



TO: Patients' Rights Advocates
FROM: Daniel Brzovic, Associate Managing Attorney
RE: County Jails: Mental Health Services
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I. INTRODUCTION

County jails are required to make mental health services available to all inmates who need the services. The standards of medical care in the community determine the scope and quality of services to be provided. In other words, all medically necessary services must be available to county jail inmates.

County Patient's Rights Advocates have a right of access to county jail inmates, inmate records, jail facilities, and jail employees providing diagnostic and treatment services. Welfare & Institution Code §5500, et seq.

Regulations governing county jails are found at Title 15 of the California Code of Regulations, Subchapter 4, "Minimum Standards for Local Detention Facilities," beginning at §1004. A state agency, the California Board of Corrections (BOC) oversees compliance with the regulations. The Board of Corrections is responsible for inspecting each county jail once every two years in order to ensure compliance with the Title 15 regulations.

Specific regulations relating to mental health services and treatment in jails are found at Title 15, Article 10, "Medical and Mental Health Services," beginning at §1200, and Article 5, "Classification and Segregation," beginning at §1050. Other general sections of the regulations may also be applicable to mental health services, and will be discussed in this memo.

The California Board of Corrections has published interpretive guidelines for the regulations. The regulations as well as the interpretive guidelines can be found on the Internet at <http://www.bdcorr.ca.gov/regulations/regulations.htm>. (or, from the California Board of Corrections website, click on "Regulations," then click on "Title 15 C.C.R. – Adult Facilities Operations.")

The regulations have the force of law. The interpretive guidelines do not. Nevertheless, the interpretive guidelines are helpful in determining what the regulations mean, and they will be discussed in this memo. They can be useful in advocating for county jail inmates because they contain information on how the Board of Corrections is likely to interpret and apply the regulations to local county jails.

All citations in this memo are to Title 15 of the California Code of Regulations, and the California Board of Corrections guidelines to those regulations, unless otherwise indicated.

II. COUNTY PATIENT'S RIGHTS ADVOCATE ACCESS TO COUNTY JAILS

A. Access To PRA clients and other jail inmates

Welfare and Institutions Code section 5530(a) provides that county patients' rights advocates (PRAs) shall have access to “all clients and other recipients of mental health services” in any mental health facility, program, or service at all times as are necessary to investigate or resolve specific complaints....” As discussed in the next section, this includes county jails.

County jails fall within the definition of “mental health facility, program, or service,” because county jails provide services to mental health clients. Welf. & Inst. Code § 5500(c). The services provided by the jail may or may not be mental health services. The important factors here are that the jail provides services of some type, and provides them to mental health clients.

A “mental health client” is a person who is receiving or has received services from a mental health facility, service or program, and who has personally, or through a guardian ad litem, entered into an agreement with a PRA for the provision of advocacy services. Welf. and Inst. Code § 5500(b). The statute does not limit the services received to mental health services: it refers to the receipt of any services from the facility, service or program.

A client is presumed competent to enter into an agreement for advocacy services with a PRA unless the Superior Court has specifically found the client to be incompetent to enter into the agreement. Welf. and Inst. Code § 5523(a). In that case, the Superior Court must appoint a guardian ad litem for the purpose of entering into the agreement.

In any event, PRAs have access to all recipients of mental health services, whether or not the recipient is a client of the PRA or the PRA program. Welf. and Inst. Code §5530(a). This includes county jail inmates who are not clients of the PRA but who have received mental health services, either inside of or outside of the jail.

PRAs have access to clients and other recipients of mental health services at all times as are necessary to investigate or resolve

specific complaints. Welf. and Inst. Code § 5530(a). Access is not limited to normal working hours and visiting hours.

B. Access to Jail Facilities

PRA's have access to jail facilities pursuant to Welfare and Institutions Code section 5530(a) which provides for PRA access to mental health facilities, programs, services, and recipients of services.

Welfare and Institutions Code section 5500(c) defines "mental health facilities, services or programs" to include "any publicly operated or supported mental health facility or program...and publicly supported agencies providing *other than* mental health services to mentally disabled clients." This definition clearly includes county jails because county jails are publicly operated or supported agencies which not only provide mental health services but also provide other services. Jails are included because jail inmates with mental health diagnoses fall within the definition of mentally disabled clients whether or not the jail provides the inmate with mental health services. Welf. & Inst. Code § 5500(b).

There is no California case which specifically holds that this section of the Welfare and Institutions Code applies to county jails. However, the United States Supreme Court has held that a statute with similar language, the Americans With Disabilities Act, applies to state prisons, because prisons provide "services, programs or activities" within the meaning of the ADA. The involuntary nature of incarceration does not affect the coverage of the ADA and the "services, programs or activities" do not need to be disability related. *See Yeskey vs. Pennsylvania Department of Corrections*, 524 US 206 (1998). By the same reasoning, a county jail is covered under section 5500(c) of the Welfare and Institutions Code because the jail provides services.

PRA's have access to the jail facilities, programs and services during normal working hours and visiting hours. Welf. and Inst. Code § 5530(a). As discussed in paragraph A above, access to clients and other recipients of mental health services for the purpose of investigating or resolving specific complaints is not limited to normal working hours and visiting hours.

C. Access to Persons Providing Diagnostic or Treatments Services

Welfare and Institutions Code section 5530(b) provides that PRAs have the right to interview all persons providing the client with diagnostic or treatment services. This section is not limited to employees or independent contractors at a mental health facility, program, or service. It applies to any person who has provided diagnosis and treatment to a jail inmate whether or not the person is a jail employee or independent contractor.

