Alameda County Behavioral Health Care Services
Adult Forensic Behavioral Health Program

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A). ACSO Inmate Rules and Information

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES

ADULT FORENSIC BEHAVIORAL HEALTH (AFBH)

Description: Adult Forensic Behavioral Health Services (AFBH) is a division of Alameda County Behavioral Health Care Services. AFBH is responsible for the provision of mental health services to inmates in the custody of the Alameda County Sheriff's Department. The goals are to alleviate psychiatric symptoms, promote recovery, and prevent relapse. AFBH staff collaborates and cooperate with the Sheriff's Department and California Forensic Medical Group to ensure communication and understanding regarding inmates' mental health needs. AFBH is under the general direction of the Director of Adult Forensic Behavioral Health Services. Senior mental health clinicians manage the daily operations of the program. The AFBH clinical staff consists of Behavioral Health Clinicians, Rehabilitation Counselors, Psychiatrists and Mental Health Specialists.

Services Provided:

I Mental Health Screening

1. **Initial (Intake):** At the time of booking in the ITR (Intake, Transfer and Release) section of Santa Rita Jail, all inmates are screened by **CALIFORNIA FORENSIC MEDICAL GROUP** medical screeners for medical and psychiatric treatment needs. The names of those inmates found to need further mental health triage / screening are forwarded on to AFBH at that time. AFBH ITR screeners may see the person while still in the booking section of the jail, or triage and assign a follow-up appointment in the clinic or inmate housing unit.

   Within 14 days California Forensic Medical Group conducts an additional mental health appraisal on all inmates as part of their History and Physical. Inmates found to need a further mental health evaluation are referred to AFBH mental health professionals who see them within 14 days of the California Forensic Medical Group referral.

   The AFBH ITR service is generally staffed seven days a week for sixteen hours each day.

   The screening assessment includes:

   - evaluation of the inmates' current psychiatric conditions and Mental Status Exam (MSE)
   - psychiatric history
   - psychiatric treatment history including hospitalizations and outpatient treatment
   - substance abuse (addictions) history and current use
   - psychiatric medication history and current need for medications
   - suicide assessment including history and current risk factors
   - assessment of intellectual functioning with attention to developmental disability
   - (females) assessment of post-partum depression and psychosis

- history of incarcerations, charges, and assessment of dangerousness
- history of head trauma or seizures
- emotional response to incarceration
- history of victimization: physical, sexual, emotional
- provisional diagnoses
- disposition: recommendations for treatment

(See copy of Initial Screening form)

2. **Post-booking:** AFBH clinicians triage and screen all inmates referred by housing unit deputies, California Forensic Medical Group nurses, other third parties, and self-referrals for mental health service needs using the Initial Screening form. Appropriate treatment plans are recommended based on the assessment.
   - AFBH provides services onsite in the special housing units and in the Administrative Segregation Housing Units (1, 2, 8, 9, and 24). These onsite services allow AFBH staff to proactively deliver mental health services to mentally ill inmates who might otherwise fall through the cracks. It also allows for identification and engagement of inmates who may not have been identified in booking as needing mental health attention.
   - Some inmates are also seen in the AFBH clinic for office appointments.

II Crisis Intervention:

1. **Onsite**: AFBH clinicians respond to urgent calls from deputies and nurses regarding seriously distressed inmates, and, where clinically indicated, provide crisis counseling, make recommendations for interventions, initiate interim Safety Cell placements, Inmate Observation Logs, Isolation cells, and/or make arrangements for psychiatric hospitalization for inmates who meet WIC 5150 criteria (danger to self, danger to others, or gravely disabled due to a mental disorder).
2. **On-call:** When there are no mental health staffs onsite, an AFBH clinician is on-call and can be reached by deputies and nurses by pager to assist with urgent mental health matters.

III Management of inmate behavioral problems:

1. AFBH clinicians collaborate with and provide consultation to deputies and California Forensic Medical Group staff in the development and implementation of plans for appropriate management of inmate behavioral problems.

