commitments</i>		
48,000	60,000	108,000
(4,000 mo. +/-)	(5,000 mo. +/-)	(9,000 mo +/-)

Time Estimates

Screening Interview

(Based upon trial usage of standardized questionnaire.)

Full Clinical Evaluation

(Current average from field survey is 30 to 45 minutes. This was doubled to allow for expanded issues of level of care assessment and brief interim treatment plan.)

Available time per month per each full-time employee (FTE)

(FTE) Clinician

(Normal work month 166 hours; allow 66 hours for leave, training, administrative time, collateral responsibilities.)

Staff Calculations

(Assuming all inmates receive a 10 minute screening interview and 25% receive one hour and 30 minutes full clinical evaluation.)

Screening (Systemwide)

9,000 Inmates x 10 minutes = 1500 hours divided by 100 hours per FTE
= 15 FTE

Evaluations

2250 Inmates x 1 hour & 30 minutes = 3375 hours divided by 100 FTE
= 33.8 FTE

Total 48.8 FTE

Current Staff (from chart adjusted) = 23.5 FTE/Required Additions = 25.3 FTE

Staffing Standards

(Based upon previous page assumptions.)

48.8 FTE required to screen and evaluate 9,000 inmates per month
= 0054 FTE per reception center case per month.

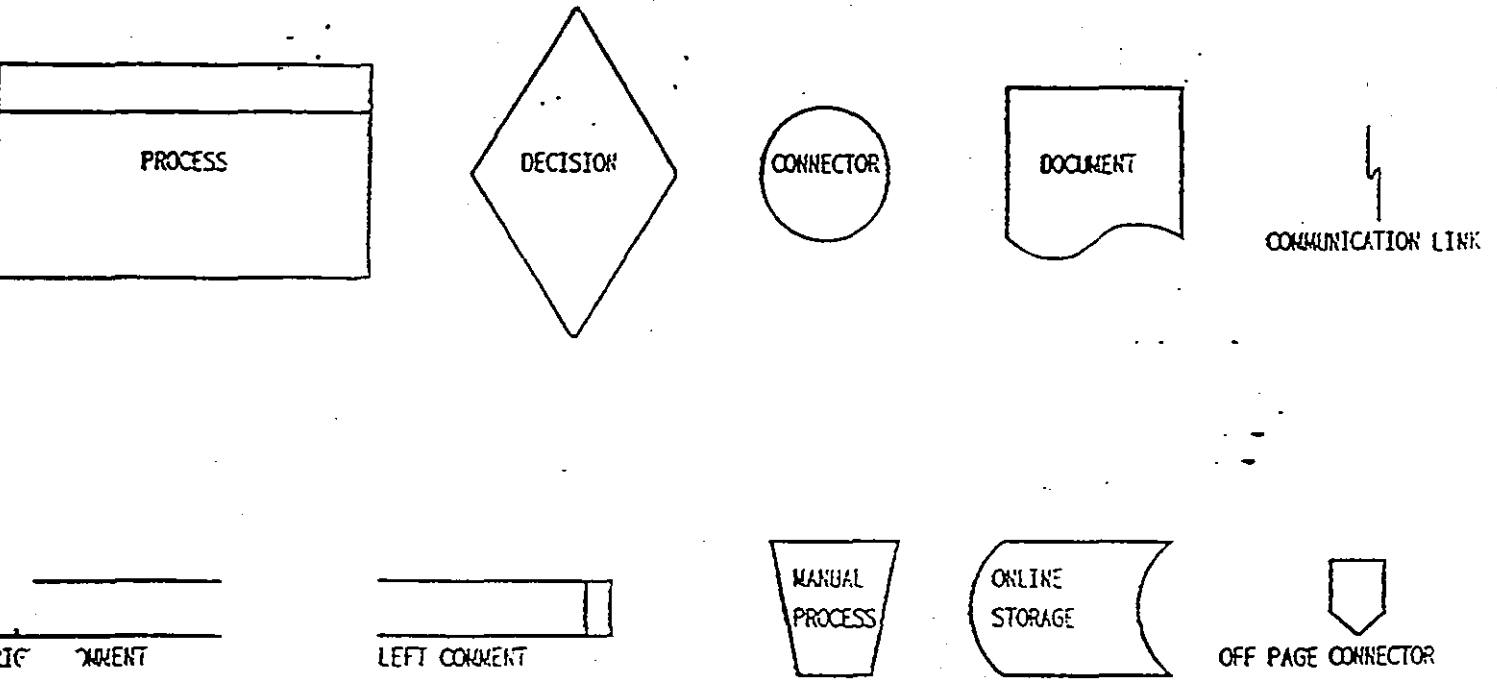
INSTITUTION STAFFING PROJECTIONS

INSTITUTION	MONTHLY INTAKE	REQUIRED ¹ POSITIONS	CURRENT PSYCHOLOGIST POSITIONS	ADJUSTED CLINICAL STAFFING	CLERICAL ADDITIONS
SQ	1841	9.9	4.0 ²	+4.9 ⁶	
DVI	600	3.2	1	+2.2	1
WASCO	1606	8.7	6 ³	+2.7	
N.K. ⁴	(1154)	(6.2)	2	+4.2	
CCI	687	3.7	1	+2.7	1
CIM	1657	8.9	6	+2.9	1
RJD	760	4.1	2	+2.1	1
NCWF	75	0.4	0	+0.4	
CCWF	400	2.2	-.5 ⁵	+2.7	1
CIW	220	1.2	2	0(-.8) ⁶	
TOTALS:	9000	48.5 Required	23.5 Currently	(24) 25 ⁶ Additions	5 Additions

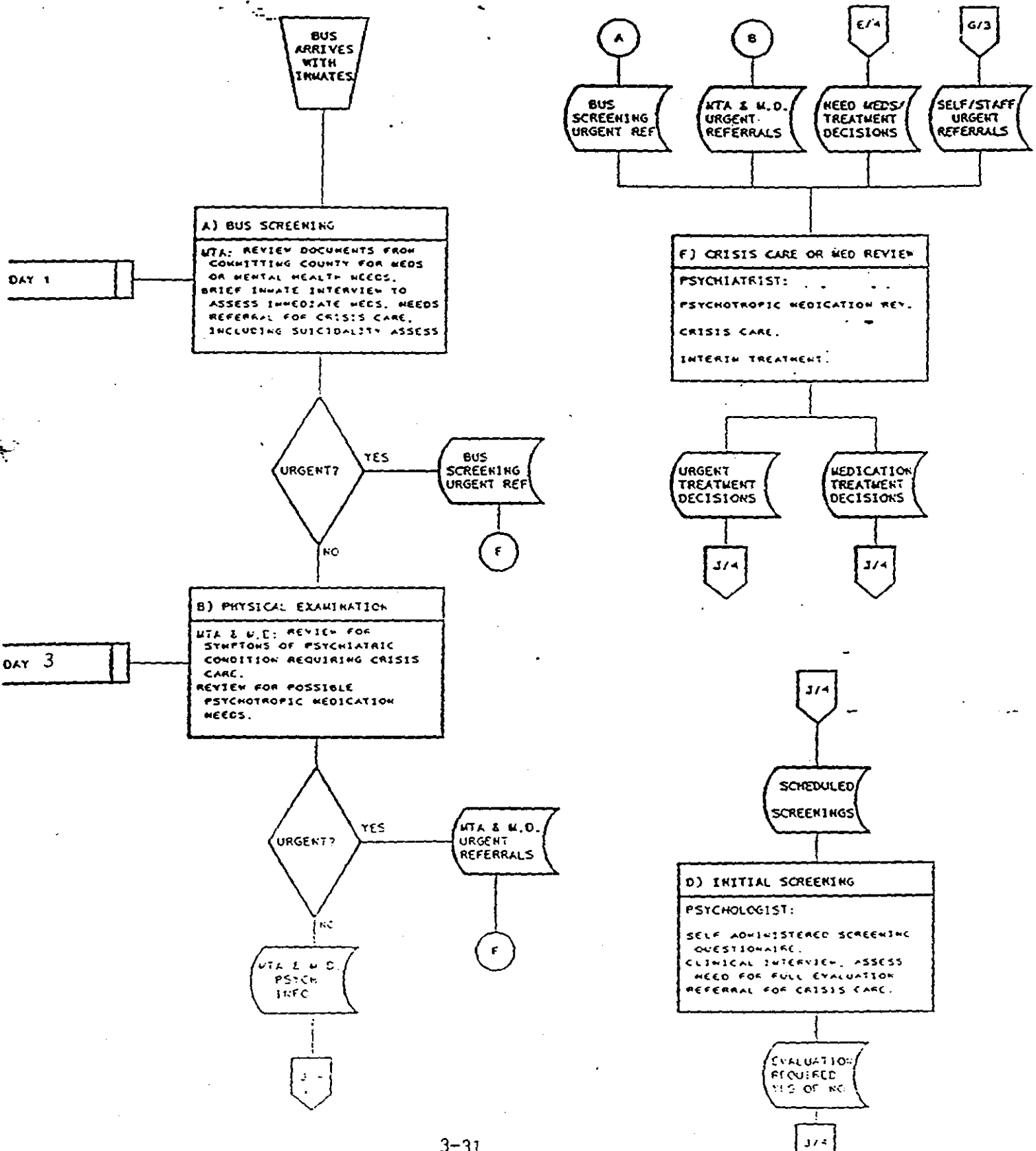
All figures based upon 1993 actual numbers except N.K.

NEW MENTAL HEALTH
RECEPTION CENTER SCREENING PROCESS
FLOWCHART SYMBOL KEY.

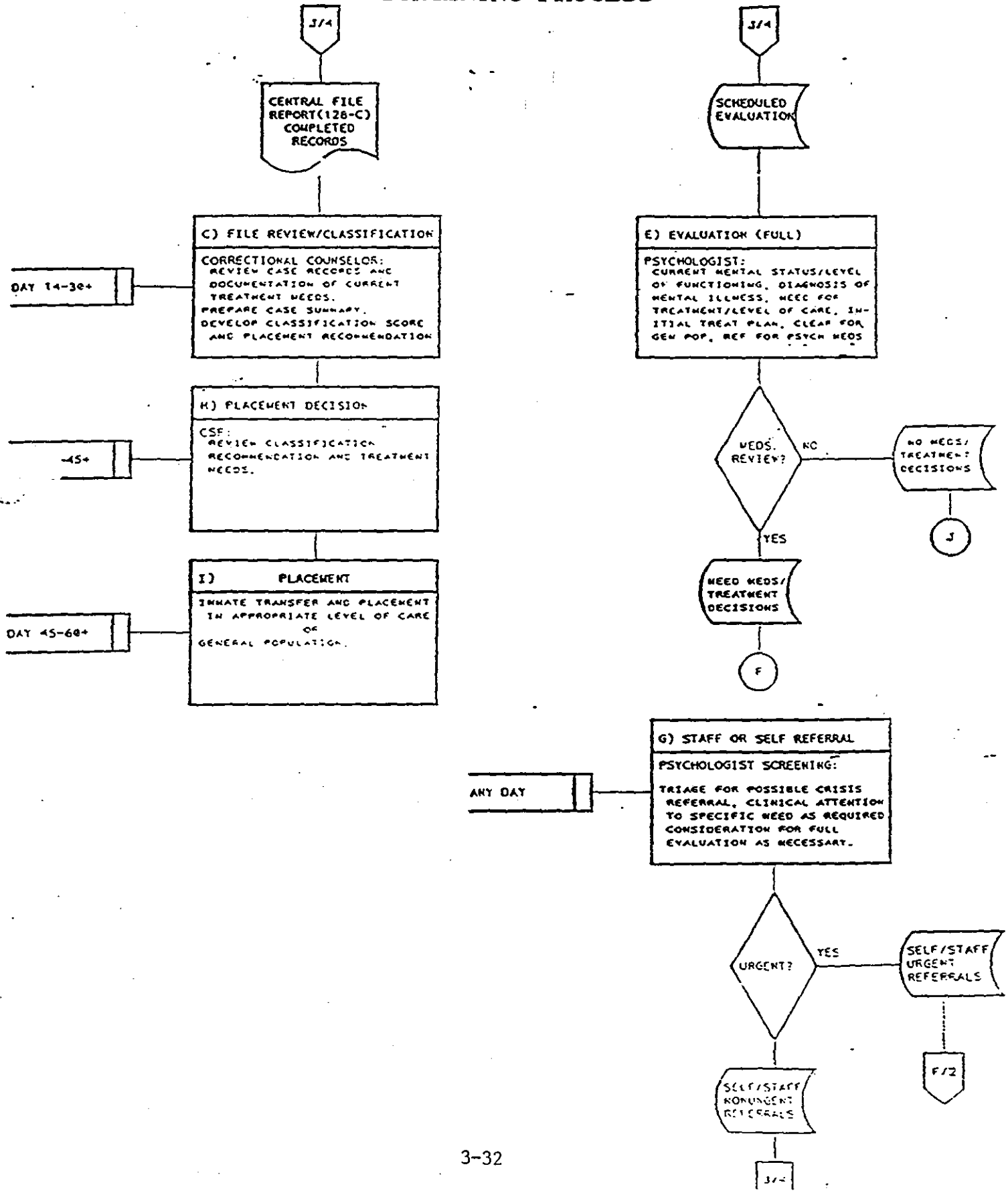
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MENTAL HEALTH RECEPTION CENTER SCREENING PROCESS

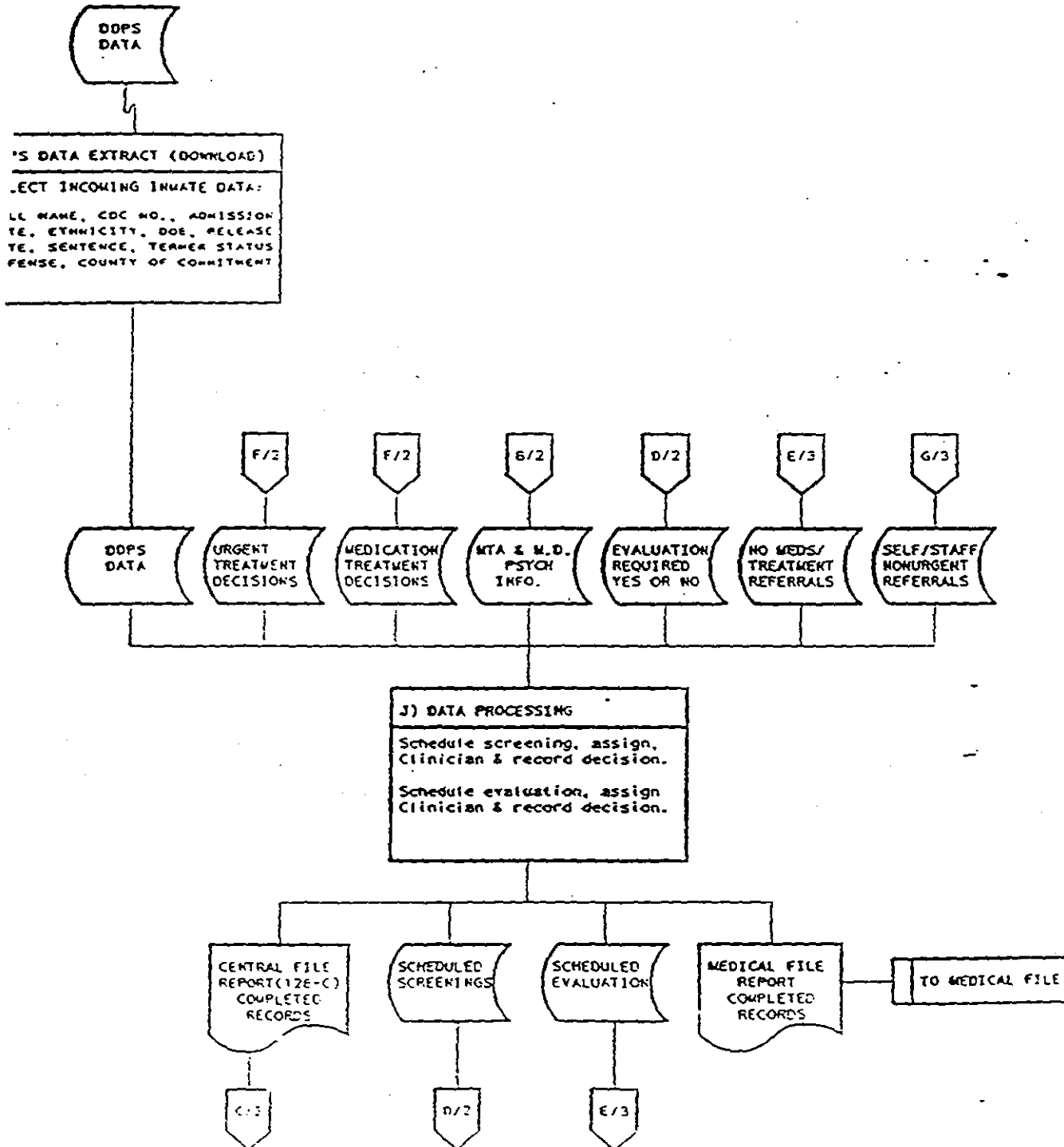


MENTAL HEALTH RECEPTION CENTER SCREENING PROCESS



04-19-1994

MENTAL HEALTH RECEPTION CENTER SCREENING PROCESS



1. BACKGROUND

Litigation alleges that standardization does not exist at CDC's Mental Health Reception Centers. Allegations assert that each institution's procedures for processing inmates has resulted in delays and a lack of uniformity in determining the need for treatment.

Depending on the severity of an inmates mental status, a variety of mental health care options are available to clinicians: Follow-up evaluation, crisis stabilization and care, inpatient hospital care, residential care, and outpatient clinic services.

Lawsuits alleging inadequacies in the mental health delivery system have resulted because the institutions cannot ensure: 1) that a uniform standard of care is provided; 2) that the mental health delivery system is operated efficiently; and 3) that accurate data is collected on the number of required mental health screenings, mental health evaluations, and the number of inmates diagnosed with a serious mental disorder.

Standardizing and automating the various multiple manual processes in the mental health service delivery system would resolve a large portion of the identified deficiencies.

2. PURPOSE

The purpose of this system is to provide: 1) a basic, statewide mechanism to ensure that a uniform standard of care is being provided to inmates; 2) that the mental health delivery system is efficiently operated; and 3) that accurate data is collected and provided in aggregate form on the number of inmate screenings, evaluation, and serious mental disorders.

Uniformed Standard of Care - To provide a uniform standard of care, each inmate must be uniformly screened for mental health problems upon arriving at the Reception Center in a correctional facility. When the screening results indicate a need for further mental health evaluations, inmates must be referred to a psychologist for assessment of their mental health needs. Depending on the inmate's needs, additional resources are available throughout the process upon referral by a clinician or when an emergency situation occurs.

In order to standardize the process, data must be collected and analyzed to determine appropriate standards. For instance, management must be able to track all different types of mental health situations that occur, each solution provided, and which of the solutions provided the best resolution for each situation.

Efficient Operation of the Mental Health Delivery System - To assure that the required screenings and evaluations are completed for each inmate within a reasonable amount of time (as well as being provided by appropriately trained CDC staff), an automated system

needs to track each inmate's screening and evaluation history. The automated collection of data needs to be upon the arrival of each new inmate. Such things as arrival date, personal data, housing, dates of referral and screening, referral source, dispositions, and medication needs are elements that need to be tracked for each inmate. This will ensure that each inmate, from the point of intake until release to the general population, will receive required standardized screenings and that additional treatment will be provided to those who have a demonstrated need. Furthermore, inmates diagnosed with a serious mental disorder will be tracked to ensure they receive appropriate follow-up care.

Collect Accurate Data and Provide in Aggregate Form - To ensure the accurate collection of data, the system will be utilized by appropriately trained CDC staff and will provide adequate safeguards to ensure the security and confidentiality of the data. The basic system will include components that will collect and aggregate data on the number of inmates screened, evaluated, and those diagnosed with a serious mental disorder.

The need to have a basic system in place has been identified by recent litigation in the Coleman vs. Wilson case where it is alleged that CDC provided inadequate treatment of inmates with serious mental disorders. In order to respond to these allegations, the Director of CDC directed Health Care Services Division to standardize and automate the Mental Health Reception Center screening process.

3. SYSTEM ENVIRONMENT

a. Processing Computer: IBM Compatible Personal Computers

b. Language: DBase III+/Other

c. Frequency: Daily

4. SPECIAL CONSIDERATIONS

Given the system environment requirements, consideration must also be given to the future needs of the Reception Center screening processes. The system design should allow for future expansion into Local Area and/or Wide Area Networking (LAN and WAN, respectively) access. In order to successfully integrate the compilation of data obtained from various sources, then aggregate and analyze such information, a local or wide area access system is pertinent.

5. INPUT

Key data entry from various functional areas utilizing personal computers and possible uploads and downloads.

6. Output

- a. Daily Control Total Report.
- b. Monthly Control Total Report.
- c. Screening Schedule Report.
- d. Referral Schedule Report.
- e. Evaluation Schedule Report.
- f. Error Exception Report.

E. Data Processing System

The automated mental health assessment process at reception centers will provide:

- 1. A basic Statewide mechanism to ensure that a uniform standard of care is being provided to inmates,
- 2. Assurance of efficiency in the process, and
- 3. Accurate cumulative data on the number of inmate screenings and evaluations, and the number diagnosed with serious mental disorders.

The system will be automated in phases. Phase I will implement the basic ability to track items one through three above in a stand alone personal computer environment. A follow-up transitional strategy will address the configuration of stand alone personal computers in a Local Area Network setting as well as the collection of treatment plan information and system enhancements.

The system design is structured in a fashion that lends itself to modular development. More specifically, portions of the system can be automated without changing the overall structure. The ultimate system will be capable of communicating with other Departmental systems, thus eliminating the need for additional hardware and software. It is important to emphasize that in order to ensure the accurate collection of data, the system will be utilized by appropriately trained by CDC staff and will provide adequate safeguards to ensure the security and confidentiality of the data.

Specific information to be processed is presented in the attached detailed data flow chart.



RECYCLED

ALL-STATE LEGAL 800-222-0510 ED11

SECTION 4: MENTAL HEALTH CRISIS BED PROGRAM GUIDE

I. MENTAL HEALTH CRISIS BED PROGRAM (MHCB)

A. Introduction

The goal of the Mental Health Crisis Bed Program (MHCB) is to provide services for conditions which require an inpatient setting to ameliorate mental health symptoms in the least restrictive environment. (Title XXII Section 79739) MHCB).

Many conditions may precipitate a mental health care crisis during prison confinement. At reception, the loss of the existing support system the individual had on the outside, and/or the stress of initial imprisonment may lead to a suicide gesture or other symptoms. In mainline institutions, stress factors unique to imprisonment, which cause a pronounced degree of emotional strain and/or physical and interactive tension, often compound existing stress factors inherent in everyday life. Such factors as the restrictions of confinement, pressures to conform to the prison lifestyle and fear of more predatory inmates may disrupt an inmate's coping abilities. An inmate with no known mental health history may suffer acute symptoms, while another with mental illness in remission may have recurring symptoms. Prior to release, fears of delayed release or inability to cope with the outside world or loss of the prison support system of food, shelter, clothing and structure of time may lead to crisis reactions.

The MHCB has a length of stay of up to 10 days. Exceptions to the length of stay must be approved by the Chief Psychiatrist, or designee. Not all crises require admission to the MHCB. Crisis episodes for one inmate may be handled on an outpatient basis. Another inmate, even if stabilized on medications, may have problems requiring placement in a structured therapeutic environment for ongoing treatment and monitoring. This may necessitate a referral to an Enhanced Outpatient Program (EOP), or if longer-term intensive care is needed, in an inpatient facility operated by the Department of Mental Health (DMH).

Presenting problems may require continuous observation or monitoring before an inmate's treatment needs can be fully assessed or the crisis brought under control. Where 24-hour care is needed, an inmate shall be placed in a MHCB for continuous nursing care. (Title XXII Section 79741 (a) Crisis care not requiring continuous nursing care or inpatient psychiatric care may be provided in another mental health treatment setting.

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B. Program Objectives

The primary objective of the MHCB is to evaluate the symptoms associated with the crisis and provide initial stabilization of the inmate's condition. More specific objectives include:

1. To observe, monitor and provide continuous nursing assistance to inmates whose condition requires 24 hours or more to achieve stabilization.
2. To assess the inmate's symptoms, formulate a provisional or differential diagnosis and develop an initial treatment plan. This may include a medical/neurological evaluation or referral for such.
3. To control symptoms of serious mental illness, using emergency medication when necessary.
4. To alleviate psychiatric distress with appropriate therapy or counseling.
5. To refer the inmate for placement in an appropriate level of care.
6. To provide an alternative to hospitalization for inmates whose condition allows placement within 10 calendar days to a lower level of care.

C. Population To Be Served

The MHCB is located in a CDC correctional institution and operates 24 hours a day, seven days a week. An inmate admitted to the MHCB for mental health treatment may be described as a seriously mentally disordered inmate.

Mental health treatment is provided, according to the level of care required, for the psychiatric conditions listed below, defined as Medically Necessary.

Overall Treatment Criteria

1. Treatment and continuous monitoring are provided to any inmate who has **current** symptoms and/or-requires treatment for the DSM IV diagnosed (may be provisional) Axis I serious mental disorders listed below:

Schizophrenia (all subtypes)

Delusional Disorder

Schizophreniform Disorder

Schizoaffective Disorder

Brief Psychotic Disorder Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)

Psychotic Disorder Due To A General Medical Condition

Psychotic Disorder Not Otherwise Specified

**Major Depressive Disorders
Bipolar Disorders I and II**

2. Medical Necessity: Crisis intervention will be provided as needed. Treatment is continued as needed, after review by a treatment review committee, for all cases in which:

Mental health intervention is necessary to protect life and/or treat significant disability/dysfunctionality in an individual diagnosed with or suspected of having a mental disorder. Treatment is continued for these cases only upon reassessment and determination by the treatment review committee that the significant or life threatening disability/ dysfunctionality continues or regularly recurs.

a. Inpatient Placement (Crisis Beds, DMH Acute Care)

Overall Treatment Criteria A (One of the serious mental disorders listed above) or B (Medical Necessity) with:

Marked Impairment and Dysfunction in most areas (daily living activities, communication and social interaction) requiring 24 hour Nursing Care

And/Or: Dangerousness to Others as a consequence of a serious mental disorder/Dangerousness to Self

These conditions usually result in a Global Assessment of Functioning (GAF) Score of 30 or less.

D. Admission

1. Emergency Services

An inmate in crisis may be evaluated where the crisis occurs (such as in the cell), or in the emergency service area of the CTC, prior to admission to the MHCB. A licensed mental health professional (M.D., Ph.D., LCSW) may assess and refer an inmate for admission to a crisis bed. A Psychiatrist or psychologist or if unavailable by staff designated by the Clinical Director may admit an inmate to the MHCB.

Occasionally, crisis referrals require immediate and involuntary admission to the MHCB. An inmate may, because of a psychotic break, be confused, disoriented, disorganized and/or gravely disabled; or, because of acute depression, may be dangerously suicidal. An inmate in crisis who is explosive and assaultive may also be admitted involuntarily if a serious mental disorder also exists. Assaultiveness that is assessed as resulting from an anti-social disorder instead of a serious mental disorder is more appropriately dealt with in Administrative Segregation, per general institution policies.

E. Treatment Modalities

Please refer to Section III, TREATMENT PROGRAM AND SCOPE OF SERVICES, for a detailed discussion of treatment.

F. Discharge

1. Discharge from the MHCB (Title XXII Section 79743 (a))

Criteria for discharge from the MHCB to the EOP or the CCCMS include a stabilization of the crisis behavior and the ability to function in a less clinically structured environment. Discharge criteria do not necessarily include complete resolution of symptoms, but a resolution sufficient to allow continuation of treatment at a lower level of care. Discharge to DMH inpatient care requires the clinical need for inpatient services of a duration greater than 10 days. Because the MHCB may provide the first and earliest intervention in serious mental disorder cases, its accessibility to the inmate is maintained by expeditious processing of all cases. This entails the prioritized (within 24 hours) transfer of any inmate who requires inpatient hospitalization. This also requires a daily case update of each case, to be done by the treating clinician., and to be documented in the inmate's medical file immediately thereafter. Most inmates will respond to medication or other forms of intervention and stabilize within a short period of time and be transferred to less restrictive care. If the inmate has a Clinical Case Manager, the Clinical Case Manager shall, at the time of discharge, be given notice of the inmate's discharge from the MHCB.

G. Organization

1. Structure

The MHCB is headed by a Clinical Director, (Title XXII Section 79741 (b)) who may be either a Chief Psychiatrist another Psychiatrist or a Senior Psychologist. Each inmate admitted as a patient to the MHCB is under the treatment of Staff Psychiatrists, Staff Psychologists and Psychiatric Social Workers. Nursing services are provided by Registered Nurses, Medical Technical Assistants, Recreational or Occupational Therapists or Psychiatric Technicians. Clerical services are provided by an Office Technician and a Medical Transcriber.

2. Administrative Staff

The MHCB is subject to the same medical staff organization, bylaws, and policies and procedures that govern the other licensed beds of the facility. (Title XXII Sections 79775, 79777) Staff serving in these positions shall meet the minimum qualifications specified in the California Code of Regulations, Title XXII. All MHCB staff are responsible to the Clinical Director.

3. Clinical Staff

Individual therapy or counseling, aftercare planning and referral services, and the clinical lead role in treatment plan development and modification shall be performed by the Staff Psychiatrist or Staff Psychologist. A Chief or Senior Psychiatrist or Senior Psychologist may also provide these clinical services in addition to his or her other supervisory or management responsibilities as directed. Supervising clinical staff may assist in these services if required by workload; staffing considerations or unusual complexity of an individual case. Psychiatric Social Workers assist with therapy, aftercare planning and rehabilitation and referral services. Staff Psychiatrists, Staff Psychologists, Psychiatric Social Workers and Senior Psychiatrists and Senior Psychologists who serve in a working capacity report to the Clinical Director. (Title XXII Sections 79749, 79751, 79753)

4. Nursing Staff (Title XXII Section 79629)

Two Supervising Registered Nurse positions oversee all nursing services delivered in the CTC: one for medical services and one for mental health services. (Title XXII Section 79755 (d)) Although the latter includes the MHCB, the use of one Supervising Registered Nurse per shift may mean that MHCB nursing functions may be supervised by the medical Supervising Registered Nurse for part of each 24-hour day.

Supervising Registered Nurses are responsible for functional supervision of CTC line nursing staff and nursing administration, which includes the MHCB. Twenty-four hour registered nursing coverage and availability of a Supervising Psychiatric Registered Nurse 40 hours a week are necessary in the MHCB. There are sufficient nurses within a 24-hour period to provide at least 2.5 hours per inmate. (Title XXII Section 79759) An inmate with higher acuity needs receives additional nursing and professional care as symptoms require.

5. Mental Health Rehabilitation Services Staff

Mental health rehabilitation therapy services shall evaluate social, recreational and vocational needs in accordance with the interests, abilities and needs of the inmate; shall develop and prepare related therapies; and shall include such evaluation, and documentation of therapy development and preparation, in the inmate's treatment plan. (Title XXII Section 79749)

Mental health rehabilitation therapy services shall be provided under the direction of the Registered Nurse, and shall be provided by a Recreational Therapist or an Occupational Therapist, or a Psychiatric Technician. (Title XXII Section 79755)

In the Department, appropriately trained Correctional Officers (COs) and Correctional Counselors may be counted to meet licensing ratios. COs and Medical Technical

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ssistants also assist in managing, observing and escorting the assaultive or suicidal inmate.

6. Clerical Staff

Clerical support in the MHCB is provided by an Office Technician, who reports to the Clinical Director, and a Medical Transcriber, who is placed in the institutional transcriber pool and reports to the pool's Supervising Medical Transcriber.

H. Staffing And Treatment Planning

The MHCB is designed to provide 24-hour care, and is subject to State licensing requirements. (Title XXII Section 79739) Consequently, it must comply with the staffing standards of the Correctional Treatment Center license under which it operates. In programs with six or less beds, these services may be provided by the Clinical Director. MHCB staff shall provide acute mental health services for inmates admitted to MHCB beds. Through contracts or temporary reassignment of other mental health staff from the Service Area, staffing shall be augmented as needed.

I. Records

1. Confidentiality

Mental health records generally have a higher standard of confidentiality than other medical records. This can be assured by restricting access to such records to those staff with a "need to know". All staff with possible access to such records shall sign an oath of confidentiality to keep any information they learn from the records strictly confidential. (Title XXII Section 79807)

2. Access

All MHCB clinicians and nursing staff must have access to the inmate's records 24 hours per day. Records shall be brought as needed from the records storage area, kept in the MHCB treatment area or clinician offices while needed, and returned to the storage area when no longer needed. If records are required outside the MHCB treatment area or clinician's offices, the records shall be hand carried by escorting staff and returned to the MHCB with escorting staff as soon as the outside business is completed. (Title XXII Section 79807)

3. Contents

The permanent mental health records shall include:

- a. Mental Health Forms (e.g., MH 1, MH 4, MH 7, MH 2).
- b. Narrative reports.
- c. Mental Health Progress Notes (MH 3).

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- d. Discharge summaries.
- e. Nursing notes.
- f. Original laboratory reports.
- g. Radiology and similar diagnostic reports.
- h. Medical/dental records.
- i. Written physician orders.
- j. Relevant legal information.
- k. Probation Officer's Report (POR).
- l. Other correctional facility (jail, other state or federal) records (if available).

Two separate sections shall also be kept. The first separate section shall contain records of medication administration, doses, changes, evaluations and problems. The second separate section shall contain records of prior diagnoses and treatment, prior assessments and evaluations, summary records from any prior DMH psychiatric treatment and other, similar collateral information. (Title XXII Section 79805)

4. Organization

The mental health record shall be appropriately subdivided into sections by tab or similar dividers. Within each tabbed section, all information shall be in chronological order. To prevent lost data, no loose sheets shall be allowed in any medical record. (Title XXII Section 79803 (d))

5. The Clinical Director shall:

- a. Ensure the History and Physical is transcribed and delivered to the MHCB as soon as possible.
- b. Ensure that previous medical records are provided to the MHCB. (Title XXII Section 79803 (d))

II. INTAKE AND TREATMENT ASSESSMENT

A. Interdisciplinary Treatment Planning (Title XXII Section 79747)

Within three working days of admission, an interdisciplinary treatment plan shall be developed and implemented by an interdisciplinary treatment team headed by a licensed mental health clinician, who is usually a Psychiatrist. The plan, which is to be filed in the inmate's health record, shall be individualized and based on a comprehensive assessment, including, at a minimum, a mental status exam and the inmate's history, with psychological testing and social service evaluations as needed. The individualized treatment plan shall do the following:

1. Provide a primary diagnosis and identify the main presenting problems targeted for treatment. The diagnosis may be provisional.

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2. For every main presenting problem, document the measurable objectives of treatment.
3. Specify the types, frequencies and providers of prescribed therapies and adjunct activities.
4. Be reviewed at least every seven days and updated accordingly.
5. Designate appropriate medications or therapies in an aftercare plan to be followed after the inmate's release from the MHCB.

B. Weekly Case Reviews And Treatment Plan Update (Title XXII Section 79747 (3))

An inmate's condition shall be assessed and monitored daily by a treating clinician, including rounds by a Psychiatrist daily. Documentation of daily updates shall be made within 24 hours in the medical record by the updating clinician. The interdisciplinary treatment team shall review each crisis case as often as necessary, but at least twice weekly, and the treatment plan updated accordingly. Whenever possible, the inmate shall be involved in case reviews and treatment planning. Each treatment plan update shall include the following:

1. Documentation of an inmate's response to treatment and his or her progress towards the goals of treatment.
2. Evaluation of factors that hinder progress and the interventions planned by the team to facilitate progress.
3. The most recent diagnoses and descriptions of the main presenting problems.
4. Review of release or discharge plans.

III. TREATMENT PROGRAM AND SCOPE OF SERVICES

As an alternative to hospitalization for an inmate suffering from crisis or acute manifestations of a serious mental disorder, the following services and treatment shall be provided in the MHCB:

A. Preadmission Screening

All inmates referred to the MHCB for services shall receive a preadmission screening. The screening shall be performed by the Clinical Director or designee. The objective of the screening is to assess the appropriateness of the admission to the MHCB. (Title XXII Section 97941 (d))

B. Intake Assessment

Upon admission to the nursing unit, an assessment (MH 1 or MH 4) shall immediately be made on how best to meet the critical needs of the seriously mentally disordered inmate.

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At a minimum, a provisional diagnosis is determined and an initial plan (MH 2) for treatment and further examination shall be conducted within 24 hours for immediate care planning and to rule out medical conditions that may be a cause of presenting symptoms. Serious medical conditions as a significant cause of the crisis may warrant acute care medical hospitalization. (Title XXII Section 79749 (a) (2))

C. Medication/Emergency Medication

An inmate in crisis who does not consent for treatment with medication may be involuntarily treated to control symptoms which constitute a danger to self or others or grave disability on the basis of a serious mental disorder. Proper legal procedures (PC 2600 administrative hearings, which simplify the previous Keyhea hearings) are followed when administering involuntary medications. (Title XXII Section 79751)

D. Nursing Care

Twenty-four hour nursing care is available to the MHCb to administer and supervise medication, provide assistance for activities of daily living, observe and monitor inmates, obtain all physician-ordered laboratory studies, and provide counseling or inmate supervision as needed. (Title XXII Section 79753)

E. Individual Therapy/Counseling

One-to-one intervention is often necessary in a crisis case. Usually, brief, intensive therapy is helpful if it focuses on issues that precipitated the admission and explores changes in behaviors, perceptions and expectations which facilitate coping with the crisis. (Title XXII Section 79749 (c) (1))

F. Rehabilitation Therapy

An inmate in a genuinely acute crisis is often unable to participate in all types of psychotherapy, and will also not be able to benefit from certain services defined as Rehabilitation Therapy. In addition, the very short-term duration of the inmate's stay in the MHCb largely precludes significant participation in such therapy. Therefore, any focus on such therapy in the MHCb shall be limited to evaluating, developing, preparing and, in a few cases, initiating the inmate into such activities. These activities shall also provide a setting for additional observation of inmates, allowing for the evaluation of exaggerated symptoms or severe symptoms that are masked. (Title XXII Section 79749 (c) (1))

G. Aftercare Planning And Referral

Planning for follow-up services is a critical component of the care an inmate needs upon release from the MHCb. This planning may lead to a referral to a program or other appropriate placement to ensure continuity of care. An inmate who clearly requires

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longer-term hospital care may be referred and transferred to an inpatient hospital program operated by the Department of Mental Health. Aftercare plans shall include:

1. The diagnosis and psychiatric problems continuing to require treatment.
2. Any other unique mental health or physical conditions that could affect treatment (e.g., allergies, special dietary needs, chronic diseases).
3. Recommendations for follow-up treatment, including medications and specific psychotherapies.
4. Referrals to other treatment programs and institutional services, including vocational or educational programs, substance abuse programs and job programs (Title XXII Section 79749 (d)).

IV. ADMISSION, TRANSFER, DISCHARGE

A. General Policies

All CTC Regulations shall be incorporated by reference herein.

The MHCB shall accept inmates who meet the criteria for care and treatment and shall continue to house only those inmates for whom care is able to be provided. (Title XXII Section 79743 (b))

The admission mental health evaluation shall be obtained within 24 hours of admission, unless it has been done within the last 30 days. In this case, the evaluation shall be updated within 24 hours of admission. (Title XXII Section 79749 (a) (2))

The Clinical Director or designee shall be responsible for the prompt care and treatment of each inmate admitted to the MHCB, development and implementation of a treatment plan, completeness and accuracy of the medical record, necessary special instructions, and transmitting reports of the inmate's condition. Whenever these responsibilities are delegated to another staff, continuity shall be ensured. (Title XXII Section 79741 (b))

No inmate shall be admitted to the MHCB until a provisional diagnosis or valid reason for admission has been stated and eligibility determined. (Title XXII Section 79743 (b))

An inmate shall be discharged only on the written order of the MHCB Psychiatrist or psychologist or designee. Should an inmate who is a voluntary patient leave the MHCB against the advice of the attending Psychiatrist or other physician, a notation of the incident shall be made in the inmate's record and a Refusal of Medical Treatment Form signed by the inmate and a witness, or signed by two witnesses. (Title XXII Section 79743 (a))

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Before the inmate's discharge from the MHCB, a nurse shall advise the inmate on medications and follow-up visits, and clear the inmate for MHCB discharge.

B. Admission Procedures

1. Purpose:

To assign responsibilities for the admission of inmates to the MHCB.

2. MHCB Clinician:

During regular working hours:

The referred inmate is evaluated by an MHCB clinician (Psychiatrist or Psychologist). The clinician facilitates the admission based on the admission criteria indicated in Section I.D above (one of the serious mental disorders listed on page 6, or Dangerousness to Self, with a Global Assessment Functioning Score of 30 or less and marked impairment and dysfunction in most areas, requiring 24-hour nursing care, and/or Dangerousness to Self or Dangerousness to Others as a consequence of a serious mental disorder).

During evenings and nights, and on weekends and holidays:

The referred inmate is evaluated by an on-call MHCB Psychiatrist. The evaluation may be face-to-face or by verbal or telephone report to the on-call Psychiatrist by an on-site licensed MHCB clinician. The Psychiatrist writes or gives a verbal or telephone order for admission (or declines to give an admission order), based on the admission criteria indicated in Section I.D above.

If the inmate has a Clinical Case Manager, the Clinical Case Manager shall, at the time of admission, be given notice of the inmate's admission to the MHCB.

3. MHCB Nurse:

The nurse shall:

- a. Interview and give orientation to the inmate.
- b. Assess the inmate and take vital signs.
- c. Notify the physician of admission status including any admission problems.
- d. Assemble the chart.
- e. Initiate the Patient Care Plan.

- f. Note and implement any admission orders, such as laboratory, x-rays, medications, etc.

(Title XXII Section 79627)

C. Physical Examination

For immediate care planning, a history and physical examination, including neurological screening, shall be completed, to the extent clinically possible, immediately before or within 24 hours of admission, unless the admission is on a weekend when it must be completed within 72 hours. If the inmate is uncooperative or otherwise cannot be fully examined, a description of all possible observations and findings of the physical examination shall be documented. The complete physical examination shall be conducted as soon as clinically possible, and documented in the medical record.

D. Transfer Procedure

At times it will be necessary to transfer an inmate to another health facility.

1. The reasons an inmate may be transferred include:

a. Specialized Services Required

The inmate may require specialized services which are not offered by the current health facility or are not available at the time. Chronic cases may require referral to a DMH facility or a lesser-intensity CDC mental health program.

b. Different Level of Care Needed

The inmate may need a more or less intense level of care than that available at the current health facility.

c. After Acute Crisis Care No Longer Required

The inmate may no longer require acute or crisis care services and the inmate's continuing care needs may be met more suitably through the institution's outpatient program.

2. Inmate Movement

- a. If there are no MHCB beds available in the institution where the inmate is currently housed, the inmate shall be transferred to the nearest institution within that Service Area that is able to provide a MHCB bed, while simultaneously providing the commensurate level of custody and security.

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- b. If the MHCB beds within the Service Area are full, the inmate shall be taken to the nearest institution with the same requirements as noted in a. above, in an adjacent Service Area.
- c. In most cases, movement from an institution to a MHCB bed shall be completed by institutional transportation staff and as such the inmate shall, within 24 hours, go to the nearest MHCB that is able to provide the appropriate level of care and security, within the Service Area.
- d. MHCB transfers shall be done under authority as "Emergency Medical Transfers" (DOM 62080.18). Upon acceptance of a MHCB transfer by the CMO of the MHCB receiving institution and completion of transportation arrangements, the C&PR at the MHCB receiving institution shall contact the Classification Services Unit for Teletype transfer approval.
- e. The escort needs for each transport are different, given the variation of custody and health care concerns that may arise. At times, the transportation may be accomplished with just custody staff. However, occasions do arise when a combination of custody and clinical staff is needed to accompany an escort. This may be needed when the inmate has highly sensitive and varying medication needs, or when the presence of a clinical staff member can substantially reduce decompensating or disruptive inmate behavior during transportation.
- f. When an inmate is moved to a MHCB bed, it is typically viewed as an emergency move and, therefore, does not require classification committee action or CSR endorsement. However, it does require communication between the medical manager and the C&PR of both institutions to ensure that all health care/classification/transportation aspects are addressed and that the inmate is not housed in an inappropriate setting. The move is followed by communications to the CSR (teletype).
- g. When a male inmate has been referred from outside the MHCB for acute inpatient care at CMF-DMH, that inmate may be placed in MHCB, to determine if such inpatient care is necessary. Male inmates referred for intermediate inpatient care at Atascadero State Hospital and female inmates referred for intermediate inpatient care at Patton State Hospital need not be placed first in MHCB.

3. Record of Transfer

In general, it is recommended that the transfer protocol be structured in a manner which shall assure that a sufficiently detailed record of the reasons for, procedures utilized and results (including any negative outcomes) of the transfer shall be generated for documentary and monitoring purposes. Such transfer records may also be valuable to a facility in terms of both long and short range planning.

4. Clinician Responsibilities

Generally, the transfer process shall be initiated by the inmate's Psychiatrist or the Clinical Director. Three steps shall occur before a decision to transfer the inmate is finalized. These are:

- a. The transferring Psychiatrist must determine whether the inmate is "medically cleared" to transfer. State law provides that, before a patient may be transferred to a health facility, the patient must be sufficiently stabilized to be safely transported. The transferring physician is responsible for determining whether the patient's condition will allow transfer. The California Code of Regulations provides, in part, that a transfer or discharge may not be carried out if, in the opinion of the patient's physician, such transfer or discharge would create a medical hazard. The transferring physician must initially evaluate the relative benefits and risks associated with transporting the patient. The determination of whether the transfer creates an unacceptable risk or a "medical hazard" will depend upon the patient's condition, the expected benefits to the patient if he or she is transferred, and whether the risks to the patient's health are outweighed by the benefits.
- b. The Receiving Facility must consent to the transfer. Title XXII licensing standards provide that a patient shall not be transferred unless and until the receiving facility has consented to accept the patient. Specifically, the California Code of Regulations provides, in part, that no patient shall be transferred or discharged for purposes of transferring to a facility, unless arrangements have been made in advance for admission to such health facility.

Therefore, the transferring clinician must secure the receiving health facility's approval in advance for the patient's admission. The transferring clinician shall document in the patient's chart that approval was obtained and from whom.

c. Informing Inmate of Transfer

The inmate shall be informed of the reasons for and destination of the transfer.