D. Access to Records

PRAs have the right to inspect and/or copy any non-confidential records of any county jail relating to an investigation on behalf of a PRA client, or which indicates compliance or lack of compliance with laws and regulations governing patients' rights. Welf. and Inst. Code §5542. In addition, PRAs have the right to inspect and copy confidential client information and records when specifically authorized by the client or a guardian ad litem. Welf. and Inst. Code §5541(b). The authorization must be in writing. Welf. and Inst. Code §5541(a).

PRAs may also obtain access to otherwise confidential records of non-clients for purposes of monitoring to ensure compliance with patient's rights laws and regulations. Welf. and Inst. Code §5520(b), §5545. No written release is required. Welf. and Inst. Code §5545.

E. Remedies for Denial of Access

If a PRA is denied access to clients, other recipients of mental health services, or a facility, program or service including a county jail, the PRA may file a petition for access with the Superior Court. Welf. and Inst. Code §5530(a). The court must set the petition for hearing within two judicial days of the filing of the petition. Welf. and Inst. Code §5530(a). The petition should be filed in the county where the facility is located. Welf. and Inst. Code §5530(a).

Welf. and Inst. Code §5550(b) provides that no person shall knowingly obstruct any county patients' rights advocate in the performance of duties including access to clients or potential clients, or to records. A person or facility which violates that section is liable for a civil penalty of not less \$100.00 or more than \$1,000.00 which shall

be deposited in the county general fund. Welf. and Inst. Code §5550(e).

III. INMATE HOUSING/CLASSIFICATION/SEGREGATION/RESTRAINT

A. Section 1050. Inmate Classification.

The county jail must have a written plan to properly assign inmates to housing units and activities according to categories which include physical and mental health needs. Cal. Code Regs. tit. 15 §1050(a).

County Jails are no longer required to segregate people with mental health needs. Segregation will depend on factors including protection of the health and safety of the inmate and others. Board of Corrections Guidelines interpreting §1050 explain the requirements as follows:

The classification systems should separate the sophisticated from the uninitiated, the violent from the non-violent, and the passive from the aggressive inmates. In addition, the classification system should: assist in identifying security risks; addressing any special physical or mental health needs; safeguard those requiring protective custody and those who may become victims to assertive and assaultive inmates and identify those eligible for facility programs.

Persons with physical disabilities and medical and mental health needs do not necessarily require separation from other inmates. An individualized approach should be taken to accommodate inmates with disabilities, allow for access to medical and mental health clinicians, and address considerations that may affect their safe housing with other inmates. Custody staff should use the inmate's behavior, rather than diagnostic labels or vague concerns as the basis for classification decision-making. There is a wide range of factors to take into account. Classification staff should work closely with health care personnel to establish routine sharing of relevant and available information.

B. Section 1520. Minors in Jails.

There are many issues relating to minors in jails. This memo can only cover a few. The main one is that, in most cases, no contact

between minors and adult prisoners shall be allowed. Section 1521. Welf. and Inst. Code §§ 208. In addition, minors must be provided an education, including special education, if needed. Section 1520.

C. Section 1052. Identification and Evaluation of Mentally Disordered Inmates

The jail must have written policies and procedures which provide for the identification and evaluation of all mentally disordered inmates. The regulation provides for segregation “if necessary to protect the safety of the inmate or others.” A physician’s opinion must be obtained within 24 hours of the identification of an inmate as mentally disordered.

The purpose of the regulation is to identify inmates who meet Lanterman-Petris-Short Act (LPS) criteria of danger to self or others, or grave disability, and to provide transfer, if clinically indicated, to an appropriate mental health treatment facility.

The Title 15 guidelines explain the purpose of the regulations as follows:

Despite this regulation, [i.e. the jail must make every effort to transfer mentally disordered inmates to appropriate treatment facilities and should document its efforts] many mentally ill people remain in jails, often because of the unavailability of an appropriately secure treatment facility in the community. When there are not alternative options and the inmate stays in custody, the facility manager needs to have screening and classification systems that identify them and protect them from abuse in the general population or injuring themselves or others. It is not always necessary to transfer a mentally disordered inmate for evaluation or treatment. If properly trained mental health staff can come to the jail to evaluate an inmate and can establish an effective outpatient treatment plan that does not require admission to a psychiatric facility, the inmate can then appropriately remain [in] the custody setting.

The segregation of mentally disordered inmates should be based on behavioral factors, not solely on the existence of a psychiatric diagnosis. Not all inmates suffering from a mental disability need to be in special, protected housing. Inmates with mental disorders vary greatly in their capacity to protect themselves. However, those who lack the ability to protect

themselves are subject to becoming victims and need to be in special housing that provides a sheltered living environment. Not all mentally disordered inmates are a danger to themselves or others. The standard discriminates between those who appear violent and those who appear to be gravely disabled; the latter being people who lack the ability to provide clothing, food and shelter for themselves and, in the jail context, may be unable to take advantage of those items as provided.

D. Section 1053. Administrative Segregation (Solitary Confinement)

Administrative segregation can be used for inmates who are “prone to: escape, assault staff or other inmates, disrupt the operations of the jail, or likely to need protection from other inmates...” Administrative segregation consists of separate and secure housing only, but shall not involve any other deprivation of privileges other than what is necessary to obtain the objective of protecting the inmates and staff.