IV Suicide Prevention:

AFBH participates with sheriff's personnel and California Forensic Medical Group medical staff in training, oversight, and procedures designed to prevent inmate suicides.

1. At the time of booking all inmates are assessed for suicide risk. Inmates seen subsequently by mental health professionals (AFBH) receive additional suicide risk assessments. (See initial screening form). In addition, AFBH conducts a suicide risk assessment on all inmates called to their attention by deputies and nurses as a result of inmates expressing suicidal thoughts or demonstrating self-injurious behaviors.
2. AFBH takes preventive action on all inmates expressing suicidal thoughts and/or demonstrating self-injurious behaviors.
    - AFBH staffs communicate with security personnel and recommend close observation of inmates who are at risk for suicidal behavior.
    - AFBH staffs provide crisis intervention counseling and initiate special housing precautions and observation including the use of interim Safety Cells, Inmate Observation Logs, or Isolation cells. AFBH must authorize the discontinuation of Safety Cell and IOL placements.
    - AFBH arranges for acute inpatient psychiatric hospitalization for inmates at high risk.
    - Special housing placements are monitored by AFBH clinicians and deputy staff.
3. When inmates return to jail from inpatient psychiatric hospitals, AFBH staff assesses them in the Outpatient Housing Unit (Infirmary) for mental stability before the inmate is housed.
4. Deputies and medical staff receive regular training in how to identify suicidal inmates and what actions to take.
5. A Suicide Prevention Committee consisting of managers from the Sheriff's Department, AFBH, and CALIFORNIA FORENSIC MEDICAL GROUP meet on a monthly basis to identify risk factors, make corrective changes, review suicide attempts and successful suicides; conduct and study research on inmate suicides; and share information with the goal of preventing inmate suicides.
6. In the event of an inmate suicide, AFBH conducts Critical Incident Stress Debriefing for inmates and personnel as needed.
7. AFBH staff work with inmates who demonstrate a risk for suicide and address risk factors, develop relapse prevention strategies including understanding warning signs (signs, symptoms, and triggers) for relapse and discuss coping strategies.

V Ongoing Treatment Services, Treatment Planning, Stabilization of Mental Disorders and Other Services: All inmates receiving mental health services are seen by AFBH clinicians who develop individualized treatment plans with the goal of assisting the inmates to achieve mental stability, develop an awareness of their psychological and behavioral problems, and acquire coping skills while incarcerated. Every effort is made to ensure that privacy of care is maintained. Clinicians develop treatment plans with short and long-term goals, identifying how these goals will be carried out. Peer review is conducted on a monthly basis. Clinicians present treatment cases for discussion and review. Inmate grievances

are reviewed by the senior clinician who responds to the complaint and takes appropriate corrective action where indicated. All grievances are logged and reviewed by the Director of AFBH.

1. **Medication Support Services:** When appropriate, inmates are evaluated by AFBH psychiatrists and prescribed psychotropic medications in order to alleviate symptoms and allow the inmates to achieve an optimal level of functioning while incarcerated. These services are provided in the AFBH clinic and on the housing units.
2. **Counseling services**: Inmates referred for counseling services receive an additional post-booking assessment in the mental health clinic or on the housing units (see assessment form) and are provided ongoing counseling sessions as determined by their treatment plan.
3. **Misdemeanant Incompetents:** Whenever possible, with regard to Misdemeanant Incompetent to Stand Trial (PC 1370.01) inmates, AFBH Staff collaborates with the courts to provide treatment geared to restoring Competence and/or refer inmates to community programs that can address Competency.
4. **Court-ordered Evaluations PC 4011.6s:** AFBH clinicians conduct court-ordered psychiatric evaluations (PC 4011.6s) to assess the need for acute inpatient psychiatric care and provide reports back to the courts. Care is taken to protect confidentiality as much as possible.
5. **Inpatient Services:** Inmates requiring acute inpatient hospitalization are sent by AFBH staff or deputies per WIC 5150 to acute psychiatric inpatient hospitals. When inmates are returned to the jail, they are held in the Outpatient Housing Unit (Infirmary) until AFBH clinicians can assess them, continue their medications, and clear them for housing
6. **Inmates who refuse treatment:** All treatment in the jail is voluntary. Inmates with serious mental illnesses who refuse treatment are monitored by AFBH staffs who make an ongoing attempt to engage them in treatment.
7. **Outreach and teamwork:** Dedicated AFBH staff (clinicians and **Psychiatrists**) work on Special Housing Units: Ad Seg, Mental, Women's. These staffs closely monitor inmates on these units. Visits occur several Times a week, including cell checks for inmates who refuse to be seen or who Are non-compliant with treatment. Staffs conduct cell checks and/or see Inmates outside their cells in the common area. This allows for team building With deputies and minimization of mentally ill inmates following through he Cracks.
    - AFBH clinicians collaborate with and provide consultation to deputies and medical nurses in the development and implementation of plans for appropriate management of inmate behavioral problems.
    - Treatment decisions are made by the mental health service provider and are not countermanded by non clinicians.
    - AFBH staffs participate in the classification process for persons with serious mental illnesses and developmental disabilities by making recommendations to the sheriff's classification unit for special housing