- d. The transfer process is initiated by the CMO of the sending institution, who contacts the receiving MHCB Clinical Director or designee. If the inmate meets transfer priorities and a bed is available, the transfer process begins.
- e. In cases where a transfer decision is not agreed to by the CMO of the sending institution and the Clinical Director or designee of the MHCB, and the clinical need for transfer remains, the CMO of the sending institution may request a higher level review through the Health Care Administrator.
- f. Institutions wishing to transfer an inmate shall submit a copy of the inmate movement worksheet for each inmate. All classification data shall be available to

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the receiving institution prior to transfer. A relevant medical summary shall be available to the receiving institution no later than the time of transfer.

g. Documentation and Classification

Documentation and classification of inmates accepted for transfer to another institution shall be consistent with procedures outlined in the Department Operations Manual (DOM). Responsibilities in the transfer and acceptance process shall include:

- (1) Sending institution medical staff generates and distributes CDC Form 1683;
 - (2) Transfers to the MHCB do not require institution classification review and approval. MHCB transfers shall be done under authority as "Emergency Medical Transfers" (DOM 62080.18). Upon acceptance of a MHCB transfer by the CMO of the MHCB receiving institution and completion of transportation arrangements, the C&PR at the MHCB receiving institution shall contact the Classification Services Unit for Teletype transfer approval (i.e., endorsement);
 - (3) Sending institution completes the appropriate classification processes required for transfer of an inmate as outlined in DOM Section 62010.4 et seq.;
 - (4) Sending institution shall clearly indicate on CDC Form 135 that the purpose of the transfer is for psychiatric treatment;
 - (5) Sending CMO generates and distributes CDC Form 128-C, documenting acceptance by receiving CMO.
- h. The Receiving and Release Sergeant shall notify the MHCB when the inmate arrives. An inmate who arrives by special transport because of urgent acuity shall be screened by a physician. If immediate admission is not possible, an inmate shall be housed in appropriate institution housing until a bed is available. (Title XXII Section 79789)

E. Discharge Planning

1. Purpose

These Policies and Procedures outline the Discharge Planning Process.

2. Discharge Assessment

Recognizing that an inmate's stay in the MHCB is 10 days or less, release or discharge plans shall be an integral part of all interdisciplinary treatment plans and shall be updated by a treating clinician with every case review. Discharge from MHCB is always accompanied by a transfer summary or discharge plan describing recommendations for aftercare. Once completed, referrals for appropriate aftercare

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placement shall be documented by a MHCB clinical staff member in the inmate's treatment plan.

3. Discharge Planning Policy

- a. The goal of Discharge Planning is the continuity of high quality inmate care in a safe environment, in the least restrictive environment, and at the most economical cost.
- b. It is the responsibility of the MHCB to provide for continuity of inmate care upon discharge to another level of care, another facility, or self-care.
- c. The inmate's medical and mental health records shall be transferred to the receiving institution at the time of discharge. Copies of admission and discharge reports, and identification information of the inmates, shall be kept on file at the sending institution. Files of discharged MHCB inmates shall be stored adjacent to files of current MHCB inmates, in the same type of filing structure.
- d. The inmate has a right to information regarding discharge on an ongoing basis during his or her stay in the MHCB.
- e. The inmate shall complete treatment in the MHCB and return to less restrictive housing with whatever continuing care is required.

4. Coordination of Discharge Services

- a. Discharge Planning is the coordination of services that facilitate the continuity of care or aftercare services.
- b. In order for Discharge Planning to be effective, it must be individualized and take into consideration the unique needs of each inmate.
- c. It is essential for staff to work closely with other professional disciplines or individuals in order to identify each inmate's aftercare service needs, make early referrals and coordinate pertinent information to be transmitted within or outside the facility.
- d. The factors to be considered for developing a Discharge Plan shall include an assessment of the needs of the inmate for medical, psychiatric, psychological, social work and rehabilitative services; nursing services; education services; and transportation.

5. Process for Discharge Planning

- a. Planning for discharge is initiated at the time of admission.

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- b. The Plan shall include an assessment by members of the interdisciplinary treatment team of the inmate's need for further service.
- c. The Plan shall include participation by the inmate to facilitate inmate responsibility for his or her care and treatment.
- d. The Plan ensures that needed services are available at the appropriate level of care.
- e. The Plan reflects appropriate coordination with and utilization of MHCBC custody staff.
- f. The Plan includes contacting, by a treating clinician prior to transfer, appropriate clinicians at the receiving institution, by both telephone and telefax, and informing the clinicians about the inmate being transferred. Information sent shall include the inmate's discharge summary, custody level, treatment needs, and any significant medical conditions.

6. Responsibility for Discharge Planning

Discharge Planning is best accomplished by an interdisciplinary team approach that begins its assessment at the time of admission. A MHCBC staff person shall serve as the Discharge Coordinator, with supportive services as needed by the MHCBC Office Technician. An MHCBC Psychiatrist will be responsible for discharge orders and discharge summary. Inmate participation, which supports inmate responsibility, shall be included. (Title XXII Section 79743)

V. MENTAL HEALTH QUALITY MANAGEMENT SYSTEM (MHQMS)

Ongoing assessment of the quality of clinical services will follow the MHQMS procedures. Please refer to the MHQMS Plan.

VI. MENTAL HEALTH CRISIS BED PROGRAM -- INTRODUCTION TO DUTY STATEMENTS

This introduction documents the assumptions and conclusions which led to: (1) the selection of specific professional disciplines and, (2) the content of actual duty statements.

A. Psychiatric Staffing

1. Background:

The Correctional Treatment Center (CTC) Regulations (Section 79741) require that "each mental health treatment program shall have a clinical director who shall direct the clinical program, provide general direction to professional and non-professional staff and be responsible for the quality of clinical services performed in the facility."

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Existing job specifications provide that a Chief Psychiatrist or Senior Psychiatrist (Supervisor) may provide multidisciplinary supervision of medical staff, including nursing, psychology, social work, rehabilitation and other ancillary staff.

2. Staffing Structure:

The MHCB (to be called MHCB once licensure is achieved) shall be supervised by a Senior Psychiatrist (Supervisor), with direct therapeutic services provided by Staff Psychiatrists and Psychologists and nursing services under the direction of a Supervising Registered Nurse (RN). In developing MHCB staffing, the MHCB Task Force considered the appropriate level of clinical management to ensure the most effective and efficient provision of services. It has recommended that a Senior Psychiatrist (Supervisor) serve as MHCB Clinical Director. If a directive is given to have this position filled by a Chief Psychiatrist, this classification shall be utilized to provide clinical management services.

B. Rehabilitative Staffing

1. Background:

The MHCB was developed as a CTC-based component of the Mental Health Services Delivery System (MHS), which provides comprehensive mental health treatment to the seriously mentally ill inmate. The MHCB is a very short-term, highly acute inpatient treatment program designed to provide intensive psychiatric intervention to such inmates in acute symptomatic crises. Its primary therapeutic goals are control of symptoms and stabilization of behavior, so that the inmate may then be evaluated and transferred to the most suitable clinical (or non-clinical) setting. MHCB staff therefore have a treatment focus primarily on the inmate's immediate situation, with an evaluative and planning focus aimed at the inmate's longer-term treatment needs. Given the acuity and relatively small size of the MHCB and its staffing, it was assessed as unrealistic to substitute Psychiatric Technicians for Registered Nursing functions.

2. Staffing Structure:

The MHCB Task Force considered various professional discipline solutions to the CTC regulation for Optional services, Mental Health Treatment Program requirement for Rehabilitation Services. Given the brief nature of MHCB treatment (up to ten days) and the acuity of the mental health problems, the Task Force recommended that the responsibilities be focused on evaluation of living skills, activities of daily living, time structuring, time alternatives to substance abuse and specialized programs and services promoting positive social interaction and productive personal actions. Such evaluation is used for the Treatment Plan, After-Care Planning and related therapeutic components. The Task Force recommended that these responsibilities be performed by a Recreational Therapist (see separate Duty Statement). If a directive is given to have these responsibilities be filled by a

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Psychiatric Technician, this classification shall be utilized to provide direct rehabilitative services.

C. Nursing Staffing

1. Background:

Since the MHCB is a licensed facility operating under the CTC license, it provides 24-hour nursing services to seriously mentally ill inmates. Its primary nursing goals are stabilization of functioning and medication levels, as needed, to support overall symptom stabilization and promote inmate evaluation and transfer to the most suitable therapeutic or non-therapeutic environment. MHCB nursing staff therefore have a treatment focus primarily on the inmate's immediate condition and need for stabilizing medical/mental health services. The nursing staff is required to cover both the mental health and the medical service needs of the entire CTC. Given the acuity and relatively small size of the MHCB and its staffing, it was assessed as unrealistic to substitute Psychiatric Technicians for Registered Nursing functions.

2. Staffing Structure:

To accomplish its nursing goals, the CTC shall be staffed with a Director of Nursing (DON), who shall direct all nursing services, including those of the MHCB. There shall be a Supervising RN in charge of the MHCB nursing staff. This includes direct supervision of RNs, Medical Technical Assistants (MTA) (or Psychiatric Technicians) and Recreation Therapists. If a directive is given to have Rehabilitation Services provided by a Psychiatric Technician, this classification shall be substituted. The Supervising RN shall also provide or arrange for training for all nursing staff, such as the specialized training required for delivery of rehabilitative services by a Recreation Therapist or a Psychiatric Technician.

D. Clerical Services

1. Background:

As a 24-hour, acute care crisis program, the MHCB shall provide very short-term services of a highly intensive nature. Its primary clerical responsibilities are the most intensive in the MHSDS, and include the rapid development of evaluations and assessments into reports through transcription, maintenance of active inmate files for ready access by all mental health staff and effective records management to promote efficient records transfer upon inmate discharge and transfer to another program or back to the general population. Clerical support for treatment team meetings, interdisciplinary consultations, training modules and program evaluations is also critical. MHCB clerical staff therefore have a focus on rapid document development turnaround, ready access to clinical information and efficient records disposition procedures.

2. Staffing Structure:

To accomplish its clerical goals, the MHCB shall be staffed with two clerical classifications, the Medical Transcriber (MT) and the Office Technician (OT). Although one MT is allocated specifically to a service area MHCB, the MT shall be placed into a transcriber pool for the entire institution, and different individual MTs shall transcribe MHCB reports as the reports come in to the pool. Placement of the MHCB MT into the pool shall fill the transcription needs of the MHCB workload. This system is designed to deliver the fastest turnaround time for transcribed documents. The MTs do transcribing almost exclusively, with other tasks performed only on an exceptional basis. The MT shall report to a Supervising Medical Transcriber located in the transcriber pool area. The OT shall be located in the MHCB, and shall report to the Chief Psychiatrist. The OT provides direct overall clerical support services to all other MHCB staff, including record-keeping, document preparation, telephone service and general communications, staff reception into MHCB, correspondence and ordering of supplies equipment.

**3. CALIFORNIA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
CORRECTIONAL TREATMENT CENTER/MENTAL HEALTH CRISIS BEDS
PROGRAM**

INTRODUCTION TO DUTY STATEMENTS

This introduction documents the assumptions and conclusions which led to: (1) the selection of specific professional disciplines and, (2) the content of actual duty statements.

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1. Background:

The CTC Regulations (Section 79741) require that "each mental health treatment program shall have a clinical director who shall direct the clinical program, provide general direction to professional and non-professional staff and be responsible for the quality of clinical services performed in the facility."

Existing job specifications provide that a Chief Psychiatrist or Senior Psychiatrist (Supervisor) may provide multidisciplinary supervision of medical staff, including nursing, psychology, social work, rehabilitation and other ancillary staff.

2. Staffing Structure:

The MHCB (to be called MHCB once licensure is achieved) shall be supervised by a Senior Psychiatrist (Supervisor), with direct therapeutic services provided by Staff Psychiatrists and Psychologists and nursing services under the direction of a Supervising Registered Nurse. In developing MHCB staffing, the MHCB Task Force considered the appropriate level of clinical management to ensure the most effective and efficient provision of services. It has recommended that a Senior Psychiatrist (Supervisor) serve as MHCB Clinical Director. If a directive is given to have this position filled by a Chief Psychiatrist, this classification shall be utilized to provide clinical management services.

B. Rehabilitative Staffing

1. Background:

The MHCB was developed as a CTC-based component of the Mental Health Services Delivery System, which provides comprehensive mental health treatment to the seriously mentally ill inmate. The MHCB is a very short-term, highly acute inpatient treatment program designed to provide intensive psychiatric intervention to such inmates in acute symptomatic crises. Its primary therapeutic goals are control of symptoms and stabilization of behavior, so that the inmate may then be evaluated and transferred to the most suitable clinical (or non-clinical) setting. MHCB staff therefore have a treatment

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focus primarily on the inmate's immediate situation, with an evaluative and planning focus aimed at the inmate's longer-term treatment needs. Given the acuity and relatively small size of the MHCB and its staffing, it was assessed as unrealistic to substitute Psychiatric Technicians for Registered Nursing functions.

2. Staffing Structure:

The MHCB Task Force considered various professional discipline solutions to the CTC regulation for Optional services, Mental Health Treatment Program requirement for Rehabilitation Services. Given the brief nature of MHCB treatment (up to 10 days) and the acuity of the mental health problems, the Task Force recommended that the responsibilities be focused on evaluation of living skills, activities of daily living, time structuring, time alternatives to substance abuse and specialized programs and services promoting positive social interaction and productive personal actions. Such evaluation is used for the Treatment Plan, After-Care Planning and related therapeutic components. The Task Force recommended that these responsibilities be performed by a Recreational Therapist (see separate Duty Statement). If a directive is given to have these responsibilities be filled by a Psychiatric Technician, this classification shall be utilized to provide direct rehabilitative services.

C. Nursing Staffing

Background:

1. Since the MHCB is a licensed facility operating under the CTC license, it provides 24-hour nursing services to seriously mentally ill inmates. Its primary nursing goals are stabilization of functioning and medication levels, as needed, to support overall symptom stabilization and promote inmate evaluation and transfer to the most suitable therapeutic or non-therapeutic environment. MHCB nursing staff therefore have a treatment focus primarily on the inmate's immediate condition and need for stabilizing medical/mental health services. The nursing staff is required to cover both the mental health and the medical service needs of the entire CTC. Given the acuity and relatively small size of the MHCB and its staffing, it was assessed as unrealistic to substitute Psychiatric Technicians for Registered Nursing functions.

2. Staffing Structure:

To accomplish its nursing goals, the CTC shall be staffed with a Director of Nursing, who shall direct all nursing services, including those of the MHCB. There shall be a Supervising Registered Nurse in charge of the MHCB nursing staff. This includes direct supervision of Registered Nurses, Medical Technical Assistants (or Psychiatric Technicians) and Recreation Therapists. If a directive is given to have Rehabilitation Services provided by a Psychiatric Technician, this classification shall be substituted. The Supervising Registered Nurse shall also provide or arrange for training for all nursing staff, such as the specialized training required for delivery of rehabilitative services by a Recreation Therapist or a Psychiatric Technician.

D. Clerical Services

1. Background:

As a 24-hour, acute care crisis program, the MHCB shall provide very short-term services of a highly intensive nature. Its primary clerical responsibilities are the most intensive in the MHSDS, and include the rapid development of evaluations and assessments into reports through transcription, maintenance of active inmate files for ready access by all mental health staff and effective records management to promote efficient records transfer upon inmate discharge and transfer to another program or back to the general population. Clerical support for treatment team meetings, interdisciplinary consultations, training modules and program evaluations is also critical. MHCB clerical staff therefore have a focus on rapid document development turnaround, ready access to clinical information and efficient records disposition procedures.

2. Staffing Structure

To accomplish its clerical goals, the MHCB shall be staffed with two clerical classifications, the Medical Transcriber (MT) and the Office Technician (OT). Although one MT is allocated specifically to a service area MHCB, the MT shall be placed into a transcriber pool for the entire institution, and different individual MTs shall transcribe MHCB reports as the reports come in to the pool. Placement of the MHCB MT into the pool shall fill the transcription needs of the MHCB workload. This system is designed to deliver the fastest turnaround time for transcribed documents. MTs do transcribing almost exclusively, with other tasks performed only on an exceptional basis. The MT shall report to a Supervising Medical Transcriber located in the transcriber pool area. The OT shall be located in the MHCB, and shall report to the Chief Psychiatrist. The OT provides direct overall clerical support services to all other MHCB staff, including record-keeping, document preparation, telephone service and general communications, staff reception into MHCB, correspondence and ordering of supplies equipment.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
CORRECTIONAL TREATMENT CENTER/MENTAL HEALTH CRISIS BEDS
PROGRAM**

**DUTY STATEMENT
CHIEF PSYCHIATRIST, CORRECTIONAL FACILITY
INSTITUTIONAL MHCB**

Description:

The Chief Psychiatrist, Institutional MHCB, serves as Clinical Director of the MHCB, reports directly to the Service Area Mental Health Care Manager and is responsible for functional supervision of mental health program professions in the MHCB.

Specific Duties Include:

- 25% Supervise the development, implementation and management of clinical activities and standards for effective and efficient delivery of mental health services in a MHCB.
- (20-50%) For a MHCB having less than six beds, the Chief Psychiatrist shall provide direct clinical services to inmates, including preadmission screening of referred inmates, admission and discharge, evaluation and crisis intervention treatment and medication prescription for MHCB inmates. (If this duty requires more than 20% of the Chief Psychiatrist's time, other duties will decrease proportionally.)
- 20% Supervise the selection, hiring and performance of Psychiatrists, Psychologists and Supervising Registered Nurses.
- 10% Supervise studies and audits of mental health services to identify deficiencies and recommend corrective actions to provide effective and efficient delivery of mental health care; supervise the development, implementation and management of corrective action plans to correct program deficiencies.
- 10% Provide direction to and ensure performance accountability of MHCB psychiatric/psychological staff efforts to comply with CTC licensing requirements.
- 5% Supervise preparation of or prepare reports for the Mentally Disordered Offender (PC 2960-2981 [except 2974] program.
- 5% Participate in automated data management and other health care records systems.
- 5% Perform other duties as required.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
CORRECTIONAL TREATMENT CENTER/MENTAL HEALTH CRISIS BEDS
PROGRAM**

**DUTY STATEMENT
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL FACILITY
INSTITUTIONAL MHCB**

Description:

The Senior Psychiatrist (Supervisor), Institutional MHCB, serves as Clinical Director of the MHCB, reports directly to the Institutional Chief Psychiatrist and is responsible for functional supervision of mental health program professions in the MHCB.

Specific Duties Include:

- 25% Supervise the development, implementation and coordination of clinical activities and standards for effective and efficient delivery of mental health services in a MHCB.
- 20% Supervise the selection, hiring and performance of staff level Psychiatrists and Psychologists, and Supervising Registered Nurses and assist in the coordination of their activities with those of other professional and supportive staff in the Service Area.
- (20-50%) For a MHCB having less than six beds, the Senior Psychiatrist (Supervisor) shall provide direct clinical services to inmates, including preadmission screening of referred inmates, admission and discharge, evaluation and crisis intervention treatment and medication prescription for MHCB inmates. (If this duty requires more than 20% of the Senior Psychiatrist (Supervisor)'s time, other duties will decrease proportionally.)
- 10% Supervise studies and audits of mental health services to identify deficiencies and recommend corrective actions to provide effective and efficient delivery of mental health care; supervise the development, implementation and management of corrective action plans to correct program deficiencies.
- 10% Provide direction to and ensure performance accountability of MHCB psychiatric/psychological staff efforts to comply with CTC licensing requirements.
- 5% Supervise preparation of or actually prepare reports for the Mentally Disordered Offender (PC 2960-2981 [except 2974] program.
- 5% Participate in automated data management and other health care records systems.
- 5% Perform other duties as required.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
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CORRECTIONAL TREATMENT CENTER/MENTAL HEALTH CRISIS BEDS
PROGRAM**

**DUTY STATEMENT
STAFF PSYCHIATRIST, CORRECTIONAL FACILITY
INSTITUTIONAL MHCB**

Description:

The Staff Psychiatrist, Institutional MHCB, reports directly to the MHCB Clinical Director and is responsible for providing psychiatric treatment, evaluations, consultations and prescribing psychiatric medication in the MHCB.

Specific Duties Include:

- 40% Provide direct clinical services to inmates, including preadmission screening of referred inmates, admission and discharge, evaluation and crisis intervention treatment and medication prescription for MHCB inmates.
- 25% Attend interdisciplinary team conferences. Participate in the development of an individualized treatment plan and discharge plan for each inmate-patient.
- 10% Participate as needed in studies and audits of mental health services to identify deficiencies and recommend corrective actions to provide effective and efficient delivery of mental health care, as well as the implementation of corrective action plans to correct program deficiencies.
- 5% Prepare reports for the Mentally Disordered Offender (PC 2960-2981 [except 2974] program).
- 5% Participate in program evaluation and quality assurance.
- 5% Consult with psychiatric, nursing and other staff regarding patient care.
- 5% Participate in automated data management and other health care records systems.
- 5% Perform other duties as required.

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CALIFORNIA DEPARTMENT OF CORRECTIONS MENTAL HEALTH SERVICES CORRECTIONAL TREATMENT CENTER/MENTAL HEALTH CRISIS BEDS PROGRAM

DUTY STATEMENT DIRECTOR OF NURSING (CORRECTIONAL TREATMENT CENTER)

Description:

The Director of Nursing reports directly to the CTC Chief Medical Officer and is responsible for functional supervision of line nursing staff and nursing administration, including direct supervision of the Supervising Registered Nurse, mental health, which includes the MHCB, and direct supervision of the Supervising Registered Nurse, medical.

Specific Duties Include:

- 30% Supervise CTC Nursing staff in both the Medical/Surgical Unit and Mental Health facilities, including the MHCB.
- 10% Participate as a member of the interdisciplinary team in developing multidisciplinary treatment efforts.
- 10% Supervise the administration of psychiatric medications and mental health treatment.
- 10% Provide observation, ongoing patient assessment and therapeutic intervention.
- 10% Communicate with clinicians.
- 10% Supervise the documentation of all nursing activities in the medical record.
- 5% Ensure a safe therapeutic environment.
- 5% Provide skills and training in the activities of daily living to patients.
- 5% Participate in automated data management and other health care records systems.
- 5% Perform other duties as required.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
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PROGRAM**

**DUTY STATEMENT
SUPERVISING REGISTERED NURSE (MENTAL HEALTH)**

Description:

Supervising Registered Nurses report directly to the CTC Director of Nursing. One Supervising Registered Nurse is responsible for functional supervision of line nursing staff and nursing administration for all medical services, and the other is responsible for functional supervision of line nursing staff and nursing administration for all mental health services. Since one of these supervisors may be used per shift, MHCB nursing functions may be supervised by either the medical or mental health Supervising Registered Nurse. The duties and percentages indicated below comprise only those duties related to MHCB nursing supervision and do not reflect supervising nurse duties in any area of the CTC outside the MHCB. Specific Duties Include:

- 20% Supervise Nursing Staff of the MHCB, the Medical Technical Assistant (if any) and Mental Health Worker staff activities, as well as those of the Recreational Therapist (if any) and/or the Psychiatric Technician (if any).
- 15% Supervise the administration of psychiatric medications and mental health treatment.
- 10% Participate as a member of the interdisciplinary team in developing multidisciplinary treatment efforts.
- 10% Provide observation, ongoing patient assessment and therapeutic intervention.
- 10% Communicate with clinicians.
- 10% Document all nursing activities in the medical record.
- 5% Ensure a safe therapeutic environment.
- 5% Assist with group activities.
- 5% Provide skills and training in the activities of daily living to patients.
- 5% Participate in automated data management and other health care records systems.
- 5% Perform other duties as required.

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CALIFORNIA DEPARTMENT OF CORRECTIONS MENTAL HEALTH SERVICES CORRECTIONAL TREATMENT CENTER/MENTAL HEALTH CRISIS BEDS PROGRAM

DUTY STATEMENT REGISTERED NURSE (PSYCHIATRIC RESPONSIBILITIES)

Description:

The Registered Nurse reports directly to the Supervising Registered Nurse and is responsible for nursing mental health treatments and services in the MHCBS.

Specific Duties Include:

- 40% Administer psychiatric medications and mental health treatment.
- 10% Participate as a member of the interdisciplinary team in developing multidisciplinary treatment efforts.
- 10% Provide observation, ongoing inmate assessment and therapeutic intervention.
- 10% Direct the Medical Technical Assistant and Mental Health Worker staff activities, as well as those of the Recreational Therapist (if any) and/or the Psychiatric Technician (if any).
- 10% Document all nursing activities in the medical record.
- 5% Ensure a safe therapeutic environment.
- 5% Assist with group activities.
- 5% Provide skills and training in the activities of daily living to inmates.
- 5% Participate in automated data management and other health care records systems.
- 5% Perform other duties as required.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
CORRECTIONAL TREATMENT CENTER/MENTAL HEALTH CRISIS BEDS
PROGRAM**

**DUTY STATEMENT
SENIOR PSYCHOLOGIST (SUPERVISOR)**

Description:

The Senior Psychologist (Supervisor), Institutional MHCB, provides general supervision of the Psychologist staff of the MHCB, reports directly to the Institutional Chief Psychiatrist and is responsible for development and supervision of crisis treatment modalities and coordination of Psychologist activities in the MHCB.

Specific Duties Include:

- 25% Supervise the development, implementation and coordination of clinical activities and standards for Psychologists for effective and efficient delivery of mental health services in a MHCB.
- 20% Supervise the selection, hiring and performance of staff level Psychologists and assist in the coordination of their activities with those of other professional and supportive staff in the Service Area.
- (20-50%) For a MHCB having less than six beds, the Senior Psychologist (Supervisor) shall provide direct clinical services to inmates, including facilitating admission, development of treatment plan treatment modalities, evaluation and crisis intervention treatment and discharge planning for MHCB inmates. (If this duty requires more than 20% of the Senior Psychologist (Supervisor)'s time, other duties will decrease proportionally.)
- 10% Act as lead for and participate in studies and audits of mental health services to identify deficiencies and recommend corrective actions to provide effective and efficient delivery of mental health care; act as lead for and participate in the development, implementation and management of corrective action plans to correct program deficiencies.
- 10% Provide direction to and ensure performance accountability of MHCB psychological staff efforts to comply with CTC licensing requirements.
- 5% Prepare and review MHCB program activity reports and statistics.
- 5% Participate in automated data management and other health care records systems.
- 5% Perform other duties as required.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
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CORRECTIONAL TREATMENT CENTER/MENTAL HEALTH CRISIS BEDS
PROGRAM**

**DUTY STATEMENT
PSYCHOLOGIST - CLINICAL, CORRECTIONAL FACILITY**

Description:

The Psychologist - Clinical, Correctional Facility reports to the MHCB Clinical Director, and is responsible for preadmission screenings, psychologist evaluation of inmates admitted to the program, crisis intervention, individual therapy, treatment and discharge planning, participating in interdisciplinary team evaluations, and consulting with the psychiatrist, nursing and other staff. The psychologist may be assigned other clinical duties throughout the institution, including participation in staff meetings, institutional committees, and consults with custody staff, as well as supervision and training to students, interns, unlicensed psychologists and other staff. The psychologist may also participate in program evaluation and research, and may provide consultation on research design and analysis of data.

Specific Duties Include:

- 30% Facilitates admission and does complete psychological evaluations of inmates admitted to the treatment program as appropriate. This includes a written report with diagnosis and recommendations for treatment.
- 25% Provides crisis intervention and individual therapy to inmates admitted to the treatment program.
- 20% Attends interdisciplinary team conferences. Participates in the development of an individualized treatment plan and discharge plan for each inmate.
- 10% Does preadmission screening of inmates referred to the treatment program.
- 5% Participates in program evaluation and quality assurance.
- 5% Consults with psychiatric, nursing and other staff regarding inmate care.
- 5% Participates in automated data management and other health care records systems.
- 5% Attends staff meetings, and performs other clinical and institution-wide duties as required.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
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PROGRAM**

**DUTY STATEMENT
PSYCHIATRIC SOCIAL WORKER**

Description:

The Psychiatric Social Worker reports to the MHCB Clinical Director, and is responsible for treatment plan development and revisions, discharge planning, participation in admission evaluations, crisis intervention, individual therapy, participation in interdisciplinary team evaluations, and consulting with the psychiatrist, psychologist, nursing and other staff. The Psychiatric Social Worker may be assigned other clinical support duties, including participation in staff meetings and consults with custody staff. The Psychiatric Social Worker may also support program evaluation and research efforts, including consultation on research design and analysis of data.

Specific Duties Include:

- 30% Provides Treatment Plan and Discharge Plan development, review, updating and consultation with other MHCB clinical staff.
- 20% Participates in clinical evaluations of inmates admitted to the MHCB, including assessments of daily living skills, overall level of functioning, and needed resources for maintenance of behavior following stabilization and discharge.
- 15% Provides and participates in individual therapy for MHCB inmates, including therapy in areas of Stress Reduction, Post-Discharge Planning and Referral and Activities of Daily Living.
- 15% Attends interdisciplinary team conferences. Participates in general review of MHCB inmates' status.
- 10% Provides MHCB program consultation to custody staff, relative to needs for behavior assessment and symptoms stabilization and discharge planning.
- 5% Participates in program evaluation and quality assurance and supports research efforts to improve program design and operation.
- 5% Consults with psychiatric, psychology, nursing and other staff regarding inmate care.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
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PROGRAM**

**DUTY STATEMENT
RECREATION THERAPIST (PROVIDING REHABILITATION SERVICES)**

Description:

The Recreation Therapist reports directly to the CTC Supervising Registered Nurse (and may have direction from the MHCB Registered Nurse), and is responsible for developing, and evaluating and preparing inmates for and initiating them into, specialized programs and services which promote social interaction, encourage profitable and appropriate use of leisure time and provide preparation for re-entry to the general population or another level of treatment. Participation on Interdisciplinary Treatment Teams and planning with primary clinicians, correctional counselors and other custody personnel is essential to the evaluation and initiation of recreational activities geared to clinical improvement in the level of inmate functioning in the MHCB.

Specific Duties Include:

- 30% Evaluate inmates with crisis-level, acute functional impairments due to serious mental illness for skills assessment, activities of daily living, communication skills, physical exercise and creative expression.
- 20% Provide treatment plan input regarding recreational activities and other therapeutic components to be initiated near or after discharge from the MHCB.
- 20% Develop and promote clinically oriented recreational and daily living programs to be initiated near or after discharge from the MHCB.
- 15% Provide clinical oversight of evaluative and planning functions for recreational activities provided by support staff, including Psychiatric Technicians and Medical Technical Assistants.
- 10% Provide Aftercare to Interdisciplinary Treatment Team treatment planning and case reviews.
- 5% Participate in automated data management and other health care records systems.
- 5% Perform other duties as required.

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CALIFORNIA DEPARTMENT OF CORRECTIONS MENTAL HEALTH SERVICES CORRECTIONAL TREATMENT CENTER/MENTAL HEALTH CRISIS BEDS PROGRAM

DUTY STATEMENT PSYCHIATRIC TECHNICIAN (PROVIDING REHABILITATION SERVICES)

Description:

The Psychiatric Technician reports directly to the CTC Supervising Nurse, (and may have direction from the MHCB Registered Nurse), and is responsible for assisting patients with living skills, evaluating inmates for rehabilitative needs for improving personal functioning, and preparing inmates for and initiating them into specialized programs and services which promote social interaction, improve overall functioning, develop appropriate personal skills and more productive use of leisure time and provide preparation for re-entry to the general population or another level of treatment. Participation on Interdisciplinary Treatment Teams and planning with primary clinicians, correctional counselors and other custody personnel is essential to the evaluation and initiation of recreational activities geared to clinical improvement in the level of inmate functioning in the MHCB.

Specific Duties Include:

- 25% Evaluate inmates with crisis-level, acute functional impairments due to serious mental illness for skills assessment, activities of daily living, communication skills, physical exercise and creative expression.
- 25% Carry out clinically oriented recreational and daily living programs to be initiated near or after discharge from the MHCB.
- 15% Observe physical condition and behavior and reports significant changes and records nursing notes.
- 15% Provide treatment plan input regarding recreational activities and other therapeutic components to be initiated near or after discharge from the MHCB.
- 10% Provide Aftercare to Interdisciplinary Treatment Team treatment planning and case reviews.
- 5% Under general supervision, assist with nursing procedures as needed.
- 5% Participate in automated data management and other health care records systems.
- 5% Perform other duties as required.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
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**DUTY STATEMENT
MEDICAL TRANSCRIBER**

Description:

The Medical Transcriber reports to the Supervising Medical Transcriber in the transcriber pool, and is responsible for transcribing dictated documents into hard copy and preparing these copies for return to MHCB clinical staff.

Specific Duties Include:

- 75% Transcribe dictated reports, evaluations, assessments and other documents into a hard copy form, producing printed documents in final form for use by clinical and support staff.
- 20% Prepare transcribed documents for return to MHCB clinical and support staff. Deliver documents to MHCB staff if necessary.
- 5% Participate in automated data management and other health care records systems.
- 5% Perform other duties as required.

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CALIFORNIA DEPARTMENT OF CORRECTIONS MENTAL HEALTH SERVICES CORRECTIONAL TREATMENT CENTER/MENTAL HEALTH CRISIS BEDS PROGRAM

DUTY STATEMENT: OFFICE TECHNICIAN

Description:

The Office Technician reports to the Clinical Director, MHCB, and is responsible for record-keeping, document preparation, telephone service and general communications, staff reception into MHCB, correspondence and ordering of supplies and equipment.

Specific Duties Include:

- 25% Maintain records system and filing arrangements for all clinical and administrative documents, including records, reports and assessments. Assure ready access and rapid filing and retrieval systems for all documents in the records system.
- 20% Word process documents prepared by any means other than dictation by MHCB clinical and support staff, including preparing documents into final form, transferring documents - especially medical records - to appropriate locations, processing documents to appropriate staff for approval and signature, and insuring appropriate copies of all documents are retained in the MHCB office as needed.
- 15% Provide communication support to MHCB staff through telephone arrangements, Fax, mail, messenger or direct contact with other offices, institutions or locations.
- 15% Participate in automated data management and other health care records systems.
- 10% Attend meetings and take notes as required, translating and word processing notes into minutes, copying final form of minutes reports and distributing to appropriate staff as directed.
- 5% Attend to administrative support arrangements regarding meetings or clinical consultations at other sites and related factors; including transportation, lodging and car rental arrangements; travel advance and refund documentation; liaison with other offices as needed.
- 5% Provide general services support for MHCB staff regarding personnel considerations, including documentation of all personnel changes as needed, benefits changes, and related issues.
- 5% Perform other duties as required.

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(f) Upon change of ownership of a CDRH, a written verification by a public accountant of all patients' monies which are being transferred to the custody of the new owners shall be obtained by the new owner in exchange for a signed receipt.

NOTE: Authority cited: Sections 1275 and 1275.2, Health and Safety Code. Reference: Sections 1250.3 and 1275.2, Health and Safety Code.

HISTORY

1. Editorial correction filed 12-15-82 (Register 82, No. 51).

§ 79357. Professional Literature.

Each CDRH shall maintain a library consistent with the needs of the CDRH staff.

NOTE: Authority cited: Sections 208(a), 1275 and 1275.2, Health and Safety Code. Reference: Sections 1250.3 and 1275.2, Health and Safety Code.

HISTORY

1. Editorial correction filed 12-15-82 (Register 82, No. 51).

§ 79359. Medical Photography.

The CDRH shall have an approved written and implemented policy which requires obtaining the patient's written consent prior to the patient being photographed.

NOTE: Authority cited: Sections 208(a), 1275 and 1275.2, Health and Safety Code. Reference: Sections 1250.3 and 1275.2, Health and Safety Code.

HISTORY

1. New section filed 12-24-82; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 83, No. 4).

§ 79361. Space Conversion.

Spaces approved for specific use at the time of licensure shall not be converted to other use without the prior approval of the Department.

NOTE: Authority cited: Sections 208(a), 1275 and 1275.2, Health and Safety Code. Reference: Sections 1250.3 and 1275.2, Health and Safety Code.

HISTORY

1. Editorial correction renumbering Article 6 (Section 79401) to Article 5 (Section 79361) filed 12-24-82 (Register 83, No. 4).

§ 79363. Hand Washing.

All personnel shall wash their hands before and after coming in direct contact with any linen or food.

NOTE: Authority cited: Sections 208(a), 1275 and 1275.2, Health and Safety Code. Reference: Sections 1250.3 and 1275.2, Health and Safety Code.

HISTORY

1. New section filed 12-24-82; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 83, No. 4).

§ 79365. General Maintenance.

(a) The CDRH shall be clean, sanitary and in good repair at all times.

NOTE: Authority cited: Sections 208(a), 1275 and 1275.2, Health and Safety Code. Reference: Sections 1250.3 and 1275.2, Health and Safety Code.

HISTORY

1. New section filed 12-24-82; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 83, No. 4).

§ 79367. Housekeeping.

(a) There shall be sufficient supplies and equipment available for housekeeping to include but not be limited to:

(1) Cleaning supplies and equipment which shall be stored in rooms for housekeeping use only.

(2) A commercial grade detergent germicide which when required shall be used for all cleaning.

(3) Mop heads which shall be removable and washed when needed.

NOTE: Authority cited: Sections 208(a), 1275 and 1275.2, Health and Safety Code. Reference: Sections 1250.3 and 1275.2, Health and Safety Code.

HISTORY

1. New section filed 12-24-82; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 83, No. 4).

79369. Maintenance Manual.

(a) A written manual on maintenance of heating, air conditioning and ventilation systems shall be adopted and implemented by each CDRH, or

(b) A record of maintenance shall be maintained.

NOTE: Authority cited: Sections 208(a), 1275 and 1275.2, Health and Safety Code. Reference: Sections 1250.3 and 1275.2, Health and Safety Code.

HISTORY

1. New section filed 12-24-82; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 83, No. 4).

Article 6. Physical Plant

NOTE: Authority cited: Sections 208(a), 1275 and 1275.2, Health and Safety Code. Reference: Sections 1250.3 and 1275.2, Health and Safety Code.

HISTORY

1. Editorial correction renumbering Article 6 (Section 79401) to Article 5 (Section 79361) filed 12-24-82 (Register 83, No. 4).

Chapter 12. Correctional Treatment Centers

Article 1. Definitions

§ 79501. Accredited Record Technician.

Accredited record technician means a person who is accredited or eligible for accreditation by the American Medical Records Association.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New chapter 12, article 1 and section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79503. Audiologist.

Audiologist means a person licensed as an audiologist by the Medical Board of California.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79507. Biological.

Biological means a product, virus, serum, toxin, antitoxin, or analogous product derived from living matter applicable to prevention, treatment or cure of disease or injury in humans.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79509. Clinical Psychologist.

Clinical psychologist means a person licensed as a psychologist by the Board of Psychology and (1) who possesses an earned doctorate degree in psychology from an educational institution meeting the criteria for subdivision (c) of Section 2914 of the Business and Professions Code and (2) has not less than two years clinical experience in a multidisciplinary facility licensed or operated by this or another State or by the United States to provide health care, or (3) is currently listed in the National Register of Health Service Providers in Psychology, as adopted by the council for the National Register of Health Service Providers in Psychology. On the effective date of this regulation, a licensed psychologist employed in a correctional setting providing inpatient mental health care for at least two years shall be deemed to meet the requirements of the regulation.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254 and 1316.5(c), Health and Safety Code; and Sections 2902 and 2903, Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79511. Clinical Restraint.

Clinical restraint means the use of a physical restraining device, during a period of mental health treatment, as a measure to protect the inmate-

patient from injury to self or others when alternative methods are not sufficient.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79513. Clinical Seclusion.

Clinical seclusion means the isolation during the period of mental health treatment of an inmate-patient in a separate, locked area, including a padded room, for the purpose of preventing injury to self or others.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79515. Communicable Disease.

Communicable disease means an illness due to a specific disease producing agent (virus, bacteria, etc.) or its toxic products which arises through transmission of that agent, or its products, from an infected person, animal, or other reservoir to a susceptible host—either directly as from an infected person or animal, or indirectly through the agency of an intermediate plant or animal host, vector or the inanimate environment.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79516. Correctional Treatment Center.

A correctional treatment center is a health facility with a specified number of beds within a state prison, county jail or California Youth Authority facility designated to provide health care to that portion of the inmate population who do not require general acute care level of services but are in need of professionally supervised health care beyond that normally provided in the community on an outpatient basis. Outpatient housing is not under the jurisdiction of this Chapter.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79517. Decubitus Ulcer.

(a) A decubitus ulcer is a lesion of the skin, which is caused by pressure.

(b) The stages of decubitus ulcers are described as follows:

(1) Stage I—Not a decubitus ulcer of itself but, rather, the precursor phase of a decubitus ulcer which is characterized by redness of the skin which is not relieved by local circulatory stimulation and/or relief of pressure.

(2) Stage II—Superficial circulatory and tissue damage which involves abrasion or skin break.

(3) Stage III—Full thickness loss of skin which may or may not include the second level and which produces drainage.

(4) Stage IV—Full thickness loss of skin with invasion of deeper tissues and/or structures such as connective tissue, muscle or bone.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79519. Dentist.

Dentist means a person licensed as such by the Board of Dental Examiners of California, pursuant to Business and Professions Code Section 1600 et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 1600, Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79521. Department.

Department means the State Department of Health Services or its delegate, pursuant to Section 1257, Health and Safety Code.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254 and 1257, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79523. Dietitian.

Dietitian means a person who is registered or is eligible for registration as a Registered Dietitian by the American Dietetic Association.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79525. Director.

Director means the Director of the State Department of Health Services.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79527. Drug Administration.

Drug administration means the act in which a single dose of a prescribed drug or biological is given to a patient. The complete act of administration entails removing an individual dose from a container (including a unit dose container), verifying the dose with the prescriber's orders, identifying the patient, giving the individual dose to the patient, and promptly recording the time, method of administration, and dose given.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79529. Drug Dispensing.

Drug dispensing means the interpretation of an order for a drug or biological and, pursuant to that order, the proper selection, measuring, packaging, labeling, and issuance of the drug or biological for a patient or for a service unit of the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79531. Governing Body.

Governing body means the person, persons, board of trustees, directors, or other body in whom the authority and responsibility is vested for conduct of the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79533. Infectious Disease.

Infectious disease means any disease caused by the growth of pathogenic microorganisms in the body. It may or may not be contagious.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79534. Informed Consent.

Informed consent means the voluntary agreement of an inmate-patient or a representative, in accordance with state law, of an incapacitated inmate-patient to accept a treatment or procedure after receiving material information concerning the treatment or procedure.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and *Cobb v. Grant* (1972) 8 Cal3d 229.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79535. Inmate.

Inmate, as used in the correctional treatment center regulations, means a detainee or offender who is under sentence to, or confined in, a prison, jail, or other correctional institution operated by the Department of Corrections, the Department of the Youth Authority, a county, city, or city and county law enforcement agency.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79537. Inmate-Patient.

Inmate-patient means an inmate who is receiving care and supervision in a correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79539. Licensed Clinical Social Worker.

Licensed clinical social worker means a person who possesses a master's degree from an accredited school of social work and two years of post master's experience in a mental health setting, and possesses a license as a clinical social worker from the Board of Behavioral Science Examiners, pursuant to Business and Professions Code Section 4996, et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 4996, Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79541. Licensed Vocational Nurse.

Licensed vocational nurse means a person licensed as such by the Board of Vocational Nurse and Psychiatric Technician Examiners, pursuant to Business and Professions Code Section 2840, et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 2840, Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79543. Licensed Marriage, Family, and Child Counselor.

Licensed marriage, family and child counselor means a person who possesses a master's degree from a school meeting the requirements of Sections 4980.37, 4980.40 and 4980.41 of the Business and Professions Code and 3000 hours of supervised experience in a mental health setting, who possesses a license as a marriage, family and child counselor by the Board of Behavioral Science Examiners, pursuant to Business and Professions Code Section 4980, et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; Section 5751.3,

Welfare and Institutions Code; and Sections 4980, 4980.37, 4980.40 and 4980.41, Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79547. Mental Health Worker.

Mental health worker means a person who does not necessarily qualify as a mental health professional, but who, through experience, in-service training, or formal education, is qualified to participate in the care of the psychiatric patient.

NOTE: Authority cited: Sections 208(a) and 1267.10(d), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79549. Nursing Unit.

Nursing unit means a designated inmate-patient care area of a correctional treatment center which is planned, organized, operated and maintained to function as a unit. It includes patients' rooms with adequate support accommodations, services and personnel providing nursing care and necessary management of inmate-patients.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79551. Occupational Therapist.

Occupational therapist means a person who is certified or eligible for certification as an occupational therapist registered by the American Occupational Therapy Association. The occupational therapist shall be a graduate of a curriculum in occupational therapy approved by the Council on Education of the American Medical Association in collaboration with the American Occupational Therapy Association.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79553. On-Call.

On-call means immediately available for consultation by telephone and available to be in the facility within sixty minutes if requested to do so.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79555. Outpatient Housing Unit.

An outpatient housing unit means a housing unit of a city, county or city and county law enforcement facility established to retain inmates who require special housing for security or protection. Typically, these are inmates whose health condition would not normally warrant admission to a licensed health care facility and for whom housing in the general population may place them at personal or security risk. Outpatient housing unit residents may receive outpatient health services and assistance with the activities of daily living. Outpatient housing unit beds are not licensed correctional treatment center beds.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79557. Pharmacist.

Pharmacist means a person licensed as such by the California State Board of Pharmacy pursuant to the Business and Professions Code Sections 4000 et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79559. Physical Therapist.

(a) Physical therapist means a person licensed as such by the Medical Board of California.

(b) Physical therapist assistant means a person who is approved as such the Physical Therapy Examining Committee of the Medical Board of California.

(c) Physical therapist aide means a person who, under the direct supervision of a licensed physical therapist, assists with physical therapy care.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79561. Physician.

(a) Physician means a person licensed as a physician and surgeon by the Medical Board of California or by the Osteopathic Medical Board.

(b) Attending physician means the physician responsible for the medical treatment of the patient in the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79563. Podiatrist.

Podiatrist means a person licensed as such by the Board of Podiatric Medicine of the Medical Board of California pursuant to Business and Professions Code Sections 2460 et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code; and Sections 2460 through 2499.6 (inclusive), Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79564. Psychiatric Mental Health Nurse.

Psychiatric mental health nurse means a registered nurse who possesses a Master's Degree in Psychiatric Mental Health Nursing and at least two years of experience in providing psychiatric mental health counseling services under the supervision of a psychiatric mental health nurse, a licensed clinical psychologist, a licensed clinical social worker, a licensed marriage, family and child counselor, or a psychiatrist.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79565. Psychiatric Technician.

Psychiatric technician means a person who is licensed as a psychiatric technician by the Board of Vocational Nurse and Psychiatric Technician Examiners pursuant to Business and Professions Code Sections 4500 et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 4500, Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

79567. Psychiatrist.

Psychiatrist means a person who is a licensed physician and surgeon in the State of California except as allowed under Section 2072 of the Business and Professions Code and who is certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board

of Neurology and Psychiatry or has completed a residency program in psychiatry approved by the American Medical Association or the American Osteopathic Association.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 2072, Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79569. Recreation Therapist.

Recreation therapist means a person with specialization in therapeutic recreation and who is registered or eligible for registration as such by the Board of Park and Recreation Personnel or the National Therapeutic Recreation Society.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79571. Registered Nurse.

Registered nurse means a person licensed as such by the Board of Registered Nursing pursuant to Business and Professions Code Sections 2700 through 2837, inclusive.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code; and Sections 2700 through 2837, Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79573. Registered Record Administrator.