Board of Corrections guidelines make it clear that administrative segregation must be reviewed regularly to determine continuing need, and privileges can be restricted only to the extent necessary considering the need for segregation, the limits of the facility, and the reasons for placement in administrative segregation. Continuing need must be based on the reasons for placement in administrative segregation. Administrative segregation cannot be used for punishment, and it cannot be used in an arbitrary manner.

Before an inmate can be placed in administrative segregation, some due process is required which includes, at a minimum, allowing the inmate to tell the inmate’s side of the story, and allowing an inmate to file a grievance. *See* §1073.

E. Section 1055. Safety Cell

The safety cell may be used only for inmates who display behavior which “results in the destruction of property or reveals an intent to cause physical harm to self or others.” The safety cell cannot be used as a substitute for treatment, and cannot be used for punishment.

The jail must have written standards requiring the following five inmate checks:

1. **Direct visual observation at least twice in every 30 minute period.** Direct visual observation shall be documented.
2. **Review** for continued detention **at least every 8 hours.**
3. A **medical assessment within 12 hours** of placement in the safety cell to determine if there are serious medical conditions which are being masked by the aggressive behavior.
4. **Medical clearance** for detention **at least every 24 hours** after the initial medical assessment.
5. A **mental health evaluation within 24 hours** of placement in the safety cell to determine the inmate's need for mental health services and suitability for detention in the safety cell.

The purpose of the inmate checks is to provide for removal from the safety cell as soon as it is safe to do so.

According to the guidelines, it is not acceptable to routinely deprive inmates in safety cells of all clothing. The complete removal of clothing must be individualized and based on clear justification that retention of the clothing represents a risk to the safety of the individual or the security of the facility.

F. Section 1056. Sobering Cell

The sobering cell is used only for inmates who are a threat to their own safety or the safety of others "due to their state of intoxication."

Inmates must be removed from the detoxification cell as soon as they are able to continue in the jail processing. The inmate must have a medical evaluation within 6 hours or be released from the cell. Intermittent direct visual examination must occur at least every half hour.

The sobering cell must not be used for inmates with life-threatening withdrawal symptoms, or for long-term detoxification. See § 1213 on detoxification treatment.

G. Section 1219. Suicide Prevention Program.

Every jail must have a written plan for suicide prevention. The plan must be designed to recognize, identify, monitor, intervene with

and provide treatment to those inmates who present a suicide risk. The program must operate in all detention areas of all facilities. According to the guidelines, continued observation and awareness of potentially suicidal behavior is an added key to prevention.

The Board has identified a number of risk factors which should be considered. These are listed in the guidelines. Also: "What the individual says and how he or she behaves while being arrested, transported to the jail and/or booked are vital for detecting suicidal behavior."

Correctional staff must closely observe any inmate who reports or has a known history of suicide gestures until the inmate can be seen by mental health services staff.

The Board of Corrections requires training for all custody and health care staff in suicide prevention and crisis intervention. *See* §1020, §1021, §1023, and §1024.

H. Section 1058. Use of Physical Restraint Devices

There must be written policies and procedures for the use of physical restraint devices.

Physical restraint "should be utilized only when it appears less restrictive alternatives would be ineffective in controlling the disordered behavior." Restraints may not be used for discipline or as a substitute for treatment. Inmates shall be placed in restraint only with the approval of the facility manager, the watch commander, or a designated physician.

There are five kinds of checks which must be accomplished whenever an inmate is held in restraints:

1. Direct visual observation at least twice in every 30 minutes.
2. **Review** for continued retention in restraints **a minimum of every 2 hours**.
3. A **medical assessment**, as soon as possible, but **within 4 hours** of placement in restraints, to determine whether the inmate has a serious medical condition which is being masked by the aggressive behavior. Inmates should not be restrained in facilities where a medical assessment cannot be accomplished within four hours.

4. **Medical clearance every 6 hours** thereafter to determine the appropriateness of continuing restraints.
5. **Evaluation by a mental health professional**, as soon as possible, but **within 8 hours** of placement in restraints, to assess whether or not the inmate needs immediate and/or long term mental health treatment.

All checks must be documented.

IV. MEDICATION

This section on medication has been placed before the section on mental health services because failure to provide prescribed medication to a county jail inmate often raises immediate concerns. Very often, no medication is provided to a new inmate because the jail does not have adequate medical records or information about the inmate's prescription. At other times, prescriptions are changed by jail treatment personnel without adequate medical justification. At other times, medications are not provided at the time called for by the prescription. Finally, medications may be provided which are medically contraindicated, or which the inmate does not want. Jails must have procedures in place to address all of these issues.

A. Section 1207. Medical Receiving Screening

Medical screening must be conducted for all new inmates at the time of intake. The screening must be performed by licensed health personnel or trained facility staff. It must include identification of mental health problems.

The screening must include a written plan to provide care for any inmate who requests or appears to be in need of medical, mental health or developmental disability treatment. Inmates must be notified of the availability of jail mental health services at the time of inmate orientation. See §1069.

Board of Corrections guidelines emphasize that:

A well-developed medical screening process can improve continuity of care for newly received inmates. It is imperative to have procedures for the timely continuation of essential prescription medications. Examples of critical medications include: antibiotics; oral contraceptives; psychotropic drugs; and medications for chronic medical conditions such as diabetes,

high blood pressure, asthma, AIDS and heart failure. In some instances, even brief lapses in therapy can result in destabilization of inmate, treatment failure or development of resistant strains of infections.