assignments. Only metnal health staff can remove these special classification designations.

- AFBH staff consult with sheriff's administrative staff with regard to housing, program assignment, disciplinary actions, and transfers of inmates with serious mental illnesses or developmental disabilities

7. **Substance abuse treatment:** Inmates have access within the jail to programs that specifically address addiction problems. AFBH clinicians also address substance abuse as part of their ongoing interventions with inmates. A focus on substance abuse recovery is integrated into mental health treatment services.

VI Mental Health On-call / Emergency Services;

1. Emergency mental health services are available 24hours a day by onsite staff or by mental health professionals who work on-call. When needed, access to 24 hour acute psychiatric hospitalization is available by means of the WIC 5150 process (involuntary hospitalization). .
2. When there are no mental health staffs onsite, an AFBH clinician is on-call and can be reached by deputies and nurses by pager to assist with urgent mental health matters
3. A AFBH psychiatrist is on-call to accommodate the continuity of psychotropic medications.

VII Discharge Planning / Continuity of Care

1. When AFBH staffs have advanced notice of an inmate's date of release, a referral for follow-up outpatient treatment is made to the Alameda County Behavioral Health Care Services ACCESS Program or to the inmate's previous community mental health services provider.

2. On a consistent basis, jail mental health staff advocate for the assignment of community case managers to persons with serious mental illnesses who are in need of comprehensive community care.

3. AFBH staff work closely with court mental health advocates CAP (Court Advocacy Project), the FACT (Forensic Assertive Community Treatment) team, the BHC (Behavioral Health Court), and community service providers in coordinating treatment plans and release plans for persons in custody with serious mental illnesses.

4. Discharge medications: For inmates who have received psychotropic medications while incarcerated, the AFBH clinician faxes the prescription to the inmate's local (county-pay) community pharmacy. In some cases, a ten-day supply of medications is provided directly to the inmate on release, or transported with the inmate to the designated post-release treatment program. .

5. Taxi vouchers are available for use in ensuring that mentally ill inmates arrive at their intended discharge locations.

VIII Training

1. The AFBH Director, the Senior Clinician(s), and other mental health professionals provide training to sheriff's personnel and civilian staffs in Mental Illnesses and Suicide Prevention on a regular basis.
2. On a daily basis, AFBH staff interacts with deputy staff and collaborate on the management of mentally ill and other inmates at risk.
3. All new AFBH staff receives 40 hours of initial training before assuming independent work assignments.
4. AFBH managers and psychiatrists provide ongoing training to AFBH line staff in topics related to the practice of jail psychiatric services.
5. AFBH schedules regular training for AFBH staff by outside trainers on a variety of topics related to jail and community mental health matters.
6. AFBH staff has access to trainings provided by the Behavioral Health Care Services (BHCS) agency.
7. The AFBH Lead Psychiatrist attends the monthly BHCS Psychiatric Practices Committee convened by the BHCS Medical Director's office. The Lead Psychiatrist shares information learned with other AFBH psychiatrists.