Registered record administrator means a person who is registered or eligible for registration as such by the American Medical Record Association.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79575. Supervision.

(a) Supervision means the instruction of employees or subordinates in the manner of carrying out their duties and overseeing or directing their work.

(b) Direct supervision means that the supervisor is in the same building as the person being supervised and available for consultation and/or assistance.

(c) Immediate supervision means that the supervisor is physically present while a task is being performed by the employee or subordinate.

NOTE: Authority cited: Sections 208(a) and 1267.10(f), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79577. Treatment Restraint.

Treatment restraint means the use of a restraining device during medically prescribed treatment or diagnostic procedures including, but not limited to, intravenous therapy, tube feeding or catheterization.

NOTE: Authority cited: Sections 208(a) and 1267.10(f), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79579. Unit Health Records.

Unit health records means a patient's health record that includes all records of care and treatment rendered to an inmate-patient.

NOTE: Authority cited: Sections 208(a) and 1267.10(f), Health and Safety Code.
Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

Article 2. Licensing and Inspection

§ 79581. Application Required.

(a) An application shall be submitted to the Department for a license to operate a correctional treatment center.

(b) The licensee shall submit an application for a corrected license to the Department when any of the following occur:

(1) Construction of a new or replacement correctional treatment center.

(2) Increase or decrease in licensed bed capacity.

(3) Change of license category.

(4) Change of name of correctional institution or detention facility within whose administration the correctional treatment center is established and licensed.

(5) Change of location of correctional treatment center.

(6) Change in bed classification.

(c) All applicants for an initial or renewal license shall provide to the Department, as part of the application, a detailed written list of the services to be offered or provided by the correctional treatment center. In the case of application for renewal license, the list shall include all proposed modifications to existing approved treatment services.

(d) If the Department denies the initial application for a license or a renewal of a license, the Department shall notify the applicant in writing, specifying the reasons for the denial.

(e) Within twenty (20) days of receipt of the Department's notice of denial, the licensee or applicant may present to the Department a written request for an informal hearing to decide the issue of whether or not the Department properly denied the applicant's initial or renewal application. The informal hearing shall be held by the Department as soon as possible, but not later than thirty (30) calendar days after the Department's receipt of the applicant's or licensee's written request. The licensee or applicant may request a formal administrative adjudication pursuant to Health and Safety Code Section 1269.

(f) The provisions of this article do not apply to any facility in which the services provided consist only of emergency stabilization pending transfer to another licensed health facility, or limited health care services that would normally be provided in the home under the care of a physician.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New article 2 and section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79583. Safety, Zoning, and Building Clearance.

(a) A license shall not be issued to any correctional treatment center that does not conform to the State Fire Marshal's requirements for fire and life safety, California Code of Regulations, Title 19, Division 1, commencing with Section 1.03 and the California Code of Regulations, Title 24, Parts 2, 3, 4, 5, 9 and 12, and local fire safety, zoning and building ordinances. Evidence of compliance with these requirements shall be presented to the Department in writing.

(b) It shall be the responsibility of the licensee to maintain the correctional treatment center in a safe structural condition. If the Department determines that an evaluation of the structural condition of a correctional treatment center is necessary, the licensee may be required to submit a report, prepared by a licensed structural engineer, establishing a basis for eliminating or correcting the structural conditions which are found to be hazardous to occupants.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79585. Issuance, Expiration, and Renewal.

(a) Each license shall expire at 11:59 p.m. on the date of expiration.

(b) Each initial license issued pursuant to this chapter shall expire twelve (12) months from the date of its issuance and shall expire on the expiration date of the license. Application for renewal of a license or special permit fee shall be filed with the Department not less than thirty (30) days prior to the expiration date. Failure to make a timely renewal shall result in expiration of the license or special permit.

(c) A renewal license may be issued for a period not to exceed two years if the holder of the license or special permit has been found in substantial compliance with all statutory requirements, regulations or standards during the preceding license period.

NOTE: Authority cited: Sections 208(a), 1267 and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254 and 1267, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79587. Separate License.

(a) Separate licenses shall be required for each correctional treatment center except for the California Medical Facility, the California Men's Colony, and the California Institution for Men, which are exempted by Section 1250(j)(5) of the Health and Safety Code.

(b) Separate licenses shall not be required for separate buildings on the grounds of the correctional treatment center, provided that they operate as one correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79589. Posting of License and Patient Information.

(a) The license, or a true copy thereof, shall be posted in a prominent location within the licensed premises and be accessible to view.

(b) Any approval of program flexibility, granted and written by the Department, shall be available for inspection within the correctional treatment center.

(c) The following information shall be available within the correctional treatment center.

(1) The name of the current administrator of the facility.

(2) The most recent licensing survey report and the facility's plans of correction, and if applicable, any subsequent licensing visit reports.

(3) The name, address, and telephone number of the district office of Licensing and Certification, State Department of Health Services, having jurisdiction over the facility.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79591. Report of Changes.

The licensee shall notify the Department within ten (10) days, in writing, of any of the following:

(a) Any change of clinical director, nursing director, or administrator of the correctional treatment center.

(b) Any change in the mailing address of the licensee.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79593. Program Flexibility.

(a) All correctional treatment centers shall maintain compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects, provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the Department. Such approval

shall provide for the terms and conditions under which the exception is granted. A written request and substantiating evidence supporting the request shall be submitted by the applicant or licensee to the Department.

(b) Any approval of the Department granted under this Section, or a true copy thereof, shall be posted immediately adjacent to the facility's license.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79595. Suspension and Revocation.

The Department may suspend or revoke any license issued under the provisions of this Chapter upon any of the following grounds:

(a) Violation by the licensee of any of the rules and regulations promulgated under this Chapter of the California Code of Regulations, Title 22.

(b) Aiding, abetting, or permitting the violation of any of the rules and regulations promulgated under this Chapter.

(c) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the maintenance and operation of the premises or services for which a license is issued.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254, 1265.2 and 1294, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

Article 3. Required Services

§ 79597. Required Services.

(a) Correctional treatment centers shall provide, but not be limited to, the following required services:

- (1) Physician.
- (2) Psychiatrist.
- (3) Psychologist.
- (4) Nursing.
- (5) Pharmaceutical Services.
- (6) Dental.
- (7) Dietary.

(b) Correctional treatment centers shall maintain written service agreements with general acute care hospitals to provide for those inmate physical health needs that cannot be met by the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New article 3 and section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79599. Physician Services.

Physician services are services provided by licensed physicians responsible for the care of individual inmate-patients in the correctional treatment center. All inmates admitted to or accepted for medical care by the correctional treatment center shall be under the care of a physician.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79601. Physician Services—General Requirements.

(a) Physician services shall include, but not be limited to:

(1) Inmate-patient evaluation, including an admission history and physical within 24 hours for immediate care planning. A complete written history and physical examination shall be in the record within 72 hours unless done within 5 days prior to admission.

(2) Reevaluation of the inmate-patient's condition, including the review and updating of orders for care at least every thirty (30) days, upon change of attending physician and upon transfer.

(3) Inmate-patient diagnosis.

(4) Advice, treatment and the determination of appropriate level of care needed for each inmate-patient.

(5) Written and signed orders for diet, care, diagnostic tests and treatment of inmate-patients by others.

(6) Health record progress notes at least every three days or more often as the inmate-patient's condition requires. A progress note will be documented on each visit by the attending physician.

(7) Provision for alternative physician coverage in the event the attending physician is not available.

(8) Provision for nonphysician practitioners to be permitted to render those medical services that they are legally authorized to perform. There shall be written policies addressing the granting of clinical privileges and the role of nonphysician providers. Nonphysician practitioner includes, but is not limited to the following:

(A) Physician's assistants who work under the responsibility and supervision of a physician approved as a supervisor by the Medical Board of California and perform only those selected diagnostic and therapeutic tasks identified in the California Code of Regulations, Title 16, Division 13.8, Section 1399.541.

(B) Nurse practitioners who have been certified as a nurse practitioner by the Board of Registered Nursing.

(C) Other registered nurses may perform medical services utilizing "Standardized Procedures" developed pursuant to Section 2725(d), Business and Professions Code, and approved by the medical director of the correctional treatment center.

(D) Certified nurse anesthetists who have completed an accredited program for the education of nurse anesthetists and have received certification as a nurse anesthetist from the Board of Registered Nursing.

(E) Certified nurse midwives who have been certified by the Board of Registered Nursing.

NOTE: Authority cited: Sections 208(a) and 1267.10(i), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Sections 2725, 2834 and 3502, Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79603. Physician Services—Policies and Procedures.

(a) Written policies and procedures shall be maintained and implemented by the correctional treatment center and shall include, but not be limited to:

(1) A description of the types and scope of physician services that the correctional treatment center will provide.

(2) Policies relating to inmate-patient care and the types of inmate-patients who may be admitted for care.

(3) Policies for the follow-up care of inmate-patients treated in the correctional treatment center.

(4) Referral of inmate-patients to other agencies or health care facilities.

(5) Provision for handling emergencies and unusual occurrences.

(6) Medical record requirements, including the frequency of documentation and time periods for completion.

(7) Information pertinent to the orientation of new physicians.

(b) Inmate-patient care policy and procedure manuals and other necessary reference materials shall be readily available for review by individual physicians.

NOTE: Authority cited: Sections 208(a) and 1267.10(i), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79605. Physician Service Staff.

A physician shall have overall responsibility for the physician service. The medical director may serve as the responsible physician.

NOTE: Authority cited: Sections 208(a) and 1267.10(f), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79607. Physician Service Space.

Sufficient space shall be maintained to meet the needs of the service and shall include at least:

- (a) Physical examination and treatment room.
- (b) Office space.

NOTE: Authority cited: Sections 208(a) and 1267.10(f), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79609. Psychiatrist/Psychologist Service.

(a) Psychiatrist/psychologist services means consultative services to inmate-patients of a correctional treatment center including diagnostic psychological assessment and treatment. Primary services may also be provided to inmates not requiring admission to a licensed bed.

(b) Inmate-patients requiring 24-hour treatment for a mental disorder shall be admitted to a correctional treatment center only if the facility meets the requirements for a mental health treatment program or has policies, procedures and sufficient staff to handle the emergency, pending transfer to a licensed psychiatric facility.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79611. Psychiatrist/Psychologist Service General Requirements.

(a) There shall be a sufficient number of psychiatrists and psychologists on the staff to meet the needs of the patients.

(b) A psychiatrist or psychologist shall be responsible for examining, diagnosing, classifying and prescribing treatment for patients. The psychiatrist or psychologist shall also record progress notes, review and update treatment orders and make other appropriate entries in the patient record.

(c) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies and procedures shall be approved by the administration and medical director. These shall include, but not be limited to:

- (1) Description of the type and scope of services to be provided.
- (2) Policies relating to patient care.
- (3) Planning for follow-up care of patients treated.
- (4) Arrangements for referral to other agencies or health facilities.
- (5) Documentation requirements for each evaluation and treatment encounter.

(d) Medical examination shall be performed by a physician as often as indicated by the medical needs of the inmate-patient.

(e) The responsibility and accountability of the psychiatrist/psychologist service to the medical staff, administration and governing body shall be defined.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79613. Psychiatrist/Psychologist Service Staff.

(a) A clinical director shall have overall responsibility for the psychiatrist/psychologist service.

(b) The clinical director responsible for the service, acting alone or through an organized staff, shall have the following responsibilities:

(1) Establishing, reviewing and maintaining policies and procedures for the psychiatrist/psychologist service. Policies and procedures shall include, but not be limited to, policies related to patient care, type and scope of services available, follow-up care and consultation and referral. These shall be reviewed at least annually.

(2) Assuring the quality of psychiatrist/psychologist services provided to inmate-patients in the correctional treatment center.

(3) Reviewing credentials and specifying clinical privileges for psychiatrist/psychologist staff, including other mental health professionals.

(c) Psychiatric and psychological postgraduate trainees, interns, residents, postdoctoral fellows or instructors may provide psychiatric and psychological services under the provisions of Sections 2065 and 2911 of the Business and Professions Code.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Sections 2065 and 2911, Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79615. Psychiatrist/Psychologist Service Space.

(a) There shall be sufficient space for conducting the service, including:

- (1) Suitable space for interviewing.
- (2) Office space.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79625. Nursing Service.

Nursing service means a service organized, staffed and equipped to provide skilled nursing care to inmate-patients on a continuous basis.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79627. Nursing Service General Requirements.

(a) Written policies and procedures shall be developed and maintained by the director of nursing in consultation with other appropriate health professionals and administration. Policies and procedures shall be approved by the administration and medical director when required by governing body bylaws.

(b) Nursing service shall include, but not be limited to, the following:

(1) Planning of patient care, which shall include at least the following:

(A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.

(B) Development of an individual, written patient care plan which specifies the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited. Each inmate-patient's care shall be based on this plan.

(C) Reviewing, evaluating and updating of the patient care plan, as necessary, by the nursing staff and other professional personnel involved in the care of the patient, at least monthly, and more often as the patient's condition warrants.

(2) Notifying the attending physician or the attending clinician promptly of:

- (A) The admission of a patient.
- (B) Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient.
- (C) An unusual occurrence involving a patient.
- (D) Any untoward response or reaction by a patient to a medication or treatment.
- (E) Any error in the administration of a medication or treatment to a patient.

(F) The facility's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed when this presents a risk to the health, safety, or security of the patient.

(G) The inmate-patient's refusal to accept a prescribed medication, treatment, or diagnostic procedure.

(c) All attempts to notify physicians or the attending clinician shall be noted in the patient's health record including the time and method of communication and the name of the person acknowledging contact, if any.

(d) Licensed nursing personnel shall verify that patients are served the diets as prescribed.

(e) Nursing staff shall maintain timely and accurate patient record documentation including:

(1) Signed, dated, nursing notes reflecting implementation of the patient care plan, the patient's response to care, and changes in patients' symptoms or behavior.

(2) A record of all medications and treatments administered.

(3) A record of all personal patient care including dietary intake and patient activity.

(4) A record of patient vital signs, weight and other appropriate measurements.

(5) An admission patient assessment and discharge summary.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79629. Nursing Service—Director of Nursing Service.

(a) The director of nursing service shall be a registered nurse and shall be employed eight hours a day, on the day shift, five days a week, except when supervision and training are required during other shifts.

(b) The director of nursing service shall have at least one year of experience in nursing supervision within the last five years.

(c) The director of nursing service shall have, in writing, administrative authority, responsibility, and accountability for the nursing services within the correctional treatment center and shall serve only one correctional treatment center in this capacity at any one time, except as provided in (d).

(d) The director of nursing service may be responsible for more than one facility if the facilities are in the same geographic region, are operated by the same governing body, and a designated registered nurse is available on-site to perform the function of the director of nursing service.

NOTE: Authority cited: Sections 208(a) and 1267.10(b), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79631. Nursing Service—Staff.

(a) Nursing service personnel shall be employed and on duty in at least the number and with the qualifications to provide the necessary nursing services for patients admitted to the correctional treatment center for care.

(b) Licensed correctional treatment centers shall have at least one registered nurse, awake and on duty in the facility at all times, day and night.

(c) Facilities licensed for fifteen (15) or more beds shall have at least one registered nurse, awake and on duty, in the facility at all times, day

and night, in addition to a director of nursing service. The director of nursing service shall not have charge nurse responsibilities in facilities of more than 15 beds.

(d) Nursing stations shall be staffed with nursing personnel when patients are housed in the nursing unit.

(e) Each facility shall employ licensed and certified nursing staff sufficient to provide 2.5 nursing hours per patient day.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79633. Nursing Service—Staff Development.

(a) Each correctional treatment center shall have an ongoing educational program, planned and conducted for the development and improvement of necessary skills and knowledge, for all facility personnel. Each program shall include, but not be limited to:

(1) Orientation to the facility, specific duties, and pertinent policies and procedures.

(2) In-service training including at least an annual review of:

(A) Care of acutely or chronically ill or disabled patients.

(B) Prevention and control of infections.

(C) Emergency care, including cardiac arrest and choking.

(b) Intravenous fluid administration certification or training shall be required for all licensed nursing staff administering intravenous fluids.

(c) All nursing staff shall attend at least six hours of nursing in-service training annually.

(d) Records shall be maintained for each staff orientation and in-service training including name and title of presenter, date, description of content and signatures of those attending.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79635. Nursing Service—Administration of Medications and Treatments.

(a) Medications and treatments shall be administered as follows:

(1) No medication or treatment shall be administered except on the order of a person lawfully authorized to give such an order.

(2) Medications and treatments shall be administered as prescribed.

(3) Tests and measurement of vital signs, upon which administration of medications or treatments are conditioned, shall be performed as required and the results recorded.

(4) Preparation of doses for more than one scheduled administration time shall not be permitted.

(5) All medications and treatments shall be administered only by licensed medical or licensed nursing personnel with the following exceptions:

(6) Unlicensed employees may, under the direct supervision of licensed nursing or licensed medical personnel, during training or after completion of training and demonstrated evidence of competence, administer the following:

(A) Medical shampoos and baths.

(B) Laxative suppositories and laxative enemas.

(C) Nonlegend topical ointments, creams, lotions, and solutions.

(7) Medications shall be administered as soon as possible, but no more than two hours after doses are prepared, and shall be administered by the same person who prepares the doses for administration. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.

(8) Patients shall be identified by wristband or other established means of identification prior to administration of a drug or treatment.

(9) Drugs may be administered in the absence of a specific duration of therapy on a licensed prescriber's new drug order if the facility imple-

ments its stop order policy for such drugs. The prescriber shall be contacted prior to discontinuing therapy as established by stop order policy.

(b) No medication shall be used for any patient other than the patient for whom it was prescribed.

(c) The time and dose of the drug or treatment administered to the patient shall be recorded in the patient's individual medication record by the person who administers the drug or treatment. Recording shall include the date, the time, and the dosage, and route of administration or injection site of the medication or type of the treatment. Initials may be used, provided that the signature of the person administering the medication or treatment is also recorded on the medication or treatment record.

(d) Oxygen equipment shall be maintained as follows:

(1) Humidifier bottles on oxygen equipment shall be changed and sterilized or replaced at least every 24 hours or, if a closed system, in accordance with the manufacturer's directions.

(2) Only sterile distilled, demineralized or deionized water shall be used in humidifier bottles.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79637. Nursing Service—Patient Care.

(a) No patient shall be admitted or accepted for care by a correctional treatment center except on the order of a physician.

(b) Each patient shall be treated as an individual with dignity and respect, and shall not be subjected to verbal or physical abuse of any kind from employees or independent contractors of the licensee.

(c) Each patient, upon admission, shall be given orientation to the unit, emergency call system, patients' rights and rules of behavior.

(d) Each patient shall be provided care which shows evidence of good personal hygiene, except where staff safety may be compromised, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming (except where contraindicated due to criminal identification purposes), cleaning and cutting of fingernails and toenails. The patient shall be kept free of offensive odors.

(e) Patients, when indicated, shall be given care to prevent formation and progression of decubiti, contractures, and deformities. Such care shall include:

(1) Changing position of bedfast and chairfast patients with preventive skin care in accordance with the needs of the patient.

(2) Encouraging, assisting and training in self-care and activities of daily living.

(3) Maintaining proper body alignment and joint movement to prevent contractures and deformities.

(4) Using pressure-reducing devices where indicated.

(5) Providing care to maintain clean, dry skin free from feces and urine.

(6) Changing of linens and other items in contact with the patient, as necessary, to maintain a clean, dry skin free from feces and urine.

(7) Carrying out of physician's orders for treatment of decubitus ulcers. The facility shall notify the physician when a decubitus ulcer first occurs, as well as when treatment is not effective, and shall document such notification.

(f) Each inmate-patient who requires help in eating shall be provided with assistance when served, and shall be provided with training or adaptive equipment in accordance with identified needs, based upon patient assessment, to encourage independence in eating.

(g) Each inmate-patient shall be provided with good nutrition and with necessary fluids for hydration.

(h) Fluid intake and output shall be recorded for each inmate-patient as follows:

(1) If ordered by the physician.

(2) For each inmate-physician with an indwelling catheter or receiving intravenous or tube feedings.

(i) The weight and length of each inmate-patient shall be taken and recorded in the inmate-patient's health record upon admission. The weight shall be taken and recorded once a month thereafter.

(j) Each inmate-patient shall be provided visual privacy during medical treatments and personal care, unless contraindicated due to security considerations.

(k) Inmate-patient call signals shall be answered promptly.

(l) The following shall be easily accessible at each nurse's station:

(1) The correctional treatment center's infection control policies and procedures.

(2) Names, addresses and telephone numbers of local health officers.

(3) The correctional treatment center's current diet manual.

(4) The correctional treatment center's current drug formulary.

(5) The correctional treatment center's current nursing policy and procedure manual.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79639. Nursing Service—Patients with Infectious Diseases.

(a) Patients with infectious diseases shall not be admitted to, or cared for, in the facility unless the following requirements are met:

(1) A patient suspected of, or diagnosed as having an airborne infectious or reportable communicable disease, or being in a carrier state, who the attending medical staff determines is a potential danger, shall be accommodated in a room, vented to the outside if airborne, and provided with a separate toilet, hand washing facility, soap dispenser and individual towels.

(2) There shall be:

(A) Separate provisions for handling contaminated linens.

(B) Separate provisions for handling contaminated dishes.

(C) Separate provisions for handling any object, article, substance or material capable of transmission of a communicable disease.

(b) The correctional treatment center shall adopt and implement written infection control policies and procedures. These policies and procedures shall be reviewed at least annually and revised as necessary.

NOTE: Authority cited: Sections 208(a) and 1267.10(h), Health and Safety Code; and Sections 2500, 2502, 2503 and 2504, Title 17, California Code of Regulations. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79641. Nursing Service—Cleaning, Disinfecting, and Sterilizing.

(a) Each correctional treatment center shall adopt a written manual on cleaning, disinfecting and sterilizing procedures. The manual shall include procedures to be used in the care of utensils, instruments, solutions, dressings, articles and surfaces and shall be available for use by facility personnel. All procedures shall be carried out in accordance with the manual.

(b) Each facility shall make provisions for the cleaning and disinfecting of contaminated articles and surfaces which cannot be sterilized.

(c) Bedside equipment including, but not limited to washbasins, emesis basins, bedpans and urinals shall be sanitized only by one of the following methods:

(1) Submersion in boiling water for a minimum of 30 minutes.

(2) Autoclaving at 15 pounds pressure and 121°C (250°F) for 20 minutes.

(3) Gas sterilization.

(d) Chemicals shall not be used as a substitute for the methods specified in (c) above.

(e) Electronic thermometers shall be cleaned and disinfected according to the manufacturer's instructions. Glass thermometers shall be cleaned and disinfected for at least 10 minutes with 70 percent ethyl alco-

hol or 90 percent isopropyl alcohol with 0.2 percent iodine. Oral and rectal thermometers shall be stored separately in clean labeled containers with fitted lids.

(f) Individual patient care supply items designed and identified by the manufacturer to be disposable shall not be reused.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79643. Nursing Service—Space.

(a) An office or other suitable space shall be provided for the director of nursing service.

(b) A nursing station shall be maintained in each nursing unit.

(c) Each nursing station shall have a cabinet, a desk, space for records, a bulletin board, a telephone and a specifically designated and well illuminated medication storage compartment with a lockable door. If a separate medication room is maintained, it shall have a lockable door and a sink with water connections for care of equipment and for hand washing.

(d) If a refrigerator is provided in a nursing station, the refrigerator shall meet the following standards:

(1) Be located in a clean area not subject to contamination by human waste.

(2) Maintain temperatures at or below 7°C (45°F) for chilling.

(3) Maintain the freezer at minus 18°C (0°F).

(4) Contain an accurate thermometer at all times.

(5) If foods are retained in the refrigerator, they shall be covered and clearly identified as to contents and date initially covered. Drugs shall be kept in a separate, closed container in a separate area of the refrigerator.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79645. Pharmaceutical Service.

Pharmaceutical service means the procuring, manufacturing, compounding, dispensing, distributing, and storing, of drugs, biologicals, and chemicals by appropriate staff and having space, equipment, and supplies to perform that service. Pharmaceutical services also include the provision of drug information to other health professionals and to inmate-patients.

NOTE: Authority cited: Sections 208(a) and 1267.10(f), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79647. Pharmaceutical Service—General Requirements.

(a) Arrangements shall be made with pharmacists licensed by the California State Board of Pharmacy to assure that pharmaceutical services are available to provide patients with prescribed drugs and biologicals.

(b) Dispensing, labeling, storage, and disposal of drugs and biologicals shall be in conformance with state and federal laws.

(c) If a pharmacy is located on the correctional treatment center premises, the pharmacy shall have a limited permit or license issued by the California State Board of Pharmacy. Pharmacies located on the licensed premises of the facility shall be opened for inspection upon the request of an authorized Department representative.

(d) The facility shall not accept money, goods, or services free, or below cost from any pharmacist or pharmacy as compensation or inducement for referral of business to any pharmacy.

(e) Written policies and procedures shall be developed for establishment of safe and effective systems for procurement, storage, distribution, dispensing, and use of drugs and chemicals. The pharmacist in consultation with other appropriate health professionals and administration shall be responsible for the development and implementation of procedures.

Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff.

(f) There shall be a system maintained whereby no person other than a pharmacist or a legally qualified individual under the immediate supervision of a pharmacist shall dispense medications.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79649. Pharmaceutical Services—Other Requirements.

(a) Pharmaceutical service shall include, but not be limited to, the following:

(1) Obtaining necessary drugs including the availability of 24-hour prescription service on a prompt and timely basis as follows:

(A) Drugs ordered "STAT" that are not available in the facility emergency drug supply shall be available and administered within one hour of the time ordered during normal pharmacy hours. For those hours during which the pharmacy is closed, drugs ordered "STAT" shall be available and administered within two hours of the time ordered. Drugs ordered "STAT" which are available in the emergency drug supply shall be administered immediately.

(B) Institutional formulary anti-infectives and institutional formulary drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within one hour of the time ordered, unless ordered "STAT".

(C) Refills of prescription drugs shall be available within 24 hours.

(2) Dispensing of drugs and biologicals.

(3) Monitoring the drug distribution system which includes ordering, dispensing and disposal of medication.

(4) Provision of consultative and other services furnished by pharmacists which assist in the development, coordination, supervision and review of the pharmaceutical services within the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79651. Pharmaceutical Service—Labeling and Storage of Drugs.

(a) Containers which are cracked, soiled or without secure closures shall not be used. Drug labels shall be legible. No medication shall be dispensed by prescription except in a new container.

(b) All drugs obtained by prescription shall be labeled in compliance with state and federal laws governing prescription dispensing.

(c) Nonlegend drugs shall be labeled in conformance with state and federal food and drug laws.

(d) Test reagents, germicides, disinfectants and other household substances shall be stored separately from drugs and shall not be accessible to patients.

(e) External use drugs in liquid, tablet, capsule or powder form shall be stored separately from drugs for internal use.

(f) Drugs shall be stored at appropriate temperatures. Drugs required to be stored at room temperature shall be stored at a temperature between 15°C (59°F) and 30°C (86°F). Drugs requiring refrigeration shall be stored in a refrigerator between 2°C (36°F) and 8°C (46°F). When drugs are stored in the same refrigerator with food, the drugs shall be kept in a closed container clearly labeled "drugs".

(g) Drugs shall be stored in an orderly manner in cabinets, drawers or carts of sufficient size to prevent crowding.

(h) Dose preparation and administration areas shall be well lighted.

(i) Drugs shall be accessible only to licensed health professionals designated in writing by the licensee.

(j) Medication shall not be kept at the patient's bedside, with the exception of prescribed sublingual or inhalation forms of drugs.

(k) Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use.

(l) The drugs of each inmate-patient shall be kept and stored in their originally received containers. No drugs shall be transferred between containers.

(m) Discontinued drug containers shall be marked, or otherwise identified, to indicate that the drug has been discontinued, or shall be stored in a separate location which shall be identified solely for this purpose. Discontinued drugs shall be disposed of within ninety (90) days of the date the drug order was discontinued, unless the drug is reordered within that time.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79653. Pharmaceutical Service—Stop Orders.

Written policies shall be established and implemented limiting the duration of new drug orders in the absence of a prescriber's specific indication for duration of therapy. The prescriber shall be contacted for new orders prior to the termination time established by the policy. Such policies shall include all categories of drugs.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79655. Pharmaceutical Service—Orders for Drugs.

(a) No drugs shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness.

(b) All drug orders shall be written, dated, and signed by the person lawfully authorized to give such an order. The name, quantity or specific duration of therapy, dosage and time or frequency of administration of the drug and route of administration if other than oral shall be specified. "P.R.N." orders shall also include the indication for the use of the drug.

(c) Verbal orders for drugs and treatment shall be received only by licensed nurses, psychiatric technicians, pharmacists, physicians and physician's assistants from their supervising physicians and others consistent with their practice acts. Such orders shall be recorded immediately in the patient's health record by the person receiving the order, and shall include the date and time of the order and the signature of the person receiving the order. The order shall be signed by the prescriber within forty-eight (48) hours, excluding weekends and holidays.

(d) The signing of orders shall be by signature or a personal computer key. Signature stamps shall not be used.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79657. Pharmaceutical Service—Drug Order Processing.

Signed orders for drugs shall be transmitted to the issuing pharmacy within twenty-four (24) hours, either by written prescription of the prescriber, or by an order form which produces a direct copy of the order.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79659. Pharmaceutical Service—Drug Order Records.

(a) Correctional treatment centers shall maintain a record which includes, for each drug ordered by prescription, the name of the inmate-patient, the drug name, and strength, the date ordered, the date and amount received and the name of the issuing pharmacy.

(b) The record shall be maintained in the correctional treatment center, or in the pharmacy with which the correctional treatment center contracts

for pharmaceutical services, for at least three years following the date of the last entry to the record so that the record may be accessible to the correctional treatment center.

NOTE: Authority cited: Sections 208(a), 1250.1(f) and 1267.10(f), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79661. Pharmaceutical Service—Personal Medications.

(a) Medications brought by or with the patient on admission to the correctional treatment center shall not be used unless the contents of the containers have been examined and positively identified after admission by the inmate-patient's physician or a pharmacist retained by the licensed correctional treatment center.

(b) The licensed correctional treatment center may use drugs from other licensed health care facilities or those drugs dispensed or obtained after admission from any licensed or governmental pharmacy and may accept the delivery of those drugs if identified and approved by a physician or pharmacist.

NOTE: Authority cited: Sections 208(a) and 1267.10(f), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79663. Pharmaceutical Service—Controlled Drugs.

(a) Drugs listed in Schedules II, III, IV and V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, Title 21, United States Code, Section 801 et seq., shall not be accessible to other than licensed nursing, pharmacy and medical personnel designated by the licensee. Drugs listed in Schedule II of the above Act shall be stored in a locked cabinet or a locked drawer, separate from noncontrolled drugs, unless they are supplied on a scheduled basis as part of a unit dose medication system.

(b) Separate records of use shall be maintained on all Schedule II drugs. Such records shall be maintained accurately and shall include the name of the patient, the prescription number, the drug name, strength and dose administered, the date and time of administration and the signature of the person administering the drug. Such records shall be reconciled at least daily and shall be retained for at least one year. If such drugs are supplied on a scheduled basis as part of a unit dose medication system, such records need not be maintained separately.

(c) Drug records shall be maintained for drugs listed in Schedules III and IV of the above Act in such a way that the receipt and disposition of each dose of any such drug may be readily traced. Such records need not be separate from other medication records.

NOTE: Authority cited: Sections 208(a) and 1267.10(f), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79665. Pharmaceutical Service—Disposition of Drugs.

(a) Drugs which have been dispensed for individual inmate-patient use and are labeled in conformance with state and federal law may be furnished to inmate-patients on discharge on the order of a physician.

(b) A record of the drugs sent with the inmate-patient shall be made in the inmate-patient's health record.

(c) An inmate-patient's drugs which remain in the facility after discharge of the inmate-patient shall be destroyed by the facility in the following manner:

(1) Drugs listed in Schedules II, III, IV and V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, Title 21, United States Code, Section 801 et seq., shall be destroyed by the facility in the presence of a pharmacist and a registered nurse or two pharmacists employed by the facility. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signature of the witness required above shall be re-

corded in the patient's health record in a separate log. Such log shall be retained for at least three years.

(2) Drugs not listed under schedules II, III, IV or V of the above Act shall be destroyed by the facility in the presence of a pharmacist or licensed nursing personnel. The name of the patient, the name and strength of the drug, and prescription number (if applicable), the amount destroyed, the date of destruction, the signature of the pharmacist or nurse witnessing the destruction, and one other witness shall be recorded in the patient's health record or in a separate log. Such log shall be retained for at least three years.

(d) Unless otherwise prohibited under applicable federal or state laws, individual patient drugs supplied in sealed containers shall be returned, if unopened, to the issuing pharmacy for disposition.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79667. Pharmaceutical Service—Unit Dose Medication System.

In correctional treatment centers employing a unit dose medication system, there shall be at least a twenty-four (24)-hour supply of all inmate-patient medications on hand at all times, except those drugs which are to be discontinued within the twenty-four (24)-hour period. Drugs that are a part of a unit dose medication system shall not exceed a forty-eight (48)-hour supply excepting weekends and holidays.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

* 79669. Pharmaceutical Service Staff.

A pharmacist shall have overall responsibility for the pharmaceutical service. He or she shall be responsible for the procurement, storage, distribution and disposal of all drugs as well as the development, coordination, supervision and review of pharmaceutical services in the correctional treatment center. Correctional treatment centers with a limited pharmacy permit shall employ a pharmacist on at least a consulting basis. Responsibilities shall be set forth in a job description or agreement between the pharmacist and the correctional treatment center. The pharmacist shall be responsible to the administrator and shall furnish him or her written reports and recommendations regarding the pharmaceutical services within the correctional treatment center. Such reports shall be provided no less often than quarterly.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79671. Pharmaceutical Service—Equipment and Supplies.

(a) There shall be equipment and supplies necessary for the provision of pharmaceutical services within the correctional treatment center, including at least the following:

- (1) Refrigerator with an accurate thermometer.
- (2) Lockable drug cabinets, drawers, closets or rooms.
- (3) Drug service trays and/or carts.
- (4) Drug preparation counter area and convenient water source.
- (5) Reference materials containing drug monographs on all drugs in use in the facility. Such monographs shall include information concerning generic and brand names, if applicable, available strengths, and dose forms and pharmacological data including indications and side effects.

(b) Emergency supplies shall be readily available at each correctional treatment center. Emergency drug supplies shall meet the following requirements:

(1) Legend drugs shall only be stored in the emergency supply, under the following conditions:

(A) Injectable supplies of legend drugs shall be limited to a maximum of six single doses in ampules or vials or one container of the smallest available multi-dose vial and shall be in sealed, unused containers.

(B) Sublingual or inhalation emergency drugs shall be limited to single sealed containers of the smallest available size.

(C) Not more than ten emergency drugs in solid, oral dosage form or suppository dosage form for anti-infective, anti-diarrhea, anti-nausea or analgesic use may be stored if in sealed containers. Not more than four doses of any one drug may be so stored.

(2) The emergency drug supply shall be stored in a portable container which is sealed in such a manner that the tamper-proof seal must be broken to gain access to the drugs. A licensed nurse shall notify the pharmacist when drugs have been used from the emergency kit or when the seal has been broken. Drugs used from the kit shall be replaced within seventy-two hours and the supply resealed by the pharmacist.

(3) The contents of the supply shall be listed on the outside of the container.

(4) The supply shall be checked at least once monthly by the pharmacist.

(5) Separate records of use shall be maintained for drugs administered from the supply. Such records shall include the name and dose of the drug administered, name of the patient, the date and time of administration and the signature of the person administering the dose.

(6) A correctional treatment center with a licensed pharmacy on the premises shall make the emergency drug supply accessible without making it necessary to enter either the pharmacy or drug storage room during hours when the pharmacist is not available. Access to the supply shall be limited to designated registered nurses. Records of drugs taken from the supply shall be maintained and the pharmacist shall be notified of such use. The records shall include the name and strength of the drug, the amount taken, the date and time, the name of the inmate-patient to whom the drug was administered, and the signature of the registered nurse. The pharmacist shall be responsible for maintenance of the supply and assuring that all drugs are properly labeled and stored. The drug supply shall contain that type and quantity of drugs necessary to meet the immediate needs of inmate-patients.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79673. Dental Service.

Dental service means the provision of emergency dental care and may include diagnostic, preventive, or corrective procedures performed by dentists with appropriate staff, space, equipment, and supplies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79675. Dental Service—General Requirements.

(a) Written policies and procedures for the scope of services to be provided shall be developed and maintained by the person responsible for the service. Procedures shall be approved by the administration.

(b) The responsibility and the accountability of the dental service to the administration shall be defined.

(c) There shall be a well-defined plan for oral health care, based on patient need, the size of the treatment center and the type of service provided.

(d) There shall be a well-organized plan for emergency dental care.

(e) There shall be a record of all dental services provided to the inmate-patient and this shall be made a part of the inmate-patient's medical record.

(f) Periodically, an appropriate committee of staff members shall evaluate the services provided and make appropriate recommendations to the treatment center administration.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79677. Dental Service Staff.

(a) A dentist shall have overall responsibility for the dental service.

(b) The dental service shall be staffed by a sufficient number of dentists along with auxiliary dental personnel to render proper dental care.

(c) When dental hygienists or dental laboratory technicians are employed, they shall work under the supervision of the dentist who is responsible for the dental service.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79679. Dental Service Equipment and Supplies.

(a) There shall be equipment, instruments and supplies maintained to meet the needs of the services offered.

(b) There shall be equipment for sterilization of instruments and supplies.

(c) All equipment installed shall comply with standards of infection control as defined by the infection control committee, whose duties and responsibilities are delineated in Section 79781(d)(2) of this Chapter.

(d) The following materials shall be available for immediate use whenever dental treatment is provided:

(1) Oxygen.

(2) Appropriate drugs.

(3) Resuscitation equipment.

(e) Radiographic equipment shall meet the requirements of California Code of Regulations, Title 17, Chapter 5, Subchapter 4, Group 1, Article 1, commencing with Section 30100 which is hereby incorporated by reference.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79681. Dental Service Space.

(a) There shall be adequate space maintained for the dental service.

(b) There shall be facilities for dental radiography.

(c) There shall be space provided for the sterilization and storage of instruments and lockable storage for bulk supplies.

(d) There shall be a secure storage area for patient records.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79683. Dietary Service.

Dietary service means the provision of nutritionally adequate food for inmate-patients with appropriate staff, space, equipment and supplies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79685. Dietary Service General Requirements.

(a) The food and nutrition needs of patients in the correctional treatment center shall be met in accordance with "The Recommended Dietary Allowance", adopted by the Food and Nutrition Board of the National Research Council, National Academy of Science, revised 1989, and "The

California Daily Food Guide", California Department of Health Services, April 1990 edition. Daily menus shall follow these recommendations.

(b) Substitutions shall be within the same food group.

(c) Not less than 3 meals shall be served daily, and with not more than a 14-hour span between the third meal and the first meal of the following day.

(d) Nourishment or between meal snacks shall be provided as required by a person lawfully authorized to give a dietary order.

(e) Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. Food shall be served at appropriate temperatures and in a form to meet individual needs.

(f) When food is provided by an outside source, the correctional treatment center shall ensure that all federal, state and local requirements are met.

(g) All regular and therapeutic diets shall be prescribed by a person lawfully authorized to give such an order and shall be planned, prepared and served under the supervision or consultation of a dietitian.

(h) A written plan shall be followed for uniform handling of inmate-patients with diabetes, pregnant women, and others whose condition requires a medically prescribed diet as part of therapeutic treatment.

(i) A current therapeutic diet manual, approved by the dietitian, shall be readily available to all medical, nursing and dietetic personnel. The manual shall be reviewed annually and revised at least every five years. NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79687. Dietary Service Policies and Procedures.

A dietary services policy and procedure manual shall be developed and available to all personnel. The manual shall be developed with the assistance of a dietitian and other appropriate staff. The manual shall address at least the following:

(a) Organization of the dietary service.

(b) Personnel management.

(c) Staff development.

(d) Menu planning.

(e) Food storage.

(f) Food preparation and services.

(g) Maintenance, sanitation and hygiene.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79689. Dietary Service Therapeutic Diets.

(a) Therapeutic diets shall be provided as prescribed by the attending physician and shall be planned by a registered dietitian. Therapeutic diets shall be prepared and served with supervision or consultation from a registered dietitian.

(b) Dietary service staff who prepare and serve therapeutic diets shall have received in-service training on the dietary standards and food groups and therapeutic diets and shall have sufficient knowledge of food values to make appropriate substitutions.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79691. Dietary Service Menus.

(a) Menus for regular and therapeutic diets shall be planned by a registered dietitian and written at least one week in advance, dated and posted in the kitchen at least three days in advance.

(b) If any meal served varies from the planned menu, the change shall be noted in writing on the posted menu in the kitchen.

(c) Menus shall provide a variety of foods and indicate standard portions at each meal. If a cycle menu is used, the cycle shall be of no less than three weeks duration and shall be revised quarterly.

(1) A copy of the menu as planned and as served shall be kept on file at least thirty (30) days.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79693. Dietary Service Food Storage.

(a) Food storage areas shall be kept clean at all times.

(b) All foods not requiring refrigeration shall be stored at least twelve inches above the floor, on shelves, racks, dollies, or other surfaces which facilitate thorough cleaning, in a ventilated room not subject to contamination by waste water backflow, condensation, leakage, rodents or vermin.

(c) Readily perishable foods or beverages shall be maintained at temperatures of 7°C (45°F) or below, or at 60°C (140°F) or above, at all times, except during necessary periods of preparation or service. Frozen foods shall be stored at -18°C (0°F) or below.

(d) Soaps, detergents, cleaning compounds, pesticides and other toxic substances shall be stored separately.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79695. Dietary Service Sanitation.

(a) All kitchen areas shall be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies and other insects.

(b) All utensils, counters, shelves and equipment shall be kept clean and maintained in good repair.

(c) Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner. Bacteriological testing shall be performed when indicated by specific problems, epidemiological findings, or recommendations by the infection control committee of the licensed correctional treatment center.

(d) Kitchen wastes not disposed of by mechanical means shall be kept in leak-proof, nonabsorbent, tightly closed containers and disposed of as frequently as necessary to prevent a nuisance or contamination of food preparation areas.

(e) Soiled containers shall be cleaned inside and outside in a way that will not contaminate food, equipment, utensils or food preparation areas.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79697. Dietary Service Cleaning and Disinfection of Utensils.

(a) All utensils used for eating and drinking and in the preparation and service of food and drink shall be cleaned and disinfected or discarded after each usage.

(b) Gross food particles shall be removed by careful scraping and rinsing in running water.

(c) Utensils not washed by mechanical means shall be placed in hot water with a minimum temperature of 43°C (110°F), washed using soap or detergent, rinsed in hot water to remove soap or detergent and disinfected by one of the following methods or an equivalent, as approved by the Department.

(1) Immersion for at least two minutes in clean water at 77°C (170°F).

(2) Immersion for at least 30 seconds in clean water at 83°C (180°F).

(3) Immersion in water containing a bactericidal chemical as approved by the Department.

(4) After disinfection the utensils shall be allowed to drain and dry in racks or baskets on nonabsorbent surfaces. Drying cloths shall not be used.

(d) Results obtained with dish washing machines shall be equal to those obtained by the methods outlined above and all dish washing machines shall meet the most current requirements contained in Standard No. 3 of the National Sanitation Foundation, which is hereby incorporated by reference. Hot water at a minimum temperature of 83°C (180°F), shall be maintained at the manifold of the final rinse.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79699. Dietary Service Equipment, Space, and Supplies.

(a) Equipment of the type and in the amount necessary for the proper preparation, serving and storage of food and for proper dish washing shall be provided and maintained in good working order.

(b) All food shall be of good quality. Food in unlabeled, rusty, leaking broken containers or cans with side seam dents, rim dents or swells shall not be retained or used.

(c) Foods held in refrigerated or other storage areas shall be covered. Liquids and foods which are prepared and not served shall be tightly covered, clearly labeled and dated.

(d) Spoiled or contaminated food shall not be served.

(e) The dietetic service area shall be ventilated in a manner that will maintain comfortable working conditions, remove objectionable odors and fumes and prevent excess condensation.

(f) Persons other than dietetic service personnel shall not be allowed in the kitchen areas unless required to do so in the performance of their duties.

(g) Smoking shall not be permitted in kitchen areas.

(h) An office or other suitable space shall be provided for the dietitian or dietetic service supervisor.

(i) Kitchen sinks shall not be used for hand washing. Separate hand washing facilities with soap, running water, individual towels and waste receptacles shall be provided.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79701. Dietary Service Staff.

(a) A dietitian shall be employed on at least a part-time or consulting basis in all correctional treatment centers. A part-time dietitian shall provide the number of hours of service in each calendar month to meet the needs of the inmate-patients. Services shall be of sufficient duration to ensure continuing liaison with medical and nursing staffs, patient care counseling, approval of menus and planning and conducting of in-service education programs.

(b) If a dietitian is not employed full time, a full time person who is a graduate of a state approved course that provides 90 or more hours of classroom instruction in food supervision shall be employed to be responsible for the operation of the food service. The dietetic supervisor may also cook, provided sufficient time is allowed for managerial responsibilities.

(c) Staff (civilian and inmate workers) shall be employed, oriented, and their working hours scheduled to provide for the nutritional needs of inmate-patients and to maintain the dietetic service area.

(d) Dietetic service personnel shall be trained in basic food sanitation techniques, shall be clean, wear clean clothing, including cap or hair net, and shall be excluded from duty when affected by skin infection or communicable diseases. Beards and mustaches which are not closely cropped and neatly trimmed shall be covered.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

Article 4. Optional Services

§ 79703. Optional Services.

(a) A correctional treatment center may provide the following services:

- (1) Laboratory.
- (2) Radiology.
- (3) Perinatal.
- (4) Outpatient surgery.
- (5) Mental health treatment program.
- (6) Standby Emergency Medical Services.

(7) Any other services requested in writing and approved by the state department in writing.

(b) A correctional treatment center may provide outpatient surgical care with anesthesia if the correctional treatment center meets the same requirements as a surgical clinic licensed pursuant to Section 1204 of the Health and Safety Code, except for the requirement that patients remain less than 24 hours.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New article 4 and section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79705. Optional Services—Laboratory Services.

(a) Clinical laboratories shall be operated in conformance with the California Business and Professions Code, Division 2, Chapter 3 (Sections 1200 to 1322, inclusive) and the California Code of Regulations, Title 17, Division 1, Chapter 2, Subchapter 1, Group 2 (Sections 1030 to 1057, inclusive).

(b) The correctional treatment center shall maintain clinical laboratory services and equipment for routine laboratory work such as urinalysis, complete blood counts, and such tests necessary to meet the needs of the correctional treatment center.

(c) The correctional treatment center shall maintain or make provision for clinical laboratory services for performance of tests in chemistry, microbiology, serology, hematology, pathology and blood banking.

(d) Written policies and procedures shall be developed and maintained by the physician responsible for the service in consultation with other appropriate health professionals and administration. Policies and procedures shall be approved by the patient care policy committee, medical director, and the governing body. Policies and procedures shall be reviewed annually.