There are several variables that may impact the ability to respond appropriately to an inmate's need for medications. If the inmate does not provide accurate or creditable information at the time of screening, delays occur. Difficulties in verifying the prescription date or name and dosage of medication may also preclude the immediate continuation of treatment. Receiving screening procedures should result in evaluation of the information in a manner that permits resumption of therapy within a medically acceptable timeframe. Upon identification of a need, procedures must be implemented that take into account the clinical importance of the medication and an attempt must be made to conform to the required dosing intervals.

Discontinuation of pre-incarceration medications for arbitrary reasons or convenience of staff is not appropriate. Even though it may be reasonable for facility medical staff to change an inmate's medication regimen, such changes must be based on an individualized evaluation and be clinically justifiable. Even in cases where an inmate has been receiving inappropriate prescriptions for narcotics, tranquilizers, or other addicting drugs, abrupt discontinuation of the medication could result in a hazardous withdrawal syndrome. An individualized evaluation and plan for detoxification is necessary in those instances.

As indicated by the above guidelines, it is very important to provide the jail with up-to-date medical information including name and telephone number of treating physician, prescription and pharmacy information, and up-to-date medical reports, if available. This puts the jail on notice of the necessity to provide medications, as prescribed, as quickly as possible.

B. Section 1216. Medication Transferred from other Detention Facilities

Board of Corrections guidelines provide:

It is appropriate to use medications transferred from other detention facilities if there is a secure method for ensuring that

individual inmate prescriptions are not tampered with between facilities and that containers are properly labeled.

This guideline enables a supply of medications to be transported with the inmate from another facility.

C. Section 1216. Medications Brought to the Jail by an Inmate or Others

The jail must have written policies and procedures for administration of medications. The Board of Corrections guidelines following this regulation describe the circumstances under which medications brought to the jail may be given to the inmate:

Medications brought by or with an inmate on admission to a facility are, generally speaking, not advisable to use but sometimes the best way to provide medication needed by an inmate and assure that continuity of care is maintained. Such medications should not be used unless the prescription is current (dated within the last two weeks or, for chronic medications, within the past three months) and the contents of the container(s) have been examined for positive identification and approved by the facility's responsible physician or designee. For security reasons, it is preferable that no medication from any source other than the facility or system is used; however, this is not always possible in smaller facilities. For larger systems, unusual medications not stocked in the facility pharmacy can be special ordered. Prescription medications brought by the inmate from outside should be recorded on the inmate property record and stored in a secure area until the inmate's release.

D. Section 1216. Dispensing of Medications

Dispensing of medications shall be done by a physician, pharmacist or person authorized by law. Administration of medication shall only be done by licensed health personnel who are authorized to administer medication acting on the order of a prescriber. Delivery of medication may be done by either licensed or non-licensed personnel, e.g. custody staff, acting on the order of a prescriber. Administration refers to giving a single dose of a prescribed drug from a bulk container of medication. Delivery refers to providing medication from a properly labeled prescription container. Psychotropic medications cannot be self-administered.

Board of Corrections guidelines make it clear that staff convenience, such as missing a pill call, does not justify refusing to provide proper dosages of medication as prescribed:

Given the realities of the custody setting, it is often difficult to provide medications on an ideal schedule. There are some medications that have to be given more frequently than others and some that have to be taken on an empty stomach. These and other issues mean health and custody staff must have written policy and procedures for melding jail operations and custody concerns with the medical and mental health needs of inmates. Inmate movement, court appearances and conflicting activities all interfere with scheduled "pill calls." Jails should consider methods for providing critical medications to those individuals who are attending court, working in areas not routinely accessible to medical staff, and those who are being transported elsewhere. It may be helpful for the prescribing physician to indicate in the medication orders how much leeway is reasonable and safe for a given medication and patient.

E. Section 1217. Psychotropic Medications.

Psychotropic medication is “any medication prescribed for the treatment of symptoms of psychoses and other mental and emotional disorders.” Board of Corrections guidelines make it clear that psychotropic medications include anti-psychotic medications as well as “any medication whose purpose is to have an effect on the central nervous system to impact behavior or psychiatric symptoms.”

Psychotropic medications may not be administered, except in an emergency, unless the inmate has given informed consent pursuant to Welfare & Institutions Code section 5326.2, or has been found to lack the capacity to give informed consent consistent with the county’s hearing procedures under the Lanterman-Petris-Short Act for handling capacity determinations and subsequent reviews.

Welfare and Institutions Code capacity hearing procedures apply to inmates in county jails who meet the LPS criteria. *See*, Welfare and Institutions Code sections 5332-5337, *Riese v. St. Mary's Hospital and Medical Center*, 209 Cal. App. 3d 1303, 271 Cal. Rptr. 199 (1987). State prison capacity hearing procedures under Penal Code section 2600 and *Keyhea v. Rushen*, 178 Cal. App. 3d 526, 223 Cal. Rptr. 746 (1986), do not apply to county jails. If an inmate does not

meet LPS criteria, no psychotropic medication can be given at all in the absence of informed consent.

Board of Corrections guidelines for capacity hearings specify:

The approach to such a hearing should be equal to, or parallel, the capacity hearing procedures that are used by the county mental health department under the Lanterman-Petris-Short (LPS) Act. Although allowances can be made to accommodate legitimate security issues, the process should contain the essential elements which safeguard the inmate/patient's rights to due process. Some counties already have procedures which meet the requirements of *Riese v. St. Mary's Hospital* capacity hearings. If these procedures are not used, similar procedures established to meet the requirements of the LPS Act should be used. A determination that an inmate lacks capacity for providing informed consent must be formally reviewed at intervals consistent with requirements of the LPS Act and schedules already established by the county's mental health director for non-incarcerated patients. This prevents situations in which inmates could otherwise be indefinitely treated without consent even if the capacity for decision-making has been restored.