IX Administration of Psychotropic Medications to Patients in a Psychiatric Emergency

As defined in section 5008(m)* of the Welfare and Institutions code, psychiatrists can legally prescribe psychotropic medication for emergency situations for the preservation of life or the prevention of serious bodily harm to the patient or others. Existing policies and procedures for emergency administration if consistent with the following principles may be relied upon.

***WIC 5008(m) "Emergency" means a situation in which action to Impose treatment over the person's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient 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.**

5332(e) In the case of an emergency, as defined in subdivision (m) of Section 5008, a person detained pursuant to Section 5150, 5250, 5260, or 5270.15 may be treated with antipsychotic medication over his or her objection prior to a capacity hearing, but only with antipsychotic medication that is required to treat the emergency condition, which shall be provided in the manner least restrictive to the personal liberty of the patient. It is not necessary for harm to take place or become unavoidable prior to intervention.

1. Program Description, Rev. 3/2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B-2	**PAGES:** 1 of 7
	RELATED ORDERS: ACA 4-ALDF-4D-02, 4D-03, 4D-05, 4D-06, 4D-07, 4D-08, 4D-10, 4D-11, 4D-12, 4D-13, 4D-14, 4D-15, 4D-18, 4D-19, 4D-20, 4D-22, 4D-26, 4D-27, 4D-28	
	ISSUED DATE:	
	REVIEW DATE: March 3 2017	
	REVISION DATE: September 1, 2015	
CHAPTER: Mental Health Program	**SUBJECT:** **Health Services Staff – Mental Health Services**	

I. **POLICY:**

A. All inmates referred for mental health services are seen in a timely and professional manner by mental health professionals who have training in the provision of mental health care in a jail environment. All services are rendered in a respectful manner consistent with Behavioral Health Care Services' Mutual Respect Policy. All services address the mental health needs of individual inmates. The goal is to assist inmates in achieving and/or maintaining as much stabilization as possible during their incarcerations and to provide crisis intervention services to prevent self-harm.

B. CALIFORNIA FORENSIC MEDICAL GROUP staff conducts a mental health screen of all inmates during the booking/intake process and a mental health appraisal as part of the History and Physical within 14 days of admission. Subsequent mental health services at the Santa Rita Jail are provided by Adult Forensic Behavioral Health (AFBH), a division of Alameda County Behavioral Health Care Services (BHCS).

C. Inmates housed at the Glenn Dyer Detention Facility (GDDF) will be seen on site by a clinician and psychiatrist. There will be weekly coverage. or other facilities are transported to the Santa Rita Jail for mental health services.

D. Mental health, medical, and substance abuse services are coordinated such that inmate management is appropriately integrated, health needs are met, and the impact of any of these conditions on each other is adequately addressed.

E. Inmates receive mental health screening during the receiving/intake process and a more in-depth screening during the health assessment. Positive screenings are forwarded to AFBH for further evaluation, triage, and treatment within 48 hours of receiving the referral.

F. Adult Forensic Behavioral Health staff conducts assessments and triage; provides ongoing treatment as needed, medication management services, crisis intervention and discharge planning services. Adult Forensic Behavioral Health staff collaborates with sheriff's staff on the classification of persons with serious mental illnesses and disabilities.

G. Treatment services include onsite or offsite crisis intervention, short-term individual and/or group therapy follow-up, monitoring of inmates in special housing areas and psychotropic medication management.

a. Special Population Housing units
AFBH provides services onsite in the special housing units and in the Administrative Segregation Housing Units (1, 2, 8, 9, and 24 D,E &F). These onsite services allow AFBH staff to proactively deliver mental health services to mentally ill inmates who might otherwise fall through the cracks. It also allows for identification and engagement of inmates who may not have been identified in booking as needing mental health attention.

i. Ongoing Treatment
AFBH clinical staff closely monitors inmates on these units. Housing unit visits occur several times a week, including cell checks for inmates who refuse to be seen or who are non-compliant with treatment. Staffs conduct cell checks and/or see inmates outside their cells in the common area.