(e) The responsibility and the accountability of the clinical laboratory service to the medical director shall be defined.

(f) The director of the clinical laboratory shall assure that:

(1) Examinations are performed accurately and in a timely fashion.

(2) Procedures are established governing the provision of laboratory services for outpatients.

(3) Laboratory systems identify the patient, test requested, date and time the specimen was obtained, the time the request reached the laboratory, the time the laboratory completed the test and any special handling which was required.

(4) Procedures are established to ensure the satisfactory collection of specimens.

(5) A communications system to provide efficient information exchange between the laboratory and related areas of the correctional treatment center is established.

(6) A quality control system within the laboratory designed to ensure medical reliability of laboratory data is established. The results of control tests shall be readily available in the correctional treatment center.

(7) Reports of all laboratory examinations are made a part of the inmate-patient's medical record as soon as is practical.

(8) No laboratory procedures are performed except on the order of a person lawfully authorized to give such an order.

(g) Tissue specimens, where obtained, shall be examined by a physician who is certified or eligible for certification in anatomical and/or clinical pathology by the American Board of Pathology or possesses qualifications which are equivalent to those required for certification. Oral specimens may be examined by a dentist who is certified or eligible for certification as an oral pathologist by the American Board of Oral Pathology. A record of their findings shall become a part of the patient's medical record. A file on these findings shall be maintained at the correctional treatment center or the principal office of the consulting pathologist.

(h) The use, storage and disposal of radioactive materials shall comply with the California Radiation Control Regulations, Title 17, Chapter 5, Subchapter 4, Group 1, Article 1, commencing with Section 30100, California Code of Regulations, as amended. These regulations are hereby incorporated by reference.

(i) Where the correctional treatment center depends on outside blood banks, there shall be a written agreement governing the procurement, transfer and availability of blood.

(j) Licensed clinical laboratory services shall be available at all times for emergencies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79707. Laboratory Service Staff.

(a) A physician shall have overall responsibility for the clinical laboratory service. The physician shall be certified or eligible for certification in clinical pathology and/or pathologic anatomy by the American Board of Pathology or the American Osteopathic Board of Pathology. If such a pathologist is not available on a full-time, regular part-time, or consulting basis, a physician or a licensed clinical laboratory bioanalyst who is available on a full-time, regular part-time, or consulting basis may administer the clinical laboratory provided a pathologist, qualified as above, is available for consultation.

(b) There shall be sufficient staff with adequate training and experience to meet the needs of the service being offered.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79709. Laboratory Service—Equipment and Supplies.

(a) There shall be sufficient equipment and supplies maintained to perform the laboratory services being offered.

(b) When the correctional treatment center maintains blood storage facilities, such facilities shall be in conformance with the provisions of Section 1002(g), Title 17, California Code of Regulations. Blood storage facilities shall be inspected by the correctional treatment center at least daily for compliance with these requirements.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79711. Optional Services—Radiology Services.

Radiology service means the use of X-ray, other ionizing radiation, and/or magnetic resonance imaging, and/or ultrasound in the detection, diagnosis, and treatment of human illnesses and injuries with a appropriate staff, space, equipment and supplies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79713. Radiology Service General Requirements.

(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies and procedures shall be approved by the governing body, the administration and the medical director. Policies and procedures shall be reviewed annually.

(b) The responsibility and the accountability of the radiological service to the medical staff and administration shall be defined.

(c) The use, storage and shielding of all radiation machines and radioactive materials shall comply with the California Radiation Control Regulations, Section 30100 et seq., Subchapter 4, Chapter 5, Title 17, California Code of Regulations.

(d) All persons operating or supervising the operation of X-ray machines shall comply with the requirements of the Radiologic Technology Regulations, Section 30400 et seq., Subchapter 4.5, Chapter 5, Title 17, California Code of Regulations.

(e) Diagnostic radiological services shall only be performed on the order of a person lawfully authorized to give such an order.

(f) The original reports of radiological service examinations shall be filed in the inmate-patient's medical record and a copy maintained in the radiology unit.

(g) X-ray films, or reproductions thereof, shall be retained for seven years.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79715. Radiology Service Staff.

(a) A physician shall have overall responsibility for the radiological service. This physician shall be certified or eligible for certification by the American Board of Radiology or the American Osteopathic Board of Radiology. If such a radiologist is not available on a full-time or regular part-time basis, a physician, with training and experience in radiology, may administer the service. In this circumstance, a radiologist, qualified as above, shall provide consultation services.

(b) Sufficient certified radiologic technologists shall be employed to meet the needs of the service being offered.

(c) Radiological services shall be available to the correctional treatment center at all times for the provision of services on all shifts and for emergencies. Such services may be provided on the correctional treatment center or through a contractual arrangement.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79717. Radiology Service Equipment and Supplies.

(a) There shall be equipment and supplies maintained or available to perform the radiological services that are offered in the correctional treatment center. As a minimum, the following equipment shall be available:

(1) At least one radiographic unit. If fluoroscopic services are provided, fluoroscopes shall be equipped with image intensifiers.

(2) Film processing equipment.

(b) Proper resuscitation and monitoring equipment shall be immediately available.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79719. Radiology Service Space.

(a) There shall be sufficient space maintained to provide radiological services. This shall include but not be limited to the following:

(1) A separate X-ray room large enough to accommodate the necessary radiographic equipment and to allow easy maneuverability of stretchers and wheelchairs.

(2) Toilet facilities located in the radiology service space or in the immediate vicinity.

(3) Dressing rooms for patients if not otherwise provided by toilet facilities.

(4) Film processing area.

(5) Sufficient storage space for all the necessary X-ray equipment, supplies, and for exposed X-ray film, and copies of reports.

(6) Suitable area for viewing and reporting of radiographic examinations.

(b) If X-ray examinations are to be performed on outpatients, outpatient access to the radiological spaces shall not traverse a nursing unit.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79721. Optional Services—Perinatal Services.

A perinatal unit means a maternity unit and newborn service of the correctional treatment center for the provision of care during pregnancy, labor, delivery, postpartum and neonatal periods.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79723. Perinatal Service General Requirements.

(a) A perinatal unit shall provide or arrange for:

(1) Care for the patient during pregnancy, labor, delivery, and the postpartum period. Labor, delivery, and neonatal care may be provided outside the correctional treatment center under a contractual agreement with a general acute care hospital, in which case only emergency delivery services will be provided by the correctional treatment center.

(2) Care for the normal infant and the infant with abnormalities which usually do not impair function or threaten life. Newborns shall not be retained beyond 24 hours at the correctional treatment center without the approval of the medical director.

(3) Care for mothers and infants needing emergency or immediate life support measures to sustain life up to 12 hours or to prevent major disability.

(4) Formal arrangements for consultation and/or transfer of an infant to an intensive care newborn nursery, or a mother to a hospital with the necessary services, for problems beyond the capacity of the perinatal unit.

(b) There shall be written policies and procedures developed and maintained by the person responsible for the service, in consultation with other appropriate health professionals and administration. These policies and procedures shall reflect the standards and recommendations of the 1989 American College of Obstetricians and Gynecologists "Standards for Obstetric-Gynecologic Services" and the 1988 American Academy of Pediatrics "Guidelines for Perinatal Care". These standards are hereby incorporated by reference. Policies shall be approved by the governing body. Procedures shall be approved by the patient care policy committee and medical director. Policies and procedures shall address but not be limited to:

(1) Relationships to other services in the correctional treatment center.

(2) Admission policies, including infants delivered prior to admission of the mother.

(3) Arrangements for maternity patient overflow.

(4) Consultation from an intensive care newborn nursery.

(5) Prevention and treatment of neonatal hemorrhagic disease.

- (6) Care and transfer of the premature or low birth weight infant.
 - (7) Resuscitation of the newborn.
 - (8) Administering and monitoring of oxygen and respiratory therapy.
 - (9) Blood Transfusion.
 - (10) PKU screening.
 - (11) Rhesus (Rh) hemolytic disease identification, reporting, and prevention.
 - (12) Management of hyperbilirubinemia.
 - (13) Induction of labor and administration of oxytocic drugs.
 - (14) Obstetric-pediatric-pathologic-radiologic conferences.
 - (15) Patient identification system.
 - (16) Care routines for the mother and infant.
 - (17) Hand washing technique.
 - (18) Bassinet techniques in caring for infants.
 - (19) Treatment of the eyes of newborn, including Crede' or antibiotic treatment.
 - (20) Breast feeding.
 - (21) Formula preparation and storage.
 - (c) The responsibility and the accountability of the perinatal service to the medical staff and administration shall be defined.
 - (d) Laboratory testing capabilities for performing blood gas analyses, pH and microtechniques shall be available.
 - (e) The correctional treatment center perinatal service shall have the capability for operative delivery, including caesarean section, available at all times.
 - (f) Infants with diarrhea of the newborn as defined in Section 2564, Title 17, California Code of Regulations, as amended, or who have draining lesions shall be transferred to a general acute care hospital.
 - (g) Infants suspected of having airborne infections shall be separated from other infants in the nursery and transferred to a general acute care hospital.
 - (h) All persons in the delivery room shall wear clean gowns, caps and masks during a delivery.
 - (i) Oxygen shall be administered to newborn infants only on the written order of a physician. The order shall include the concentration (volume percent) or desired arterial partial pressure of oxygen and be reviewed, modified, or discontinued after 24 hours.
 - (j) All patients shall be attended by a physician or registered nurse when under the effect of anesthesia or regional analgesia, when in active labor, during delivery and in the immediate postpartum period.
- NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79725. Perinatal Service Staff.

- (a) A physician shall have overall responsibility for the service. This physician shall be certified or eligible for certification by the American Board of Obstetrics and Gynecologists, the American Board of Pediatrics, the American Osteopathic Board of Obstetrics and Gynecology or the American Osteopathic Board of Pediatrics. If a physician with one of the above qualifications is not available, a physician with training and experience in obstetrics and gynecology or pediatrics may administer the service. In this circumstance, a physician with either of the required qualifications shall provide consultation to the service.
- (b) A physician who is certified or eligible for certification by the American Board of Pediatrics shall be responsible for the nursery.
- (c) There shall be one registered nurse on duty on each shift assigned to the labor and delivery suite. In addition, there shall be sufficient trained personnel to monitor and evaluate labor and to assist with a delivery.
- (d) There shall be one registered nurse on duty for each shift assigned to the antepartum and postpartum areas. In addition, there shall be sufficient licensed personnel to assess patients and provide care.

(e) A registered nurse who has had training and experience in neonatal nursing shall be responsible for the nursing care in the nursery.

(1) A registered nurse trained in infant resuscitation shall be on duty on each shift.

(2) A ratio of one licensed nurse to eight or fewer infants shall be maintained for normal infants.

(f) The correctional treatment center shall provide directly or by arrangement continuing education and training programs for the nursing staff in perinatal nursing and infection control.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79727. Perinatal Service Equipment and Supplies.

- (a) General equipment shall include at least the following:
 - (1) Amniocentesis tray.
 - (2) DC defibrillator immediately available.
 - (3) Blanket warmer.
 - (4) Solutions and supplies for intravenous fluids, blood, plasma and blood substitutions or fractions.
 - (b) A fetal heart rate monitor shall be available.
 - (c) Labor rooms shall contain at least the following equipment:
 - (1) Oxygen and suction outlets.
 - (2) A labor bed with adjustable side rails.
 - (3) Footstool.
 - (4) One or more comfortable chairs.
 - (5) Hand washing facilities for staff.
 - (6) Toilet and hand washing facilities shall be in or immediately adjacent to labor room and shall be shared by no more than two patients.
 - (7) Adjustable examination light.
 - (8) Sphygmomanometer/cuff.
 - (9) Regular and fetal stethoscope.
 - (d) Delivery rooms shall have at least the following equipment:
 - (1) Adjustable delivery table.
 - (2) Surgical overhead light.
 - (3) Equipment for inhalation anesthesia and regional analgesia.
 - (4) Clock with sweep second hand.
 - (5) An elapsed time clock.
 - (6) Emergency supplies such as packings, syringes, needles and drugs.
 - (7) Emergency call system.
 - (8) Provision for oxygen and suction for mother and infant.
 - (9) Thermostatically controlled incubator or radiant heating device.
 - (10) Erythromycin ophthalmic ointment and solutions for prophylactic Crede' treatment of eyes.
 - (11) Sterile clamps or ties for umbilical cord.
 - (12) Resuscitation equipment and supplies to include at least:
 - (A) Glass trap suction device with catheter.
 - (B) Pharyngeal airways, assorted sizes.
 - (C) Laryngoscope, including a blade suitable for premature infants.
 - (D) Endotracheal catheters, assorted size with malleable stylets.
 - (E) Arterial catheters, assorted sizes.
 - (F) Ventilatory assistance bag and infant mask.
 - (G) Bulb syringe.
 - (H) Stethoscope.
 - (I) Syringes, needles and appropriate drugs.
 - (e) Nursery equipment shall include at least the following:
 - (1) A separate bassinet made of easily cleanable material such as metal or clear plastic for each infant.
 - (2) Enclosed storage unit for clean supplies for each infant.
 - (3) Diaper receptacles with a cover, foot control and disposable liner.
 - (4) A hamper with a disposable liner for soiled linen.
 - (5) A wall thermometer and hygrometer.
 - (6) Accurate beam scales or the equivalent.

(7) Thermostatically controlled incubators or radiant heating devices to maintain proper ambient temperature.

(8) Oxygen and compressed air supply regulating devices and administration equipment.

(9) Resuscitation equipment as required in delivery rooms.

(10) Suction equipment.

(11) At least one duplex electrical outlet for every two bassinets.

(12) One hand washing sink with controls not requiring direct contact of the hands for operation for each six bassinets. Wrist or elbow blade handles are not acceptable.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79729. Optional Services—Outpatient Surgical Care.

Outpatient surgical care means the provision of surgical services to patients not requiring hospitalization, with appropriate staff, space, equipment, and supplies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79731. Outpatient Surgical Care—General Requirements.

(a) If outpatient surgery is performed, the written policies and procedures, approved by the governing body of the correctional treatment center, shall make provision for at least the following:

(1) The types of operative procedures that may be performed shall be specified.

(2) The types of anesthesia that may be used shall be specified.

(3) Preoperative evaluation of the patient, meeting the same standards as apply to inpatient surgery.

(4) Informed consent.

(5) The delivery of all anatomical parts, tissues and foreign objects removed to a pathologist designated by the hospital with a report of findings to be filed in the patient's medical record.

(6) Written preoperative instructions to patients covering:

(A) Applicable restrictions upon food and drugs before surgery.

(B) Any special preparations to be made by the patient.

(C) Any postoperative requirements.

(D) An understanding that admission to a hospital may be required in the event of an unforeseen circumstance.

(7) Examination of each patient by a physician prior to discharge.

(b) Where general anesthesia is to be administered, written policies and procedures shall be developed and maintained by the physician responsible for the service in consultation with other appropriate health professionals and administration. Policies and procedures shall be approved by the administration and medical director. The policies and procedures shall include provision for at least:

(1) Preanesthesia evaluation of the patient by a physician or a certified registered nurse anesthetist with appropriate documentation of pertinent information relative to the choice of anesthesia and the surgical or obstetrical procedure anticipated.

(2) Review of the patient's condition immediately prior to induction of anesthesia.

(3) Safety of the patient during the anesthetic period.

(4) Recording of all events taking place during the induction of, maintenance of and emergence from anesthesia, including the amount and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood fractions.

(c) Prior to commencing surgery, the person responsible for administering anesthesia, or the surgeon if a general anesthetic is not be administered, shall verify the patient's identity, the site and side of the body to

be operated on, and ascertain that a record of the following appears in the patient's medical record:

(1) An interval medical history and physical examination performed and recorded within the previous 24 hours.

(2) Appropriate screening tests, based on the needs of the patient, accomplished and recorded within 72 hours prior to surgery.

(3) An informed consent, in writing, for the contemplated surgical procedure.

(d) The requirements of subsection (c), above, do not preclude rendering emergency medical or surgical care to a patient.

(e) A register of operations shall be maintained including the following information for each surgical procedure performed.

(1) Name, age, sex and identity number of the patient.

(2) Date and time of the operation and the operating room number.

(3) Preoperative and postoperative diagnosis.

(4) Name of surgeon, assistants, anesthetists and scrub and circulating assistants.

(5) Surgical procedure performed and anesthetic agent used.

(6) Complications, if any, during the operation.

(f) An affiliation agreement or contract for the referral and transfer of patients with emergency medical problems shall be established and available for inspection by the Department.

(g) Periodically, the patient-care policy committee shall evaluate the services provided and make appropriate recommendations to the medical director and administration.

NOTE: Authority cited: Sections 208(a), 1205.1(k) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79733. Outpatient Surgical Care Staff.

(a) A physician shall have overall responsibility for the surgical service. This physician shall be certified or eligible for certification in surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. If such a surgeon is not available, a physician, with additional training and experience in surgery, shall be responsible for the service.

(b) A registered nurse with training and experience in operating room techniques shall be responsible for the nursing care and nursing management of the operating room service.

(c) There shall be registered nurses, licensed vocational nurses, and operating room technicians in the appropriate ratio to ensure that a registered nurse is available at all times to serve as the circulating assistant when a licensed vocational nurse or operating room technician is serving as a scrub assistant.

(d) There must be a registered nurse available for emergency treatment whenever there is an outpatient surgical care patient in the correctional treatment center.

(e) The correctional treatment center shall maintain records of continuing education and training programs for the nursing staff to be available to the Department upon request.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79735. Outpatient Surgical Care Equipment and Supplies.

Equipment and supplies shall be maintained to meet the needs of the services offered, including at least the following monitoring equipment and supplies:

(a) Cardiac monitor, with a pulse rate meter, for each patient receiving a general anesthetic.

(b) DC defibrillator.

(c) Electrocardiographic machine.

(d) Oxygen and respiratory rate alarms.

(e) Supplies and drugs for emergency use.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79737. Outpatient Surgical Care Space.

(a) A correctional treatment center providing outpatient surgical care shall maintain an operating room, or operating rooms, as follows:

(b) Construction of the operating room shall be in compliance with provisions of California Code of Regulations, Title 24, Chapter 10C, Section 1020C(a) and applicable sections of the California Building Standards Code.

(c) Operating room space shall conform to the provisions of California Code of Regulations, Title 24, Chapter 10C, Section 1020C(a).

(d) Special rooms such as cast rooms, fracture rooms, and cystoscopic rooms, if provided, shall maintain space in accordance with the provisions of California Code of Regulations, Title 24, Chapter 10C, Section 1020C(b).

(e) Postanesthesia recovery areas shall maintain space as required in California Code of Regulations, Title 24, Chapter 10C, Section 1020C(c).

(f) Laboratory, radiology and pharmacy services shall be readily accessible to the outpatient-surgical service.

(g) The operating room shall be located so that it does not connect directly with a corridor designed and used for through traffic.

(h) Facilities shall be maintained for the sterilization of equipment and supplies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79739. Mental Health Treatment Program.

A mental health treatment program is organized, staffed and equipped to provide mental health treatment services for inmate-patients who require 24-hour inpatient care and treatment for acute or nonacute mental health disorders.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79741. Mental Health Treatment Program—General Requirements.

(a) The mental health treatment program shall only be for inmate-patients with diagnosable mental disorder who require 24-hour mental health care.

(b) Each mental health treatment program shall have a clinical director who shall direct the clinical program, provide general direction to professional and nonprofessional staff and be responsible for the quality of clinical services performed in the facility.

(c) The clinical director of mental health treatment program, in consultation with other mental health professionals, shall develop and implement written policies and procedures for the mental health treatment program.

(d) There shall be preadmission patient screening for each inmate-patient completed by the clinical director or his or her designee.

(e) Release of medical records or mental health treatment information concerning any inmate-patient shall be only as authorized under Section 5328 of the Welfare and Institutions Code.

(f) Involuntary mental health treatment including involuntary medication, shall be provided only as authorized under Section 5328 of the Welfare and Institutions Code, as interpreted by the courts.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code; and Sections 5325 and 5328, Welfare and Institutions Code. Reference: Sections

56 et seq. and 1798 et seq., Civil Code; Sections 990 et seq. and 1158, Evidence Code; Sections 1250(j), 1254, 1278, 1293.9 and 1795, et seq., Health and Safety Code; Sections 5150 et seq. and 5328-5330, Welfare and Institutions Code; and *Keyhaz v. Rushen*, 178 Cal App. 3d 526 (1986).

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79743. Mental Health Treatment Program—Admission and Discharge Policies.

(a) Each mental health treatment program shall develop and implement written admission and discharge policies approved by the Governing Body encompassing which staff members authorized by law to diagnose and treat may admit or discharge inmate-patients, the types of diagnoses for which inmate-patients may be admitted, limitations imposed by law or licensure, staffing limitations, preadmission patient screening, rules governing emergency admission, limitation of services, termination of services, discharge of patients and other relevant functions.

(b) No inmate-patient may be placed in a mental health treatment program who is not admitted as an inmate-patient by a member of the mental health treatment program staff.

(c) The inmate-patient's condition, provisional diagnosis and a plan for initial treatment shall be determined by the admitting staff within 24 hours of admission.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79745. Mental Health Treatment Program—Multidisciplinary Treatment Team.

(a) The multidisciplinary treatment team shall be comprised of those persons who work directly with the inmate-patient in each of the disciplines or service areas that provide service to the inmate-patient, including the clinical director or designee, a psychiatrist, a clinical psychologist, a licensed clinical social worker, a member of the nursing staff and any other staff person who is involved in the treatment and care of the inmate-patient.

(b) The multidisciplinary treatment team shall provide assessment, and any reassessment, of an inmate-patient's need for services and shall develop and implement the inmate-patient's individual treatment plan.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79747. Mental Health Treatment Program—Individual Treatment Plan.

(a) The individual treatment plan shall:

(1) Be developed in writing by the multidisciplinary treatment team and, where possible, in collaboration with the inmate-patient. The treatment plan shall be developed as soon as possible, but no longer than 72 hours following the patient's admission.

(2) Be based on a comprehensive assessment of the inmate-patient's physical, mental, emotional and social needs.

(3) Be reviewed and updated as often as indicated, but no less often than every seven (7) days, weekends and holidays excepted, for acute mental health patients and every thirty (30) days for nonacute mental health patients.

(4) Include, but not be limited to:

(A) A statement of the patient's physical and mental condition, including all mental health diagnoses.

(B) Prescribed medication, dosage and frequency of administration.

(C) Specific goals of treatment with intervention and actions that identify steps toward improvement or recovery and observable, measurable objectives.

(D) Identification of methods to be utilized, the frequency for conducting each treatment method and the person(s) or discipline(s) responsible for each treatment method.

(E) Documentation of the success or failure in achieving stated objectives.

(F) Evaluation of the factors contributing to the inmate-patient's progress or lack of progress toward recovery and a statement of the multidisciplinary treatment decision for follow-up action.

(G) An activity plan.

(H) A plan for other services needed by the inmate-patient which are not provided by the mental health treatment program.

(I) Goals for aftercare and a plan for post-discharge follow-up.

(b) The individual treatment plan shall be in writing and be approved by a clinical psychologist, psychiatrist, licensed clinical social worker, licensed marriage, family, and child counselor, or a psychiatric mental health nurse designated by the clinical director.

(c) The staff shall observe and note any changes in the inmate-patient's condition and the treatment plan shall be modified in response to the observed changes.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79749. Mental Health Treatment Program—Services.

(a) Psychiatric and psychological services.

(1) Psychiatrists or clinical psychologists, within the scope of their licensure and subject to the rules of the facility, shall be responsible for the initial diagnosis of each inmate-patient.

(2) Inmate-patients shall be evaluated as soon as possible but not later than seventy-two (72) hours from the time staff determines that the inmate-patient requires or may require psychotropic medication.

(b) Social work services shall be organized, directed and supervised by a licensed clinical social worker.

(c) Mental health rehabilitation therapy services.

(1) Mental health treatment programs shall provide and conduct organized therapeutic social, recreational and vocational activities in accordance with the interests, abilities and needs of the inmate-patients, and will include the opportunity for exercise.

(2) Mental health rehabilitation therapy services shall be designed by and provided under the direction of a licensed mental health professional, a recreational therapist or an occupational therapist.

(d) Aftercare plan.

(1) A written aftercare plan shall describe those services that should be provided to an inmate-patient following discharge, transfer or release from the mental health program for the purpose of enabling the inmate-patient to maintain stabilization and/or achieve an optimum level of functioning.

(2) Prior to or at the time of discharge, transfer or release from the mental health treatment program, each inmate-patient shall be evaluated concerning the inmate-patient's need for aftercare services. This evaluation shall consider the inmate-patient's potential in-custody housing, proximity to release from incarceration, probable need for community treatment and social services, and need for continued mental health care.

(3) Aftercare plans shall include, but not be limited to, the following:

(A) Arrangement for medication supervision and follow-up care.

(B) Referral to social, vocational or education services, if available and appropriate.

(4) A member of the multidisciplinary treatment team designated by the clinical director shall be responsible for ensuring that the referral of the inmate-patient to the appropriate aftercare service has been completed and documented in the inmate-patient's health record.

(5) Arrangements for necessary community referral, placement, conservatorship or post-discharge care shall be made prior to release from custody.

(6) A copy of the aftercare plan conforming to the requirements of Health and Safety Code Section 1284 and Welfare and Institutions Code Section 5622 shall be transmitted to the local director of mental health services or a designee in the county of residence for any inmate-patient referred to community services funded by the Bronzan-McCorquodale Act.

(7) The inmate-patient shall receive a copy of the aftercare plan when referred to community services.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254 and 1282, Health and Safety Code; and Section 5622, Welfare and Institutions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79751. Acute Mental Health Care.

Acute mental health care means that level of voluntary or involuntary 24-hour care that is required to provide ongoing intensive evaluation and treatment by mental health staff to inmate-patients suffering from severe mental disorder. Acute levels of care include, but are not limited to: (1) treatment of acute levels of severe mental disorder or (2) clinical restraint and seclusion. Such inmate-patients would be those who, if in the community, would require a licensed health facility providing 24-hour acute mental health hospitalization. Such facilities include but are not limited to psychiatric health facilities or acute psychiatric hospitals.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79753. Nonacute 24-Hour Mental Health Care.

Nonacute 24-hour mental health care means that level of voluntary or involuntary care that is required to provide mental health services to mentally disordered inmate-patients who are not in need of acute mental health care, but who require general mental health evaluation, diagnostic assessment, treatment, nursing and/or related services, on a 24-hour-per-day basis in order to achieve stabilization and/or an optimal level of functioning. Such inmate-patients would be those who, if in the community, would require a licensed health facility providing 24-hour subacute mental health care. Such facilities include but are not limited to skilled nursing facilities with special treatment programs. Subacute has the same meaning as nonacute as defined in this section.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79755. Mental Health Treatment Program Staffing—Basic Requirements.

(a) Each mental health treatment program shall have a clinical director who shall be a psychiatrist, clinical psychologist, licensed clinical social worker, licensed marriage, family, and child counselor, or a psychiatric mental health nurse operating within his or her scope of licensure. The clinical director shall have at least three years of direct clinical experience with the severely mentally disordered after completion of his or her last year of graduate education.

(b) Only that portion of correctional treatment center staff or contracted employee hours spent on the care of patients in the mental health treatment program may be counted as part of the required staffing pattern.

(c) The required minimum staffing ratios shall be calculated based upon the actual census of inmate-patients receiving 24-hour mental health care.

(d) Mental health treatment program nursing services shall be provided under the direction of a registered nurse who shall meet at least the following qualifications:

(1) Master's degree in psychiatric nursing or related field with experience in administration; or

(2) Two years of experience in psychiatric nursing; or

(3) Two years of experience in nursing administration or supervision and one year experience in psychiatric nursing.

(e) A registered nurse with experience in psychiatric nursing shall be employed forty (40) hours per week.

(f) There shall be a registered nurse, a licensed vocational nurse or a psychiatric technician in the mental health treatment area at all times.

(g) In addition to the minimum staffing required above, the mental health treatment program shall employ professional and other staff on all shifts in the number and with the qualifications to provide all necessary services for those patients admitted for care.

(h) Clinical psychologists, licensed clinical social workers, and licensed marriage, family, and child counselors shall be employed pursuant to the provisions of Section 5751.2, Welfare and Institutions Code.

(i) Psychiatric postgraduate trainees, interns, residents, postdoctoral fellows or instructors may practice psychiatric medicine under the provisions of Section 2065 of the Business and Professions Code.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; Section 5751.2, Welfare and Institutions Code; and Section 2065, Business and Professions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

Acute Mental Health Care Census:

	1-5	6-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
Staff: Psychiatrist or Clinical Psychologist or Licensed Clinical Social Worker or Licensed Marriage, Family and Child Counselor, or Psychiatric Mental Health Nurse	5	1	2	3	4	5	6	7	8	9	10
Registered Nurse or Licensed Vocational Nurse or Psychiatric Technician	3	4	5	6	8	10	12	14	16	18	20
Mental Health Worker	1.5	3	5	8	10	13	15	18	20	23	25
TOTALS	5	8	12	17	22	28	33	39	44	50	55

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79759. Mental Health Treatment Program.

Staffing—Nonacute Care Requirements.

Nonacute 24-hour mental health care may be provided by any correctional treatment center meeting the basic staffing requirements specified in Section 79631, Nursing Service Staff, including the requirements for 2.5 nursing hours per patient day and by the Mental Health Treatment Program Staffing—Basic Requirements, set forth in Section 79755.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79761. Mental Health Treatment Program—Space.

(a) Space shall be provided for the conduct of the mental health treatment program and shall include:

- (1) A consultation room for interviewing.
- (2) An observation room for acutely disturbed inmate-patients.
- (3) Indoor or outdoor facilities for therapeutic activities.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79757. Mental Health Treatment Program

Staffing—Acute Care Requirements.

Mental health treatment programs that provide acute 24-hour mental health care shall meet the following dedicated full-time equivalent staff to census ratio only for acute inmate-patients in any 24-hour period. This staffing pattern includes all staff that is required for the treatment of acute patients. Staff required by earlier sections of this Chapter for the disciplines listed in this section may be counted toward meeting the staffing pattern required in this section for that portion of their time that is spent in caring for acute patients. The above staffing requirements in this Section for registered nurse, licensed vocational nurse or psychiatric technician shall be followed instead of the requirement of 2.5 nursing hours per patient day required for other correctional treatment center inmate-patients. That portion of the time of a psychiatric mental health nurse that is counted toward one category of the staffing requirements shall not be counted toward another category of the staffing requirements. Unlicensed custody staff, to the degree they do work that would otherwise be done by mental health workers and who meet the qualifications of mental health workers, as defined in this chapter, may be counted toward the mental health worker requirement.

§ 79763. Standby Emergency Medical Services, Physician on Call, Definition.

Standby emergency medical service, physician on call, means the provision of emergency medical care in a specifically designated area of the correctional treatment center which is equipped and maintained at all times to receive patients with urgent medical problems and capable of providing physician service within a reasonable time.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79765. Standby Emergency Medical Service, Physician on Call, General Requirements.

(a) Written policies and procedures shall be developed and maintained by the physician responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff.

(b) The responsibility and the accountability of the emergency medical service to the medical director, administration and governing body shall be defined.

(c) There shall be a roster of names and telephone numbers of physicians who are available to provide emergency service.

(d) A communication system employing telephones, radiotelephone or similar means shall be in place for establishing and maintaining contact with law enforcement authorities, rescue squads, and other emergency medical services of the community.

(e) The correctional treatment center shall require continuing education of all emergency medical service personnel.

(f) Medical records shall be maintained on all inmate-patients who are admitted for emergency medical care. These records shall become part of the inmate-patient's medical record. Past medical records shall be available to the emergency medical service.

(g) An emergency room log shall be maintained and shall contain at least the following inmate-patient information: name, date, time and means of arrival, age, sex, record number, nature of complaint, treatment, disposition and time of departure. The names of those dead on arrival shall also be entered in the log.

(h) Standardized emergency nursing procedures shall be developed and approved by the patient care policy committee and administration.

(i) A list of referral services shall be available in the emergency service. This list shall include the name, address, and telephone number of the following:

- (1) Police department, if applicable.
- (2) Blood bank, if applicable.
- (3) Antivenin service.
- (4) Burn center.
- (5) Poison control information center.
- (6) Director of State Department of Health Services or designee.
- (7) Local health department.
- (8) Clergy.
- (9) Emergency psychiatric service.
- (10) Chronic hemodialysis service.
- (11) Intensive care newborn nursery (if applicable).
- (12) Emergency maternity service (if applicable).
- (13) Radiation accident management service.
- (14) Ambulance transport and rescue services.
- (15) County coroner or medical examiner.

(j) An appropriate committee of the correctional treatment center staff shall annually evaluate the services provided and make appropriate recommendations to the administration.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79767. Standby Emergency Medical Service, Physician on Call, Staff.

(a) A physician shall have overall responsibility for the service. That physician, or his or her designee, shall be responsible for:

- (1) Implementation of established policies and procedures.
- (2) Development of a system for assuring physician coverage on call 24-hours a day to the emergency medical service.
- (3) Assurance that physician coverage is available within a reasonable length of time, relative to the inmate-patient's illness or injury.
- (4) Development of a roster of specialty physicians available for consultation.
- (5) Assurance of continuing education in emergency care procedures for the medical and nursing staff.

(b) All physicians, dentists and podiatrists providing services in the emergency treatment area shall be employed by the correctional treatment center.

(c) A registered nurse with training in emergency medical care shall be present or on call to the correctional treatment center at all times to provide emergency nursing care.

(d) There shall be sufficient other personnel to support the services offered.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79769. Standby Emergency Medical Service, Physician on Call, Equipment and Supplies.

Equipment and supplies necessary for life support shall be available. Equipment shall include, but not be limited to: airway control and ventilation equipment; suction devices; cardiac monitor defibrillator; intravenous fluids, including blood expanders; and administering devices.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79771. Standby Emergency Medical Service, Physician on Call, Space.

(a) The following space provisions and designations shall be met:

- (1) Designated emergency treatment area.
- (2) Observation room.

(b) Observation beds in the emergency medical service shall not be counted in the total licensed bed capacity of the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

Article 5. Administration

§ 79773. Governing Body.

(a) The governing body shall have full legal authority and responsibility for the operation of the correctional treatment center including compliance with all applicable laws and regulations.

(b) The governing body shall appoint a medical director with delegated authority to carry out the functions of the correctional treatment center and the responsibility for ensuring that the correctional treatment center conforms to all applicable federal, state and local laws and regulations. The governing body shall appoint an administrator whose authority, qualifications and duties shall be defined in writing.

(c) The governing body shall adopt administrative policies and procedures designating in writing all services provided and shall oversee the management and fiscal affairs of the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New article 5 and section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79775. Medical Director.

(a) Each correctional treatment center shall employ or otherwise provide a medical director. The medical director shall be a licensed physician. The medical director shall be responsible for the daily administration and clinical management of only one correctional treatment center unless both of the following apply:

(1) All facilities for which the medical director is responsible are in the same geographic region and are operated by the same governing body.

(2) The medical director shall designate a physician who is knowledgeable in the policies and procedures of the correctional treatment center to fulfill the functions of the medical director during the medical director's absence.

(b) The medical director shall be on the premises of the correctional treatment center a sufficient number of hours to attend to the clinical operation of the facility. The Department may require the medical director to spend additional hours in the facility whenever the Department determines, through a written evaluation, that such additional hours are needed to provide adequate clinical direction of the correctional treatment center.

(c) The medical director's responsibilities, acting alone or through an organized medical staff, shall include:

(1) Establishing and approving policies and procedures for each basic and optional service provided by the correctional treatment center. These policies and procedures shall be reviewed annually.

(2) Assuring the quality of medical care provided to all inmate-patients treated by the correctional treatment center.

(3) Reviewing and approving all protocols used by the correctional treatment center.

(4) Establishing and implementing a system of peer review pursuant to written procedures.

(5) Reviewing credentials and delineating clinical privileges for the licensed professionals providing services in the correctional treatment center.

(6) Assuring that a physician, physician's assistant, or registered nurse is available whenever medical services are provided.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79777. Administrator.

(a) The governing body shall appoint an administrator. The administrator's responsibilities include, but are not limited to, the following:

(1) Establishing written administrative, management and personnel policies and procedures.

(2) Maintaining policies and procedures for each basic and optional service provided by the correctional treatment center. These policies and procedures shall be reviewed annually.

(3) Informing appropriate staff of applicable additions, deletions and changes to correctional treatment center regulations.

(4) Maintaining and monitoring contracts for professional consultant staff and health service support agencies.

(5) Reviewing employee accident and incident reports and taking appropriate corrective action.

(6) Assuring that current copies of the California Code of Regulations, Title 22 regulations pertaining to correctional treatment centers are available to all personnel.

(7) Assuring that the correctional treatment center provides only those services for which it is organized, staffed and equipped.

(8) Informing the Department within 24 hours of any unusual occurrences, as specified in these regulations.

(b) The medical director may perform the duties of the administrator.

(c) The administrator shall be in the correctional treatment center for a sufficient number of hours to permit adequate attention to the management and administration of the center.

(d) The administrator shall possess one of the following qualifications:

(1) A master's degree in health services administration and one year of experience in hospital administration in either a licensed skilled nursing facility or a general acute care hospital; or

(2) A master's degree in a health related field and two years of administrative experience in a state or local correctional health care setting; or

(3) A bachelor's degree in a health related field and four years of health related administrative experience.

(4) State civil service appointment as a correctional health services administrator.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79779. Administrative Policies and Procedures.

(a) Written administrative, management and personnel policies shall be established and implemented to govern the administration and management of the correctional treatment center. Policies and procedures

shall not supersede the custody and security requirements of the correctional treatment center.

(b) Policies and procedures shall be reviewed at least annually, revised as needed, and approved in writing by the governing body.

(c) Each correctional treatment center shall establish at least the following:

(1) Personnel policies and procedures which shall include:

(A) Written job description detailing qualifications, duties and limitations of each classification of employee shall be available to all personnel.

(B) Employee orientation to facility, job, patient population, policies, procedures and staff.

(C) Staff development.

(D) Employee health.

(E) Verification of licensure, credentials and references.

(2) Policies and procedures for patient admission, leave of absence, transfer, discharge, categories of patients accepted and retained, types of services offered and limitations of services.

(3) Policies and procedures governing patient health records which shall be developed with the assistance of a person skilled in health record administration.

(4) Policies and procedures relating to the inmate-patient's right to refuse treatment when refusal of treatment results in a life-threatening situation.

(5) Policies and procedures governing conflict resolution shall address at least:

(A) The roles and responsibilities of medical and custodial personnel regarding the housing of inmate-patients in the correctional treatment center.

(B) The notification responsibilities of custodial personnel to health staff regarding any special security needs of inmate-patients admitted to the center.

(C) The notification responsibility of health care staff to custody staff regarding any special medical and mental health needs of the inmate-patient admitted to the correctional treatment center.

(d) The correctional treatment center shall have a written organizational chart showing the major programs of the facility, the person in charge of each program, the lines of authority, responsibility, and communication and the staff assignments. Accountability and responsibility shall be defined.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79781. Required Committees.

(a) Each correctional treatment center shall have at least the following committees: patient care policy, infection control and pharmaceutical service.

(b) Minutes of every committee meeting shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed and action taken.

(c) In those correctional treatment centers where appropriate, these functions may be performed by a committee of the whole.

(d) Committee composition and function shall be as follows:

(1) Patient Care Policy Committee.

(A) A patient care policy committee shall establish policies governing the following services: Physician, psychiatrist, psychologist, dental, nursing, dietetic, pharmaceutical, health records, housekeeping and such additional services as are provided by the facility.

(B) The committee shall be composed of at least the medical director, the administrator (if appointed), the director of nursing service, a pharmacist and a representative of each required service as appropriate.

(C) The committee shall meet at least annually.

(D) The patient care policy committee shall have the responsibility for reviewing and approving all policies relating to patient care. Based on

reports received from the facility administrator, the committee shall review the effectiveness of policy implementation and shall make recommendations for the improvement of patient care.

(E) The committee shall review patient care policies annually and revise as necessary. Minutes shall list policies reviewed.

(F) The patient care policy committee shall implement the provisions of Health and Safety Code Sections 1315, 1316, and 1316.5, by means of written policies and procedures.

(G) Only physicians shall assume the overall medical care of patients, including performing the admitting history, and the physical examinations and the issuance of orders for medical care.

(2) Infection Control Committee.

(A) An infection control committee shall be responsible for infection control in the facility.

(B) The committee shall be composed of representatives from at least the following services; physician, nursing, administration, dietary, pharmaceutical, housekeeping, and laundry.

(C) The committee shall meet at least quarterly.

(D) The functions of the infection control committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for investigating, controlling and preventing infections, including tuberculosis, in the correctional treatment center. These shall be based on the 1990 recommendations of the Centers for Disease Control.

2. Maintaining, reviewing and reporting statistics of the number, types, sources and locations of infections within the facility. This shall include maintaining a confidentiality log which contains the dates and results of Mantoux tuberculin skin tests recorded in millimeters of induration and chest X-ray results of all correctional treatment center employees and inmate-patients.

(E) A registered nurse shall be assigned on a full-time or part-time basis to infection control surveillance.

(3) Pharmaceutical Service Committee.

(A) A pharmaceutical service committee shall direct the pharmaceutical services in the facility.

(B) The committee shall be composed of the following; a pharmacist, the director of nursing service, the administrator (if appointed), and the medical director or at least one physician.

(C) The committee shall meet at least quarterly.

(D) The functions of the pharmaceutical service committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for the safe procurement, storage, distribution and use of drugs, biologicals, and chemicals.

2. Reviewing and taking appropriate action on the pharmacist's quarterly report.

3. Recommending measures for improvement of services and the selection of pharmaceutical reference materials.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254, 1315, 1316 and 1316.5, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79783. Use of Outside Resources.

(a) If a correctional treatment center does not employ qualified personnel to render a specific service to be provided by the correctional treatment center, there shall be arrangements through a written agreement and/or contract with outside resources. Outside resources shall meet the standards and requirements of all applicable regulations before an agreement and/or contract may be entered into and shall continue to meet all applicable regulations during the term of the agreement and/or contract. Outside resources may include other facilities, organizations, individuals, or public or private agencies.

(b) Signed and dated copies of agreements, contracts, or written arrangements for advice, consultation, services, training or transportation, with outside resources shall be on file in the facility. Copies of these agreements and/or contracts shall be readily available for inspection and review by the Department. The agreements and/or contracts shall include, but not be limited to, a description of the services to be provided, the financial arrangements, the methods by which the services are to be provided, the conditions upon which the agreement or contract can be terminated, signatures of parties to the agreement, and effective dates for the agreement.

(c) The governing body shall be responsible and accountable for all services provided through agreements and/or contracts.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79785. First Aid and Referrals.

If a correctional treatment center does not maintain an emergency medical service, its employees shall exercise reasonable care to determine whether an emergency exists, render necessary life-saving first aid, and transfer the inmate-patient to the nearest hospital that can render the needed services.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79787. Reporting.

(a) Reportable communicable diseases shall be reported to the local health officer and all unusual occurrences shall be reported to the Department by the licensed correctional treatment center within twenty-four (24) hours, either by telephone with written confirmation or by telephone facsimile (FAX).

(b) The reporting of communicable diseases and outbreaks shall be in conformance with Sections 2500, 2502, 2503 and 2504 of Title 17, California Code of Regulations.

(c) Events constituting an unusual occurrence shall include, but not be limited to:

(1) Poisonings.

(2) Fires or explosions.

(3) Death of an inmate-patient, employee, or visitor because of unnatural causes.

(4) Sexual acts involving inmate-patients who are minors, nonconsenting adults, or persons incapable of consent.

(5) Physical assaults on inmate-patients, employees, or visitors.

(6) All suspected criminal acts involving inmate-patients, employees, or visitors.

(7) All suspected incidents of physical or sexual abuse to an inmate-patient.

(8) Unexplained or illicit disappearance or loss of an inmate-patient or inmate-patient remains.

(9) Disruption of services of the licensed correctional treatment center.

(d) The licensed correctional treatment center shall furnish other pertinent information related to such occurrences as the local health officer or the Department shall require.

(e) All reports required in this Section shall be retained on file by the licensed correctional treatment center for three (3) years.

(f) Every fire or explosion that occurs in or on the premises shall be additionally reported immediately to the local fire authority, or in the areas not having an organized fire service, to the State Fire Marshal.

(g) The local health officer of the county to which an inmate-patient is to be released shall be notified at least one day in advance before an inmate-patient on any tuberculosis medication is released from the correctional facility.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79789. Patient Transfer.

(a) The licensee shall maintain written transfer agreements with one or more general acute care hospitals to make the services of those facilities accessible and to facilitate the transfer of patients. Complete and accurate patient information, in sufficient detail to provide for continuity of care, shall be transferred with the patient at the time of transfer. A copy of the current agreement shall be available for review by the Department.

(b) No patient shall be transferred or discharged for purposes of effecting a transfer from a facility to another facility, unless arrangements have been made in advance for admission to such a health facility.

(c) When a patient is transferred to another facility, the following shall be entered in the patient health record:

(1) The date, time, condition of the patient and a written statement of the reason for the transfer.

(2) Documentation that the receiving facility has been informed of the patient's transfer.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79791. Personnel Policies.

(a) Each correctional treatment center shall adopt and implement written personnel policies concerning qualifications, responsibilities, and conditions of employment for each classification employed which shall be available to all personnel. Such policies shall include but not be limited to:

(1) Hours of work.

(2) A plan for orientation for all new staff members that shall ensure that all new staff providing program services shall receive at least 20 hours of orientation and training within 14 days of employment. Staff attendance shall be documented. Initial training shall include, but not be limited to, the following:

(A) Orientation to all policies, procedures and objectives of the facility.

(3) A plan for at least annual evaluation of employee performance.

(b) Provision of a continuing in-service education program designed to improve patient care and employee efficiency. This training shall be in compliance with Section 79797 of this Chapter. All staff members shall attend, and attendance shall be documented.

(c) Personnel policies shall require that employees and other persons working in or for the facility familiarize themselves with the California Code of Regulations, Title 22, pertaining to correction treatment centers and such other regulations as are applicable to their duties.

(d) The facility shall recruit qualified personnel.

(e) If language or communication barriers exist between facility staff and patients, arrangements shall be made for interpreters or for the use of other means to ensure adequate communications between patients and personnel.

(f) All correctional treatment center staff shall be subject to the reasonable application of security procedures necessary for the operation of the jail or prison. Written policy and procedures governing the application of security procedures to correctional treatment center programs and staff shall be developed and adopted by the jail or prison administrator with input from the correctional treatment center administrator or director. Correctional treatment center staff shall not be primarily responsible for the enforcement of security policies or procedures.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79793. Employee Personnel Records.

(a) All facilities shall maintain personnel records of all employees. Such records shall be retained for at least three (3) years following termination of employment.

(b) The record shall include the employee's full name, Social Security number, the license or registration number, if any, a brief resume of experience, employment classification, date of beginning employment and date of termination of employment.