Due to the significance of these procedures, jail administrators should consult with their county counsel and work with their county mental health director in their development. The important components are those which assure that the inmate/patient has representation by a patients' rights advocate or attorney who is completely independent of the criminal justice system and that the hearing officer is similarly disinterested. Counties that do not have their own inpatient mental health facilities should establish procedures for referral to nearby treatment units and initiation of hearing procedures in the usual fashion associated with that unit.

Please note that both *Riese* and *Keyhea* require a judicial determination of incapacity. This requires at a minimum, a hearing officer who is appointed by the Superior Court. Welf. & Inst. Code § 5334(c). The jails cannot circumvent this requirement and, at the same time, have a hearing process which complies with LPS.

Board of Corrections guidelines provide that psychotropic medications should be provided in accordance with community standards. The Board of Corrections counsels that jails which provide involuntary treatment in unlicensed facilities must be prepared to justify their procedures as being comparable to those which would apply in the open community.

Jails are required to have a policy which limits the length of time that both voluntary and involuntary psychotropic medications may be administered. There must be a plan of monitoring and reevaluating all inmates receiving psychotropic medications, including a review of all emergency situations. The administration of psychotropic medication is not allowed for disciplinary reasons.

A complete copy of the psychotropic medication regulations and guidelines are attached as an appendix to this memo for your reference.

V. MENTAL HEALTH SERVICES

A. Section 209(a). Mental Health Services

Each jail must have policies and procedures to provide mental health services. These services shall include but not be limited to the following:

1. Screening for mental health problems,
2. Crisis intervention and management of acute psychiatric episodes,
3. Stabilization and treatment of mental disorders, and
4. Medication support services.

B. Section 1207. Initial Screening

As discussed in the previous section, all inmates must be screened at the time of intake. The screening must include medical, mental health issues, and developmental disabilities.

Following the screening, there must be a written plan to provide care for any inmate who appears at the screening to be in need of, or who requests, medical, mental health, or developmental disability treatment.

C. Section 1208. Access to Services

The jail must have a written plan for identifying, assessing, treating and/or referring any inmate who appears to be in need of medical, mental health or developmental disability treatment at any time during incarceration subsequent to the initial screening.

Board of Corrections guidelines provide that policies and procedures related to access to services should include, at a minimum:

1. A written procedure for 24-hour emergency access to medical, dental and mental health services personnel;
2. A written plan for non-emergency access to medical, dental and mental health services which permits inmates to refer themselves for preliminary evaluation and ensures that the inmates will be seen by a member of the health staff within a reasonable period of time;
3. A written procedure for timely referral by custody and/or health staff to mental health services for those inmates who exhibit signs of mental or emotional disorder and inmates who request evaluation;
4. A written method by which family or advocates for inmates may make requests for preliminary psychiatric evaluations, for medical attention or for evaluation by the Regional Center for Developmental Disabilities;
5. A written procedure for transportation or escort to ensure inmate access to health services; and
6. A written procedure for ensuring access to health care specialists including a description of the referral, transportation, treatment and follow-up processes.

In addition, section 1057 requires the facility to identify inmates with developmental disabilities, and to contact the Regional Center which is responsible for the inmate with the developmental disability. According to Board of Corrections guidelines, the jail should develop a working relationship with the Regional Center so that services can be provided by the Regional Center while the inmate is in custody, and after release.

D. Quality of Care

1. Section 1200. Responsibility for Health Care Services

The jail administrator must ensure the provision of emergency and basic health care services. Each facility must have at least one physician available to treat physical disorders.

The regulation does not specify how services are to be provided. Under the regulation, all health care can be provided in the facility, all health care can be provided outside of the facility by transporting inmates to doctors offices or hospitals, or something in between.

The facility must have a written plan which specifies how this will be done. Board of Corrections guidelines provide that the health care provided must be comparable to that which is in the community. This includes timely provision of service.

Under the regulations, each county jail must designate a “health authority” to be the individual responsible for health care services at the county jail. The health authority may, but need not be, a jail employee. Cal. Code Regs. tit. 15 §1006.

The rules and procedures which specify responsibility for health care services must be made available for public and inmate review pursuant to Section 1045.

2. Section 1203. Staff Qualifications.

Jail health care personnel are subject to the same licensing requirements as health care personnel in the community. For example, a physician treating jail inmates must be licensed to practice medicine in California.

3. Section 1204. Health Care Staff Procedure

Medical care performed by personnel other than a physician shall be performed pursuant to written protocol or order of the responsible physician.

In addition, Board of Corrections guidelines require that a clinical function or service which is delegated to health care staff other than a physician must be performed by staff operating within the scope of practice.

Inmates cannot provide health care services.

The use of prolonged physical restraints (§1058) is covered by this section.

4. Section 1210. Individualized Treatment Plans

Every inmate receiving mental health services must have a written treatment plan. The treatment plan shall include referral to treatment after release from the facility when recommended by treatment staff.