ii. **Inmates who refuse treatment:** All treatment in the jail is voluntary; however inmates who are identified for services in special population housing units who refuse treatment are monitored by AFBH staffs who make an ongoing attempt to engage them in treatment. IF an inmate refuses to be seen for their appointment the clinician and/or psychiatrist are required to see the inmate at their cell door the same day.

iii. **IOL**

iv. **Rescheduling** – if an inmate is out to an appointment or they refuse and we are unable to see them cell side, they should be rescheduled within seven days.

v. **Refusals** –Inmates who are refusing services, should be seen by AFBH clinical staff within a 30 day period.

b. **General population clinic services –** Criteria for treatment –

i. if on medications

ii. inmates experiencing distress who become stable, should be discharged after four sessions

H. Prior treatment records will be requested as the need is identified. With the advent of electronic medical records, AFBH staff will be able to access the psychiatric records of persons treated by other BHCS agencies in the community

I. Referrals from non-medical personnel including, but not limited to, custody staff and clergy, as well as others interacting with the inmate at any time during his or her incarceration will be accepted.

J. Treatment plans are developed for each inmate requiring mental health care. Discharge planning is part of the treatment plan.

K. Adult Forensic Behavioral Health staff participate in regular peer review, ongoing staff development trainings, supervision, and performance evaluations.

L. All mental health clinicians have professional post-graduate degrees in the mental health field and are either licensed or registered to be licensed. Psychiatrists have medical degrees with specialization in psychiatry and are licensed in the State of California and also hold other required certifications.

II. **PROCEDURES:**

A. PROVISION OF TREATMENT**:** Mental Health treatment decisions are made by AFBH staff and are not countermanded by non-clinicians.

B. PERSONNEL QUALIFICATIONS: Mental health services are performed by qualified mental health professionals.

1. Job descriptions and criteria-based performance evaluation forms for each employee are onsite and are approved by the health authority**.**

2. All mental health professionals are licensed or registered to be licensed. Copies of licenses and credentials are kept on-site and at the BHCS' Human Resources Department.

C. CREDENTIALS: All mental health clinicians are licensed or registered to be licensed with the State of California Board of Behavioral Sciences or the California Medical Board.

1. All psychiatrists hold valid medical licenses and comply with all state and federal licensing and certification requirements.

2. Copies of licenses, registrations, credentials, and certifications are on file in the facility.

3. Job descriptions for each job classification are on file at the facility.

D. EMPLOYEE HEALTH: All AFBH staff assigned to direct inmate contact receive a tuberculosis test as part of their pre-employment physical examination, and annual tests thereafter. All direct care staff are also offered the Hepatitis B vaccine series.

E. EMERGENCY RESPONSE: Adult Forensic Behavioral Health staff are trained to respond to health-related situations within a four-minute response time. The training is conducted annually and is established by the Health Authority in cooperation with the jail administrator. The training covers:

1. Recognition of signs and symptoms and knowledge of action that is required in potential emergency situations

2. Administration of basic first aid

3. CPR training

4. How to obtain assistance

5. Signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal

6. Procedures for transfers to acute psychiatric facilities

7. Suicide intervention.

F. STUDENTS AND/OR INTERNS: If interns are used in the delivery of mental health services as part of a formal training program, they will work under staff supervision to commensurate with their level of training.

1. Written agreements are required between AFBH and the training or educational facility. The agreements cover the scope of their work, length of agreement, and any legal or liability issues.

2. Students or interns agree in writing to abide by all facility policies including those related to security and confidentiality of information.

G. INMATE ASSISTANTS: The policy of the Sheriff's Office prohibits the use of inmates as assistants due to security concerns.

H. NOTIFICATION: Individuals designated by the inmate are notified in the case of a serious event such as suicide. Notification is done by the Sheriff's Office per policy and procedure.

I. CONFIDENTIALITY: All inmates' mental health information and records are confidential and protected by State of California and Federal laws.