(c) Records of hours and dates worked by all employees during at least the most recent six-month period shall be kept on file at the place of employment.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79795. Employee Health Examinations and Health Records.

(a) A health examination, performed by a person lawfully authorized to perform such an examination shall be performed as a prerequisite for employment within ninety (90) days prior to employment or within one (1) week after employment. Written examination reports, signed by the person performing the examination, shall verify that employees are able to perform assigned duties and do not have any health conditions that would create a hazard for the employee, fellow employees, patients or visitors.

(b) The initial health examination shall include a tuberculin skin test using the Mantoux method using a 5 Tuberculin Unit dose of Purified Protein Derivative (PPD) stabilized with Tween-80, the result of which is read and recorded in millimeters of induration. If the result is positive, a chest film shall be obtained. A tuberculin skin test need not be done on a person with a documented positive reaction to PPD but a baseline chest X-ray shall be obtained.

(1) Policies and procedures that address the identification, employment utilization and medical referral of persons with positive skin tests, including those who have converted from negative to positive, shall be written and implemented.

(2) An annual skin test for tuberculosis shall be performed on those individuals with a previously documented negative tuberculin skin test. If an individual with a previously documented negative skin test has a subsequent positive reaction, a chest X-ray shall be obtained.

(c) Employee health records shall be maintained by the facility, and shall include the records of all required health examinations. Such records shall be kept for a minimum of three (3) years following termination of employment.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79797. Staff Development.

(a) Each correctional treatment center shall have an ongoing educational program planned and conducted for the development and improvement of necessary skills and knowledge for all facility personnel. Each program shall include but not be limited to:

(1) Orientation of all newly employed staff to all appropriate facility policies and procedures and specific job requirements.

(2) Prevention and control of infections.

(3) Fire prevention and safety.

(4) Cardiopulmonary resuscitation.

(5) All newly developed policies and procedures.

(6) Internal and external disaster plans.

(7) Applicable security policies and procedures of the correctional institution or detention facility.

(8) Suicide prevention techniques.

(b) Records shall be retained of all orientations and training and shall include date and time of training, title of presenter, summary of content and signatures of those attending.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79799. Inmate-Patients' Rights.

(a) Written policies regarding the rights and restrictions of inmate-patients admitted to a correctional treatment center shall be established and implemented, and made available to the inmate-patient and to the public. Inmate-patients will be afforded such rights as are commonly afforded to medical/mental patients and are consistent with jail or prison policies and procedures. Such policies and procedures shall ensure that each inmate-patient admitted to the correctional treatment center shall have the following rights and be notified of the treatment center's obligations:

(1) To be fully informed, prior to or at the time of admission and during his or her stay, of these rights and of all rules and regulations governing inmate-patient conduct.

(2) To be fully informed, prior to, or at the time of admission and during his or her stay, of services available in the correctional treatment center.

(3) To be fully informed by a physician of his or her medical condition and to be afforded the opportunity to discuss medical treatment.

(4) To give informed consent or to refuse any treatment or procedure or participation in experimental research.

(5) To be informed of and provided access to grievance forms and procedures.

(6) To be free from mental and physical abuse.

(7) To be free from chemical and (except in emergencies) clinical and treatment restraints except when necessary to protect the patient from injury to himself or to others.

(8) To be assured confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the correctional treatment center, except in the case of transfer to another health care facility, or as required by law or third party payment contract.

(9) To be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs, when not in conflict with security and custodial policies.

(10) To refuse convulsive treatment including, but not limited to, any electroconvulsive treatment, any treatment of a mental condition which depends on the induction of a convulsion by any means, and insulin coma treatment.

(11) To refuse psychosurgery as defined in Section 5325 of the Welfare and Institutions Code.

(12) To review his or her medical or psychiatric record upon request and consistent with statutory and case law.

(b) An inmate-patient's rights, as set forth above, may be denied or limited only for good cause which shall be evidenced by the written order of the attending physician or other person lawfully authorized to prescribe care, and may only be denied or limited if such denial or limitation is required by the reasonable application of security procedures or is otherwise authorized by law or regulation. Reasons for denial or limitation of such rights shall be documented by the attending physician in the inmate-patient's health record.

(c) If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this Section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. The patient's incapacity shall be determined by a court in accordance

with state law or by the patient's physician unless the physician's determination is disputed by the patient or patient's representative.

(d) These rights, written in English and Spanish, shall be prominently posted.

(e) Sections 863.1, 863.2, 865.2 and 865.5 of Title 9 of the California Code of Regulations pertaining to the assignment and duties of patients' advocate(s), good cause for denial of rights, and restoration of rights shall apply to every correctional treatment center, including the appointment of a patients' advocate for a correctional treatment center. These provisions are hereby incorporated by reference.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 5325, Welfare and Institutions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79801. Clinical Restraint, Treatment Restraint, and Clinical Seclusion.

(a) Written policies and procedures concerning the use of clinical restraint, treatment restraint, and clinical seclusion shall be developed and approved by the correctional treatment center administration.

(b) Clinical restraint and clinical seclusion shall only be used on a written or verbal order of a psychiatrist or clinical psychologist. Clinical restraint shall additionally require a physician's or physician's assistant's or a nurse practitioner's (operating under the supervision of a physician) written or verbal approval. The order shall include the reason for restraint or seclusion and the types of restraints. Under emergency circumstances clinical restraint or clinical seclusion may be applied and then an approval and/or an order must be obtained as soon as possible, but at least within one hour of application. Emergency circumstances exist when there is a sudden marked change in the inmate-patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate-patient or others, and it is impractical to first obtain an order and approval. Telephone orders and approvals for clinical restraint and clinical seclusion shall be received only by licensed medical and mental health care staff, shall be recorded immediately in the inmate-patient's health record, and shall be signed within twenty-four (24) hours.

(c) A physician shall complete a medical assessment of an inmate-patient at the earliest opportunity but not later than within twenty-four (24) hours after the inmate-patient has been placed in clinical restraint or clinical seclusion.

(d) Clinical restraint, treatment restraint, and clinical seclusion shall only be used as a measure to prevent injury to self or others. Clinical restraint, treatment restraint, and clinical seclusion shall only be used when less restrictive alternative methods are not sufficient to protect the inmate-patient or others from injury, and shall not be used as punishment or as a substitute for more effective programming or for the convenience of the staff. Removing an inmate-patient from an activity or area to another unlocked area for a period of time as a way to use separation as a behavioral modification technique shall not be considered clinical seclusion.

(e) Each order for clinical restraint and clinical seclusion shall be in force no longer than twenty-four (24) hours.

(f) There shall be no PRN orders (as needed orders) for clinical restraint and clinical seclusion.

(g) An inmate-patient placed in clinical restraint shall be physically checked at least every fifteen (15) minutes by nursing staff to assure that the restraints remain properly applied, that circulation is not impaired, that the inmate-patient is not in danger of harming himself or herself, and that other medical problems are not present. Routine range of motion exercises shall be done with clinically restrained inmate-patients. Fluids and nourishment shall be provided every two (2) hours, except during sleep. An inmate-patient placed in clinical seclusion shall be observed by nursing staff at least every fifteen (15) minutes. A written record shall

be kept of these checks and range of motion exercises and maintained in the individual inmate-patient's health record.

(h) The inmate-patient's health record shall include written justification for the application of clinical restraints, note the times of application and removal of restraints and document the inmate-patient's status and the judgment of the physician or clinical psychologist on the necessity for continuation of clinical restraints at a minimum of once every twenty-four (24) hours.

(i) Clinical and treatment restraints shall be used in such a way as to minimize the risk of physical injury to the inmate-patient and to ensure the least possible discomfort. Minimum force shall be used. Belts and cuffs shall be well padded.

(j) Clinical restraints shall be placed on inmate-patients only in an area that is under direct observation of staff. Such inmate-patients shall be afforded protection from other inmate-patients who may also be in the area.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 5325, Welfare and Institutions Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79803. Health Record Service.

(a) The correctional treatment center shall maintain a health record service in accordance with accepted professional standards and practices. The health record service shall have sufficient staff, facilities, and equipment, and be conveniently located to facilitate the accurate processing, checking, indexing and filing of all health records.

(b) The health record service shall be under the direction of a staff member with at least two years of training and experience in records administration, at a level of responsibility equivalent to a health record technician, or a medical record technician. This designated staff member shall be assisted by such qualified personnel as are necessary to conduct the service. A registered record administrator or accredited records technician shall provide consultation on at least a quarterly basis to designated staff members responsible for record administration.

(c) If a facility, in addition to inpatient services, is providing outpatient, emergency, day treatment, or crisis intervention service, a unit health record system shall be established.

(d) The facility shall have a continuing system of collecting and recording data that describe patients served in such form as to provide for continuity of care, program services, and data retrieval for program patient care evaluation and research. Health records shall be stored and systematically organized to facilitate retrieval of information. Retrievability shall be assured by the use of an acceptable coding system such as the latest version of the International Classification of Diseases (ICD-9).

(e) Policies and procedures shall be established and implemented to ensure the confidentiality of access to patient health information, in accordance with federal, state and local laws and acceptable standards of practice.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79805. Inmate-Patient Health Record Content.

(a) Each inmate-patient's health record for inpatient services shall consist of at least the following:

(1) Admission and discharge record identification data including, but not limited to, the following:

- (A) Name.
- (B) Inmate-patient identification number.
- (C) Date of Birth.
- (D) Sex.
- (E) Marital status.
- (F) Religion (optional on part of inmate-patient).

(G) Date of admission.

(H) Date of discharge.

(I) Name, address and telephone number of person or agency responsible for the inmate-patient, or next of kin.

(J) Initial diagnostic impression.

(K) Discharge or final diagnosis.

(2) Mental status.

(3) Admission medical history and physical within 24 hours of admission. This shall include written documentation of a Mantoux tuberculin skin test within the past year, unless a previously positive reaction can be documented or completion of adequate preventive therapy or adequate therapy for active disease can be documented. If no written documentation is available, the Mantoux tuberculin skin test shall be administered within 24 hours of admission, and recorded in millimeters of induration in the medical history.

(4) Dated and signed observations and progress notes recorded as often as the inmate-patient's condition warrants by the person responsible for the care of the inmate-patient.

(5) Consultation reports.

(6) Medication, treatment and diet orders.

(7) Social service evaluation, if applicable.

(8) Psychological evaluation, if applicable.

(9) Dated and signed health care notes including, but not limited to, the following:

(A) Patient care plan.

(B) Concise and accurate records of nursing care provided.

(C) Records of pertinent nursing observations of the inmate-patient and the inmate-patient's response to treatment.

(D) The reasons for the use of and the response of the inmate-patient to PRN medication administered and justification for withholding scheduled medications.

(E) Record of type of restraint, including time of application and removal.

(F) Rehabilitation evaluation, if applicable.

(G) Interdisciplinary treatment plan, if applicable.

(H) Progress notes including the patient's response to medication and treatment rendered and observation(s) of patient by all members of treatment team providing services to the patient.

(I) Medication records including name, dosage, and time of administration of medications, and treatments given. The route of administration and site of injection shall be recorded if other than by oral administration.

(J) Treatment records including group and individual psychotherapy, occupational therapy, recreational or other therapeutic activities provided.

(K) Vital sign record sheet.

(L) Consent forms as required, signed by the inmate-patient or the appropriate surrogate decision maker.

(M) All dental records, if applicable.

(N) Records of all laboratory tests ordered.

(O) Reports of all cardiographic or encephalographic tests performed.

(P) Reports of all X-ray examinations ordered.

(Q) All reports of special studies ordered.

(R) A discharge summary prepared by the admitting or primary care practitioner which shall recapitulate the significant findings and events of the inmate patient's treatment, his/her condition on discharge and the recommendation and arrangements for future care.

(S) Discharge or transfer information and continue care instructions.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79807. Inmate-Patient Health Record Availability.

(a) Records shall be kept on all inmate-patients admitted or accepted for treatment. All required records, either as originals or as accurate reproductions of the contents of such originals, shall be maintained in a

confidential manner, and be legible, and readily accessible upon request of persons authorized by law to have access to such records including, but not limited to persons authorized pursuant to Health and Safety Code, section 1795 et seq., those professional persons who are providing services to the patient and authorized representatives of the Department.

(b) The correctional treatment center shall safeguard the information in the record against loss, defacement, tampering, or use by unauthorized persons.

(c) Inmate-patient health records or reproductions thereof, shall be safely preserved for a minimum of seven years following discharge of the inmate-patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.

(d) If a correctional treatment center ceases operation, the Department shall be informed, within 48 hours prior to cessation, of the arrangements made for safe preservation of inmate-patient health records.

(e) Inmate-patient records shall be filed in an easily accessible manner in the facility or in an approved health record storage facility off the facility premises.

(f) Inmate-patient records shall be completed within 14 days following the inmate-patient's discharge.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79809. Transfer Summary.

A transfer summary shall accompany or precede the inmate-patient upon transfer to another facility where continuing care will be provided. The transfer summary shall include essential information relative to the inmate-patient's diagnosis, treatment course, medications, dietary requirements, known allergies and treatment plan.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79811. Fire and Internal Disasters.

(a) A written fire and internal disaster program, incorporating evacuation procedures, shall be developed with the assistance of local fire, safety and other appropriate experts. A copy of the program shall be available on the premises for review by the Department.

(b) The written program shall be implemented in the event of a fire, or internal or external disaster, and shall include but not be limited to the following:

- (1) Plans for the assignment of personnel to specific tasks and responsibilities.
- (2) Instructions relating to the use of alarm systems and signals.
- (3) Information concerning methods of fire containment.
- (4) Systems for notification of appropriate persons.
- (5) Information concerning the location of fire fighting equipment.
- (6) Identification of evacuation routes and procedures.
- (7) Other provisions as the local situation dictates.

(c) Fire and internal and external disaster drills shall be held at least semi-annually for each shift of facility personnel and under various conditions. Actual evacuation of patients during a drill is optional.

(d) The evacuation plan shall be available in the correctional treatment center and shall include but not be limited to the following:

- (1) Evacuation routes.
- (2) Location of fire alarm boxes.
- (3) Location of fire extinguishers.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79813. Custodial Personnel.

(a) Custodial personnel, or other nonmedical staff, may perform patient care support activities. At no time shall custodial personnel be used as replacements for required nursing staff.

(b) Custodial personnel assigned to the correctional treatment center shall receive orientation to the correctional treatment center and instruction in any patient care support activity they will perform prior to commencing the activity. Permitted inmate-patient care support activities, conducted in conjunction with nursing staff, may include:

- (1) Supervision of ambulatory, self-care inmate-patients.
- (2) The serving of meals to self-feed inmate-patients.
- (3) The serving of snacks or nourishment to inmate-patients.
- (4) Ambulating (exercising) independent, ambulatory inmate-patients.
- (5) Holding or immobilizing a patient during a treatment or a diagnostic procedure.

(6) Observation of inmate-patient mental behavior in conjunction with regular observation performed by nursing staff.

(7) Cardiopulmonary resuscitation and first aid, in emergencies, by personnel certified to perform those specific activities.

(c) Custodial personnel shall not perform any inmate-patient care activity requiring any of the following:

- (1) Medical record documentation.
- (2) Specialized training or medical knowledge, except first aid and cardiopulmonary resuscitation by certified personnel.
- (3) Medication or treatment administration.
- (4) Direct inmate-patient treatment contact, e.g., bathing, feeding, repositioning, and dressings.

(d) Custodial personnel and other nonmedical staff assigned to the correctional treatment center shall be subject to the employee health requirements of Section 79795 of this Chapter.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79815. Inmate-Patient Identification.

Each inmate-patient shall be provided with a wristband identification tag or other means of identification which shall be worn at all times. Minimum information shall include the name of the inmate-patient and the name of the correctional treatment center and/or correctional institution.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79817. Equipment and Supplies.

(a) Equipment and supplies in each correctional treatment center shall be of the quality and in the quantity necessary for care of inmate-patients as ordered or indicated. At least the following items shall be provided and properly maintained at all times:

- (1) Airways.
- (2) Bedpans.
- (3) Catheter equipment.
- (4) Clerical supplies and equipment.
- (5) Denture cups.
- (6) Drug service trays and/or carts.
- (7) Ear syringes.
- (8) Emergency oxygen supply and equipment for administration.
- (9) Emesis basins.
- (10) Examination light.
- (11) First aid supplies, as determined by the patient care policy committee.
- (12) Flashlights.
- (13) Gloves (sterile and unsterile).
- (14) Ice caps.

(15) Intravenous therapy supplies, if the correctional treatment center provides such services.

(16) Medicine droppers.

(17) Medicine glasses, cups, or other small containers which are accurately calibrated.

(18) Mortar and pestle.

(19) Rectal speculum.

(20) Refrigerator with accurate thermometer.

(21) Rubber tubing.

(22) Scales for weighing all inmate-patients.

(23) Shower and commode chairs, wheelchairs, and walkers.

(24) Soap for bathing.

(25) Soap dishes or soap containers.

(26) Sphygmomanometers/cuffs.

(27) Sterile dressings.

(28) Stethoscopes.

(29) Suction apparatus.

(30) Suture tray.

(31) Suture removal equipment.

(32) Syringes and needles.

(33) Test supplies necessary to perform urine sugar and acetone testing.

(34) Thermometers.

(35) Tongue depressors.

(36) Urinals.

(37) Vaginal speculum, if applicable.

(38) Washbasins.

(39) Water pitchers and drinking vessels.

(b) The correctional treatment center shall provide current authoritative, pertinent, basic books, periodicals and reference materials related to all services provided. At least the following shall be provided:

(1) Dictionaries, medical and standard.

(2) Directories of available community resources.

(3) A selection of current health care publications.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

Article 6. Physical Plant and Safety

§ 79819. Alterations to Existing Buildings or New Construction.

(a) Alterations to existing buildings licensed as correctional treatment centers or new construction shall be in conformance with Chapter 10F, Part 2, Title 24, California Code of Regulations, other applicable sections of the California Building Standards Code, and the requirements of the State Fire Marshal.

(b) Facilities licensed or subject to licensure and in operation prior to the effective date of Title 24 regulations for correctional treatment centers shall not be required to institute corrective alternatives or construction to comply with such new requirements except where specifically required or where the Department determines that a definite hazard to health and safety exists. Any facility for which preliminary or working drawings and specifications have been approved by the Office of State-wide Health Planning and Development prior to the effective date of changes to construction regulations shall not be required to comply with such new requirements provided substantial actual construction is commenced within one year of the effective date of the new requirements.

(c) Patients and/or correctional treatment center services shall not occupy buildings or spaces which have been remodeled or newly constructed without the written approval of the Department.

(d) The correctional treatment center shall maintain in operating condition all buildings, fixed equipment, utilities and spaces in the numbers

and types as specified in the construction requirements under which the facility or unit was first licensed, unless the correctional treatment center has made alterations in compliance with subsequent requirements.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1275 and 15007, Health and Safety Code.

HISTORY

1. New article 6 and section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79821. Space Conversion and Remodeling.

(a) Spaces approved for specific uses at the time of licensure shall not be converted to other uses or remodeled without the written approval of the Department, and shall also be in compliance with the requirements of the California Building Standards Code and the State Fire Marshal.

(b) Where remodeling, space conversion or new construction involves displacement or disruption of services which result in relocating a patient, the facility shall develop an implementation plan. Such plans shall be submitted to and be approved by the Department.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1276 and 15007, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79823. Inmate-Patient Capacity.

(a) A correctional treatment center shall not have more inmate-patient or beds set up for use than the number for which it is licensed, except in case of emergency when temporary permission may be granted by the Director or designee.

(b) Inmate-patients shall not be housed in areas which have not been approved by the Department for inmate-patient housing and which have not been given a fire clearance by the State Fire Marshal except as provided in subsection (a) above.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1275 and 15007, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79825. Fire Safety.

All correctional treatment centers shall be maintained in conformity with the regulations adopted by the State Fire Marshal for the prevention of fire and for protection of life and property against fire and panic. All correctional treatment centers shall secure and maintain fire safety clearance from the State Fire Marshal's office or its designee.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79827. Inmate-Patient Rooms.

(a) Each inmate-patient room shall be labeled with a number, letter, or combination of the two for identification.

(b) Inmate-patients shall be accommodated only in rooms meeting the space requirements of Section 1015F(a), Chapter 10F, Part 2, Title 24, California Code of Regulations.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79829. Inmate-Patient Room Furnishings.

(a) A clean, comfortable bed with a mattress, pillow, blankets, bed linen and provisions for the storage of personal items shall be provided for each licensed bed. All furnishings will be in good repair and suitable for special inmate-patient needs.

(b) Adjustable beds, side rails and overbed tables shall be provided as required by the inmate-patient's condition.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

79831. Special Rooms.

Special rooms shall be maintained for the isolation of a single patient in the ratio of one room for each 35 beds or major fraction thereof. These rooms shall be used for isolation of inmate-patients with infectious disease, acute or terminal illness, or those who become agitated and create a disturbance. At least one special room shall be maintained with toilets, hand washing and bathing or showering facilities which are not shared with other inmate-patients. These rooms shall also comply with applicable provisions of the California Building Standards Code regarding isolation rooms.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79833. Provision for Emptying Bedpans.

(a) Bedpans shall be emptied and cleaned in soiled utility rooms or in toilets adjoining or within patients' rooms. Such toilets shall be equipped with flushing attachments for bedpan washing and vacuum breakers.

(b) Utility rooms shall be maintained in each correctional treatment center and shall be designed for separation of clean and dirty work areas. Separate clean and dirty utility rooms may be provided alternatively. Each utility room shall include a work counter, a hand washing fixture, and a rim flush clinic sink.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

79835. Central Sterile Supply.

(a) The correctional treatment center shall have a sufficient supply of properly sterilized equipment and materials for the patient care needs.

(b) The correctional treatment center shall provide for the storage of a sufficient supply of sterile materials and shall have a system to dispense them throughout the correctional treatment center. The area in which the sterile materials are stored and dispensed shall be designated, equipped and staffed for this purpose.

(c) A specific person shall be designated to be in charge of the central sterile supply.

(d) There shall be written procedures developed and implemented pertaining to the preparation, handling and distribution of sterile supplies and equipment.

(e) There shall be effective separation of soiled or contaminated supplies and equipment from the clean or sterile supplies and equipment to prevent cross-contamination of the clean or sterile supplies and equipment.

(f) Sterile supplies and equipment shall be stored in clean cabinets, cupboards or on clean shelves. An orderly system of rotation and utilization of sterile supplies shall be used based on the shelf life of the wrap.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79837. Preparation of Sterile Supplies and Equipment.

(a) The processing and sterilizing of equipment and supplies shall be under the supervision of a person who has knowledge of principles of cleaning, sterilizing and infection control as evidenced by training and experience.

(b) Policies and procedures shall be developed, maintained and implemented on the proper decontamination, disinfection and sterilization of equipment and supplies. Procedures shall include, but not be limited to, the following:

(1) Proper techniques for utilization of the sterilization equipment, including the loading and unloading of equipment and supplies.

(2) Establishing the proper parameters for sterilization, e.g., temperature, pressure and period of exposure for steam sterilization.

(3) Length of aeration period of gas sterilized items.

(4) Packaging, labeling and dating of sterilized items, including date of sterilization and expiration of safe shelf life.

(5) A recall system including quarantine periods and procedures to be implemented in the event of a recall.

(c) The efficacy of the sterilization process shall be verified at least weekly by the use of appropriate biological indicators. All sterilized items shall be provided with appropriate physical indicators to verify that they have been exposed to the sterilization process. For gas sterilizers, a biological test shall be incorporated into each sterilizing cycle.

(d) Each sterilizer shall be identifiable to facilitate any necessary recall actions.

(e) Where appropriate, records shall be made of relevant sterilization parameters to confirm the adequacy of each sterilization cycle, and the records shall be retained for at least three years.

(f) Sterilizers shall be maintained in proper operating condition. A sterilizer no longer in use shall be conspicuously labeled as nonoperational and disconnected from steam or gas lines.

(g) If sterilized equipment and/or supplies are obtained from an outside source, the correctional treatment center shall assure that the provider meets the same or comparable standards as set forth in this regulation.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79839. Call Systems.

(a) A call system shall be maintained in operating order in all nursing units. Call systems shall be maintained to provide visible and audible signal communication between nursing personnel and patients. The minimum requirements shall be:

(1) A call station or stations providing readily accessible patient controls to each patient bed.

(2) A visible signal in the corridor above or adjacent to the door of each patient room.

(3) An audible signal and light, on a continuous or intermittent basis indicating the room from which the call originates shall be located at the nurses' stations. Alternate systems must be approved in writing by the Department.

(b) The call system shall be extended to each patient's toilet room, bathroom and shower room in locations easily accessible to the patients.

(c) The call systems shall be designed to require resetting at the place of origin unless a two-way voice communication component is included in the system.

(d) The requirements for call systems in psychiatric units serving ambulatory patients may be waived by the Department.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79841. General Maintenance.

(a) The correctional treatment center shall be in good repair and working order.

(b) The correctional treatment center shall have an organized program to ensure that the buildings and grounds are reasonably free of environmental hazards and nuisances which may adversely affect the health or well-being of patients, personnel and visitors.

(c) The fixed equipment of the correctional treatment center shall be in proper working order. The correctional treatment center shall have an organized program for the routine inspection, testing and maintenance of the hospital's fixed equipment including the heating, air conditioning and

ventilation systems, all fire warning and fire safety systems, and other building support systems which are identified by hospital policy as capable of creating a significant physical or environmental hazard if not properly maintained.

(d) The patient care equipment of the correctional treatment center shall be in proper working order. The correctional treatment center shall have an organized program for the routine inspection, maintenance and calibration of the correctional treatment center's diagnostic, therapeutic and other patient care equipment identified by correctional treatment center policies as posing a significant risk to patients if not properly maintained.

(e) The correctional treatment center's maintenance program for fixed and patient care equipment shall include the following:

(1) A written policy identifying the types of hospital equipment likely to cause risk to patients if not properly maintained.

(2) Written procedures specifying the scope of the inspection, testing and maintenance to be performed on the equipment. The procedures shall be consistent with current standards related to health care equipment established by nationally recognized safety agencies.

(3) Nominal inspection, testing and/or maintenance intervals for the equipment. Testing shall be performed prior to initial use and thereafter at intervals consistent with current standards established by nationally recognized safety agencies, but not exceeding 12 months. Inspection and/or testing shall be completed within 60 days of the established interval.

(4) Records documenting the inspection, testing and maintenance performed. Such records shall be maintained for at least three years.

(f) All equipment used for inspection and testing shall be included in the documented calibration program to assure its accuracy. Records shall be kept for at least three years.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79843. Housekeeping.

The correctional treatment center shall be kept in a clean, safe, orderly, and sanitary condition, free from offensive odors.

(a) Each correctional treatment center shall make provision for the routine cleaning of articles and surfaces such as furniture, floors, walls, ceilings, supply and exhaust grills and lighting fixtures with a detergent and/or disinfectant as appropriate.

(b) There shall be written policies and procedures developed and implemented to include but not limited to the following:

(1) Cleaning of occupied patient areas, nurses' stations, work areas, halls, entrances, storage areas, rest rooms, laundry, pharmacy and offices.

(2) Cleaning of specialized care areas such as operating rooms.

(3) Cleaning of isolation areas.

(4) Cleaning of kitchen and associated areas.

(5) Cleaning of walls and ceilings.

(6) Terminal cleaning of patient unit upon discharge of patient.

(7) Utilization of housekeeping cleaning supplies and equipment.

(c) The correctional treatment center shall designate a specific person to be in charge of the housekeeping services, who shall also participate in the correctional treatment center's infection control committee.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79845. Electrical Systems.

(a) The electrical system shall be in conformance with the California Building Standards Code.

(b) Emergency power and lighting.

(1) The emergency power system/generator shall be maintained in operating condition to provide automatic restoration of power to the correctional treatment center's essential systems within ten (10) seconds after the loss of primary power.

(2) The readiness of the batteries or other starting mechanism shall be verified at intervals not exceeding seven (7) days. The generator(s) shall be started and run under the connected load for a period of not less than thirty (30) minutes at least once every thirty (30) days. Once a year the emergency power system/generator shall be operated under connected load until the engine has reached the normal operating temperatures specified by the manufacturer, but for a period of not less than five (5) hours.

(3) A written record of all tests and maintenance performed, inspection performance, exercising period and repairs shall be maintained and kept for three (3) years.

(c) The correctional treatment center shall have an electrical system which provides adequate levels of power and lighting in a safe manner to all of the facility's electrically powered equipment and systems.

(d) Electrical outlets shall be tested for proper polarity and tension upon installation and replacement. Electrical outlets in patient care areas shall be tested for tension at least annually.

(e) Environmental electrical safety conditions in patient care areas shall be checked at least annually. At a minimum, this shall include a visual inspection of the electrical outlets and light fixtures.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79847. Storage and Disposal of Solid Waste.

(a) Solid waste shall be stored and disposed of in a manner which minimizes the risk of transmitting communicable disease. These wastes shall not be a nuisance or a breeding place for insects or rodents nor be a food source for either.

(b) Solid waste containers shall be stored and located in a manner that will protect against odors.

(c) Syringes and needles shall be disposed of safely as biohazardous and/or radioactive waste in puncture proof containers, in accordance with Health and Safety Code Sections 25080 through 25082, pertaining to medical waste and, if applicable, the California Code of Regulations, Title 17, Chapter 5, Subchapter 4, Group 1, Article 1, Sections 30285 and 30289, pertaining to radioactive materials.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79849. Solid Waste Containers.

(a) All containers, used for storage or transporting of solid wastes, shall be in good repair and be leakproof and rodent proof.

(b) Movable containers shall additionally have the approval of the local health department if applicable.

(c) All containers holding or receiving medical or putrescible wastes shall have tight-fitting covers and shall be emptied at least every four (4) days, or more often if necessary.

(d) Solid waste containers shall be thoroughly washed and cleaned each time they are emptied unless soil contact surfaces have been completely protected from contamination by disposable liners, bags or other devices removed with the waste. Each movable bin shall provide for suitable access and a drainage device to allow complete cleaning at the storage area.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250, 1276, 25117 and 25117.5, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79851. Medical Waste.

Medical waste, as defined in Health and Safety Code Section 25023.2, shall be handled and disposed of in accordance with the Medical Waste Management Act, Health and Safety Code Section 25015 et seq. and the regulations adopted thereunder, California Code of Regulations, Title 22, Division 4, Chapter 21, Articles 1 through 4, commencing with Section 65600 and ending with Section 65628.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254 and 25023.2, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79853. Gases for Medical Use.

(a) Provision shall be made for safe handling and storage of medical gas cylinders, by the type of gas and its associated hazards.

(b) Transfer of gas by facility personnel from one cylinder to another is prohibited except when approved by the Department.

(c) The correctional treatment center shall insure that connections for different medical gas supplies are not interchangeable.

(d) Where a medical gas distribution system is provided, the correctional treatment center shall maintain a complete and current set of written test results which confirm that the proper gases are being provided at all of the system outlets. Testing shall be performed prior to initial use, and for all potentially affected outlets after any modification or breach of the system which could possibly result in a cross connection. The outlets shall be tested for conformance to appropriate gas delivery parameters e.g., flow and pressure and proper operation of the alarms.

(e) The correctional treatment center shall have a written procedure for ensuring an adequate supply of medical gases for normal and emergency operating conditions.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79855. Water Supply and Plumbing.

(a) Plumbing and drainage facilities shall be in compliance with the California Building Standards Code.

(b) Water for human consumption from an independent source, such as private wells, shall be subjected to bacteriological analysis by the local health department, State Department of Health Services or a licensed commercial laboratory at least every three (3) months. A copy of the most recent laboratory report shall be available for inspection.

(c) Plumbing fixtures including backflow preventers shall be maintained in operating condition.

(d) For hot water used by or readily accessible to patients, there shall be temperature controls to automatically regulate the temperature between 40.5°C (105°F) and 48.9°C (120°F).

(e) Hot water at a minimum temperature of 82.2°C (180°F) shall be maintained at the final rinse section of dish washing facilities unless alternate methods are approved by the Department.

(f) Taps delivering water at 51.6°C (125°F) or higher shall be identified prominently by warning signs with letters 5cm (2 inches) high.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79857. Lighting.

Adequate illumination shall be maintained for the comfort and safety of inmate-patients and staff, and shall be in compliance with the California Building Standards Code.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79859. Heating, Ventilating, and Air Conditioning.

(a) Heating, ventilating and air conditioning shall be in compliance with the California Building Standards Code and shall be maintained to assure the systems are in operating condition to provide comfortable environmental conditions.

(b) Air filters.

(1) All filters shall be inspected and tested at least every three (3) months and cleaned or replaced as necessary to maintain adequate ventilation flow rates and filtration integrity.

(2) Written records documenting air filter inspections, testing and servicing reports shall be maintained and kept for three (3) years.

(A) Testing shall include but not be limited to static pressure drop across each filter bank.

(B) Replacement filters shall have efficiency ratings not less than the most recently permitted by the Office of Statewide Health Planning and Development for the subject air handling unit.

(C) Following filter replacement or cleaning, the installation shall be visually inspected for torn media and bypass in filter frames by means of a flashlight or equivalent, both with fans in operation and stopped. Tears in filter media and bypass in filter frames shall be eliminated in accordance with the manufacturer's directions and as required by the Department.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

§ 79861. Laundry Service.

(a) Laundry and linen.

(1) An adequate supply of serviceable clean linen shall be provided to meet the needs of the correctional treatment center. This shall include, but not be limited to, at least three (3) complete bed changes for the correctional treatment center's licensed bed capacity.

(2) There shall be written policies and procedures developed and implemented supporting infection control policies in the handling, storage, transportation and processing of linens. Such policies shall be reviewed and approved by the infection control committee.

(3) If the facility operates its own laundry, such laundry shall be:

(A) Located in such relationship to other areas that steam, odors, lint and objectionable noises do not reach patient care, dining or kitchen areas.

(B) Well-lighted, ventilated and adequate in size for the needs of the hospital and for safe operation.

(C) Maintained in a sanitary manner and kept in good repair.

(D) Not part of a storage area.

(4) The laundering of correctional treatment center linens shall comply with the following:

(A) All linens shall be washed using an effective soap or detergent and thoroughly rinsed to remove soap or detergent and soil. Linens shall be exposed to water at a minimum temperature of 71°C (160°F) for at least 24 minutes during the washing process, or a lower temperature of 60°C (140°F) for 24 minutes may be utilized if the linens are subsequently passed through a flatwork ironer at 110-115 feet per minute at a temperature of 300°F, or a tumbler dryer at a temperature of 180°F.

(B) The facility shall implement a procedure for affirming the efficacy of the laundry process, including quarterly sample testing procedures for bacterial, chemical and stain residue and overall fabric quality.

(5) Clean linen and soiled linen shall be stored in separate rooms of the facility. Linen storage rooms in the laundry area shall be adequate in size for the needs of the correctional treatment center and shall not be used for any other purpose.

(6) Laundry personnel shall be provided hand washing and toilet facilities at locations convenient to the laundry, to avoid traversing patient and dietary areas.

(7) Soiled and clean linen carts shall be so labeled and provided with covers made of washable or cleanable materials. The carts and covers shall be maintained in a clean condition. Linen carts used for the storage or transportation of dirty linen shall be thoroughly washed before being used for the storage and transportation of clean linen.

(8) If the correctional treatment center does not maintain a laundry service, the commercial laundry utilized shall meet the standards of this Section.

(b) Soiled linen.

(1) Soiled linen shall be handled, stored and processed in a safe manner to prevent the spread of infection.

(2) Policies and procedures shall be developed and implemented pertaining to linen from isolation rooms and pathology and linen soiled with chemotherapeutic agents or radioactive substances.

(3) Soiled linen shall be sorted in a separate enclosed room by a person instructed in methods of protection from contamination. This person shall not have responsibility for immediately handling clean linen until protective attire worn in the soiled linen area is removed, hands are washed, and other hospital infection control procedures observed.

(4) Soiled linen shall be stored and transported in a closed container which prevents airborne contamination of corridors, dietary areas and areas occupied by patients, and also precludes the cross-contamination of clean linen.

(5) Chutes shall not be used for transporting soiled linen in correctional

treatment centers constructed after the effective date of this regulation. If chutes are utilized in correctional treatment centers constructed before the effective date of this regulation, they shall be maintained in a clean, sanitary state.

(c) Clean linen.

(1) Clean linen shall be sorted, handled and transported in such a manner as to prevent contamination.

(2) Clean linen carts shall be used only for the purpose of transportation or storage of clean linen.

(3) Staff persons processing clean linen shall be dressed in clean garments at all times while on duty, and shall not handle soiled linen unless appropriate infection control procedures are observed.

(4) Clean linen from a commercial laundry shall be delivered to the correctional treatment center completely wrapped and delivered to a designated clean area.

(5) Clean linen in patient care units shall be stored in clean locations such as ventilated closets or clean utility rooms.

(6) If clean linen is stored in the laundry area, it shall be stored in a room separate from the sorting room, laundry room or soiled linen room. A partial partition or a curtain does not meet the requirements of this subsection.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

HISTORY

1. New section filed 6-10-94; operative 1-1-96 pursuant to Health and Safety Code section 1250 (Register 94, No. 23).

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SECTION 5: DEPARTMENT OF MENTAL HEALTH INPATIENT PROGRAM

A. INMATE IDENTIFICATION AND DEPARTMENT OF MENTAL HEALTH REFERRAL CRITERIA

1. Only institutions with Mental Health Crisis Bed (MHCB) programs or Enhanced Outpatient Programs (EOP) or both can initiate Department of Mental Health (DMH) referrals.
2. Inmates in the general population (GP), Reception Centers (RC), or Correctional Clinical Case Management (CCCMS) who need higher levels of care per the Program Guide shall be transferred to MHCB or EOP according to their clinical needs. Exceptions to this procedure - e.g., when crisis beds within reasonable proximity are not available and direct referral to the California Medical Facility (CMF)-DMH results in quicker access to a needed bed - may be made with approval by the Chief, Mental Health Services, or designee. Per Program Guide, emergency cases shall be transferred to MHCB within 24-hours.
3. The EOP and MHCB clinicians shall evaluate inmates who appear to need DMH placement using the attached form, Condensed Mental Health Assessment and Transfer (also known as MH4; Attachment 1) and determine if they meet the criteria for DMH placement at an acute or intermediate care level (Attachment 2).
4. The MHCB and EOP shall refer inmates needing longer-term (more than 10 days) inpatient care to either CMF-DMH or the California Institution for Women (CIW) for acute care or to California Men's Colony (CMC) or CIW for intermediate care. Inmates in MHCB who stabilize shall be referred to the appropriate lower level of care.

B. ADDITIONAL DOCUMENTATION

For admission to CMF-DMH and Patton State Hospital (PSH) (via CIW), a medical history is also required on the Inmate Information: M&R/Transfers/Referrals Form (Attachment 3).

C. CLINICAL CONTACTS AND APPROVAL

1. Contact the following institutions about clinical issues concerning DMH referral:

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- a. The CMC as the DMH-hub institution for male referrals for intermediate care at Atascadero State Hospital (ASH);
- b. The CIW as DMH-hub institution for female referrals for both acute and intermediate care at PSH;
- c. The CMF DMH program for acute care for male referrals

Exceptions to this procedure include CMF which processes its own placements to ASH and Pelican Bay State Prison (PBSP) which sends all inmates who need inpatient care to CMF per Madrid agreement.

- d. For CMC: Contact and FAX MH4 to the Chief Psychiatrist or designee. (805/547-7957; FAX 805/547-7526).
- e. For CIW: Contact and FAX MH4 and the Inmate Information: M&R/Transfers/Referrals Form to the Chief Psychiatrist or designee. (909/597-1771 ext. 4928; FAX 909/605-4905) at CIW.

For CMF: Call the Clinical Assessment Team (CAT) for the CMF-DMH program who will take the mental health information they need by phone. The MH4 may be FAXed later or transported with the inmate. FAX the Inmate Information: M&R/Transfers/Referrals Form to the CMF Chief Medical Officer (CMO) at 707/453-7019. The CMF-DMH will not accept inmates until they have been medically cleared by the CMF CMO.

- f. Obtain preliminary clinical approval from the DMH-hub institution for appropriateness of transfer of inmate as a DMH referral.

D. HEALTH CARE POPULATION MANAGEMENT MONITORING

1. EOP and MHCB clinical staff shall complete an INPATIENT MENTAL HEALTH REFERRAL chrono (128-C; Attachment 4) and submit this to Health Care Population Management Unit (HCPMU). **Be sure to indicate in the "Behavioral Alert" section of the chrono and also verbally inform HCPMU when a transfer is an emergency, (e.g., "inmate is a serious suicide risk" or "inmate is at serious risk to others").**
2. The HCPMU shall contact the sending institution Classification and Parole Representative (C&PR) and obtain a summary of custody case factors that might affect the treatment and management of inmates clinically approved for transfer.
3. Based upon the clinical determination of treatment need and custody case factors affecting placement, the HCPMU shall either recommend the transfer to CMC or recommend placement at CMF-DMH.

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VITEK HEARINGS

Hearings for inmates who refuse placement at ASH or PSH (Vitek hearings) shall be conducted following assessment at CMC or CIW. Those institutions shall also obtain a waiver of hearing for inmates willing to transfer.

F. CLASSIFICATION ACTION AND TRANSFER

1. The Classification Services Unit (CSU) provides the endorsement for transfer. **All cases referred for DMH inpatient care require immediate and special transport procedures including teletyped CSU endorsement when a Classification Staff Representative is not onsite.**
2. The C&PRs make appropriate transportation arrangements. All transfers to CMF-DMH or to CMC or CIW for DMH referrals to ASH or PSH shall be by special transport from the sending institution and shall occur within 72-hours of endorsement.
3. Copies of all necessary documentation must be FAXed to CMF-DMH or the DMH-hub institutions prior to transfer, and included into the health record and central file to be transported with the inmate.
4. At CMC and CIW, clinical staff shall further assess the inmate and complete the necessary referral documents for final DMH placement. The Chief Psychiatrist at those institutions shall render a final approval to transfer inmates under Penal Code Section 2684 and shall document this approval on a CDC 128-C provided to the C&PR at the institution for processing of final endorsement.
5. Inmates with final approval for DMH placement shall be transferred to ASH or PSH within two weeks of receiving the inmates at CMC or CIW.
6. The HCPMU shall monitor the transfer of inmates referred to DMH programs to the point of placement.

Attachment 1

State of California, Department of Corrections: N/C/S Region, SA = __, Institution = __ ☐ Male ☐ Female		
CONDENSED MENTAL HEALTH ASSESSMENT & TREATMENT SETTING TRANSFER:		Date: __/__/__
Variety Use Include: Admission Intake, Transfer, Parole, Discharge, MHCB Screen & Assessment.		Page 1 of 5
Current Setting: ☐ GP ☐ Ad Seg ☐ SHU ☐ RC ☐ CCCMS ☐ EOP ☐ PSU ☐ MHCB ☐ Other: _____		
I/M Ethnicity: _____	Non English Language: _____	Level: I / II / III / IV / AS / SHU
CDC Arrival date: _____	CDC Release date: _____	☐ MH 1, MH 4, MH 7 Date: __/__/__
Inmate interviewed on: __/__/__	Level of Cooperation: _____	DDPS _____ - _____ ☐ Not Noted.
I. Purpose for Condensed Mental Health Assessment:		
A. ☐ Condensed Initial Assessment (Intake) Form (May Replace or Delay MH 1 Assessment / Data Base.)		
☐ MH 1; ☐ MH 7; ☐ Bus Screening; ☐ Page 2 (Psychiatric History) as ☐ Update or ☐ Initial history		
B. ☐ Transfer to New Setting Recommended DDPS Code Change To: _____		
☐ Return to Custody ☐ GP ☐ POC & Complete Page 5.		
☐ To Out-patient ☐ CCCMS		
☐ EOP: Was tele-fax used? yes ☐ no ☐ ; Was approval obtained? yes ☐ no ☐ Conditional ☐		
☐ PSU		
☐ To In-patient ☐ MHCB ☐ Infirmary: CTC pre-screening? yes ☐ no ☐ Details: _____		
☐ DMH ☐ Criminal History Supplemental Form needed. DMH Care Level → ☐ Intermediate ☐ Acute		
Describe referral methods: _____		
Describe current symptoms/concerns that indicate a need for Inpatient: _____		
Desired Inpatient Treatment outcome: _____		
Was Above: ☐ Intra or ☐ Inter Institution ☐ Other (Outside) _____ ☐ No ☐ Yes Transfer Chrono by _____		
C. ☐ Pre Parole Release (Complete page 5: MH 4> CCI > C&PR > Form 611> Parole Regional HQ & POC Clinician.)		
D. ☐ Department of Correction Discharge. No CDC Follow Up. ☐ Inter State Compact to: _____ (state)		
☐ To Other Treatment Sources:		
Name: _____ Telephone: () _____ FAX: () _____		
Address: _____		
☐ Consent to Release Specific Records, Coordinate with Health Records. ☐ QA Follow Up Plan Discussed Below.		
II. Brief Narrative Summary: ☐ Expanded on Insert-a-Page		

CONDENSED MENTAL HEALTH ASSESSMENT & TREATMENT SETTING TRANSFER & PAROLE/DISCHARGE FORM MH 4 Page 1 of 5 [3-28-96] Use Insert-a-Page of MH 1 Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	Last Name: _____ First Name: _____ MI: _____ CDC # _____ DOB __/__/__
---	---	--

I. MENTAL HEALTH & HEALTH HISTORY: ☐ See Unit Health Record

(If an item is normal, check normal or none. If a deviation, elaborate.)

A. Developmental Problem ☐ Normal ☐ Abnormal ☐B. Marital: circle: S / M / D / W ☐C. Work History: ☐ None ☐ Some ☐ Erratic ☐ Extensive ☐D. Mental Health History: ☐ None known ☐ Yes ☐E. Issues and Problems ☐

1. Psychiatric Hospitalization ☐ None ☐ Yes
2. Psychotropic Medication in the last 2 years ☐ None ☐ Yes
3. Outpatient Treatment ☐ None ☐ Yes
4. MH Treatment while incarcerated/paroled ☐ None ☐ Yes
5. History of Substance Abuse ☐ None ☐ Yes
6. Release of information requested ☐ No ☐ Yes

F. Suicidal Behavior ☐ Denies History ☐ None Found ☐ Present ☐G. Violent Behavior ☐ Denies History ☐ None Found ☐ Present ☐H. Discuss Significant Medical History (Head Traumas, HIV, Seizures) ☐ None Found ☐ Present ☐I. Other or Additional Comments: ☐CONDENSED MENTAL HEALTH ASSESSMENT
& TREATMENT SETTING TRANSFER
& PAROLE/DISCHARGE FORM

MH 4

Page: 2 of 5 [3/28/96]

Use Insert-a-Page of MH 1

Confidential Client/Patient Information

See W & I Code, Section 5328

LEVEL OF
CARE

Inpatient

Outpatient

Last Name:

First Name:

MI:

CDC #

DOB

IV. Present Mental Status Date <u> </u> / <u> </u> / <u> </u>			
A) Appearance ☐ WNL			
B) Behavior ☐ WNL		Speech ☐ WNL	
C) Mood ☐ WNL	Sleep ☐ WNL	Appetite ☐ WNL	Affect ☐ WNL
D) Cognition:			
1) Fund of Information ☐ WNL			
2) Intellectual Functions ☐ WNL			
3) Organization of Thought ☐ WNL			
4) Association of Thought ☐ WNL			
5) Reality Contact ☐ WNL			
6) Thought Quality ☐ WNL			
E) Perception Disturbances (Hallucinations) ☐ None			
F) Thought Content (Delusions) ☐ None			
G) Sensorium (Orientation, Memory, Attention, Concentration) ☐ WNL			
H) Insight & Judgment ☐ WNL			
I) Interview Attitude ☐ WNL			
J) Current Suicidality ☐ None noted or stated.			
K) Current Violence Risk ☐ None noted or stated.			