Board of Corrections guidelines provide as follows:

Individualized treatment plans should address not only a plan of care during incarceration, but should also anticipate where there is needed to facilitate a smooth transition back into the community after release. The process of making specific arrangements in advance of a scheduled release date might be termed “pre-release planning.” Possible considerations include provision for continuation of medications, special medical equipment, follow-up appointments, and even housing needs. Although it is not always possible or practical to accomplish this type of planning, it is the overall interest of both the inmate and the community to prevent unnecessary lapses in treatment after release. A related form of pre-release planning might include the provision of required health clearances for inmates being released to residential drug treatment programs.

E. Section 1211. Daily Sick Call

Each jail must have written policies and procedures for a daily sick call conducted for all inmates. If a facility does not have sick call, it must provide that any inmate requesting medical/mental health attention be given such attention.

According to Board of Corrections guidelines, sick call does not decide who needs medical attention, but to appropriately refer everyone making a request for medical or mental health attention.

If an inmate misses a regularly scheduled sick call, and requests health attention, there must be a provision for referring that individual to health services as soon as possible.

F. Section 1209(b). Transfer to Treatment Facilities

An inmate who meets LPS criteria shall be transferred to a designated treatment facility for diagnosis and treatment. Penal Code §4011.6 provides for involuntary transfer for observation and treatment. Penal Code §4011.8 provides for voluntary transfer for observation and treatment.

An inmate who meets criteria for LPS observation and treatment must be transferred to a designated facility unless the jail is a designated treatment facility.

Board of Corrections guidelines provide:

Dealing with seriously mentally disordered inmates is becoming an increasingly acute problem for facility administrators, as community resources disappear. The experience in many communities is that there are no suitable facilities to which inmates can be transferred, forcing decisions to enhance the quality of services provided in local detention facilities. Facility administrators are being asked to expand the mental health services available in jails even though the Board of Corrections, mental health personnel and facility administrators across the state agree that it is best to get seriously mentally disordered people out of jails. Administrators must work cooperatively with mental health officials and others in the community to improve mental health services outside the jail in lieu of using the jail as the mental health service provider of last resort.

If a jail is a designated LPS facility, or provides mental health level of care comparable to a community facility, it must have a Correctional Treatment Center license.

Private medical insurance may be available to pay for medical care for a patient who is transferred to a community facility. Medi-Cal is available to pay for medical care in a community facility if the inmate is placed on probation or is transferred pursuant to a medical probation court order. Cal. Code Regs. tit. 22 §50273(c)(1)(D) and (E), §50273(c)(4). Board of Corrections guidelines following section 1207 discuss these Medi-Cal rules.

G. Section 1214. Informed Consent

An inmate who has the capacity to do so must give informed consent to medical treatment, absent an emergency. If a patient does not have the capacity to give informed consent, Riese hearing procedures must be followed in order to establish lack of capacity.

A court order is necessary for treatment in other situations if an inmate lacks capacity to give informed consent.

Jails are also required to honor advance directives. Board of Corrections guidelines provide as follows:

Although the concept of advance directives is relatively straightforward, the custody setting poses special dilemmas with respect to their implementation. Concerns may be raised as to whether an inmate's state of mind is being influenced by the fact of being incarcerated. For this reason, advance directives created *prior* to incarceration may be less likely to reflect temporary negative factors influencing the judgment of the individual. For jail administrators, there are concerns over how to manage and report in-custody deaths that have been allowed to take a natural course. Additional questions arise about whether or not interventions should be made in the case of assault-related injuries or a suicide attempt involving an inmate who has requested non-intervention for a terminal medical condition. On the other hand, it is clearly established medical principle that health providers cannot render unwanted treatment.

VI. INMATE RIGHTS/DUE PROCESS

A. Section 1205. Confidentiality of Medical Records

Medical records must be kept confidential in the same way that non-jail medical records would be kept confidential.

B. Section 1045. Access to Records.

Each jail must have available for inspection the Board of Corrections Title 15 and Title 24 regulations. Each jail must also must have available for inspection rules and procedures relating to the public information plan (§1045), inmate programs and rights (§1061-1072), inmate grievances (§1073), inmate discipline (§1080-1083) and responsibility for health care services (§1200).

C. Other Inmate Rights

Section 1061 through section 1072 list inmate rights. These include the right to visitors, correspondence, library service including access to legal reference materials, exercise and recreation, books, newspapers and periodicals, access to telephones, access to the courts and counsel, voting, and religious observances.

Section 1069 provides that at inmate orientation, orientation must cover at least the following:

- 1 Correspondence, visiting, and telephone usage rules.
- 2 Rules and disciplinary procedures.
- 3 Inmate grievance procedures.
- 4 Programs and activities available and method of application.
- 5 Medical services.
- 6 Classification/housing assignments.
- 7 Court appearances where scheduled, if known.

D. Section 1073. Inmate Grievance Procedure

Each facility must have an inmate grievance procedure which includes:

- 1 A grievance form or instructions for registering a grievance.
- 2 Resolution of the grievance at the lowest appropriate staff level.
- 3 Appeal to the next level of review.
- 4 Written reasons for denial of grievance at each level of review which acts on the grievance.
- 5 Provision for response within a reasonable time limit.
- 6 Provision for resolving questions of jurisdiction within the facility.

VII. APPENDIX

1217. Psychotropic Medications.

The responsible physician, in cooperation with the facility administrator, shall develop written policies and procedures governing the use of psychotropic medications. An inmate found by a physician to be a danger to him/herself or others by reason of mental disorders may be involuntarily given psychotropic medication appropriate to the illness on an emergency basis. Psychotropic medication is any medication prescribed for the treatment of symptoms of psychoses and other mental and emotional disorders. An emergency is a situation in which action to impose treatment over the inmate's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate or others, and it is impracticable to first gain consent. It is not necessary for harm to take place or become unavoidable prior to treatment.