1. The records are kept separate from custody files and are not accessible to staff unauthorized to view them.

2. Release of mental health information must be with written consent of the inmate or as otherwise specified by law.

3. The California Welfare and Institutions Code Sections 5328, et seq., a part of the Lanterman-Petris-Short Act (LPS), establishes and protects the confidentiality of mental health information that is obtained in the course of providing voluntary or involuntary mental health treatment. It specifies under what circumstances such information can be disclosed.

4. The California Confidentiality of Medical Information Act (California Civil Code, Sections 56 et. seq) and the privacy regulations of the federal Health Insurance Portability and Accountability Act (HIPAA; 45 CFR 164) impose additional protections and procedural requirements for the maintenance and disclosure of individually identifiable health information, including mental health information.

5. <u>Substance Abuse Treatment Information:</u>

a. California Health and Safety Code, Section 11845.5 establishes and protects the confidentiality of substance abuse treatment information.

b. The Federal Public Health Service Act governs the confidentiality and disclosure of information regarding treatment for Alcohol and Other Drugs (AOD) conditions provided by programs that receive federal funding, including programs that treat Medicare beneficiaries and accept Medicare payments, such as BHCS. [42 USC 290; 42 CFR 2]

6. Mental health staff may share limited information with custody and medical staffs regarding the mental health management of an inmate.
    a) Information shared is restricted to the mental health needs as they relate to housing, security, program placement, and transport.
    b) Only that information which is necessary to preserve the health and safety of an inmate, other inmates, volunteers, visitors or deputy staffs can be provided.
    c) The disclosure of all other information must be consistent with California state and federal laws that protect the confidentiality of mental health records and information.

J. INFORMED CONSENT: All inmates seen by AFBH for ongoing assessments and mental health treatment are asked to sign standard BHCS informed consent forms for services provided by counselors, therapists, and psychiatrists. Language lines are available to assist with the interpretation of information on the forms for non-English speaking inmates.
    1) Special consent forms are used by psychiatrists to obtain consent for use of psychotropic medications.
    2) Inmates have the right to refuse appointments and treatment. AFBH has a refusal form that inmates are asked to sign:
    3) If the inmate refuses to sign the form, the refusal is documented and signed by two witnesses
    4) The form is returned to the mental health office and reviewed by the clinic supervisor.
    5) If there is concern that the inmate is seriously mentally ill, and/or is impaired in his or her decision making capability, AFBH will schedule follow-up contacts to attempt to engage the person in treatment or monitor his or her functioning.
    6) There is no forced treatment with the exception of the very restricted use of emergency psychiatric medications, the use of which is in compliance with California State law and follows established policies and procedures.

K RESEARCH: Adult Forensic Behavioral Health does not conduct research using inmates as subjects.

L. PRIVACY: Mental health interviews are conducted with as much privacy as possible in the jail setting.
    1. Inmates seen in the mental health clinic area are interviewed in private counseling rooms.
    2. Inmates seen on the housing units are seen in common areas, but at a distance from custody staffs.
    3. When inmates are seen at their cell doors, custody staffs will stand nearby for safety reasons, but far enough away so as not to easily hear what is said.

M. TRANSFER: Inmates who are acutely mentally ill and/or suicidal may be transferred to an acute psychiatric inpatient unit following California State law, code section WIC 5150 which provides for a 72-hour psychiatric emergency evaluation of a person who is dangerous to self, dangerous to others, or gravely disabled due to a mental illness. All protocols are followed consistent with the state code. Once inmates arrive at the acute facility, there are many legal protections overseen by hearing officers and patient rights advocates to protect their civil liberties.

N. USE OF RESTRAINTS: Adult Forensic Behavioral Health does not authorize the use of physical restraints. If chemical restraints (involuntary /emergency medications) are used, they are done so in emergencies only and pursuant to the AFBH policy on Involuntary Administration (emergency medications). Four/five point restraints are not authorized in the jail.