V. DSM IV Numerical - Transferring / Discharge / Provisional (Discussion, diagnostic certainty.)		
Axis I		
Axis II		
Axis III		
Axis IV	(current)	
Axis V	GAF = _____ (Discuss basis.)	
Discussion and Diagnostic Certainty		

CONDENSED MENTAL HEALTH ASSESSMENT & TREATMENT SETTING TRANSFER & PAROLE/DISCHARGE FORM MH 4 Page: 3 of 5 [3/28/96] Use Insert-a-Page of MH 1 Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	Last Name: _____ First Name: _____ MI: _____ CDC # _____ DOB <u> </u> / <u> </u> / <u> </u>
--	---	---

VI. Present Treatment Summary (See Treatment Plan detail, MH 2, ___/___/___)
Page 4 of 5
a. Medication Chronology: ☐None ☐No Side Effects Noted ☐Medication Concern Issue ☐Keyhea **Discuss below.**
Allergies:

Name of Medication	Target Symptom	Dose	Side Effect

c. Laboratory Results:
d. Special Consultations:
Clinician Name: _____ **Clinician Title:** _____ **Date:** ___/___/___

Clinician Signature: _____ **Telephone:** () _____ **Ext.** _____

VII. NEW SETTING ASSESSMENT & INITIAL TREATMENT PLAN:
Date Receiving Above Assessment ___/___/___ **Time** ____; ____; **Received by:** _____

Identify Setting:
Receiving Assessment:
Receiving Plan:
Receiving Clinician's Name:
Signature:
Clinician Contact Regarding Discharge: Name & Position

CONDENSED MENTAL HEALTH ASSESSMENT & TREATMENT SETTING TRANSFER & PAROLE/DISCHARGE FORM MH 4 Page: 4 of 5 [3/28/96] Use Insert-a-Page of MH 1 Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE	Last Name: _____ First Name: _____ MI: _____
	Inpatient Outpatient	CDC # _____ DOB ___/___/___

ate of California, Department of Corrections: N / C / S Region, SA = , Present Institution =

VIII. PAROLE DATA: Condensed Mental Health Assessment & Parole Transfer Page 5 of 5

Date Completed: ___/___/___ MH> CCI> C&PR> Form 611>Parole HQ>POC DDPS Noted ☐ Yes ☐ No

Allergies:

Anticipated Date of Discharge:

Other:

Medication Provided at Discharge ☐ None ☐ See page 3

Name of Medication	Dose size	# of Tablets	Name of Medication	Dose size	# of Tablets

Housing Plans: Reside with: Relationship:

Address:

Telephone: () In whose name is telephone listed?

Other housing issues:

Suggested Aftercare Approach Plan:

Completed By CDC Clinician: Clinician Title: Date: ___/___/___

Clinician Signature: Telephone: () Ext. _____

CCI Name: Telephone: () Ext. _____ C&PR Confirmed by: _____

**CONDENSED MENTAL HEALTH ASSESSMENT
& TREATMENT SETTING TRANSFER
& PAROLE/DISCHARGE FORM
MH 4**

Page: 5 of 5 [3/28/96]
Use Insert-a-Page of MH 1
Confidential Client/Patient Information
See W & I Code, Section 5328

**LEVEL OF
CARE**

Inpatient

Outpatient

Last Name: First Name: MI:

CDC # _____ DOB ___/___/___

ATTACHMENT 2

DMH REFERRAL CRITERIA

The Overall Treatment Criteria for the Mental Health Services Delivery System also apply to DMH inpatient placement (see Program Guide). That is, inpatient placement requires a serious mental disorder diagnosis on Axis I or the existence of medical necessity. It further requires marked impairment and dysfunction in most areas, requiring 24-hour nursing care; and/or dangerousness to self/dangerousness to others as a consequence of a serious mental disorder.

DMH admission criteria are further defined in the Memorandum of Understanding between CDC and DMH:

A. Criteria for Acute Care hospitalization at PSH and the CMF/DMH Unit are:

1. An inmate who suffers impairment of functioning with signs and symptoms of an acute serious mental disorder or acute exacerbation of a chronic serious mental disorder. Such signs and symptoms may render the inmate unable to adequately carry out the normal routines of the institution, unable to provide for his basic needs or use the support of treatment resources available to him, and/or place the inmate at a significant risk of harm to himself or others.
2. An inmate who has been assessed as a severe suicidal risk shall be immediately hospitalized on the CMF/DMH Unit if no Mental Health Crisis Bed is readily available.
3. An inmate may also be admitted if he/she is clinically assessed as posing a moderate or serious suicidal risk.
4. An inmate who is demonstrating impairment of functioning or other problematic behaviors, the etiology of which cannot be readily determined, may be admitted for observation and diagnostic study.

B. Criteria for Intermediate Care at ASH and PSH are:

1. In general, an inmate whose commitment to CDC does not expire within 60 days of actual admission to a DMH hospital; available treatment time at the DMH hospital should be as long beyond 60 days as possible. Exceptions to the above shall be arranged on a case-by-case basis.
2. Clinical criteria for admission to inpatient mental health care shall include any one of the following:
 - a. A provisional or diagnosed Axis I serious mental disorder, acute, subacute, or chronic requiring treatment; or
 - b. Requires specialized evaluation and/or treatment which is available in a DMH hospital but not available in CDC; or
 - c. Request for intensive psychological/diagnostic evaluation; or
 - d. Has had an evaluation indicating that the inmate meets Mentally Disordered Offender Program (MDO) PC 2960-2981 (except PC 2974) criteria, or has been ordered by the Board of Prison Terms for MDO conditions of parole; or
 - e. Any compelling clinical reason for referral.

ATTACHMENT 3

INMATE INFORMATION

M&R/TRANSFERS/REFERRALS

Name: _____ CDC# _____ DOB _____ Send. Inst. _____
Date Init. Cont. _____ List type (G1, G2, GP, G3, LE) _____ List # _____
Date Acptd. _____ Custody Lvl _____ ERPD _____ Proj. Dt. Acpt. _____
Referring Inst. Representative _____ Date Info. Rcvd. _____ Urgency _____
Reason for Ref. Surg. _____ Med. _____ HIV _____ Apt. Sched. _____

Brief History Pert. Physical Examination _____ Date History and Physical Rcvd. _____

Present Medical Hx (other problems)

CA (type) _____ TBC _____ DM(Ins. Dep.) _____ Dialysis _____
Para/hemiplegia _____ Wheelchr _____ Blind _____ HIV _____
Other _____

Medication List: _____

Recent Studies: MRI CT EEG Chem11 CDC X-ray EKG

Study/Date/Results: _____

CMO-CMF
(707) 453-7019

MEDICAL HISTORY AND PHYSICAL EXAMINATION

Date: _____

Pat Name: _____ CDC#: _____

History of Present Illness:
Chief Complaint as patient describes: _____

History of Present Illness: _____

Past Medical History:
Serious Illnesses: _____
Hospitalizations: _____
Surgeries: _____
Childhood Illnesses: _____
Immunization Status: _____
TB Status-Skin Test Result/Date: _____
HIV Test/Hepatitis Infection/Immunization: _____
Allergies to Medications: _____
Medications: _____

Social History:
Drugs/Tobacco/Alcohol: _____
Length of Stay: _____ Parole Date _____
Sex, Preference/Marital Status: _____

Family History:
Mother: _____ Father: _____ Brother/Sister: _____
Family Illnesses: DM ___ HTN ___ HD ___ TBC ___ CA ___ HEM ___ KD ___ Other _____

Review of Symptoms:
Gen: Weight Loss/Gain ___; Fever/Night Sweat ___; Fatigue ___
Integ: Pruritis ___; Rash ___; Mole change ___; Sores ___
HEENT: Headache ___; Visual Change ___; Rhinitis ___; Sore Throat ___; Sinusitis HX ___
C-R: Cough ___; Chest pain ___; SOB ___; DOE ___; PND ___; Orthop ___; Palpit ___
Night Sweat ___; Night Fever ___; Sputum ___
GI: N/V/D ___; Dyspepsia ___; Heartburn ___; Hemetemeses ___; Melena ___
GU: Dysuria ___; Frequency ___; Nocturia ___; Hematuria ___; Discharge ___
MS: Joint Swelling ___; Joint Pain ___; Limitation of Motion ___; Paralysis ___; Swelling ___
Neuro: Headache ___; Gait ___; Paralysis ___; Weakness ___; Numbness ___
Heme: Bleeding Tendencies ___; Hx Anemia ___; Hx Sickle Cell ___
Endo: Excessive Thirst ___; Excessive Urination ___; Excessive Appetite ___

Physical Examination:
Gen Appear: Well Devel ___; Well Nour ___; Blk/Cauc/Hisp/Other ___
Male in acute distress Y ___ N ___
Vital Signs: T ___ P ___ R ___ BP ___
Skin: Hot/Warm/Cold ___; Moist/Dry ___; Doughy ___; Turgor ___; Tenting ___
HEENT: Normoceph ___; Trauma ___; Battle's Sign ___; Eyes - Conj ___ EOM ___; Fundi ___
ENT - Muc Mem ___; Eryth ___; Exud ___
Neck: Thyroid ___; Trachea ___; JVD ___; Lymph ___; Carotids ___
Chest: Auscultation and Percussion/Visual
CV: Murmurs ___; Gallops ___; Rate ___; PMI ___; Percussion ___
ABD: Masses ___; Organomegally ___; BS ___; Guarding ___; Perc Tend ___
GU: Escitcheon ___; Lesions ___; Testes ___; Prostate ___
Rectal: Hemorrhoids ___; Prostate ___; Hematest ___
Ext: ROM ___; Edema ___; Cyanosis ___; Clubbing ___
Neuro: Cr. N 2-12 ___; Sensory ___; Motor ___; Gait ___; Rhomberg ___

Impressions:
Plans:
Signed _____ M.D.

ATTACHMENT 4
INPATIENT MENTAL HEALTH REFERRAL

NAME: _____ CDC#: _____ HOUSING: _____
Last First MI

CURRENT STATUS: ☐ REC. CTR OR C^{MS} (Circle) ☐ EOP ☐ MHCB
RECOMMENDED LEVEL OF CARE: ☐ CRISIS CARE ☐ DMH INPATIENT (FROM EOP OR MHCB ONLY)
LEVEL OF FUNCTIONING ASSESSMENT (GAF score): _____ PSYCHOTROPIC MEDICATION: ☐ Yes ☐ No
BEHAVIORAL ALERTS: _____

CLINICAL APPROVAL VIA CONSULTATION WITH:
☐ MHCB ☐ CMC OR CIW (FOR PLACEMENT AT ASH OR PSH FROM EOP OR MHCB)) ☐ CMF/DMH (ACUTE CARE VIA CAT)

NAME OF CONSULTING CLINICIAN: _____ DATE OF ONTACT: _____

Referring Clinician's Name	Phone/Extension	Referring Clinician's Signature	CDC
128C			Date:



RECYCLED

ED11

ALL-STATE THERMAL 800-325-0510

SECTION 6: ENHANCED OUTPATIENT PROGRAM

A. Introduction

The Enhanced Outpatient Program (EOP) provides the most intensive level of outpatient mental health care in the Mental Health Services Delivery System (MHSDS). Located in the institution with the highest custody level in each Service Area, the program is characterized by a separate housing unit and structured activities for mentally ill inmates who, because of their illness, experience adjustment difficulties in a General Population (GP) setting, yet are not so impaired as to require 24-hour inpatient care. It is the MHSDS alternative to placement in Transitional Outpatient Care, or non-acute Intensive Outpatient Care in the previous Mental Health Outpatient Program.

Critical components include:

1. A comprehensive array of mental health services delivered within the framework of an Interdisciplinary Treatment Team (IDTT), which is composed of representatives from a cross-section of clinical disciplines as well as prison custodial and counseling staff. Treatment is focused on resolution of institutional adjustment problems which impede functioning within the GP. Services include management of activities of daily living, group and individual psychotherapy, medication management, recreational therapy, and clinical pre-release planning.
2. A designated housing unit with restricted access and alternative educational, work, and recreational opportunities specifically provided for inmates whose mental illness precludes their placement and participation in the GP programs.
3. Active interface with custodial staff, including Correctional Counselors (CC), which enhances the assessment and treatment process and optimizes the inmate functioning within the prison environment.

B. Program Objectives

The goal of the EOP is to provide focused evaluation and treatment of mental health conditions which are limiting an inmate's ability to adjust to a GP placement. The overall objective is to provide clinical intervention to return the individual to the least restrictive clinical and custodial environment.

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More specific objectives include:

1. Provide short to intermediate term (a range of three to 12 months for most cases), focused care for inmates in transition from crisis states who do not require 24-hour inpatient care. Short term treatment goals are directed to symptom reduction sufficient for transition to the Correctional Clinical Case Management System (CCCMS) level of care.
2. Provide longer term alternative placements for chronically impaired inmates whose symptoms have stabilized, but whose level of functioning is insufficient to allow GP placement. Supportive care, recreational therapy, anger control, reality therapy, and programs associated with clinical pre-release planning are offered.
3. Provide secure custodial placements with clinical resources which address behavioral problems for mentally ill inmates who are transitioning from Security Housing Units (SHU).

C. Population To Be Served

Mental health treatment is provided, according to the level of care required, for the psychiatric conditions listed below, defined as Medically Necessary.

Overall Treatment Criteria

1. Treatment and continuous monitoring are provided to any inmate who has **current** symptoms and/or requires treatment for the Diagnostic and Statistical Manual (DSM) IV diagnosed (may be provisional) Axis I serious mental disorders listed below:

Schizophrenia (all subtypes)
Delusional Disorder
Schizophreniform Disorder
Schizoaffective Disorder
Brief Psychotic Disorder
Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)
Psychotic Disorder Due To A General Medical Condition
Psychotic Disorder Not Otherwise Specified
Major Depressive Disorders
Bipolar Disorders I and II

2. Medical Necessity: Crisis intervention will be provided as needed. Treatment is continued as needed, after review by a treatment review committee, for all cases in which:

Mental health intervention is necessary to protect life and/or treat significant disability/dysfunctionality in an individual diagnosed with or suspected of having a mental disorder. Treatment is continued for these cases only upon reassessment and

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determination by the treatment review committee that the significant or life threatening disability/dysfunctionality continues or regularly recurs.

Enhanced Outpatient Care (Designated Housing Unit)

Overall Treatment Criteria A or B and:

Acute Onset or Significant Decompensation of a serious mental disorder characterized by increased delusional thinking, hallucinatory experiences, marked changes in affect, and vegetative signs with definitive impairment of reality testing and/or judgment

And/Or: Inability to Function in General Population Based Upon:

Inability to Program in work or educational assignments, or other correctional activities such as religious services, self-help programming, canteen, recreational activities, visiting, etc. as a consequence of a serious mental disorder; **Or:**

Dysfunctional or Disruptive Social Interaction including withdrawal, bizarre or disruptive behavior, extreme argumentativeness, inability to respond to staff directions, provocative behavior toward others, inappropriate sexual behavior, etc., as a consequence of a serious mental disorder; **Or:**

Impairment in Activities of Daily Living including eating, grooming and personal hygiene, maintenance of housing area, and ambulation, as a consequence of a serious mental disorder.

These conditions usually result in Global Assessment Functioning Scores of 50 or Less.

D. Admission To Program

Referral Process

1. The evaluating clinician at a reception center, Primary Clinician in a Mental Health Crisis Beds (MHCB) program, or Clinical Case Manager (CCM) in a CCCMS setting determines that EOP placement appears to be indicated. The basis of this decision is documented in an updated clinical evaluation (MH 7, MH 1 or MH 4), which is placed in the Unit Health Record (UHR).
2. If the referral is generated for an inmate at a GP institution without an EOP, the CCM at the referring institution may contact the Chief Psychiatrist at the closest EOP site to confer regarding the need for EOP level of care (where disagreements exist as to the appropriateness for placement after this preliminary review is completed, the inmate will be accepted for further evaluation at an EOP).

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3. Documentation via a 128-C chrono for the UHR and central file is prepared by the referring clinician and briefly states the need and reasons for EOP level of care. The chrono is then forwarded to classification staff for processing and Classification Staff Representative (CSR) endorsement for institutional placement. Initial EOP placements from within the same institution are accomplished with the approval of the institution's Chief Psychiatrist, and will be documented via a 128C chrono for classification action and CSR endorsement. Following this endorsement, the inmate may be placed into the EOP bed. Subsequent placements of the same individual into the EOP require only Classification and Parole Representative (C&PR) sign-off (this process is subject to review following the implementation of the Health Care Population Management Unit). A weekly count of filled and vacant EOP beds will be provided to Health Care Services Division Operations Unit for population management.
4. Referrals from Reception Centers (RC) for initial EOP placements do not require prior clinical approval from the receiving institution, and are simply contingent upon bed availability.
5. Expedited classification processing and transportation are accomplished to ensure placement within no more than 21 days (transfers within the same institution of inmates previously endorsed for EOP placement, or from MHCB should occur on the same day, or within 24 hours of referral).
6. Examples of types of transfer may include:
 - a. An inmate in the MHCB whose immediate crisis situation has been alleviated and who needs longer term care but does not require inpatient care. These transfers must be expedited to free available crisis beds for other inmates.
 - b. An inmate in the CCCMS who decompensates to where he/she can no longer function in the GP and needs a more structured environment with greater clinical intervention. Since these inmates continue to receive outpatient care, and are not in crisis states, a regular classification review and institutional transfer can normally be accomplished.
 - c. An inmate who is ready for discharge from the Inpatient Program in a Department of Mental Health (DMH) facility, but who cannot yet function in the GP and still needs a structured housing and clinical environment. These must be expedited placements to free available inpatient beds.
 - d. An inmate receiving clinical case management level of care in a SHU, who has completed his/her security housing term, but still is potentially dangerous as a consequence of mental illness, and requires a higher level of custodial supervision than is available in a GP setting. These inmates will be placed in custody level IV EOP's.
 - e. An inmate in a SHU who is determined by the IDTT to meet the clinical criteria for EOP level of care. He/She is involved in nonviolent incidents and determined not to be a risk

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to others. In the case of a SHU inmate, the SHU term shall be suspended prior to EOP placement.

Initial Evaluation Process

The initial clinical assessment involves a review of available clinical records, including the evaluation of the referring clinician and records from prior institutional placements. A review of these evaluations and an observation period will be utilized to establish a functional baseline and working clinical diagnosis. This process should be completed within 14 calendar days.

Institutional central files are to be reviewed to gain a more comprehensive understanding of the inmate's social, psychological, clinical history, and criminal factors relating to his/her presenting problems. The referring clinician and custodial staff, as well as others (e.g. work supervisors, teachers, chaplains, etc.) with relevant information may be contacted to broaden the range of information.

At the conclusion of the evaluation process (14 calendar days), the Treatment Team will review all relevant clinical, institutional, and criminal history data, interview the inmate and make one of the following determinations:

1. Admit to the Program
2. Decline Admission (indicate clinical option)
3. Extend Evaluation Process for Additional 14 Days.

All decisions regarding change of treatment level made by the Treatment Team shall be documented with a 128-C chrono for classification review and central file update. An individualized treatment plan shall include the recommendations of the treatment team and specifics such as type of therapeutic activities, schedule, duration, outcome expectations, and anticipated length of stay. Treatment activities should consider the commitment offenses and current institutional maladjustment.

Release after Initial Evaluation

If, at the conclusion of the initial evaluation process, the treatment team determines that the EOP placement is inappropriate, this is documented in the health record. A 128-C chrono noting the decision, and recommending more appropriate placement is prepared for classification processing and transfer. If inpatient care is indicated, the Team Leader will initiate this placement through appropriate procedures.

E. Treatment Services

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Each inmate will be offered a minimum of ten hours per week of structured therapeutic activities which are prescribed as part of the treatment plan. Specific treatment activities are described below:

Treatment Services

1. **Individual Treatment Planning** involves a meeting of the treatment team and inmate for identifying treatment needs, developing treatment plans, assessing treatment progress, and updating treatment plans.
2. **Group Therapy** provides inmates with an opportunity to express, explore and resolve issues with the assistance of clinical staff, as well as supportive interactions with inmates who have similar problems or experiences.
3. **Short Term Individual Therapy** provides inmates with the opportunity to discuss personal problems which may not be adequately addressed in a group setting.
4. **Recreational Therapy** provides inmates with supervised recreational activities or exercise programs designed to reduce stress, improve physical fitness, foster positive interpersonal interactions, and promote constructive use of leisure time.

Core Treatment Modules

The EOP may offer some or all of the following Core Treatment Modules, depending on the needs of their patient population:

1. **Daily Living Skills** - train and assist inmates in developing, or re-establishing skills in maintaining appropriate personal hygiene and grooming habits. These activities include educating and prompting inmates in bathing, dressing, and maintaining a clean living environment. The focus of these activities is to promote responsibility for self-care, enhance self-image and esteem and provide a predictable daily routine.
2. **Medication Management** - educates inmates on how to improve compliance and responsibility in taking medication. It stresses the benefits of medication and teaches how to correctly take medication. It explains side effects and when certain side effects need to be brought to the attention of clinical staff. This module will increase skills in obtaining information about anti-psychotic medication. Additionally, by acquiring better communication skills, the inmate will be able to relay information to the clinical staff so that a better clinical picture can be developed.
3. **Social Skills/Communication** - focus on activities which allow inmates to interact in a positive manner with other individuals, both staff and inmates. It will teach development of communication skills to provide for interaction that is appropriate and socially acceptable.

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4. **Anger Management** - educates inmates in the socially acceptable and appropriate ways of handling anger and expressing feelings. This module is geared towards reducing assaultive behavior by developing self-control skills. It will teach inmates the processes to be used in a prison setting to resolve conflicts and handle problems appropriately without resorting to violence.
5. **Stress Management** - identifies recurring stressors in prison life and provides specific techniques of stress reduction and minimizing the effects of stress on one's behavior and mental health.
6. **Substance Abuse Group** - provides education on the effects of chemical abuse, particularly on inmates with mental illness or utilizing prescription medications. This group offers supportive interactions to explore issues of chronic abuse and develop alternatives.
7. **Human Sexuality** - provides education on basic human sexuality and sexual dysfunctions, sexually transmitted diseases, management of sexual impulses, and effects of sexually inappropriate behavior on others.
8. **Offense Specific Therapy** - provides clinical support for insight oriented treatment related to causative factors in criminal behavior leading to imprisonment, emphasizing alternative courses of conduct
9. **Rational Behavior/Reality and Decision Making** - emphasizes taking responsibility for one's actions, accepting the reality of the living environment, developing more productive and pragmatic life scripts, developing strategies to achieve attainable goals.
10. **Family Issues** - focus on stressful experiences associated with spousal abuse, childhood sexual abuse, separation from offspring, dysfunctional relationships, pregnancy issues, etc.

Daily Activity Schedules

Utilizing the above treatment descriptions (and additional optional activities as may be developed at the institutional level), each inmate will have a weekly activity schedule incorporated into the individual treatment plan from a unit schedule of treatment activities. Development of and adherence to the schedule is a joint responsibility of the inmate and primary clinician, with periodic review by the IDTT. Establishment of additional unit activities available to all inmates is also the responsibility of the IDTT. An example of a unit treatment activity schedule is presented on attachment #1:

Nursing and Supportive Care

Although 24 hour nursing care is not required for inmates within the EOP, expanded services from those offered to GP inmates are provided by Registered Nurses (RN) and/or psychiatric technicians. These services include:

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1. Monitored administration of psychotropic medications
2. Provision of medical treatment and nursing procedures as required
3. Management of activities of daily living, including maintenance of living quarters, personal hygiene, and eating habits
4. Regular clinical staff supervision and support of out of cell activities
5. Expedited access to crisis care
6. Availability of clinical escorts (such as assistance in traveling to a location outside the treatment unit).

Aftercare Planning and Referral

Planning for follow-up services is a critical component of care that inmates need upon release from the EOP. The Treatment Team Leader is responsible for assuring that this is accomplished prior to an inmate's discharge from the program. It must include referral to another treatment level or program, or other appropriate placement to ensure continuity of care. Inmates whose level of functioning has improved significantly to the point where the structure of the EOP therapeutic and housing environment is no longer needed shall be referred to the CCCMS. Inmates who experience decompensation in the form of crisis shall be referred to the MHCB or the DMH Inpatient Program.

Aftercare plans should describe:

1. The diagnosis and the psychiatric problems continuing to require treatment
2. Any other unique mental health or physical conditions (e.g., allergies, special dietary needs, chronic diseases), or comprehension difficulties (e.g., developmental problems, insufficient education or language barriers) that could affect adjustment and treatment
3. Recommendations for follow-up treatment, including medications and specific psychotherapies
4. Referrals to appropriate programs and other institutional services, including chaplain services, substance abuse programs, education and job programs.

Clinical Pre-Release Program

This is designed to provide systematic planning, support and education to inmates who are approaching their date of release (at the time the inmate's parole package is prepared) to the

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community, and who are not expected to transition to another level of care before release. This modality is designed to maximize the inmate's opportunities for successful transition into community living. In addition to the issues covered in the other treatment activities described above, this modality also includes such issues as development of independent living skills, development of placement options and coordination with Parole Outpatient Clinic (POC) for community outpatient care.

F. Staffing And Case Management

The EOP staffing structure is based on clinical needs for this level of care and the staffing ratios developed to meet these needs. A basic component of at least five staff positions is required for the smallest 24 bed unit, as recommended in the comprehensive MHSDS Study, which provides the framework for the overall treatment program. Attachment #2 provides a table of staffing distributions for various sizes of EOP. Subsequent attachments provide general duty statements for each of the classifications involved in service delivery.

In addition to those individual duties, all staff have a role in the following assignments:

Interdisciplinary Treatment Team

The responsibilities for overall treatment planning within the EOP rests with an IDTT. These responsibilities include:

1. Admission decisions for individual cases
2. Approval of initial treatment plans
3. Periodic case reviews and rejustifications of treatment
4. Discharge decisions
5. Overall utilization review of available beds
6. Overall program quality improvement.

The IDTT is composed of, at a minimum, a Psychiatrist, a Psychologist and a Psychiatric Social Worker. Recreation Therapists, RNs, Medical Technical Assistants or Psychiatric Technicians will also normally participate. Each member of the team will provide input into the overall treatment plan. Input from additional staff, including correctional counselors and custody personnel is strongly encouraged. A representative from the IDTT should be present in all classification hearings regarding inmates in treatment.

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The program Clinical Director or designee will be the Treatment Team Leader who will facilitate coordination and completion of clinical tasks. Additional responsibilities include the assignment of a primary clinician and the review of aftercare plans for each case.

Primary Clinician

One clinical staff member of the team is designated as the primary clinician for each inmate. This individual maintains active therapeutic involvement with the inmate, but also utilizes additional treatment providers in carrying out the treatment plan. Specific responsibilities include:

1. Documentation of initial and updates to treatment plan
2. Weekly clinical contacts with assigned inmates
3. Scheduling for periodic treatment team reviews
4. Response to inquiries regarding clinical status of inmate
5. Notification to CCCMS case manager of change of treatment level.

The selection of the primary clinician is a Treatment Team Leader responsibility and is determined primarily by the severity of symptoms, and focus of the treatment for the given individual. Where alleviation of symptoms through adjustments of medication and improved medication management are primary goals, the psychiatrist would likely be the primary clinician. This responsibility might fall to the psychologist when individual psychotherapy is emphasized. The social worker would likely be responsible for individuals with high needs for improved socialization, or pre-release planning.

G. Case Review And Discharge

In order to maximize the utilization of the limited bed assignments available for EOP placements, and ensure optimal progress toward achieving the program goal of resolution of symptomatology sufficient for placement in the least restrictive clinical and custodial environment, a structured process of case review and rejustification of treatment is required for this level of care. This will occur on at least a quarterly basis, and will be the responsibility of the treatment team.

The primary clinician for each individual will prepare a case summary for quarterly treatment team review which will consist of the following:

1. Summary of clinical diagnoses and brief history of previous clinical interventions
2. Current length of stay in EOP

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3. Current treatment plan
4. Assessment of current level of functioning and progress in achieving treatment goals
5. Recommendations for modifications to treatment plan, including level of care
6. Where a change in treatment level is contemplated, input from the previous CCCMS case manager
7. Anticipated length of stay.

Results of treatment team reviews will be entered into the clinical case file progress notes, with modifications to the treatment plan as required. A full case summary, with a recommendation for either continued placement or transfer to an alternative level of care will be completed on an annual basis, with the results summarized in the clinical file and notification provided via a 128-C chrono to the CC for updating the inmate's classification status. Any recommendations for change in treatment level at any time will also be so documented.

Average length of stay for the EOP is estimated to be four to six months. Inmates who respond quickly to brief psychotherapy and medication adjustments may be referred by the primary clinician to the treatment team for review after as few as 30 days. Chronic cases may require placement to term, although some attempts at GP placement should be made in all cases. Referral for intermediate care inpatient placement in a DMH facility pursuant to Section 2684 of the Penal Code should also be considered for these cases.

Discharge from the EOP will be based upon a decision by the treatment team that the inmate:

1. Has reached optimal benefit of EOP services and can function in a GP setting with CCCMS support
2. Has no current symptoms of mental illness and can be placed in full GP status (this includes inmates who are determined to be malingering)
3. Has clinically decompensated to the extent that placement into 24 hour inpatient care (either MHCB or DMH hospitalization) is required
4. Is determined to be a danger to others due to assaultive behavior, and requires transfer to a SHU
5. Refused to participate in treatment; in these cases, the inmate will be referred to CCCMS level of care in the appropriate custody setting for continued tracking and access to clinical services should his/her condition or willingness to receive treatment change; inmates who meet criteria for involuntary treatment will be referred to MHCB

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6. Has reached his/her parole date and clinical services will be transferred to a POC.

A decision to transfer an inmate from the EOP will be communicated to the inmate's CCCMS case manager, who continues to have system-wide tracking responsibilities for the case until discharge from clinical services to full GP status or parole.

H. Mental Health Quality Management System

Ongoing assessment of the quality of clinical services will follow the Mental Health Quality Management System (MHQMS) procedures. Please refer to the MHQMS Plan.

ATTACHMENT 1

SAMPLE EOP UNIT ACTIVITY SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
0800	INITIAL INTAKE UNIT REVIEWS	INDIVIDUAL THERAPY	ANGER MANAGEMENT GROUP	AFTER CARE PLANNING	PROBLEM SOLVING GROUP
0900		RECREATION ACTIVITIES	INDIVIDUAL THERAPY PLANNING	INDIVIDUAL THERAPY	
1000	TREATMENT TEAM REVIEWS			TREATMENT TEAM REVIEWS	RECREATION ACTIVITIES
1100		ANGER GROUP			
1200	LUNCH				
1300	ADL	ADL	ADL	ADL	ADL
1400	MED. GROUP	SOCIAL SKILLS GROUP	SUBSTANCE ABUSE GROUP	SOCIAL SKILLS GROUP	INDIVIDUAL THERAPY
1500	RECREATION ACTIVITIES	PRE-RELEASE GROUP	RECREATION ACTIVITIES	MED. GROUP	RECREATION ACTIVITIES
1600					
1700					

**CALIFORNIA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
ENHANCED OUTPATIENT PROGRAM
DUTY STATEMENT
SENIOR PSYCHOLOGIST (SUPERVISOR), CORRECTIONAL FACILITY
PSYCHOLOGIST - CLINICAL, CORRECTIONAL FACILITY**

Description: Under the supervision of the Enhanced Outpatient Program (EOP) Director, this position provides evaluations, diagnoses, and treatment for inmates in a service area EOP. The responsibility and authority for initial acceptance of inmates from other levels of care, after an initial telephonic case conference, will normally rest with this position. Through involvement on the Interdisciplinary Treatment Team, this individual will participate in full intake assessments, including treatment planning. Where required, psychological testing may be administered to clarify diagnoses, address issues of possible malingering, and contribute to treatment planning. This will also include completion of an assessment of overall level of functioning, such as provided by the Brief Psychiatric Rating Scale. Group and individual psychotherapy will be provided. The staff level position will be assigned responsibilities as a primary clinician for individual cases. These responsibilities include comprehensive case reviews, regular updating of treatment plans, and preparation of discharge plans. In lieu of these individual case management responsibilities, the Senior position will assume overall administrative responsibilities as the EOP Director, and report directly to the Mental Health Care Manager.

Specific duties include:

- 20% (Senior position only) Administrative responsibilities as part of Enhanced Outpatient Program Director role.
- 20% (Clinical position only) Case management responsibilities associated with the role of primary clinician, including intake and level of functioning assessments, mental status examinations, and institutional discharge planning
- 15% Individual and group psychotherapy.
- 15% Administration of psychological testing, including malingering scales, as needed.
- 15% Participation on Inter-Disciplinary Treatment Team treatment planning sessions and case reviews.
- 10% Participation in overall program development and management, including quality improvement, bed utilization review, staff training, and interface with other levels of mental health services.

EOP PSYCHOLOGIST DUTY STATEMENT (Continued)

- 10% Non-EOP clinical responsibilities, including Board of Prison Reports, P.C. 2692 evaluations, and other clinical evaluations as needed.
- 5% Informal initial screening for new program admissions.
- 5% Individual professional development, including participation in professional training and conferences, upgrading of automation skills, etc.
- 5% Other duties as required.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
ENHANCED OUTPATIENT PROGRAM
DUTY STATEMENT
STAFF PSYCHIATRIST**

Description: Under the supervision of the Chief Psychiatrist, this position is responsible for direct provision of psychiatric services for inmates in a service area EOP. This includes evaluation, diagnosis, and treatment of inmates; participation in general program development and operations, including quality improvement and utilization review; and consultant services to non-EOP programs as needed. Regular participation on Interdisciplinary Treatment Teams is required, and assignment as the primary clinician for individual cases is possible. The position also provides training to inmates and staff on management of psychotropic medications.. Specific duties include:

- 25%** Initial and follow-up medication reviews and prescription adjustments as required.
- 20%** Participation on Inter-Disciplinary Treatment Team treatment planning sessions and case reviews.
- 20%** Case management responsibilities associated with role as primary clinician, including intake and level of functioning assessments, mental status examinations, institutional discharge planning.
- 15%** Non-EOP clinical responsibilities, including Board of Prison Reports, P.C. 2692 evaluations, psychiatric sick-call coverage, and other psychiatric services.
- 5%** Participation in overall program development and management, including quality improvement, bed utilization review, staff training, and interface with other levels of mental health services.
- 5%** Oversight of Medication Management training for staff and inmates.
- 5%** Individual professional development, including participation in professional training and conferences, upgrading of automation skills, etc.
- 5%** Other duties as required

**CALIFORNIA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
ENHANCED OUTPATIENT PROGRAM
DUTY STATEMENT
PSYCHIATRIC SOCIAL WORKER**

Description: Under the supervision of the Supervising Senior Psychologist, and/or Chief Psychiatrist, the Psychiatric Social Worker assists in assessment and treatment of mental illness, with emphasis on the area of inmate social functioning; develops clinical pre-release plans; participates in Inter-Disciplinary Treatment Team reviews; and provides additional clinical services for inmates in a service area Enhanced Outpatient Program. Formal and informal group interactions and activities are organized and supervised by this staff person, with a goal of improved inmate functioning within the social environment of a prison, or, in the case of inmates approaching parole, the free community. Management of anger and stress, necessity for compliance with institutional rules, ability to participate in general population work and educational assignments, and maintenance of acceptable standards of personal hygiene are stressed. Liaison with interested family members in the community is provided as needed. Specific duties include:

- 20% Clinical Pre-release planning for inmates approaching parole to facilitate transition to community care programs.
- 20% Social skills assessment and training to address institutional adjustment issues
- 20% Participation on Inter-Disciplinary Treatment Team treatment planning sessions and case reviews.
- 15% Case management responsibilities, including level of functioning assessments, institutional discharge planning, program placement decisions, etc.
- 10% Liaison with general population institutional programs, including educational and vocational staff, correctional counselors, chaplains, etc.
- 5% Liaison with family members and other interested parties in the community.
- 5% Individual professional development, including participation in professional training and conferences, upgrading of automation skills, etc.
- 5% Other duties as required.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
ENHANCED OUTPATIENT PROGRAM
DUTY STATEMENT
REGISTERED NURSE**

Description: Under the direction of the institutional Supervising Nurse, and EOP Staff Psychiatrist, the Registered Nurse provides basic nursing care to inmates in a service area Enhanced Outpatient Program. This includes administration of medications, observances of effects of such medications, and referrals for prescription adjustments. Assistance to inmates in maintaining/improving basic activities of daily living, including maintenance of living quarters, personal hygiene, and nutritional needs is provided. This staff person may also participate in group and individual treatment and educational programs, including medication management, stress reduction, and reality and decision making groups. Observation and care of inmates with suicide risk is provided, as is attention to non-psychiatric medical problems. Specific duties include:

- 25% Administer and monitor effects of psychotropic and other medications
- 20% Monitor and assist inmates in maintenance of activities of daily living, including housing quarters, personal hygiene, and nutritional needs.
- 10% Assist in care and monitoring of inmates with suicide risk
- 10% Provide input and follow-up to Inter-Disciplinary Treatment Team treatment planning and case reviews.
- 10% Assist in group and individual educational and treatment programs, particularly on medication management and institutional adjustment issues.
- 5% Maintain up to date medical record.
- 5% Coordinate with other medical staff for non-mental health medical needs.
- 5% Manage psychiatric sick call within EOP
- 5% Individual professional development, including participation in professional training and conferences, upgrading of automation skills, etc.
- 5% Other duties as required.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
ENHANCED OUTPATIENT PROGRAM
DUTY STATEMENT
RECREATION THERAPIST**

Description: Under the supervision of the Chief Psychiatrist, the Recreation Therapist provides specialized programs and services for inmates in a service area Enhanced Outpatient Program which promote social interaction, encourage profitable and appropriate use of leisure time, and provide preparation for re-entry to the general population or parole. Participation on Inter-Disciplinary Treatment Teams and cooperative planning with primary clinicians, educational staff, correctional counselors, and custody personnel is essential to the development and implementation of recreational activities geared to clinical improvement in the level of functioning of inmates within the EOP. Specific duties include:

- 40% Develop and provide individualized programs of clinically oriented recreational activities geared to address problems of activities of daily living, communication skills, physical exercise, and creative expression for inmates with functional impairments due to serious mental illness.
- 20% Develop and administer a schedule of group recreational activities for therapeutic use of leisure time for all inmates within the EOP.
- 20% Clinical oversight of recreational activities provided by support staff, including Psychiatric Technicians and Medical Technical Assistants.
- 10% Provides input and follow-up to Inter-Disciplinary Treatment Team treatment planning and case reviews.
- 5% Individual professional development, including participation in professional training and conferences, review of optional recreational programs and equipment, etc.
- 5% Other duties as required.

**CALIFORNIA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
ENHANCED OUTPATIENT PROGRAM
DUTY STATEMENT
PSYCHIATRIC TECHNICIAN**

Description: Under the direction of the Supervising Senior Psychologist (or Supervising Senior Psychiatrist where appropriate), the Enhanced Outpatient Program Psychiatric Technician is responsible for providing assistance to mentally ill inmates in such areas as daily living skills, medication utilization, recreational activities, clinical escorts, pre-release planning, and social skills development. This is the primary staff person involved directly with inmates within the housing unit on a day-to-day basis who observes and assists in maintaining inmates' abilities to manage basic living requirements, such as nutritional needs, maintenance of living environment and personal hygiene, and utilization of personal time constructively. The staff person will also work closely with the EOP Recreational Therapist in providing therapeutic recreational activities for the unit as a whole. Specific duties include:

- 25% Monitor and assist inmates in maintenance of activities of daily living, including housing quarters, personal hygiene, and nutritional needs.**
- 15% Assist in social skills training**
- 15% Supervise recreational activities**
- 10% Dispense of prescribed medication.**
- 10% Provide clinical escorts**
- 10% Assist in Treatment Team planning sessions**
- 5% Provide behavioral observations for treatment planning**
- 5% Individual professional development, including participation in professional training and conferences, upgrading of automation skills, etc.**
- 5% Other duties as required**



SECTION 7: CORRECTIONAL CLINICAL CASE MANAGEMENT SYSTEM

A. Introduction

The California Department of Corrections' (CDC) Mental Health Services Delivery System (MHSDS) delivers most mental health services through the Correctional Clinical Case Management System (CCCMS) available at all institutions. In community mental health programs, use of more cost-effective outpatient services has increased as a result of better understanding of the nature of mental illness, improved therapeutic interventions, and more effective psychotropic medications. For General Population (GP) outpatient services to be effective (i.e., sustain improved functioning and prevent use of inpatient care), inmates must know what services are available and how to access them. An effective case management system ensures access to mental health care and helps decrease the use of expensive inpatient hospitalization. Outpatient services delivered through a well-designed clinical case management system is a cost-effective means to maintain adequate functioning among the seriously mentally disordered (SMD).

1. The strength of good clinical case management is its capability to monitor CDC's mentally disordered population, its clinical needs and its movement within as well as among institutions. With this service delivery mode, CDC provides the best possible means to assure continuity of care while optimizing use of available resources.
2. Clinical case management improves the quality of mental health care and its delivery by timely therapeutic intervention, utilizing a sophisticated tracking system, fostering information-sharing among all staff who provide service to each individual inmate and skillful administration of professional time.

The Correctional Clinical Case Management System

Traditionally, case management facilitates proper care by linking inmates to needed services and providing them sustained support for accessing such services. Clinical case management adds to the usual functions of traditional case management, a clinical component utilizing a therapeutic working relationship between inmate and case manager. This therapeutic relationship makes the case manager a more effective agent in helping the inmate achieve individualized treatment goals. In the most effective models, the Clinical Case Manager (CCM) assumes the role of the Primary Clinician who provides some of the treatment required by the inmate and assures continuity of care.

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As in the community, most mental health services in CDC will be provided as GP outpatient services to minimize the stigma of segregating the mentally disordered and to promote normalization. Cases requiring more specialized services, such as 24-hour nursing care in an inpatient facility or the greater structure of the Enhanced Outpatient Program (EOP), will be transferred out of CCCMS.

1. Through its universal availability and as the least restrictive level of care, CCCMS forms the foundation of the CDC's delivery system.
2. Achievement of CCCMS treatment goals increases the security and safety of the institution and may contribute to lowering the recidivism rate of inmates released on parole or discharged to the community.

The CCCMS is a very special type of clinical case management. In the general community outside prisons, disabilities associated with SMD often render primacy to developing and maintaining resources to meet the basic needs of food, shelter, and clothing. In contrast, within the CDC, the fact that basic needs are already provided allows CCMs to concentrate on helping resolve mental health problems. Prisons ease case manager responsibilities in other ways. Adjunct services which help maintain or improve functioning, e.g., education, substance abuse groups, and work training assignments, are available within the perimeter of the institution and are thus relatively easy for inmates to physically access. In the general community, such resources are not always readily available and when they are, distance creates access problems for individuals unable, on their own, to use existing transportation.

While certain features of correctional settings facilitate clinical case management responsibilities, others pose special problems for clinical practice. Prison inmates represent a specialized clientele in whom treatment of serious mental disorders may be complicated by dual diagnosis and behavior management problems. Further, security considerations have to be appropriately considered in treatment plans and service delivery methods.

Psychiatric Social Workers and psychologists will assume the role of CCMs in most instances. Occasionally and as dictated by clinical needs, psychiatrists may also be designated CCMs. All institutions will have clinical case management staff available to inmates.

1. Using Correctional Counselors (CC), CDC provides case management for institutional programming with which CCCMS shall interface. In effect, each CCCMS inmate will have both a CCM and a CCI working, as members of an Interdisciplinary Treatment Team (IDTT) and within the scope of their designated duties, to coordinate and deliver services.

Custody personnel are considered a functional component of the IDTT. As the staff involved in day-to-day interactions with inmates, custody can provide input in assessing clinical status and continuing needs and support in implementing treatment programs.

The CCCMS outpatients are expected to represent the widest spectrum of functioning abilities among the various levels of care in the delivery system.

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1. For the highest functioning outpatients, tracking and monitoring -- usually, medication monitoring -- are often sufficient to respond to this group's clinical needs. Monitoring determines when clinical services are no longer needed (resulting in discharge) or when changes in clinical status require an increased level of services. Of all GP outpatients, this group is most involved in institutional programming.
2. For outpatients with significant impairment, CCCMS provides, in addition to monitoring, appropriate linkages to psychotherapy and other available supportive services. In such cases, CCMs are also likely to directly provide counseling and therapy.
3. Although scheduled at different intervals according to outpatient needs, CCCMS monitoring entails regular assessments and treatment plan updates in every case.

B. Program Objectives

The goal of the CCCMS is to maintain or improve adequate functioning of seriously mentally disordered inmates in the least restrictive (i.e., least structured) treatment setting possible within a correctional community. While doing so enables CCCMS to prevent use of more expensive higher-end services, outpatient treatment, if appropriate and feasible, is also clinically preferred. The array of CCCMS services available to GP inmates extends to inmates in segregated housing units [Administrative Segregation (Ad/Seg) and Security Housing Units (SHU)]. The CCCMS also helps maintain adequate functioning among "nonpatients" by providing crisis intervention to those experiencing situational crises.

1. To accomplish its goal, this program ensures:
 - a. Prompt access to mental health professionals for diagnosis and treatment through the availability of outpatient services in all institutions. Timely screening and identification ensures access to appropriate levels of care for seriously mentally disordered inmates experiencing the onset or exacerbation of illness.
 - b. Continuity of care by tracking inmates' progress and by timely referral to appropriate levels of care, from crisis intervention through prerelease programs.
 - c. Linkage to adjunct services available to GP inmates (i.e., work assignments, school and vocational education programs). Such services form a significant component of a comprehensive treatment regimen.
 - d. Linkage to existing prerelease programs and parole outpatient treatment services for inmates about to parole.
2. Like other programs in the MHSDS, treatment in CCCMS will:
 - a. Ensure that inmates participating in treatment address the following areas:

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- i. Orientation and adjustment to the day-to-day requirements of prison living.
 - ii. The offense or crime itself and what, for the individual inmate, were precursors or contributing factors (including cognitive, behavioral, and emotional indicators).
 - iii. The nature of the diagnosed mental disorder including symptom identification, coping strategies, medication compliance issues, and identification of high-risk situations that can lead to decompensation, psychosis and loss of self-control.
- b. Minimize crisis episodes and inpatient hospitalization among inmates through timely therapeutic intervention, regular assessments and treatment plan updates.
 - c. Help reduce clinical recidivism upon release from CCCMS by clinical pre-release planning and coordinating the follow-up of mental health services with CCs and the Parole Outpatient Clinic (POC).