If psychotropic medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition. The medication shall be prescribed by a physician in written form in the inmate's record or by verbal order in dosage appropriate to the inmate's need. Verbal orders shall be entered in the inmate's record and signed by a physician within 72 hours. The responsible physician shall develop a protocol for the supervision and monitoring of inmates involuntarily receiving psychotropic medication.

Psychotropic medication shall not be administered to an inmate absent an emergency unless the inmate has given his or her informed consent in accordance with Welfare and Institutions Code Section 5326.2, or has been found to lack the capacity to give informed consent consistent with the county's hearing procedures under the Lanterman-Petris-Short Act for handling capacity determinations and subsequent reviews.

There shall be a policy which limits the length of time both voluntary and involuntary psychotropic medications may be administered and a plan of monitoring and re-evaluating all inmates receiving psychotropic medications, including a review of all emergency situations.

The administration of psychotropic medication is not allowed for disciplinary reasons.

Guideline: Please see **Section 1209, Transfer to a Treatment Facility** and **Section 1214, Informed Consent**, for a discussion of issues related to this

regulation. This regulation applies to any facility in which psychotropic medications are administered, but has particular significance for those that undertake treatment on an involuntary basis. Most commonly, this will be limited to Type II and III facilities, although some larger Type I facilities may also have the medical resources for such treatment. Aspects of the regulation relating to policies for voluntary administration of psychotropic medications also apply to Type IV facilities.

This regulation recognizes that a facility will be in a better position to defend practices that mirror those in the local community. In other words, unless specific law specifies otherwise, the same principles of medical practice and preserving patients' rights apply in jails. This means that psychotropic medications must be given with full understanding and consent of the patient (except in emergencies, as discussed below), and persons involved in making the diagnosis and treatment decisions must carefully adhere to the boundaries of their training and licensure.

In spite of obvious shortages of mental health treatment facilities in most communities, it is important that jails do not attempt to become unlicensed substitutes for such facilities merely because they are the "port of last resort." Persons with suspected severe mental disorders may actually be medically ill and at risk for deterioration and even death if not properly diagnosed. In addition, treatment with medications, particularly those that are given on an involuntary basis, can result in serious side effects that require close medical monitoring. Consequently, it is crucial that persons whose conditions cannot be readily diagnosed and brought under control be transferred promptly to a treatment facility that is equipped to meet these needs. While a few jails operate licensed mental health units, most find it necessary to refer to community based facilities. Jail administrators should bear in mind their option under **Penal Code Section 4011.6** to transfer a disordered inmate to a treatment unit for 72-hour treatment and evaluation pursuant to **Section 5150 of the Welfare and Institutions Code**. At a minimum, initiating a transfer under **Penal Code Section 4011.6** should result in an evaluation (which can be conducted at the jail) by the mental health director or designee. In addition, transfer for treatment on a voluntary basis is possible under **Penal Code Section 4011.8 (Section 1209, Mental Health Services and Transfer to a Treatment Facility)**.

The issue of involuntary treatment in jails is a source of controversy. Many facilities choose to prohibit involuntary treatment altogether. Others, by virtue of the prevalence of severe mental illness in their population, or because of large distances separating them from treatment facilities, find it necessary to make provisions for intervention at the jail site. Facilities which choose to undertake involuntary mental health treatment in the absence of operating a fully licensed

treatment program must be prepared to justify their procedures as being comparable to those which would apply in the open community.

The diagnosis of a mental disorder necessitating intervention should be made by a medical professional trained and licensed to perform such an evaluation. (In general, this would be a physician; under rare circumstances, it might be a registered nurse or physician's assistant with telephone communication with a physician who would later examine the patient to verify the diagnosis. It is not essential that the physician be a psychiatrist; however, the physician should be trained and competent in management of mental disorders.) The less that is known about an inmate's psychiatric and medical history, the more crucial is the immediate and hands-on involvement of a physician. Initiation of involuntary psychotropic medications without a physician first examining the inmate is strongly discouraged. Medications must not be utilized as a convenience, as that practice is hazardous from a medical point-of-view, particularly when undertaken in non-medical settings, and subject to considerable liability for detention administrators. Using sufficient, but the least restrictive option, is medically the safest approach and most defensible legally with respect to patients' civil liberties.

Under these regulations, involuntary treatment can be initiated only in the case of an emergency. "Emergency" is strictly limited to those circumstances in which the inmate's mental disorder is considered to pose imminent threat of harm to self or others: "a situation in which action to impose treatment over an inmate's objections is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate or others, and it is impractical to first gain consent. It is not necessary for harm to take place or become unavoidable prior to treatment." In such cases, the physician may proceed to medicate an inmate in order to avert that immediate threat.

Only that type and amount of medication necessary to deal with the emergency itself can be provided under emergency circumstances. If the emergency is not resolved with a single dose of medication, or if the patient does not then continue treatment on a voluntary basis, consideration should be given to prompt transfer of the inmate to a treatment facility. If the diagnosis is in doubt, physical restraint and rapid transfer is preferable to medicating involuntarily, since the effects of the medication may obscure a diagnosis when the inmate is ultimately evaluated. Repeated administration of involuntary medication ("perpetual emergencies") becomes increasingly difficult to justify from both a medical practice and a legal standpoint. Likewise, it is inappropriate to administer long-acting, injectable, anti-psychotic medications, which are designed for maintenance treatment, under emergency circumstances. Treating medical staff must document justification of the emergency in the medical record each and every time that it

occurs. It is clearly preferable that physicians write orders for medication after examining an inmate and prior to implementation of treatment; in extreme situations where that is not possible, the order may be issued verbally or by telephone but must be signed by the physician within 72 hours.