O. SEXUAL ASSAULT:

1. All AFBH staff are trained in PREA (Prison Rape Elimination Act) and comply with requirements set forth in the legislation. (See AFBH Policy and Procedure B 21 d)

2. The Sheriff's Office makes referrals to AFBH for monitoring, assessment, and counseling.

3. Upon referral, mental health staff will assess victims and perpetrators of sexual assault and provide treatment as needed.

4. Adult Forensic Behavioral Health staff is prohibited by the BHCS Ethical Conduct Policy and the Sheriff's Office Code of Ethics to engage in sexual conduct with inmates. Adult Forensic Behavioral Health staff found in violation of this section is subject to administrative and criminal disciplinary sanctions.

5. The mental health records of inmates referred for assessment and treatment following victimization from a sexual assault are retained as are all mental health records in accordance with BHCS' policy on maintenance of records. All records are retained onsite, stored electronically, or stored in secure storage.

P. HEALTH RECORDS: AFBH creates and maintains confidential mental health records on all inmates seen for mental health services. The records are standardized and consistent with AFBH and BHCS recordkeeping requirements. The recordkeeping and safekeeping of records is approved by the health authority, and the mental health record is available to all mental health staff that have contact with the inmates. The record contains:

1. Patient identification on each sheet
2. A chronological list of all mental health contacts
3. An initial assessment form and/or a completed receiving screening form if the person is referred at the time of booking.
4. Mental status assessment
5. Documentation of symptoms and other identified problems
6. Identified treatment needs
7. Diagnoses, treatment, and disposition
8. Record of prescribed medications and their administration
9. Laboratory results
10. Individualized treatment plans
11. Progress notes with diagnosis, date, time, and type of intervention for all contacts
12. Discharge notes when advance notice of release is available
13. Legible signature, title, and stamp of provider for each service contact
14. Consent for treatment and medication forms
15. Refusal forms
16. Release of information forms

Q. TRANSFER: The records for non-emergency transfers of inmates to other facilities are provided by CALIFORNIA FORENSIC MEDICAL GROUP.

1. California Forensic Medical Group records contain a mental health section for inmates seen for mental health care while in jail custody.

2. Adult Forensic Behavioral Health provides a transfer medication order for inmates who were receiving psychiatric medication while in jail.

3. Adult Forensic Behavioral Health will provide additional information to the receiving facility upon request post-transfer.

R. INACTIVE RECORDS: Adult Forensic Behavioral Health retains all inactive records in compliance with California State Law and the policy of Behavioral Health Care Services Agency.
   1. Inactive records are kept electronically or kept onsite for a period of two years following the closing of the record due to the release or transfer of the inmate.

   2. Inactive records older than two years are scanned and stored electronically or sent to secure storage through a contractor, GRM.

   3. Upon receiving written consent for release of records from the former patient/inmate AFBH will copy and send copies of records to the requester.

Reviewed and revised 03/2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT BEHAVIORAL MENTAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:**B-3 a,b,c,d	**PAGES:** 1 of 4
	RELATED ORDERS: ACA 4-ALDF-4D-24, 4D-25	
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 3, 2017	
CHAPTER: Personnel	**SUBJECT**: **Internal Peer Review Quality Assurance; External Peer Review and Credentialing**	

I. **POLICY**: Adult Forensic Behavioral Health Services (AFBH), a division of Alameda County Behavioral Health Care Services (BHCS) has an established system for external and internal peer review and credentialing.

II. **PROCEDURE**:

a) QUALITY ASSURANCE:

1. Adult Forensic Behavioral Health staff participate in a multi-disciplinary quality improvement committee. Adult Forensic Behavioral Health managers participate in a jail-wide monthly Medical Audit Committee (MAC) meeting, a quarterly California Forensic Medical Group Health Continuous Quality Assurance meeting, a monthly Persons of Continued Interest (PCI) meeting, a monthly Suicide Prevention Committee (SPC) meeting, as well as the Mortality Review Committee.

2. Adult Forensic Behavioral Health managers and clinicians participate in internal, monthly training classes on jail psychiatric practices.

3. Collecting, trending and analyzing data combined with planning, interviewing and reassessing: BHCS provides data to AFBH on numbers of inmates seen, their diagnoses, medication utilization reports, etc. In addition, AFBH managers, with support staff, monitor utilization of services and plan staffing accordingly.