C. Population Served

Mental health treatment is provided, according to the level of care required, for the psychiatric conditions listed below, defined as Medically Necessary.

Overall Treatment Criteria

1. Treatment and continuous monitoring are provided to any inmate who has **current** symptoms and/or requires treatment for the Diagnostic and Statistical Manual (DSM) IV diagnosed (may be provisional) Axis I serious mental disorders listed below:

Schizophrenia (all subtypes)

Delusional Disorder

Schizophreniform Disorder

Schizoaffective Disorder

Brief Psychotic Disorder

Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)

Psychotic Disorder Due To A General Medical Condition

Psychotic Disorder Not Otherwise Specified

Major Depressive Disorders

Bipolar Disorders I and II

2. Medical Necessity: Crisis intervention will be provided as needed. Treatment is continued as needed, after review by a treatment review committee, for all cases in which:

Mental health intervention is necessary to protect life and/or treat significant disability/dysfunctionality in an individual diagnosed with or suspected of having a mental disorder. Treatment is continued for these cases only upon reassessment and

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determination by the treatment review committee that the significant or life threatening disability/dysfunctionality continues or regularly recurs.

Correctional Clinical Case Management

Overall Treatment Criteria A or B and:

Stable functioning in the GP and

Criteria not met for higher levels of care

These conditions usually result in Global Assessment Functioning scores above 50.

All inmates (including those in SHU or Ad/Seg) needing crisis intervention and or continued treatment also receive services from CCCMS staff. For details, please refer to Ad/Seg and SHU Sections of Program Guide.

Once entered in CCCMS, inmates will be tracked and will continue to be tracked as they cycle through all levels of care.¹

1. Whenever inmates are transferred to more intensive levels of care within the same Service Area, they will remain in the same caseload and their automated CCCMS files will stay active in the tracking system; however, primary responsibilities for mental health care are transferred to the other programs.
2. Transfer to another institution or Service Area requires transfer to the receiving institution's caseload (hence, also, a new CCM). To ensure continuity of care, all transfers to another CCCMS require direct contact between the CCMs in the transferring and the receiving institutions.

When inmates are returned to case management, responsibility for mental health care is resumed by the CCM and the inmate's CCCMS files are updated. In relatively rare cases when inmates are released directly to the community from more intensive levels of care, CCCMS tracking will also be terminated.

D. Treatment and Assessment Services

The CDC's CCCMS relies on both mental health staff and custody staff, as members of an IDTT (see "Staffing" for details) working together within the scope of their credentials and job descriptions, to provide the seriously mentally disordered inmate with prescribed services. **The CCCMS has a basic treatment philosophy: Inmates need comprehensive services to maintain adequate functioning in the GP as well as in Ad/Seg and SHU. That is, in addition to mental health treatment, institutional services such as occupational training**

The Department is developing a systemwide Health Management Information System that will take three to five years. In the interim, the Health Care Services Division will assist each Service Area in implementing local transitional automation strategies.

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and education are potentially therapeutic and are integral elements in a comprehensive treatment plan for GP inmates. For SHU inmates, treatment plans shall be modified to take into account security concerns and status. This correctional-clinical model of case management requires custody and clinical staff to work in tandem, from the beginning, to assess the treatment and programming needs of seriously mentally disordered inmates and to ensure that they receive the mental health and institutional services specified in their treatment plans.

A Flow Chart of the CCCMS process is presented in Figure 1 at the end of this section.

Referral to CCCMS

Inmates are referred to the program from a variety of sources. A large percentage will come from Reception Centers (RC), identified in the routine process of screening and evaluation. Others are referred from EOP, Mental Health Crisis Beds or, less frequently, Department of Mental Health (DMH) Inpatient Programs. Still others are referred from the mainline or segregated housing units by custody staff or through self-referrals. All referrals to CCCMS shall be processed in a timely manner and entered into an automated tracking system.

1. Referral shall be made on one of several forms, depending on referral source: Inmate Request for Interview; Staff Referral ,128B; from RCs on Mental Health Evaluation form (MH 7) and Mental Health Placement Chrono (CDC 128C) (Attachment #1); from other level of care on the Condensed Mental Health Assessment and Treatment Setting Transfer form (MH 4) and a CDC 128C.
2. The Clinical Director or designee shall be the clinical referral coordinator who shall receive all referrals. The clinical referral coordinator monitors referrals by entering inmates' names, CDC numbers, reasons for referral, dates and sources of referral in a referral file of the tracking system. The coordinator shall then arrange for inmates to be seen within one working day by a Staff Psychiatrist if a medical and/or psychiatric evaluation is immediately needed.
3. The clinical referral coordinator shall assign cases to an individual CCM who must complete a Clinical Intake Assessment (MH 1 or MH 4) within five working days of referral. (Attachment #2)
4. Institution referrals (by staff or by inmate) shall be screened by a CCM to determine what services the inmate needs (Attachment #3). Inmates with indicators for serious mental disorder will receive a Clinical Intake Assessment within five working days of screening.²

Crisis Intervention

² Inter-institution transfers require teletyped approval from Classification.

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Clinical case management staff are available for the initial screening of inmates referred for crisis episodes. In this initial screen, level of required clinical intervention will be assessed and proper action taken.

1. Institution referrals (custody staff referrals or self-referrals) for crisis episodes as well as CCCMS inmates in crisis shall be evaluated the same day of referral by CCCMS staff and referred, when necessary, to a psychiatrist for evaluation of medication needs and placement in the Mental Health Crisis Bed Program (MHCB).
2. Inmates requiring inpatient placement shall be transferred to the MHCB on the same day of acceptance to that program. All transfers shall follow established institutional procedures.
3. Procedures in the Suicide Prevention Plan shall be followed for inmates who make suicide attempts.
4. Names, CDC numbers, referral reasons, placement, and patient status of all crisis referrals shall be entered into a crisis care file of the automated tracking system.
5. The CCMs shall continue to track inmates in inpatient crisis care by maintaining contact with the MHCB.
6. "Nonpatient" inmates not referred to an inpatient program shall be further evaluated to determine need for placement in a mental health program
7. Inmates whose crises are resolved without further recommendations for level of care placement shall be given a "nonpatient" status.

Clinical Intake Assessment

While the CDC's MHSDS provides screening and assessment for a SMD upon reception, a more comprehensive assessment is critical in formulating a treatment plan in CCCMS. The assessment includes the inmate's personal strengths, achievements and goals, and, if available, past responses to intervention. Inmates placed directly from RCs will have a psychological evaluation (MH 7) with at least a provisional diagnosis as well as an initial treatment plan. More comprehensive evaluations and treatment plans are available for those transferred from more intensive levels of care. In all cases, assessments and treatment plans shall be updated to include an evaluation of the inmate's current readiness for institutional programming (e.g., work, substance abuse counseling, school, prerelease transition). (Attachment #4)

1. In consultation with the IDTT, the CCM conducts a Clinical Intake Assessment (CIA) within five working days of referral. The CIA shall use a standardized format (MH 1 or MH 4) and shall include:
 - a. A review of the inmate's Central File and Unit Health Record (UHR) and a face-to-face interview with the inmate

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- b. Recent (within 90 days) psychiatric and psychological evaluations using standardized formats (Attachment #1);
 - c. A readiness evaluation based on appropriate educational and vocational testing that takes into account degree of psychiatric impairment, physical (medical) limitations, and housing restrictions; and
 - d. A diagnosis from the current Diagnostic and Statistical Manual.
2. For Ad/Seg and SHU inmates, the CIA shall also include a review of disciplinary records and an evaluation of current level of dangerousness.
3. For inmates who meet clinical case management criteria, the CCM will notify custody staff (in person or by phone or fax) to update the inmate's status as an "outpatient;" "nonpatient" will be used for referrals not meeting criteria; they will fill out a 128-C Chrono.
4. Patient status of admitted inmates shall be entered into a movement file of the automated tracking system; other patient data shall be entered, as appropriate, into other system files.

Treatment Planning

The CCMs shall develop mental health Treatment Plans for all CCCMS inmates. Treatment Plans shall be based on current assessments and with as much participation from the inmate as possible. They shall specify both mental health and other institutional services that will help resolve main problem areas. All activities including work, education, and recreation are potentially therapeutic if they can improve, develop or preserve coping skills.

1. The CCM, in consultation with the IDTT, shall develop an individualized comprehensive Treatment Plan within seven working days of a referral. The MH 2 Mental Health Form is used for this purpose. (Attachment #4)
2. Appropriate information from the intake assessment and the Treatment Plan shall be shared with the CCs for inclusion in the initial Institutional Classification Committee review.
3. The Treatment Plan shall include:
 - a. Basic identifying data about the inmate (age, race, committing county commitment offense, and current Earliest Possible Release Date or Minimum Eligible Parole Date).
 - b. A diagnosis, identified problems, and treatment objectives measurable in behavioral terms;
 - c. Treatment services and other institutional services designed to impact main problems and achieve individual treatment objectives;

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- d. Proposed frequencies of services to be provided including case monitoring contacts;
 - e. Appropriate forms such as a signed Release of Information necessary to obtain prior records, if needed, and signed Consent to Treatment and Heat Warning forms particularly for those inmates prescribed psychotropic medication; and
 - f. Aftercare and clinical pre-release plans.
- 4. The Treatment Plan shall be entered into a treatment plan file of the CCCMS tracking system.
 - 5. Within 10 working days of completing the Treatment Plan, the CCM sends a CDC 128-C Mental Health Placement Chrono to the appropriate Classification and Parole Representative in order to notify custody that the inmate meets the criteria for participation.
 - 6. Treatment Plans are updated at least annually, whenever a change in level of care occurs, or when clinical judgment indicates the need for an update.
 - 7. Services to inmates shall reflect the most current updates.
 - 8. All updates shall be entered in the tracking system and a CDC 128-C Mental Health Placement Chrono shall be produced annually and with every change in level of care (see "Patient Monitoring and Case Review" for more details).

Treatment Modalities

Providing treatment is a significant component of CCCMS. A therapeutic working relationship between the inmate and the CCM is essential to the success of the treatment outcome.

Based on identified needs, treatment modalities may include:

- 1. Orientation and supportive counseling for institutional adjustment
- 2. Medication review and monitoring
- 3. Individual counseling and crisis intervention
- 4. Group therapy such as anger management and relapse prevention
- 5. Social skills training
- 6. Family counseling
- 7. Occupational therapy

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8. Consultation services
9. Onsite assessment/treatment services for Ad/Seg and SHUs
10. Clinical pre-release planning

Institutional programming is an essential component of the treatment regimen of most clinical case management participants. The CCMs will make specific recommendations for programs such as education, work, and substance abuse counseling and coordinate with CCs to ensure appropriate linkages to these programs.

Transfer and Clinical Discharge

An important function of CCMs is making a clinical determination as to when and how to transfer inmates to more intensive levels of care and to clinically discharge those no longer needing services or are being paroled. Clear and measurable criteria for both clinical discharge and transfer to higher levels of care are important (see attached chart "MHSDS Levels of Care"). Equally important are follow-up with units or programs which will take over the care and/or monitoring of the inmate and coordination of pre-release planning with correctional counseling staff.

1. Inmates shall be clinically discharged from CCCMS if they have been in continuous remission for one year and are functioning adequately in the mainline without treatment (including medication).
2. Inmates admitted on the basis of medical necessity will be discharged when the crisis or problem necessitating treatment is resolved
3. Inmates shall be transferred to MHCB for crisis episodes requiring 24-hour nursing care.³
4. Most inmates requiring more intensive services within a structured setting shall be transferred to an EOP. Inmates presenting clear signs of need for intermediate inpatient care shall be transferred to the EOP at California Men's Colony, or the EOP at California Institution for Women (CIW) for further evaluation for placement at Atascadero State Hospital or Patton State Hospital (PSH). Inmates requiring acute inpatient care shall be transferred directly to the DMH program at the California Medical Facility or to CIW for transfer to PSH. See Section on DMH Inpatient Care.
5. The CCM shall present a recommendation for clinical discharge or transfer to EOP in a clinical case review with the IDTT.⁴ If, after consultation, the team endorses the recommendation, the CCM shall complete a Discharge/Transfer Summary (MH 4 transfer

³ Transfer to the Mental Health Crisis Beds is described under "Crisis Intervention."

⁴ Further details on case review are presented in "Patient Monitoring and Case Review."

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form) within 30 days prior to the scheduled clinical discharge date or no longer than three weeks prior to transfer to EOP.

6. The Discharge/Transfer Summary shall include the diagnosis (current DSM IV version), particularly Axis I and Axis V, a brief summary of the inmate's course of treatment in CCCMS and recommendations for follow-up care (Aftercare Plans).
7. Clinical pre-release plans included as part of the Treatment Plan shall be updated as appropriate but at least at every annual clinical case review.
8. Inmates awaiting EOP transfer shall have updated Treatment Plans (MH 2) providing for adequate care.
9. Immediately before transfer to EOP, CCMs shall contact the EOP Treatment Team Leader to ensure continuity of care and provide the most recent, relevant clinical information regarding the inmate's clinical care. If an inmate requires transfer to an inpatient program while in EOP, EOP staff shall contact and, when necessary, consult the inmate's CCM about the transfer.
10. The CCM shall coordinate with the CC regarding plans for release and follow-up of the inmate to be paroled. Discharge/Transfer Summaries (MH 4) shall be forwarded to the POC or other pertinent clinical pre-release program providers after signed Releases of Information have been obtained. While necessary for record transactions with other agencies, a signed release is not needed within the Department.
11. Prior to CCCMS termination (clinical discharge or program transfer), the CCM completes a CDC 128-C Mental Health Placement Chrono to notify custody.
12. The tracking system shall be updated upon all terminations.

E. Patient Monitoring and Clinical Case Review

Monitoring Contacts

Progress is assessed by the case manager during regularly scheduled contacts with the inmate. The frequency of these contacts will vary based on outpatient needs. The majority of CCCMS outpatients will require minimal contacts because they have been stabilized on psychotropic medication and are capable of functioning quite adequately in the mainline. Usually, they can manage the symptoms of their mental illness and report with little prompting for renewal of medication prescriptions. A certain percentage of inmates will manifest greater needs and thus require more frequent contacts.

1. Face-to-face contacts between the CCM and the CCCMS outpatient shall occur as clinical needs dictate but at least every 90 days.

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2. Inmates recently released from more intensive levels of care, admitted directly from RCs, or recently admitted to SHUs may initially require daily to weekly contacts.
3. Monitoring contacts and attendance at treatment activities shall be entered into a patient contact file of the automated tracking system
4. Significant patient contacts shall be documented in the Mental Health Progress Notes (MH 3) in the UHR no less frequently than quarterly (Attachment #5).

Clinical Case Review

In consultation with the IDTT, a full review of outpatient progress that includes clinical status and performance in vocational, social, and daily-living activities shall be done to ascertain the appropriateness of current level of care placement. This review may or may not result in modifications of the Treatment Plan.

1. **Clinical case reviews shall be done at least annually**, prepared prior to, and included as applicable in Classification Committee hearings reviewing inmate status. The first annual clinical review shall be scheduled in the month prior to a classification hearing and annually thereafter.
2. The annual review culminates in a Mental Health Treatment Plan Rejustification (MH 2). This report shall include a description of current clinical status, participation in treatment and institutional programming, and reasons for continuation or termination of CCCMS services.
3. Clinical case reviews shall also be done every time placement in more intensive levels of care is indicated or change to nonpatient status is imminent within 90 days. These case reviews are documented in Condensed Mental Health Assessment & Treatment Setting Transfer (MH 4).⁵
4. For SHU inmates, clinical reviews shall be scheduled as required to fulfill the inmates' SHU terms or when clinical changes indicate a possible change in placement.
5. Clinical case reviews shall include the clinical staff of the IDTT. The CCs and other custody staff who manage the inmate's day-to-day routine will be included whenever possible. The CCMs will document the presence of the inmate during the review and indicate reasons for the inmate's absence.

F. Staffing

The clinical staff shall be coordinated by the Clinical Director and shall include: 1) The CCMs at the institution; and 2) other clinicians for medication reviews, crisis intervention, psychotherapy and clinical evaluations. Clinical staff enhancements are also available at

⁵ Transfer Summaries are described in more detail under "Treatment and Assessment Services."

Mental Health Services Delivery System Program Guides - Health Care Services Division

institutions with SHUs. Each IDTT will select a Treatment Team Leader who will facilitate clinical decision-making.

For planning purposes, allocations for CCM positions are roughly based on a ratio of 100 inmates for every case manager. While these ratios may be adjusted as program evaluation data are collected to validate planning assumptions, they are deemed appropriate for correctional settings where basic necessities (food, shelter, and clothing) are already provided for and other case management responsibilities (service linkages and assessment and monitoring) are facilitated. The CCMs will coordinate certain functions with CCs who will continue their assigned role in the institutional programming of inmates. The majority of CCCMS inmates will mostly require quarterly monitoring, annual case reviews, and institutional programming.

Staff training is crucial to the successful operation of the CCCMS. Training is essential because CCCMS, as a formalized systemwide approach to outpatient treatment in inmates' regularly assigned living units, is relatively new not only to CDC but to correctional settings in general. Training facilitates standardizing basic elements of CCCMS service delivery. Duty statements for psychiatrists, psychologists, and social workers who shall perform the following roles are found in Attachment #6.

Clinical Director

A Clinical Director is critical to the success of CCCMS. The Director takes the lead in implementing local policies and procedures for clinical case management, oversees the client tracking system, ascertains that case assignments match inmate needs with case manager skills, facilitates training, and coordinates system monitoring functions contained in Quality Assessment and Improvement Plans. The Clinical Director can be any licensed mental health professional with experience running a complex case management system.

Clinical Case Manager

Under the direction of the Clinical Director, CCMs perform the necessary case management functions for all outpatients in their caseloads. This includes assessment, treatment planning and treatment, clinical monitoring, and clinical case reviews. They coordinate with in ensuring timely linkages with institutional services that are considered helpful in maintaining or improving inmate functioning. The CCMs shall screen institution referrals to the CCCMS, including those for crisis episodes. Most CCMs will be psychiatric social workers; however, based on institutional and clinical needs other clinicians may be assigned as CCMs.

Other Clinicians (Psychiatrists and Psychologists)

Generally, psychiatrists and some psychologists will not carry designated caseloads except when clinical needs dictate. These other clinicians provide any of a wide array of mental health services within the scope of their licenses: medication review and prescription, crisis intervention, psychiatric and psychological assessments, and individual and group therapy. These clinicians as well as those in MHCB and the EOP may provide case consultations to

Mental Health Services Delivery System Program Guides - Health Care Services Division

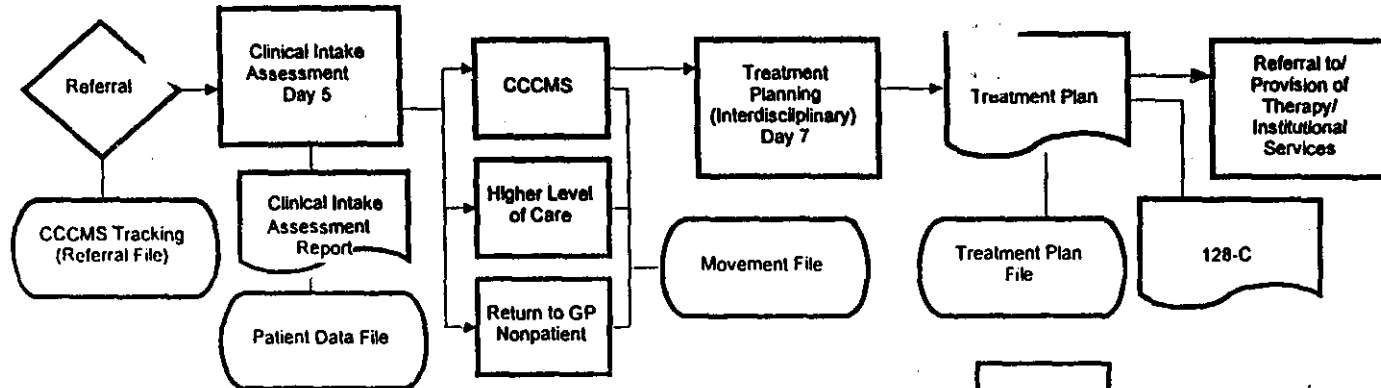
CCMs as well as to custody staff on the effective management of inmates exhibiting behaviors which may be indicative of mental illness.

Clerical Support

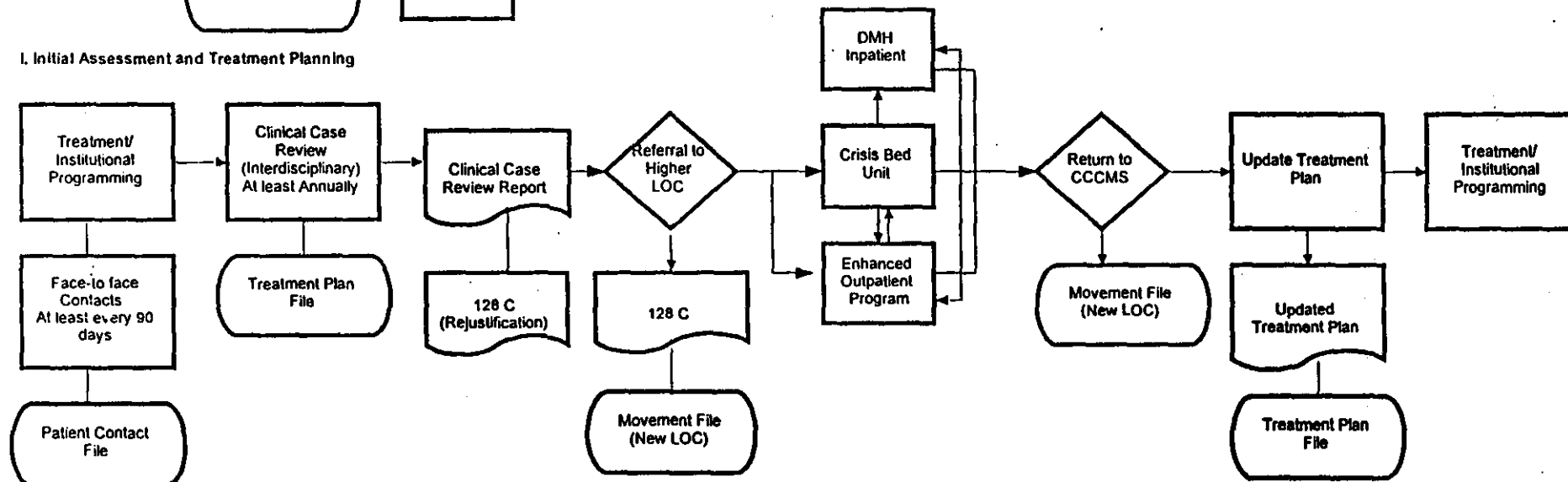
Medical Transcribers or Office Technicians will provide clerical support to clinicians. Clerical support includes record keeping, assisting with scheduling, and transcribing and typing reports and forms used in referral, assessment, treatment planning, patient contacts, and clinical case reviews. Occasionally, this position would also include computer data entry.

G. Mental Health Quality Management System

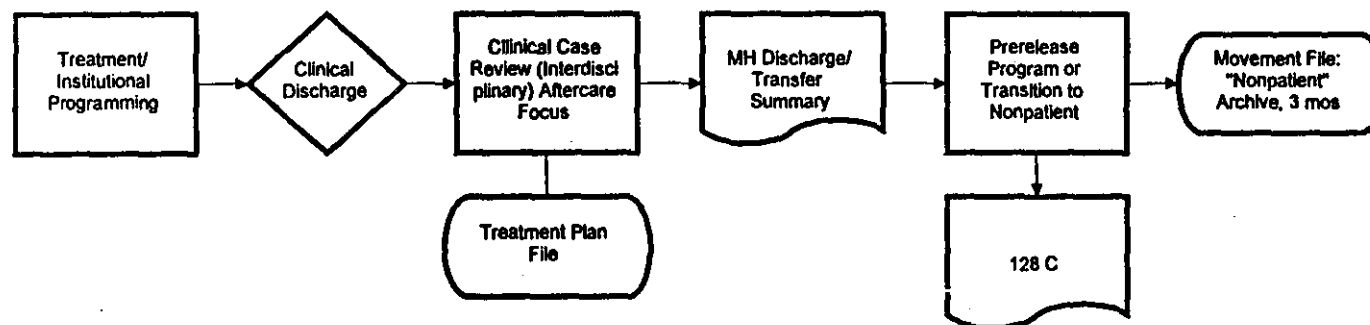
Ongoing assessment of the quality of clinical services will follow the Mental Health Quality Management System (MHQMS) procedures. Please refer to the MHQMS Plan.



I. Initial Assessment and Treatment Planning



II. Monitoring and Transfer to Higher Level of Care



III. Clinical Discharge from CCCMS

Figure 1. CORRECTIONAL CLINICAL CASE MANAGEMENT SERVICE FLOW

MENTAL HEALTH PLACEMENT

LAST FIRST MI CDC# HOUSING:

ate has completed a mental health evaluation with the following results:

☐ DOES NOT MEET CRITERIA FOR INCLUSION IN THE
MH TREATMENT POPULATION☐ MEETS CRITERIA FOR INCLUSION IN THE MH
TREATMENT POPULATION (SEE LOC BELOW)

Level of Functioning Assessment (GAF score or equivalent):

Psychotropic Medication: ☐ Yes ☐ No

Behavioral Alerts:

Level of Care Recommendation (LOC):

☐ Inpatient DMH☐ Crisis Bed (MHCB)☐ Enhanced Out Patient (EOP)☐ Clinical Case Management (CCCMS)

CLINICIAN'S NAME (PRINT)

PHONE/EXTENSION

CLINICIAN'S SIGNATURE

DATE

CDC 128C

Mental Health Placement Chrono Form Instructions

This form is to be completed by the clinician who has performed the Psychological Evaluation which provides the basis for mental health placement. Please write legibly.

<u>Item</u>	<u>Institution</u>
1) Identifiers (top line)	Self-explanatory
2) ☐ Does not meet criteria for inclusion in the mental health treatment population.	Check this box if inmate does not meet criteria displayed in I in the attached Level of Care Placement Decision Criteria.
3) ☐ Meets criteria for inclusion in the mental health treatment population.	Check this box if inmate meets criteria displayed in I in the attached Level of Care Placement Decision Criteria. If checked, one of the LOC boxes must be checked.
4) ☐ Level of Functioning	Please indicate current GAF score.
5) Psychotropic Medication	Check yes if the inmate is currently on psychotropic medication; no if not.
6) Behavioral Alerts	Indicate any behavior of importance to custody or clinical staff e.g., unpredictability; physically aggressive; suicidal. If none known, so indicate.
7) Level of Care Recommendation (LOC)	One of the four LOC boxes must be checked. See II, III, IV in the attached Level of Care Placement Decision Criteria.
8) Signature Block	Self-explanatory.
9) Distribution	C-File; Medical File; clinician; inmate

a:

REQUEST FOR PSYCHIATRIC / PSYCHOLOGICAL SERVICES STAFF REFERRAL

NAME: _____ CDC#: _____ HOUSING: _____
LAST FIRST MI

REFERRED BY: _____ TITLE: _____ PHONE: _____

☐ Non English Speaking Primary Language: _____

REASON FOR REFERRAL: (Please check the primary reason(s) and give an example or comment on the lines below)

- | | |
|--|---|
| ☐ History of Psychiatric care needs re-assessment | ☐ Recommend psychiatric medication review |
| ☐ Expresses suicidal ideation or recent attempts | ☐ Exhibits bizarre behavior (describe below) |
| ☐ Incapable / unwilling to care for self | ☐ Poor appetite / sad / fearful / nervous |
| ☐ Confused / disoriented / withdrawn | ☐ Poor self control / unpredictable / interrupts daily routines of self and others |
| ☐ Unprovoked hostility / assaultiveness | ☐ Hears things / sees things / imagines things |

Describe: _____

DATE:

CDC 1218

STATE OF CALIFORNIA
1 (9/92)

INMATE REQUEST FOR INTERVIEW

DEPARTMENT OF CORRECTIONS

NAME	TO		FROM (LAST NAME)		CDC NUMBER
HOUSING	BED NUMBER	WORK ASSIGNMENT		JOB HOURS FROM TO	
OTHER ASSIGNMENT (SCHOOL, THERAPY, ETC.)				ASSIGNMENT HOURS FROM TO	

Clearly state your reason for requesting this interview.

You will be called in for interview in the near future if the matter cannot be handled by correspondence.

Do NOT write below this line. If more space is required, write on back.

INTERVIEWED BY	DATE
SITING	

State of California, Department of Corrections: Region N / C / S, SA = _____, Institution = _____

RECEPTION CENTER MENTAL HEALTH EVALUATION: Page 1 of 3: Date ____/____/____ **Critical Issue** ☒**I. IDENTIFYING INFORMATION**Arrival date this RC: ____/____/____ Ethnicity: ☐ Non-English ☐ English ☐Data Source (s): ☐ Interview ☐ Central File ☐ Unit Health Record ☐ Outside _____**II. BASIS OF REFERRAL/PRESENTING PROBLEM**Screening Report: ☐ Possible Thought Disorder ☐ Possible Mood Disorder ☐ Possible Major Depression☐ Possible Suicidality ☐Staff Referral: ☐ ☐ History of Mental Illness ☐ Medication Review ☐ Danger to self ☐Self Referral: ☐ (State reason) _____☐ Other Behavioral Signs or issues. Describe (include self referral detail): _____**III. MENTAL HEALTH HISTORY: (If it is normal, check normal or none, if a deviation, check yes and explain.)**A. Developmental Problem ☐ Normal ☐ Abnormal _____ ☐B. Marital: circle: S / M / D / W _____ ☐C. Work History: ☐ None ☐ Some ☐ Erratic ☐ Extensive _____ ☐D. Mental Health History: ☐ None known ☐ Yes _____ ☐E. Issues and Problems _____ ☐1. Psychiatric Hospitalizations ☐ None OR ☐ Yes _____2. Psychotropic Medication
in the last 2 years ☐ None OR ☐ Yes _____3. Outpatient Treatment ☐ None OR ☐ Yes _____4. MH Treatment while
incarcerated/paroled: ... ☐ None OR ☐ Yes _____5. History of Substance Abuse ☐ None OR ☐ Yes _____6. Release of information requested ☐ Yes _____ ☐ NoF. Suicidal Behavior ☐ None ☐ Present1. History ☐ None ☐ Present☐ Describe _____ ☐G. Violent Behavior ☐ None ☐ Present1. History ☐ None ☐ Present☐ Describe _____ ☐**MENTAL HEALTH ASSESSMENT:
RECEPTION CENTER
MENTAL HEALTH EVALUATION**

MH 7 [3/22/96]

Page 1 of 3

Use Insert-a-Page of MH 1

Confidential Client/Patient Information

See W & I Code, Section 5328

**LEVEL OF
CARE**

Inpatient

Outpatient

Last Name:

First Name:

MI:

CDC # _____ DOB ____/____/____

IV. CURRENT MENTAL STATUS: ("Within- Normal-Limits" = WNL; Describe Deviations)		Critical ☒
A. Appearance..... ☐ WNL	☐	
B. Behavior ☐ WNL	Speech ☐ WNL	☐
C.. Mood ☐ WNL		☐
1. Sleep..... ☐ WNL		
2. Appetite..... ☐ WNL		
3. Affect ☐ WNL		
D. Cognition:		☐
1. Fund of Information..... ☐ WNL		
2. Intellectual Functioning ... ☐ WNL		
3. Organization of Thought.. ☐ WNL		
4. Association of Thought.... ☐ WNL		
5. Reality Contact..... ☐ WNL		
6. Thought Quality ☐ WNL		
E. Perception Disturbance (Hallucination) ☐ None		☐
F. Thought Content (Delusions, Preoccupation) .. ☐ None		☐
G. Sensorium (Orientation, Memory, Attention, Concentration)..... ☐ WNL		☐
H. Insight and Judgment ☐ WNL		☐
I. Interview Attitude ☐ WNL		☐
J. Current Suicidality..... ☐ None		☐
K. Current Violence Risk ☐ None		☐
Discussion:		
Is Substance Abuse an issue? ☐ No ☐ Yes		

MENTAL HEALTH ASSESSMENT: RECEPTION CENTER MENTAL HEALTH EVALUATION MH 7 [3/22/96] Page 2 of 3 Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	<table style="width: 100%;"> <tr> <td style="width: 33%;">Last Name:</td> <td style="width: 33%;">First Name:</td> <td style="width: 33%;">MI:</td> </tr> <tr> <td style="height: 40px;"></td> <td></td> <td></td> </tr> <tr> <td colspan="2">CDC # _____</td> <td>DOB ____/____/____</td> </tr> </table>	Last Name:	First Name:	MI:				CDC # _____		DOB ____/____/____
Last Name:	First Name:	MI:									
CDC # _____		DOB ____/____/____									

V. DSM IV Numerical - (Diagnosis, including provisional diagnosis and degree of uncertainty.)		
Axis I.	#	
	#	
	#	
Axis II.	#	
	#	
Axis III.		
Axis IV.	(current)	
VI. NEED FOR TREATMENT/LEVEL OF CARE:		
Axis V.	GAF=	Score based on: ☐
Treatment Motivation:		
☐ DOES NOT MEET CRITERIA FOR INCLUSION IN THE MH TREATMENT POPULATION		☐ MEETS CRITERIA FOR INCLUSION IN THE MH TREATMENT POPULATION (SEE LOC BELOW)
Evaluations: ☐ Crisis Eval. ☐ Medication Eval. ☐ Psychological Testing ☐ Other, describe below		
Recommended CDC Setting: ☐ GP ☐ CCCMS ☐ EOP ☐ MHCB ☐ DMH DDPS # ____-____		
Rationale:		
Initial Treatment Plan (Include medication(s) target symptom & dose prescribed):		
Evaluation Follow up: (Who and When)		
Medication Follow up: (Who and When)		
Reception Center Mental Health Evaluation Completed by:		Date:
Clinician Name: _____		Clinician Title: _____
Clinician Signature: _____		Telephone: () Ext.: _____

MENTAL HEALTH ASSESSMENT: RECEPTION CENTER MENTAL HEALTH EVALUATION MH 7 [3/22/96] Page 3 of 3 Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	<table style="width: 100%;"> <tr> <td style="width: 33%;">Last Name:</td> <td style="width: 33%;">First Name:</td> <td style="width: 33%;">MI:</td> </tr> <tr> <td colspan="3"> </td> </tr> <tr> <td colspan="2">CDC # _____</td> <td>DOB ____/____/____</td> </tr> </table>	Last Name:	First Name:	MI:				CDC # _____		DOB ____/____/____
	Last Name:	First Name:	MI:								
	CDC # _____		DOB ____/____/____								

State of California, Department of Corrections: N / C / S Region, SA = _____, Institution = _____

Part One: HISTORY SECTION Page 1 of 8 Began on Date ____/____/____ Critical Issue → ☒

I. Identifying Data From: ☐ C File; ☐ POR; ☐ CCI; ☐ MH Records - _____; ☐ Inmate Interview ____/____/____ ☐			
CDC Setting: ☐ GP ☐ CCCMS ☐ EOP ☐ PSU ☐ MHC & Infirmary ☐ Other: DDPS - _____			
Current Commitment Date: ____/____/____		Term Length ____ yr.	County: _____ Ethnicity: _____
Current Offense(s) with PC Codes: _____			☐
Gang & Juvenile Data: _____		Religious Preference: _____	
Arrival date this facility: ____/____/____		Classification Score: _____	Release Date: ____/____/____ ☐
Report Reliability: ☐ Reliable ☐ Marginal ☐ Poor ☐ Want to Fake as Poor		Custody Level: I / II / III / IV ☐	

II. A. Referral Source: ☐ RC Screening ☐ Med. Staff ☐ Custody Staff ☐ Self Referral ☐ Other Staff ☐

II. B. Presenting Issues and Problems: ☐

III. Mental Health and Social History:	
A. Developmental Problem: ☐ Yes ☐ No	Highest Grade Completed: _____ ☐

Raised by: ☐ Both Parents ☐ One Parent ☐ Raised by Other: _____		
☐ History of Childhood Violence	☐ History of Teenage Violence	☐ Teen Arrest / Detention
☐ Frequent Runaway	☐ High School Dropout	☐ Poor School Attendance
☐ School Discipline Problems	☐ Slow Learner in Schools	☐ Did Sex Offense
☐ Childhood/Teen Sexual Abuse	☐ Child / Teen physical abuse	☐ Child Neglect
☐ Subject ☐ Alcohol ☐ Drug ☐	☐ Arson at age _____ ☐	☐ Animal Cruel at age _____ ☐
☐ Parental ☐ Alcohol ☐ Drug		

B. Marital: S / M / D / W / O = _____; # Marriages = _____	Longest Marriage = _____
Children: (number) ____ F ____ M	With you, pre-incarceration: # _____ Child Status Now _____

C. Work: _____ ☐ Always ☐ Periodic ☐ Rarely	Adult years employed _____
Income: _____ ☐ SSI ☐ Disability ☐ AFDC ☐ Homeless Issue	☐

Vocation: _____	☐
-----------------	--------------------------

MENTAL HEALTH ASSESSMENT: MENTAL HEALTH DATA BASE Part One - History Section Part Two - Diagnostic Section + Placement Addendum: Add-a-Page / Insert-a-Page MH 1 [3/19/96] Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE	Last Name: _____	First Name: _____	MI: _____
	Inpatient			
	Outpatient			
		CDC # _____	DOB ____/____/____	

Part One: History Section Narrative:

Page 2 of 8

Date ____/____/____

Critical Issue

✓

D. Developmental History: ☐ N/A☐E. Social History: ☐ N/A☐

F. Criminal History:

☐G. Adjustment to Incarceration: ☐ Adequate☐H. Mental Health History: ☐ None ☐ Yes, see below. ☐ Release Signed ☐ Records Requested☐

Age & Type	Adm. Date	Disc. Date	Diagnosis	Medication & Dose	Hospital & Doctor	Data Source	Data Requested
< 13 InPt							
< 13 OtPt							
< 13 SA							
13-18 InPt							
13-18 OtPt							
13-18 SA							
> 18 InPt							
> 18 OtPt							
> 18 SA							

Use Insert-a-Page for detail, as needed.

☐Coordinated with Health Record Department Yes ☐ No ☐☐
MENTAL HEALTH ASSESSMENT:
MENTAL HEALTH DATA BASE

Part One - History Section

Part Two - Diagnostic Section + Placement

Addendum: Add-a-Page / Insert-a-Page

MH 1 [3/19/96]

Confidential Client/Patient Information

See W & I Code, Section 5328

**LEVEL OF
CARE**

Inpatient

Outpatient

Last Name:

First Name:

MI:

CDC # _____ DOB ____/____/____

Part One: History Section

Page 3 of 8

___/___/___ Critical Issue ☒**I. Incarceration / Parole Treatment;** ☐None☐Yes ☐Records Requested ☐In Record ☐Psychotropic Medication _____ ☐County Jail ☐State Prison ☐Parole ☐Other _____Psychiatric Treatment Unit _____ ☐County Jail ☐State Prison ☐Parole ☐Other _____**J. Use of Psychotropic and other Medication During Last 2 years.** ☐No Psych Meds. ☐No Physical Meds.Name of Medication . Dosage, Last dose. Duration Target problems. Compliance, Side effects. Effectiveness ☐

K. Suicidal Behavior: (*Ideation, threat, gesture and attempt to cause serious self injury or death.*) ☐1. History ☐None ☐Yes as → ☐Child ☐Teenager ☐Adult ☐

Frequency: _____

2. Nature behavior: lethality _____

Date(s) of any suicidal behavior within the last three years: _____

3. Discuss Suicidal Risk: ☐N/A ☐See Mental Status ☐**L. Violent Behavior:** (*Thought, threat, gesture and attempt to cause harm to others.*) ☐1. History ☐None ☐Yes as → ☐Child ☐Teenager ☐Adult ☐

Frequency: _____

2. Nature behavior: describe _____

Number of violent episodes within the last three years: _____

Present spouse abuse issues: ☐No ☐Yes (detail): _____ ☐3. Discuss Violence Risk: ☐N/A ☐See Mental Status ☐4. Custody Input: ☐**MENTAL HEALTH ASSESSMENT:
MENTAL HEALTH DATA BASE**

Part One - History Section

Part Two - Diagnostic Section + Placement

Addendum: Add-a-Page / Insert-a-Page

MH I [3/19/96]

Confidential Client/Patient Information

See W & I Code, Section 5328

**LEVEL OF
CARE**

Inpatient

Outpatient

Last Name:

First Name:

MI:

CDC # _____ DOB ___/___/___

IV. Part One: History Section		Page 4 of 8	Date <u> </u> / <u> </u> / <u> </u>	Critical Issue ☒
A. Substance Abuse: ☐ Denies Street Drugs ☐ Admits -- ☐ Denies Significant Alcohol ☐ Admits ☐				
B. Prevalent Drug Use:				
☐ Heroin	☐ Methamphetamine (speed)	☐ Cocaine	☐	
☐ Sedative:	☐ Heroin-cocaine (speedballs)	☐ Cocaine (rock)		
☐ Hallucinogenic	☐ Opium/Morphine	☐ Inhalant: ☐ Paint, ☐ Glue, ☐ Gas		
☐ Cannabis	☐ PCP	☐ Prescription type		
	☐ Other			
[Include frequency, duration, amount, route -- use Insert-a-Page, as needed] ☐				
Current / recent drug(s) of choice _____				
Started using illegal drugs at age: _____ Drug(s): _____				
Adverse Reaction ☐ Instant Offense ☐ React Violent ☐ Drug Arrest ☐ Unpredictable ☐				
C. Prevalent Alcohol Use: ☐ Denies use past three years ☐				
☐ Use admitted	☐ Daily	☐ Weekly	☐ Weekends	☐ Monthly ☐
Preference Type	How Much?	☐ Minimizes ☐		
Adverse Reaction:	☐ DUI's	☐ Violent ___/Mo	☐ Blackout ___/Mo	☐ Public Drunk ☐
1) Have you ever felt you ought to Cut down on your drinking? yes ☐ no ☐ 2) Have people Annoyed you by criticizing your drinking? yes ☐ no ☐ 3) Have you ever felt bad or Guilty about your drinking? yes ☐ no ☐ 4) Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (an Eye opener)? yes ☐ no ☐				
D. Alcohol or Drug Rehabilitation Programs Attended: ☐ N/A ☐ Yes Dates: _____ ☐				
☐ Voluntary ☐ Required ☐ Non Compliance ☐ Compliance ☐ Completion ☐ Present Clean & Sober				
Describe: _____ ☐				
Interests in substance abuse programs: ☐ yes ☐ no; Interest other programs: _____ ☐ yes ☐ no				

V. Allergies, Medical Problems or History: ☐ None Known. ☐ Allergic Issues ☐ Medication Allergies ☐			
☐ Seizure Disorder	☐ Active	☐ Controlled	Present Medication _____
☐ Head Injury	☐ Minor	☐ Severe	Discuss _____
☐ History of Coma	Duration of Coma _____	Dates or age _____	
☐ Hormonal Problem	Type / disability _____	☐ Cardiovascular	☐ Strokes
☐ Thyroid Disorder	☐ Active + Rx.	☐ Unresolved	☐ Surgery ☐ Medication Problems
Discuss above, including any allergies (use Insert-a-Page as needed):			

HISTORY SECTION OF MENTAL HEALTH ASSESSMENT COMPLETED BY:		
Clinician Name: _____	Clinician Title: _____	Date <u> </u> / <u> </u> / <u> </u>
Clinician Signature: _____	Telephone: () _____ - _____	Ext. _____

MENTAL HEALTH ASSESSMENT: MENTAL HEALTH DATA BASE Part One - History Section Part Two - Diagnostic Section + Placement Addendum: Add-a-Page / Insert-a-Page MH 1 [3/19/96] Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	Last Name: _____ First Name: _____ MI: _____ CDC # _____ DOB <u> </u> / <u> </u> / <u> </u>
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B. Initial Problem & Symptom List (Limited and focused problems. Link to DSM IV criteria.)

# 1	
# 2	
# 3	
# 4	

C. DSM IV Numerical (Diagnosis and diagnostic discussion including degree of diagnostic certainty.)

Axis I.		
Axis II.		
Axis III.		
Axis IV.	(current)	
Axis IV.	(instant offense)	
Axis V.	GAF = _____ Score based on:	

D. Readiness for Treatment: ☐ Amenable ☐ Motivated ☐ Not Motivated ☐ Resistant

☐ Refusing MH Care, use CDC 7225. ☐ Refusal Form Signed. ☐ Refuses to Sign Refusal Form -- initial _____

Discuss & Include Reason: (Document and follow CCCMS) _____

Strengths and Weaknesses: Address spiritual, cultural, social, occupational, family -- _____

Anticipated Medical / Legal Issues: ☐ None ☐ Keyhea ☐ MDO 2962 ☐ DMH 2684 ☐ 'R' ☐ Other _____

MENTAL HEALTH ASSESSMENT: MENTAL HEALTH DATA BASE Part One - History Section Part Two - Diagnostic Section + Placement Addendum: Add-a-Page / Insert-a-Page MH 1 [3/19/96] Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	Last Name: _____ First Name: _____ MI: _____ CDC # _____ DOB ____/____/____

VIII. Issues of Placement; Post Mental Health Assessment Decisions. (Select A. or B. or C.)**A. ☐ REMAIN PRESENT SETTING** Check below.☐ Pending ___ weeks observation.Begin MH 2 Treatment Plan: ☐ GP ☐ CCCMS ☐ EOP ☐ PSU ☐ MHCB or Infirmary**B. ☐ TREATMENT SETTING TRANSFER DELAY** Reason below.

Length delay: = ___ weeks

☐ Interim: ☐ Completing MH ☐ Present Setting probable. ☐ Detail Referrals Made Below.

Detail of Referral to Psychological Testing, Psychotropic Medication Evaluation, Neurological Evaluation, Laboratory, X-ray, Medical Evaluation, OSAP Assessment, Self Help Programs.

☐ Retention this setting confirmed. ___/___/___ OR ☐ Change Setting. ___/___/___ (Complete C. below)☐ Pre Parole Guidance. Transfer to Paroles in ___ months or on about ___/___/___.☐ Clinical Discharge from Mental Health Treatment to Non Patient General Population on ___/___/___.☐ Department (CDC) Discharge (Include Inter State Compact to ___) Leaving prison on or near ___/___/___.**C. ☐ TRANSFER TO A NEW TREATMENT SETTING .**Transfer to New CDC: ☐ N/A ☐ CCCMS ☐ EOP ☐ PSU ☐ MHCB or Infirmary ☐ Other ___Treatment Setting: DMH: ☐ N/A ☐ DMH (CMF) ☐ DMH (ASH) ☐ DMH (Patton) ☐ Also note MDO

Describe steps taken for (see c above).