There must be procedures in place to require a formal review of each emergency in which medications are administered involuntarily. At a minimum, this review process should involve the county mental health director or designee, the treating physician, and a custody representative. The purpose of such a review is to assure that practices within the jail setting withstand the scrutiny of community practice standards. It also sends the important message that involuntary treatment is a serious intervention that should not be undertaken casually. The review process is an opportunity to discuss options for managing disordered behavior and to assure that less restrictive approaches are first utilized whenever possible.

If jail treatment staff believe that an inmate would benefit from treatment with psychotropic medications for a period of time beyond an immediate emergency, the inmate must either provide informed consent or a competency hearing must first be conducted. The approach to such a hearing should be equal to, or parallel, the capacity hearing procedures that are used by the county mental health department under the Lanterman-Petris-Short (LPS) Act. Although allowances can be made to accommodate legitimate security issues, the process should contain the essential elements to safeguard the inmate/patient's rights to due process. Some counties already have procedures that meet the requirements of **Riese v. St. Mary's Hospital** capacity hearings.¹ If these procedures are not used, similar procedures established to meet the requirements of the LPS Act should be used. A determination that an inmate lacks capacity for providing informed consent must be formally reviewed at intervals consistent with requirements of the LPS Act and schedules already established by the county's mental health director for non-incarcerated patients. This prevents situations in which inmates could otherwise be indefinitely treated without consent, even if the capacity for decision-making has been restored.

Due to the significance of these procedures, jail administrators should consult with their county counsel and work with their facility and county mental health director in their development. The important components are those which assure that the inmate/patient has representation by a patients' rights advocate or attorney who is completely independent of the criminal justice system and that the hearing

¹ Riese v. St. Mary's Hospital is case law which has defined requirements for competency hearings for hospitalized mental health patients in the community, now codified in the Welfare and Institutions Code, Section 5332, et seq.

officer is similarly disinterested. Counties that do not have their own inpatient mental health facilities should establish procedures for referral to nearby treatment units and initiation of hearing procedures in the usual fashion associated with that unit.

In contrast to existing law applying to involuntary administration of medication to mental health patients, this regulation uses a broader term that encompasses medications other than those solely defined as "anti-psychotic." The term "psychotropic medications" applies to any medication whose purpose is to have an effect on the central nervous system to impact behavior or psychiatric symptoms. Psychotropic medications include, but are not limited to, anti-psychotic, anti-depressant, lithium carbonate and anxiolytic drugs, as well as anti-convulsants or any other medication when used to treat psychiatric conditions. This definition acknowledges current trends in treatment, which include a wide array of medications utilized in treating mental disorders. According to these regulations, if a medication is being prescribed with the intent of modifying an inmate's behavior or psychiatric symptoms, it should be prescribed and monitored in the same manner that has elsewhere applied to anti-psychotic medications.

While all non-emergency medical care requires the understanding and agreement of the inmate, there is special emphasis on "informed consent" in the case of psychotropic medications. This has to do with several considerations including: (a) implications of a psychiatric diagnosis and treatment in an inmate's case, including ability to participate in their defense during criminal proceedings; (b) potential for behavior control (i.e., "medical restraint"); and (c) possibilities of serious side effects. Obtaining informed consent from the inmate is defined in the **Welfare and Institutions Code Section 5326.22** and requires that the prescribing physician discuss the following information: (1) the nature of the mental illness or behavior that is the reason the medication is being given or recommended; (2) the likelihood of improving or not improving without the medications; (3) reasonable alternative treatments available; (4) the name and type, frequency, amount, and method of administering the medications, and the probable length of time that the medication will be taken; and (5) anticipated or possible side-effects associated with the medication (**Section 1214 Informed Consent**). Although documenting this discussion in the medical record is minimally adequate, it is common practice (and sometimes required as a condition of funding by certain programs) to use a detailed consent form. In either case, the inmate's agreement with treatment must be clearly ascertained. Under no circumstances can psychotropic medications be used as a disciplinary tool or to control behavior that is not the result of a mental disorder.

2 This section applies to persons who are involuntarily detained for the purpose of mental health evaluation and treatment.

Good medical practice requires periodic monitoring for efficacy of treatment and identification of side effects. While this regulation imposes parameters describing the length of time involuntary psychotropic medications can be administered (i.e., immediate emergencies or as determined through a hearing process), this regulation also requires that there be policy which establishes the minimum time frames for re-evaluating inmates who are maintained on psychotropic medications voluntarily. This regulation does not seek to extend these time frames beyond those allowed in the community. At a minimum, it seeks to mimic those standards established for non-incarcerated mental health patients. The ordering of psychotropic medications "until release" is unacceptable. Because jail inmates tend to be inherently less stable than their counterparts in the free community, there is a strong argument to be made for monitoring their progress on a somewhat more frequent basis. Some facilities choose to limit voluntary psychotropic medication orders to 30 days or less, in contrast to a common community practice of 90 days. This approach serves to trigger a re-evaluation of the inmate in conjunction with renewal of the medication