D. INTERIM TREATMENT PLAN: Team Members

Clinician's Name: _____

Clinician's Title: _____

Date: ___/___/___

Clinicians Signature: _____

Telephone #: () _____

Ext. _____

MENTAL HEALTH ASSESSMENT:**MENTAL HEALTH DATA BASE**

Part One - History Section

Part Two - Diagnostic Section + Placement

Addendum: Add-a-Page / Insert-a-Page

MH 1 [3/19/96]

Confidential Client/Patient Information

See W & I Code, Section 5328

LEVEL OF CARE

Inpatient

Outpatient

Last Name: _____

First Name: _____

MI: _____

CDC # _____

DOB ___/___/___

ADDENDUM: Add-x-Page; Insert-x-Page **N / C / S Region, Service Area = _____, Institution = _____**

Additional Page and/or Update Page Use with Assessments, Data Base, Treatment Plan

☐ Insert as Additional Information: Behind Page # _____, Form _____, Date: ____/____/____ completed.☐ Add to Top as Update or Correction: Top Form _____, Regarding Page # _____, Date: ____/____/____ completed.[illegible]

MENTAL HEALTH ASSESSMENT: MENTAL HEALTH DATA BASE Part One - History Section Part Two - Diagnostic Section + Placement Addendum: Add-a-Page / Insert-a-Page MH 1 [3/19/96] Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	Last Name: _____ First Name: _____ MI: _____ CDC # ____ - ____ - ____ - ____ - ____ DOB ____ / ____ / ____
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State of California, Department of Corrections: N / C / S Region, SA = _____, Institution = _____ ☐ Male ☐ Female		
CONDENSED MENTAL HEALTH ASSESSMENT & TREATMENT SETTING TRANSFER: Date: ____/____/____		
Primary Use Include: Admission Intake, Transfer, Parole, Discharge, MHCB Screen & Assessment. Page 1 of 5		
Current Setting: ☐ GP ☐ Ad Seg ☐ SHU ☐ RC ☐ CCCMS ☐ EOP ☐ PSU ☐ MHCB ☐ Other: _____		
I/M Ethnicity: _____	Non English Language: _____	Level: I / II / III / IV / AS / SHU _____
CDC Arrival date: _____	CDC Release date: _____	☐ MH 1, MH 4, MH 7 Date: ____/____/____
Inmate interviewed on: ____/____/____	Level of Cooperation: _____	DDPS _____ - _____ ☐ Not Noted.
I. Purpose for Condensed Mental Health Assessment:		
A. ☐ Condensed Initial Assessment (Intake) Form (May Replace or Delay MH 1 Assessment / Data Base.)		
☐ MH 1; ☐ MH 7; ☐ Bus Screening; ☐ Page 2 (Psychiatric History) as ☐ Update or ☐ Initial history		
B. ☐ Transfer to New Setting Recommended DDPS Code Change To: _____		
☐ Return to Custody ☐ GP ☐ OSAP ☐ POC & Complete Page 5.		
☐ To Out-patient ☐ CCCMS		
☐ EOP: Was tele-fax used? yes ☐ no ☐ ; Was approval obtained? yes ☐ no ☐ Conditional ☐		
☐ PSU		
☐ To In-patient ☐ MHCB ☐ Infirmary: CTC pre-screening? yes ☐ no ☐ Details:		
☐ DMH ☐ Criminal History Supplemental Form needed. DMH Care Level → ☐ Intermediate ☐ Acute		
Describe referral methods: _____		
Describe current symptoms/concerns that indicate a need for Inpatient: _____		
Desired Inpatient Treatment outcome: _____		
Was Above: ☐ Intra or ☐ Inter Institution ☐ Other (Outside) ☐ No ☐ Yes Transfer Chrono by _____		
☐ Pre Parole Release (Complete page 5: MH 4 > CCI > C&PR > Form 611 > Parole Regional HQ & POC Clinician.)		
D. ☐ Department of Correction Discharge. No CDC Follow Up. ☐ Inter State Compact to: _____ (state)		
☐ To Other Treatment Source:		
Name: _____ Telephone: () _____ - _____ FAX: () _____ - _____		
Address: _____		
☐ Consent to Release Specific Records, Coordinate with Health Records. ☐ QA Follow Up Plan Discussed Below.		
II. Brief Narrative Summary: ☐ Expanded on Insert-a-Page		

CONDENSED MENTAL HEALTH ASSESSMENT & TREATMENT SETTING TRANSFER & PAROLE/DISCHARGE FORM MH 4 Page: 1 of 5 [3/28/96] Use Insert-a-Page of MH 1 Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	Last Name: _____ First Name: _____ MI: _____ CDC # _____ DOB ____/____/____
--	---	--

II. MENTAL HEALTH & HEALTH HISTORY: ☐ See Unit Health Record

(If an item is normal, check normal or none. If a deviation, elaborate.)

A. Developmental Problem ☐ Normal ☐ Abnormal ☐B. Marital: circle: S / M / D / W ☐C. Work History: ☐ None ☐ Some ☐ Erratic ☐ Extensive ☐D. Mental Health History: ☐ None known ☐ Yes ☐E. Issues and Problems ☐

1. Psychiatric Hospitalization ☐ None ☐ Yes
2. Psychotropic Medication in the last 2 years ☐ None ☐ Yes
3. Outpatient Treatment ☐ None ☐ Yes
4. MH Treatment while incarcerated/paroled ☐ None ☐ Yes
5. History of Substance Abuse ☐ None ☐ Yes
6. Release of information requested ☐ No ☐ Yes

F. Suicidal Behavior ☐ Denies History ☐ None Found ☐ Present ☐G. Violent Behavior ☐ Denies History ☐ None Found ☐ Present ☐H. Discuss Significant Medical History (Head Traumas, HIV, Seizures) ☐ None Found ☐ Present ☐I. Other or Additional Comments: ☐
**CONDENSED MENTAL HEALTH ASSESSMENT
& TREATMENT SETTING TRANSFER
& PAROLE/DISCHARGE FORM
MH 4**

Page: 2 of 5 [3/28/96]
Use Insert-a-Page of MH 1
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See W & I Code, Section 5328

**LEVEL OF
CARE**

Inpatient

Outpatient

Last Name:

First Name:

MI:

CDC # _____ DOB ____/____/____

Condensed Mental Health Assessment & Treatment Setting Transfer:**Page 3 of 5****V. Present Mental Status** Date / / A) Appearance ☐ WNLB) Behavior ☐ WNLSpeech ☐ WNLC) Mood ☐ WNLSleep ☐ WNLAppetite ☐ WNLAffect ☐ WNL

D) Cognition:

1) Fund of Information ☐ WNL2) Intellectual Functions ☐ WNL3) Organization of Thought ☐ WNL4) Association of Thought ☐ WNL5) Reality Contact ☐ WNL6) Thought Quality ☐ WNLE) Perception Disturbances (Hallucinations) ☐ NoneF) Thought Content (Delusions) ☐ NoneG) Sensorium (Orientation, Memory, Attention, Concentration) ☐ WNLH) Insight & Judgment ☐ WNLI) Interview Attitude ☐ WNLJ) Current Suicidality ☐ None noted or stated.K) Current Violence Risk ☐ None noted or stated.**V. DSM IV Numerical - Transferring / Discharge / Provisional (Discussion, diagnostic certainty.)**

Axis I		
Axis II		
Axis III		
Axis IV	(current)	
Axis V	GAF = _____ (Discuss basis.)	
Discussion and Diagnostic Certainty:		
☐ Dual Diagnosis		

**CONDENSED MENTAL HEALTH ASSESSMENT
& TREATMENT SETTING TRANSFER
& PAROLE/DISCHARGE FORM****MH 4**

Page: 3 of 5 [3/28/96]

Use Insert-a-Page of MH 1

Confidential Client/Patient Information

See W & I Code, Section 5328

**LEVEL OF
CARE**

Inpatient

Outpatient

Last Name:

First Name:

MI:

CDC # _____

DOB / /

Medication Chronology: ☐None ☐No Side Effects Noted ☐Medication Concern Issue ☐Keyhea Discuss below.

Allergies:

Name of Medication	Target Symptom	Dose	Side Effect

c. Laboratory Results:
d. Special Consultations:
e. Treatment Setting Change, if any:
Clinician Name: _____ **Clinician Title:** _____ **Date:** ___/___/___

Clinician Signature: _____ **Telephone:** () _____ **Ext.** _____

VII. NEW SETTING ASSESSMENT & INITIAL TREATMENT PLAN:
Date Receiving Above Assessment ___/___/___ **Time** ___:___; **Received by:** _____

Identify Setting:
Receiving Assessment:
Receiving Plan:
Receiving Clinician's Name:
Signature:
Clinician Contact Regarding Discharge: Name & Position
**CONDENSED MENTAL HEALTH ASSESSMENT
& TREATMENT SETTING TRANSFER
& PAROLE/DISCHARGE FORM**
MH 4
Page: 4 of 5 [3/28/96]
Use Insert-a-Page of MH 1
Confidential Client/Patient Information
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**LEVEL OF
CARE**
Inpatient
Outpatient
Last Name:
First Name:
Mi:
CDC #
DOB

SCREENING OF INSTITUTION REFERRALS (CRITERIA)

Screening of referrals from custody staff and inmates (including self-referrals) to the Correctional Clinical Case Management System shall cover the following areas:

- 1. Significant mental health treatment (including psychiatric hospitalization)**
- 2. Past and current psychotropic medications**
- 3. Suicidality including suicidal ideation and behavior**
- 4. Dangerousness to others based on a serious mental illness**
- 5. Thought disorders**
- 6. Serious mood disorders**
- 7. Other bizarre or unusual behaviors indicative of mental illness**
- 8. Serious functional disabilities (eating, hygiene and grooming)**

All inmates admitted since July, 1994, will also have the results of a Reception Center standardized screening form (Offender Profile Report) available in their medical records. This should be reviewed as part of the screening of institution referrals.

Date Completed: ____/____/____ MH> CCI> C&PR> Form 611>Parole HQ>POC DDPS Noted ☐ Yes ☐ No _____

Allergies:	
Anticipated Date of Discharge:	
Other:	

Medication Provided at Discharge ☐ None ☐ See page 3					
Name of Medication	Dose size	# of Tablets	Name of Medication	Dose size	# of Tablets

Housing Plans:	Reside with:	Relationship:
Address:		
Telephone: ()	In whose name is telephone listed?	
Other housing issues:		

Suggested Aftercare Approach Plan:

Completed By CDC Clinician: _____	Clinician Title: _____	Date: ____/____/____
Clinician Signature: _____	Telephone: () _____ - _____ Ext. _____	
CCI Name: _____	Telephone: () _____ - _____ Ext. _____	C&PR Confirmed by: _____

CONDENSED MENTAL HEALTH ASSESSMENT & TREATMENT SETTING TRANSFER & PAROLE/DISCHARGE FORM MH 4 Page: 5 of 5 [3/28/96] Use Insert-a-Page of MH 1 Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	<table style="width: 100%;"> <tr> <td style="width: 33%;">Last Name:</td> <td style="width: 33%;">First Name:</td> <td style="width: 33%;">MI:</td> </tr> <tr> <td style="height: 40px;"></td> <td></td> <td></td> </tr> <tr> <td colspan="3"> CDC # _____ DOB ____/____/____ </td> </tr> </table>	Last Name:	First Name:	MI:				CDC # _____ DOB ____/____/____		
Last Name:	First Name:	MI:									
CDC # _____ DOB ____/____/____											

State of California, Department of Corrections: N / C / S Region, Service Area = ____, Institution = ____

MENTAL HEALTH TREATMENT PLAN: Sequential Part One Identifier Number Page 1 of 2☐ Original ☐ Update ☐ Rejustification ☐ CCCMS Annual Case Review**I. General Information:**

Arrival Date This Treatment Setting: ____/____/____

☐ CCCMS ☐ EOP ☐ MHC/B/Infirmary☐ PSU -- ☐ ____ week observation.

Anticipated Date of Transfer to GP: ____/____/____

Custody Level: I / II / III / IV / AdS / SHU

By: ☐ Team ☐ Individual Clinician☐ MH 6 ☐ C File ☐ Health Record☐ Unit Health Record ☐ MH 1☐ MH 4 ☐ Prior MH 2 ____/____/____

Today Date

____/____/____

Next Up Date

____/____/____

II. Print Treatment Team Members**Position****Telephone & Extension****III. Present Mental Status** Date ____/____/____ By ____ Title ____A) Appearance ☐ WNLB) Behavior ☐ WNLSpeech ☐ WNLC) Mood ☐ WNLSleep ☐ WNLAppetite ☐ WNLAffect ☐ WNL

D) Cognition:

1) Fund of Information ☐ WNL2) Intellectual Functions ☐ WNL3) Organization of Thought ☐ WNL4) Association of Thought ☐ WNL5) Reality Contact ☐ WNL6) Thought Quality ☐ WNLE) Perception Disturbances (Hallucinations) ☐ NoneF) Thought Content (Delusions) ☐ NoneG) Sensorium (Orientation, Memory, Attention, Concentration) ☐ WNLH) Insight & Judgment ☐ WNLI) Interview Attitude ☐ WNLJ) Current Suicidality ☐ None noted or stated.K) Current Violence Risk ☐ None noted or stated.**MENTAL HEALTH
TREATMENT PLANS,
UPDATES, REJUSTIFICATION
MH 2 [3/29/96]**Part One: General, Team, MSE
Diagnosis, Problems, Inmate Strengths

Part Two: Problem Pages -- Results

Use Insert-a-Page of MH 1

Confidential Client/Patient Information

See W & I Code, Section 5328

**LEVEL OF
CARE**

Inpatient

Outpatient

Last Name:

First Name:

MI:

CDC # ____ DOB ____/____/____

IV. DSM IV Numerical ☐ Last MSE __/__/__ ☐ Last TP __/__/__ MH 1 ☐ __/__/__ Last MH 4 ☐ __/__/__

Axis I

Axis II

Axis III

Axis IV

Axis V

(current)

GAF = _____ Describe basis.

V. Problem / Symptom List

#1

#2

#3

VI. Inmate's Strength and Weakness, Goals

Inmate's Treatment Goals, ☐ MH 6 InputTreatment Readiness: ☐ Amenable ☐ Motivated ☐ ResistantVII. Discharge Plan To: ☐ GP ☐ CCCMS ☐ EOP ☐ MHCB ☐ DMH

Signature(s)

**MENTAL HEALTH
TREATMENT PLANS,
UPDATES, REJUSTIFICATION
MH 2 [3/29/96]**

Part One: General, Team, MSE
Diagnosis, Problems, Inmate Strengths
Part Two: Problem Pages – Results
Use Insert-a-Page of MH 1
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**LEVEL OF
CARE**

Inpatient

Outpatient

Last Name:

First Name:

MI:

CDC # _____ DOB __/__/__

State of California, Department of Corrections: N / C / S Region, Service Area = , Institution,

TREATMENT PLAN PART TWO: PROBLEM → # _____ pg. _____ Today Date: ____/____/____
☐ Initial Treatment Plan ☐ Update because _____ ☐ Re-justify, _____ weeks

[illegible]

MENTAL HEALTH TREATMENT PLANS, UPDATES, REJUSTIFICATION MH 2 [3/29/96] Part One: General, Team, MSE Diagnosis, Problems, Inmate Strengths Part Two: Problem Pages -- Results Use Insert-a-Page of MH 1 Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	Last Name: _____ First Name: _____ MI: _____ CDC # _____ DOB ____/____/____
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State of California, Department of Corrections – Institution: _____ Prior Page Number : _____

CHRONOLOGICAL INTERDISCIPLINARY PROGRESS NOTES: All Staff, Clinicians, Treatment Teams.

[illegible]

MENTAL HEALTH INTERDISCIPLINARY PROGRESS NOTES MH 3 [3/21/96] Confidential Client/Patient Information See W & I Code, Section 5328	LEVEL OF CARE Inpatient Outpatient	Last Name: _____ First Name: _____ MI: _____ CDC # ____ - ____ - ____ - ____ DOB ____ / ____ / ____
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PSYCHIATRIST - STAFF CORRECTIONAL CLINICAL CASE MANAGEMENT SYSTEM

Duty Statement

GENERAL: The Psychiatrist in a Correctional Clinical Case Management System is a member of an Interdisciplinary Treatment Team providing general population outpatient services to inmates. The Team includes other psychiatrists, psychologists, and psychiatric social workers assigned to a Service Area consisting of two or more institutions. While psychiatric social workers are expected in most instances to be Clinical Case Managers in charge of assessing, treatment scheduling, and tracking a clinical caseload, psychiatrists may occasionally carry caseloads as clinical needs dictate. In general the Staff Psychiatrist in case management performs psychiatric evaluations, participates in treatment planning and case reviews, prescribes medications, and provides crisis intervention and psychotherapy. The Staff Psychiatrist also provides consultations and training in treatment approaches to both clinical and custody staff of the Interdisciplinary Treatment Team.

- 25% **Evaluation, Diagnosis, and Treatment Planning.** Performs evaluations of inmates referred for various reasons to case management including crisis evaluations and specialized psychiatric evaluations for specific clinical conditions such as suspected physical or neurologic conditions, need for psychiatric medications or need for placement in an inpatient program. Provides a diagnostic impression, delineates major mental health problems, and participates as member of the Team in mental health treatment planning.

- 25% **Psychiatric Medications Prescription and Monitoring.** Performs follow up or initial assessments on the psychiatric medication of new admissions to Correctional Clinical Case Management or subsequent assessments of existing cases already on medication. With the Clinical Case Manager, monitors the effectiveness of the medication on specific target symptoms and for alleviating or enhancing specific problems. Ensures that medications are properly delivered and taken and orders any laboratory studies clinically indicated. Documents the presence as well as the absence of any medication side effects. Ascertains that medical records include properly executed signed informed consents regarding psychiatric medication and ensures that all policies of CDC regarding the administration and monitoring of the temperature deregulating medications are followed by the facility.

- 10% **Crisis Intervention and Clinical Consultation to Other Settings.** In addition to crisis evaluations, provides other crisis intervention services such as brief intensive therapies to inmates in serious crisis situations. Provides clinical consultation about specific inmates or about treatment and management procedures to staff in other levels of care in the same facility.

- 10% **Treatment Team Meetings and Case Review and Monitoring.** Plays an active role in all Team meetings, quality assurance meetings, and other case-specific meetings, adding specific psychiatric insights to all cases. Uses team meetings to provide training and supervision to part time and new psychiatrists.

- 5% **Individual & Group Psychotherapy.** Provides group or individual psychotherapy either to an assigned caseload or to other cases referred by Clinical Case Managers. Teaches or provides consultation on psychotherapy procedures to other members of the Team.

- 5% **Psychiatric Manager.** Exercises clear authority for final clinical decision-making of Interdisciplinary Treatment Team. While lead management of the program may be an appointed position among any professional staff members with managerial skills, clinical veto power rests, first, with the Staff Psychiatrist and, ultimately with the Chief Psychiatrist. Maintains a close working relationship with all medical staff committees, the Chief Medical Officer and Chief Psychiatrist, as well as the Warden and any key custody staff.

- 5% **Automated Tracking.** Like other clinical staff, supports, maintains and monitors a computerized scheduling, tracking and assessment system within the Correctional Clinical Case Management System of the facility. Participates in activities resulting in computer literacy of professional staff, automated documentation of a standard medical record, clarity of the recorded material, and accuracy and completeness of recording of mental health contacts.

- 5% **Staff Training.** Ensures continuity of psychiatric approach and up-to-date knowledge of legal issues, psychiatric medication management issues, and other treatment issues unique to corrections such as malingering and symptom exaggeration by providing training sessions to staff, beyond those of supervision in team meetings or in consultation for a second opinion.

- 5% **Continuing Medical Education and In service Training.** Participates in training for licensing and as required by the facility.

- 5% **Other duties as required.** These include return to duty evaluations for custody as well as clinical evaluation of legal issues: Provides consultation and lends expert advice in sometimes complicated clinical situations of custody staff, most involving return-to-work issues, and fitness for duty evaluations CDC staff. Performs medical-legal assessments of inmates and clinical evaluations of complex medical - legal - union issues under supervision of the facilities Chief Psychiatrist or Senior Psychiatrist.

SENIOR PSYCHOLOGIST (SUPERVISING) - CORRECTIONAL FACILITY CORRECTIONAL CLINICAL CASE MANAGEMENT SYSTEM

Duty Statement

GENERAL. The primary responsibility of a Senior Psychologist (Supervising) assigned to the Correctional Clinical Case Management System (CCCMS) is to provide direction and leadership to the CCCMS's Interdisciplinary Treatment Team including implementing local policies and procedures, overseeing a client tracking system, effective matching of inmates with case managers, and coordinating system monitoring functions. The Senior Psychologist supervises and coordinates training for CCCMS staff and consults with the Clinical Case Manager, the psychiatrist, and custody staff. He/She may also participate in staff meetings and institutional committees; evaluate inmates; provide crisis intervention, individual and group psychotherapy; participate in interdisciplinary team evaluations, treatment planning, and aftercare planning. In some cases, the psychologist may serve as a Clinical Case Manager. Psychologists help maintain the security of the institution and work materials and prevents escapes and injury to themselves, others, and property.

- 25% Provides direction and leadership in system implementation including policies and procedures, client tracking system, and inmate-Clinical Case Manager matching.
- 20% Coordinates system monitoring functions such as program evaluation and quality assessment and improvement, and occasional research studies.
- 20% Provides supervision and coordinates training of CCCMS staff
- 10% Provides assessment and crisis intervention to inmates transferred to Security Housing Units and Administrative Segregation and any inmate experiencing temporary situational stress.
- 10% Provides individual and group psychotherapy including brief intensive therapy, anger management, stress reduction, and relapse prevention.
- 10% Does psychological evaluations of program admissions including a written report with diagnosis and recommendations for treatment; attends team conferences and participates in an individualized treatment and discharge planning.
- 5% Consults with clinical and custody staff regarding patient care and with management regarding conditions that exacerbate or alleviate symptoms of mental disorders in the institution.

PSYCHOLOGIST - CLINICAL - CORRECTIONAL FACILITY CORRECTIONAL CLINICAL CASE MANAGEMENT SYSTEM

Duty Statement

GENERAL. A Clinical Psychologist assigned to the Correctional Clinical Case Management System evaluates inmates admitted to the program; provides crisis intervention, individual and group psychotherapy; participates in interdisciplinary team evaluations, treatment planning, and pre-release planning; and consults with the Clinical Case Manager, the psychiatrist, and custody staff. In some cases, the psychologist may serve as the Clinical Case Manager. The psychologist also participates in staff meetings and institutional committees; provides supervision and training to students, interns, unlicensed psychologists, and other staff; and participates in program evaluation and research including consultations on research design and data analysis. The psychologist maintains the security of the institution and work materials and prevents escapes and injury to themselves, others, and property.

- 20% Does psychological evaluations of inmates admitted to the program. This includes a written report with a diagnosis and recommendations for treatment.
- 20% Provides crisis evaluation and intervention, brief intensive therapy, individual and group psychotherapy including anger management, stress reduction, and relapse prevention.
- 20% Attends interdisciplinary team conferences. Participates in the development of an individualized treatment plan and discharge planning.
- 10% Provides assessment and crisis intervention to inmates transferred to Administrative Segregation and Security Housing Units.
- 10% Provides counseling and crisis intervention to any inmate who is experiencing temporary situational stress.
- 5% Participates in program evaluation and quality assessment and improvement.
- 5% Consults with clinical and custody staff regarding inmate-patient care. Assists the inmate in accessing adjunct services such as vocational, educational, and work assignments.
- 5% Consults with and makes contacts with individuals outside the institution in order to enhance the inmate's adjustment to the prison setting and to facilitate release into the community. This may include parole officers, staff in the parole outpatient clinics, family, and others.
- 5% Performs other clinical and institution-wide duties as required.

PSYCHIATRIC SOCIAL WORKER - CORRECTIONAL FACILITY CORRECTIONAL CLINICAL CASE MANAGEMENT SYSTEM

Duty Statement

GENERAL. A Psychiatric Social Worker assigned to the Correctional Clinical Case Management System will serve as a Clinical Case Manager to inmates with a diagnosable Axis I mental disorder who can be treated in a general population setting. As a member of an Interdisciplinary Treatment Team, the Clinical Case manager (CCM) is responsible for a broad range of tasks that include direct treatment, coordination of services with other correctional staff, patient monitoring, and resource and program development. The Psychiatric Social Worker develops and maintains a therapeutic relationship with inmates on his/her caseload, ensuring awareness of inmates' strengths as well as needs. He/She also does what is required to maintain public and institutional safety.

- 40% As the CCM, serves as the lead in performing clinical intake assessments, developing treatment plans, monitoring progress, and performing case reviews of inmates in the caseload. These entail file reviews, data gathering, completing reports and other required documentation, participating in Classification and other conferences, preparing and presenting case summaries, and consulting with other professionals.
- 15% Coordinates with custody staff to establish linkage to all institutional services called for in comprehensive treatment plans; consults with custody staff regarding participation and progress of caseload in these services. These services include education, training and work assignments, special groups such as AA, and recreation.
- 15% Provides direct treatment to inmates in the caseload including individual and group psychotherapy
- 10% In coordination with custody staff, develops aftercare or clinical pre-release plans for inmates in the caseload including making family contacts, testifying in court or before the Board of Prison Terms, and ensuring follow-up with Parole Outpatient Clinics.
- 10% Provides crisis intervention including suicide assessments and brief intensive counseling and screens requests for services of inmates not in the delivery system.
- 5% Participates in program evaluation and quality assessment and improvement.
- 5% Performs other duties as required.

1/20/95



SECTION 8: ADMINISTRATIVE SEGREGATION

A. PURPOSE

The Administrative Segregation Mental Health Services (Ad/Seg MHS) program is part of the California Department of Corrections' Mental Health Services Delivery System (MHSDS). This program guide outlines program policies and provides basic institutional operational procedures to assure the effective delivery of clinical services to inmates with serious mental disorders who, for custodial reasons, require housing in Administrative Segregation.

B. RESPONSIBILITY

1. Overall institutional responsibility for the program shall rest jointly with the Health Care Manager and the Warden.
2. Institutional operational oversight of the Ad/Seg MHS shall be the responsibility of the Chief Psychiatrist, at institutions with such positions, and mental health clinical staff designated by the Health Care Manager at all others.
3. Custodial responsibilities, including initial placement, disciplinary actions, correctional counseling services, classification, inmate movement, and daily management shall rest with the warden or designee.
4. Individual clinical case management, including treatment planning and placement determinations, shall be approved by an Interdisciplinary Treatment Team (IDTT), consisting of, at a minimum, the assigned clinical case manager, Chief Psychiatrist (or highest ranking mental health clinician), and custodial administrator at the rank of Captain or above.

C. PROGRAM GOALS AND OBJECTIVES

The goal of the Ad/Seg MHS program is to provide necessary mental health services for the population of seriously mentally disordered inmates who, for custodial reasons outlined in California Code of Regulations Title 15, Section 3335, require placement in Ad/Seg. Specific program objectives include the provision of:

Mental Health Services Delivery System Program Guides - Health Care Services Division

1. Continuation of care for inmates with identified mental health treatment needs.
2. A system for screening and evaluation of inmates who develop symptoms of serious mental disorders at the time of initial placement into or during the course of stay in Ad/Seg.
3. Expeditious placement into Mental Health Crisis Beds (MHCB) for inmates requiring inpatient mental health care.
4. Assessment for appropriate mental health placement at the time of discharge from Ad/Seg by an assigned clinical case manager.

D. TREATMENT POPULATION

Please refer to the Overall Treatment Criteria in the MHSDS Program Guides and Sections VII, VIII, and IX below.

Overall Treatment Criteria

1. Treatment and continuous monitoring are provided to any inmate who has **current** symptoms and/or requires treatment for one of the Diagnostic and Statistical Manual (DSM) IV diagnosed (may be provisional) AXIS I-serious mental disorders listed below:
 - Schizophrenia (all subtypes)
 - Delusional Disorder
 - Schizophreniform Disorder
 - Schizoaffective Disorder
 - Brief Psychotic Disorder
 - Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)
 - Psychotic Disorder due to a General Medical Condition
 - Psychotic Disorder Not Otherwise Specified
 - Major Depressive Disorders
 - Bipolar Disorders I and II
2. Medical Necessity

Mental Health intervention is necessary to protect life and/or treat significant disability/dysfunctionality in an individual diagnosed with or suspected of having a mental disorder. Treatment is continued for these cases only upon reassessment and determination by the treatment review committee that the significant or life threatening disability/dysfunctional continues or regularly recurs.

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To receive mental health services in Ad/Seg., inmate/patient must meet the above overall treatment criteria A or B.

E. REFERRAL

There are five sources of referral for Ad/Seg MHS, as noted below:

1. *Current MHSDS treatment cases:* All inmates placed into Ad/Seg shall be reviewed for initial identification of current MHSDS treatment status by the time of the initial 114d review (on the first work day following an inmate's placement). Current MHSDS treatment inmates are identified accomplished by checking the Ad/Seg placements reported on the Institutional Daily Movement Sheet with the treatment identifier code in the Distributed Data Processing System (DDPS) or other institutional automated tracking system for inmate treatment cases. During the initial review, mental health staff will ensure the continuity of mental health care, including prescribed medications. Upon inmate's placement into Ad/Seg, the MTA shall transfer the inmate's Medication Administration Record to Ad/Seg, consistent with the post orders.
2. *Staff referral:* Any staff member who observes possible signs or symptoms of a serious mental disorder may refer an inmate for clinical evaluation by completing a Mental Health Services 128B Staff Referral Chrono and forwarding it to mental health staff. Any inmate who is observed to be a suicide risk or in any other condition that requires crisis care shall be immediately referred to mental health staff. Such referrals shall be hand delivered to mental health staff for expeditious review.
3. *Self referral:* Inmates in Ad/Seg may request a clinical interview to discuss mental health needs. These requests shall be made on a Request for Interview form and forwarded to mental health staff on the following working day. These requests shall be reviewed by clinical staff daily, with a determination made as to the need for immediate response. If clinically determined as needing immediate attention, an evaluation shall be initiated by the next working day following the receipt of referral. All such requests shall receive a response in writing or by direct clinical contact. In no case shall this response be completed in excess of one week from date of receipt of request.
4. *Clinical rounds:* A mental health staff member, usually a Psychiatric Technician, shall conduct rounds a minimum of five days per week in all Ad/Seg housing units to attend to the mental health needs of all inmates. Those not previously identified as having mental health treatment needs who exhibit possible signs and symptoms of serious mental disorders shall receive a follow-up clinical evaluation.
5. *Screening Questionnaire:* All inmates who are retained in Ad/Seg after Institutional Classification Committee (ICC) review who have received no mental health referral to that time shall receive a mental health screening interview, utilizing the mental health

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screening questionnaire that is currently used in the Reception Centers. The interview shall be conducted by a mental health clinician or trained support staff. The results of the questionnaire shall be evaluated either by hand-scoring or on an approved automated scoring system to determine the need for further evaluation. Inmates who have been cleared by a previous screening questionnaire at a Reception Center within the previous year shall not require a subsequent clearance.

All clinical referrals and results of evaluations shall be recorded in individual inmate health records on approved forms, and entered into the institutional management information system. Results of positive screening questionnaires processed at different institutions shall be telephonically communicated to referring staff on the same day. Decisions to provide treatment via placement into an outpatient program or Crisis Beds shall be documented into DDPS.

F. CLINICAL EVALUATION

Referrals from any of the above sources will be reviewed by the Chief Psychiatrist, or in institutions without such a position, the Health Care Manager or designee, by the next working day. He/she shall assign a clinician to conduct a clinical evaluation. These evaluations shall be scheduled and initiated in a timeframe clinically determined appropriate, and shall consist of the following:

1. A review of the health record and if necessary, the central file shall be completed and documented on approved forms as a part of the assessment process for all inmate referrals. Past treatment needs, medications, and program placements shall be noted.
2. An individual clinical interview shall be conducted to determine the nature of the problem, with a full mental status examination to be completed where signs and symptoms of a possible serious mental disorder are identified. This examination shall be documented on approved departmental forms, and placed into the Unit Health Record for subsequent review.
3. Where necessary (as determined by the evaluating clinician in consultation with the Chief Psychiatrist), psychological and neuropsychological testing shall be conducted as a part of the diagnostic assessment of all cases not previously identified as having mental health treatment needs (testing is discretionary for inmates currently receiving care who have not previously undergone such testing). This testing may include the following:
 - Hare Psychopathy Checklist - Revised
 - Minnesota Multi-phasic Inventory Scale-2
 - Malingering Scale
 - Intelligence Screen
 - Neuropsychological screening (where possible neurological problems are noted)

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4. All assessments shall conclude with a clinical diagnosis and, where a DSM IV Axis I condition is determined to be present, a level of functioning (Axis V) evaluation shall also be completed and documented for the Unit Health Record.
5. Inmates who are identified as a result of the above process as meeting the clinical criteria for the inmate treatment population shall also receive an evaluation by a psychiatrist for possible medication needs and other interventions as deemed appropriate (including placement into a Crisis Bed for initiation of involuntary medication).

G. INPATIENT PLACEMENT

Inmates who are determined to meet the clinical criteria for referral to the MHCB for inpatient care shall immediately be transferred for such treatment, upon authorization by the Chief Psychiatrist of the sending institution. If an Ad/Seg inmate/patient in MHCB is determined to meet the clinical criteria for referral to California Medical Facility (CMF)/Department of Mental Health (DMH), the Chief Psychiatrist of the sending institution shall contact the Clinical Assessment Team for the CMF/DMH program for approval.

H. CORRECTIONAL CLINICAL CASE MANAGEMENT SYSTEM (CCCMS) CARE

Inmates who are determined to meet the clinical criteria for treatment at the CCCMS level of care (see CCCMS Program Guide) shall be referred to the institutional IDTT for assignment of a clinical case manager and development of an interim treatment plan pending release from Ad/Seg. The IDTT shall include the inmate's Correctional Counselor, who shall present circumstances of the Ad/Seg placement for consideration in development of the treatment plan and initiation of an aftercare plan.

The treatment intervention shall meet the guidelines set forth in the CCCMS Program Guide, and may include the following:

- Regular (at least five days per week) monitoring of symptoms by clinical staff
- Individualized therapy by clinical staff
- Medication treatment and monitoring of compliance
- When necessary, supportive care for Activities of Daily Living

At the conclusion of proceedings leading to the Ad/Seg placement, the clinical case manager shall prepare a clinical summary for the purpose of IDTT review and determination regarding subsequent treatment, including, where appropriate, placement into a Security Housing Unit (SHU) or Psychiatric Services Unit (PSU).

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I. ENHANCED OUTPATIENT PROGRAM (EOP) CARE

Inmates who are determined by the IDTT to meet the clinical criteria for treatment at the EOP level of care (see EOP Program Guide) shall be referred to the ICC for determination of placement. The Chief Psychiatrist, or in institutions without such a position, the Health Care Manager or designee, is a member of the ICC. In that capacity he/she shall present the IDTT's recommendation for the EOP level of care, and provide clinical input regarding credit assessment and custody level as well as mental health placement options based on the inmate's clinical needs. Placement options include:

1. Referral to a Level IV EOP for inmates who are involved in non-violent incidents and determined to not be a risk to others.
2. Referral to a PSU for interim placement of inmates who are pending the possible imposition of a SHU term (placement of these cases requires consultation with and acceptance by the Chief Psychiatrist at the PSU institution prior to ICC referral and Classification Staff Representative) endorsement).
3. Referral to the Psychiatric Management Unit at CMF
4. Retention in Ad/Seg for inmates who are involved in serious rule violations and whose propensity for threat to others and/or the security of the institution is so high that no other alternative placement is considered appropriate during the judicatory period. These inmates constitute exceptional cases for whom regular tracking and continued follow-up care by clinicians shall be provided, consistent with updated individualized treatment plan, including five days per week monitoring.

Once identified as requiring EOP level of care, an inmate shall be processed through investigations and disciplinary hearings on a priority basis. Where court proceedings are required, staff will make every effort to expediently support the Court's adjudicative process.

J. PLACEMENT REVIEW AND CLINICAL INPUT IN CLASSIFICATION COMMITTEE

1. All inmates within the Ad/Seg MHS treatment program shall appear before the IDTT at times indicated in their individual treatment plan. This period is not to exceed 90 days. The clinical case manager assigned to the case shall present a case summary with recommendations for continued treatment or discharge. Inmates should normally appear in person for these reviews. The results of the IDTT reviews and decisions shall be documented in both the central file and Unit Health Record, and a 128C noting the results forwarded to the Correctional Counselor for necessary classification actions. All placement options noted above for the assessment process are also available at the time of scheduled IDTT reviews.

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2. Chief Psychiatrist, or in institutions without such a position, the Health Care Manager or designee, shall attend the ICC to provide clinical input at the committee meeting. (See IX EOP care)

K. INTERDISCIPLINARY TREATMENT TEAM

1. The Ad/Seg MHS IDTT shall be chaired by the Chief Psychiatrist, or, in institutions without such a position, a mental health clinician designated by the Health Care Manager. At least one additional clinical member (normally the designated clinical case manager for the inmate under review) shall be required for decisions. Other regular participants in IDTT reviews shall include the unit Facility Captain, Supervising Correctional Counselor, unit Lieutenant, and mental health and custodial staff who have specific information relevant to cases under review. The IDTT reviews may include classification actions in the Department Operations Manual Section 62010.8.2 and California Code of Regulations Section 3375 if appropriate, when classification staff and necessary documentation are present.
2. All IDTT actions shall be documented within the individual inmate Unit Health Record on approved forms, and, where custodial issues are involved, on 128C Chronos for the central file.
3. The responsibility for overall treatment planning within the Ad/Seg MHS rests with the IDTT.
4. All IDTT sessions that involve a change in treatment plans should include the presence of the inmate under review. Inmate participation in the development and adjustment of treatment plans is essential.

L. CLINICAL CASE MANAGER

Each inmate within the treatment component of the Ad/Seg MHS shall be assigned a clinical case manager through the CCCMS program, normally a Psychiatric Social Worker or Psychologist. This individual shall maintain weekly clinical involvement with the inmate, as well as performing casework functions, including the following:

1. Documentation of initial and updates to the treatment plan.
2. Weekly monitoring of clinical symptoms.
3. Scheduling for periodic treatment team reviews.

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4. Response to inquiries regarding clinical status of the inmate.
5. Attendance at IDTT reviews of the inmate.
6. Individual psychotherapy as needed.
7. Crisis intervention and referral for inpatient care as needed.

M. UNIT HEALTH RECORD

1. A current record of all treatment plans and progress notes shall be maintained on departmentally approved forms within the individual Unit Health Record. Only designated staff shall have access to this record. This shall include all members of the IDTT.
2. There are many legitimate exceptions to confidentiality requirements (e.g., institutional security). However, every member of the Ad/Seg MHS, including correctional staff, shall treat all clinical information with professional discretion. No information shall be divulged without clinical or correctional necessity.

O. CUSTODIAL OPERATIONS

Inmates within the Ad/Seg MHS are subject to all rules, custodial requirements, activities, and privileges of other Ad/Seg inmates.

P. PHYSICAL PLANT

Where available, screening and evaluation interviews and treatment activities are accomplished in existing interview rooms and exercise areas within current Ad/Seg units. The IDTT interviews may require inmate escorts to classification rooms. Privacy of individual interviews is clinically determined, consistent with the security of the institution and the safety of staff members. Cell recreational activities are emphasized. Clinical monitoring and routine interviews may be provided through cell-front contacts as clinically appropriate.

DUTY STATEMENT

PSYCHIATRIC TECHNICIAN, ADMINISTRATIVE SEGREGATION

Description: Under the direct supervision of the Supervising Senior Psychologist and clinical supervision of the Director of Nursing, the Administrative Segregation Psychiatric Technician is responsible for providing assistance to inmates in Administrative Segregation with mental health needs. This is the primary staff person responsible for timely identification of current Mental Health Services Delivery System inmates, monitoring all inmates placed in Ad/SEG, for need for treatment, and implementing the assigned treatment plan adopted by the Interdisciplinary Treatment Team (IDTT) for the inmates' care. Normal activities include making daily clinical rounds, participating in the IDTT, assisting inmates in Activities of Daily Living, supervising Recreational Therapy, administering mental health screening questionnaires, coordinating treatment activities with custody and clinical staff, and distribution of prescribed medications. Close contact will be maintained with the Clinical Case Manager in charge of the treatment delivery and tracking of all inmates with identified serious mental disorders. Specific duties include:

- 20% Administering Mental Health Screening Questionnaire to inmates retained in Administrative Segregation beyond ten days
- 15% Supervision of Activities of Daily Living and Recreational Therapy for inmates with identified mental health treatment needs
- 25% Conducting daily clinical rounds and monitoring of all inmates in Administrative Segregation for signs and symptoms of mental illness
- 10% Distribution of prescribed psychotropic medications to inmates in Administrative Segregation
- 10% Participation in Interdisciplinary Treatment Team reviews
- 10% Liaison activities with Custody personnel in management of seriously mentally disordered inmates in Administrative Segregation
- 5% Professional development, including participation in professional training and conferences, upgrading of automation skills, etc.
- 5% Other Duties as Required

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SECTION 9: SECURITY HOUSING UNIT

A. POLICY

It is the policy of the Department of Corrections (CDC) to provide inmates in a prison setting prompt access to mental health services, regardless of their housing designation. Mental health services in a Security Housing Unit (SHU) is part of the CDC's Mental Health Services Delivery System (MHSDS) and is specifically geared to achieving symptom maintenance through regular case management activities, medication administration and monitoring, and referrals to higher level of care as needed.

B. PURPOSE

This program guide outlines program policies and provides institutional operational procedures to assure the effective delivery of mental health services to inmates with serious mental disorders who, for custodial reasons, require housing in SHU, according to California Code of Regulations Title 15, Section 3341.5.

C. RESPONSIBILITY

1. Overall institutional responsibility for the program shall rest jointly with the Health Care Manager and the Warden.
2. Institutional operational oversight of the Mental Health Services in SHU shall be the responsibility of the Chief Psychiatrist, at institutions with such positions, and mental health clinical staff designated by the Health Care Manager (HCM) at all others.
3. Custodial responsibilities, including initial placement, correctional counseling services, classification, inmate movement, and daily management shall rest with the Warden or designee.
4. Clinical case management, including treatment planning and placement recommendations, shall be performed by assigned Clinical Case Manager (CCM) and approved by the institution Interdisciplinary Treatment Team (IDTT), consisting of, at a

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minimum, the assigned CCM, Chief Psychiatrist (or highest ranking mental health clinician), and Correctional Counselor.

D. PROGRAM GOALS AND OBJECTIVES

The goal of the mental health services in SHU is to enable inmates with serious mental disorders to adequately function in SHU. Inmates with exceptional clinical needs shall be referred to the Institution Classification Committee (ICC) for consideration of alternative treatment programs. The program objectives are to provide:

1. Regular case management activities and medication monitoring, consistent with the MHSDS Correctional Clinical Case Management System (CCCMS) Program Guide to enable inmates to maintain current level of functioning and avoid decompensation.
2. Inmates whose mental health needs cannot be met in SHU shall be referred for alternative treatment programs by mental health clinicians.

Final clinical placement decisions are made in ICC meetings as a joint effort between the clinical and custody staff, after considering all relevant clinical and custody factors, consistent with Department Operational Manual Section 62050.13.23 ICC/Suspension of SHU terms).

E. SOURCES OF REFERRAL FOR MENTAL HEALTH SERVICES

1. Current MHSDS treatment cases: Current MHSDS treatment inmates are identified by checking the SHU placements reported on the Institutional Daily Movement Sheet by the Case Managers who will continue to provide services to ensure the continuity of mental health care, including prescribed medications.
2. Staff referral: Any staff member who observes possible signs or symptoms of a serious mental disorder may refer an inmate for evaluation, following the established referral procedure.
3. Self referral: Inmates in SHU may request an evaluation by the clinical staff, by completing a Request for Interview form.

Both staff and self referrals shall be hand delivered to mental health staff within one working day for expeditious review. Evaluation shall be initiated in a timeframe clinically determined appropriate.

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F. PLACEMENT REVIEW AND CLINICAL INPUT IN INSTITUTIONAL CLASSIFICATION COMMITTEES

The appropriateness of inmates placement in SHU shall be reviewed in regularly scheduled ICC meetings. The Chief Psychiatrist, or, in institutions without such a position, the HCM or designee, is a member of the ICC. In that capacity, he/she shall present the IDTT's recommendations regarding placement recommendations, based on the inmate's clinical needs.

All identified CCCMS inmates in SHU shall receive continued mental health services provided by the assigned CCM. An exception to this policy will occur at Pelican Bay State Prison (PBSP) when an inmate meets the Madrid exclusionary criteria.

An inmate whose clinical needs cannot be met through regular case management activities shall be referred to ICC for consideration of alternative clinical placement. Upon approval by the Chief Psychiatrist, or in institutions without such a position, the HCM or designee, the CCM shall initiate such referrals, based on the direct observation and assessment.

The ICC shall review all referrals for alternative placement and may recommend one of the following placement options, based on the clinician input and Correctional counselor review of case factors:

1. Transfer to the Mental Health Crisis Beds (MHCB) program. This option is for inmates who require 24-hour crisis care and requires no ICC review.
2. Transfer to California Medical Facility (CMF)/Department of Mental Health (DMH) program. This option is for inmates who meet the clinical criteria for referral to CMF/DMH.
3. Transfer to the Psychiatric Services Unit at PBSP. This option is for male inmates who meet the Madrid exclusionary criteria, requiring both maximum custodial controls and Enhanced Outpatient Program (EOP) level of care. Female inmates will continue to be treated in SHU, consistent with updated individualized treatment plans.
4. Suspension of SHU term and placement in the Level IV EOP: This option is for inmates who are determined by the ICC to no longer require the maximum custodial controls of SHU

G. CLINICAL CASE MANAGER (CCM)

The CCMs will continue to provide mental health services to inmates in their caseload after they are placed in SHU. CCMs will also provide mental health services to inmates who meet

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the clinical criteria of MHSDS, resulting from staff referrals or self referrals. Functions of the CCM may include the following:

1. Development and documentation of initial and updated treatment plan which also address security concerns and status.
2. Weekly monitoring.
3. Participation in IDTT and provision of clinical input for ICC.
4. Crisis intervention and referral for a higher level of care as needed.
5. Liaison with custody and correctional counseling staff regarding overall management of inmates.

H. UNIT HEALTH RECORD

A current record of all treatment plans and progress notes shall be maintained on departmentally approved forms within the inmate Unit Health Record. Only designated staff shall have access to this record. All staff shall adhere to the confidentiality requirements. No information shall be divulged without clinical or correctional necessity.

I. CUSTODIAL OPERATIONS

Inmates with a serious mental disorder within the SHU are subject to all rules, custodial requirements, activities, and privileges of other SHU inmates.

J. PHYSICAL PLANT

Where available, treatment activities shall be provided in existing interview rooms and exercise areas within current units to maximize the inmate confidentiality and privacy, consistent with the security of the institution and safety of staff members. Cell recreational activities are emphasized. Clinical monitoring and routine interviews may be provided through cell-front contacts, as clinically appropriate.