4. Evaluating defined data: AFBH managers look at data and analyze it in order to determine what new procedures or policies are needed. For example, suicide threats, gestures, attempts, and actual deaths are closely monitored to determine risk factors and improve prevention efforts.

5. Onsite monitoring of health service outcomes is done by AFBH managers on a regular basis to address effectiveness of service delivery.

b). INTERNAL PEER REVIEW:

1. The AFBH clinical managers conduct chart reviews to review legitimacy of grievances and monitor quality of health records.

2. The BHCS Medical Director's office reviews prescribing practices and administration of medications to assess the appropriateness of selected medications and doses. Findings are documented and kept in the AFBH Psychiatrists' Peer Review binder.

3. All AFBH clinicians and psychiatrists present one of their assigned cases at a Peer Review meeting annually. The details of the case, focus of the review, and discussion are written up and filed in the AFBH Peer Review binder

4. Adult Forensic Behavioral Health managers conduct a systematic investigation of all grievances including timely written responses; appropriateness of responses, and logging. All grievances and responses are reviewed by the AFBH Director.

5. Adult Forensic Behavioral Health managers develop and monitor corrective action plans to address employee performance problems. Performance evaluations are documented using the BHCS criteria-based performance evaluation tool. Adverse incidents are addressed by the designated AFBH supervisor in collaboration with the BHCS Department of Human Resources.

6. There is a review of all in custody deaths through the Medical Audit Committee (MAC), the Suicide Prevention Committee (SPC) and the Mortality Review Committee. Internal AFBH debriefings with AFBH clinical staffs occur on all inmate suicides.

7. Adult Forensic Behavioral Health programs are reviewed and evaluated on an ongoing basis. New measures are implemented to improve the delivery of care and improve efficiency of operations.

8. Changes in operations or corrective measures are reviewed on an ongoing basis to determine if they are accomplishing their intended goals.

9. On an ongoing basis, identified training needs are incorporated into the AFBH monthly training calendar.

10. Records of peer review, process studies, and outcomes as well as all training activities for AFBH staff are maintained.

11. On a monthly basis, all internal review activities and findings are reported to the health services administrator and the facility administrator through the Medical Audit Committee.

12. Internal review complies with legal requirements and confidentiality of records.

c) EXTERNAL PEER REVIEW:

There is an external peer review process in place in which AFBH psychiatrists are reviewed at least every two years by the BHCS Medical Director's office All AFBH staff participate in

annual criteria-based performance evaluations which are reviewed by department managerial staff (offsite).

1. At least once every two years, AFBH psychiatrists are reviewed by the BHCS Medical Director's office. The Medical Director's office is located at BHCS Headquarters, 2000 Embarcadero, Oakland, California. Physicians sign off on the review and a certificate of review is placed in their professional file.

2. On an annual basis, all AFBH staff meets with their supervisors and participate in a performance review. Performance will be rated using the established criteria-based tool developed and approved by BHCS Human Resources Department for each job classification. These evaluation forms are on file. Upon completion of the evaluation, the performance rating will be reviewed by a "Reviewer" who is not the immediate supervisor.

d) QUALITY ASSURANCE AND CREDENTIALING:

Behavioral Health Care Services has a department Quality Assurance office, and a quality assurance director. The following practices are in place on a department-wide basis to support quality assurance.

1. Credential Committee reviews applications for practitioner credentialing. All Physician cases and adverse decisions are reviewed by the Medical Director. In the case of adverse decisions as a result of application or medical disciplinary cause or reason, the due process afforded to the specific practitioner requires a Peer Review panel decision. All adverse decisions are reviewed and approved by the BHCS Medical Director and the BHCS Agency Director. The objective is to address the credentialing and practice of specific individual practitioners.

2. Formalized Case Reviews, including a Peer Review panel, are initiated in instances of adverse events, such as beneficiary death or accidents, with an emphasis on the case and all organizational provider practitioners engaged in the case. The objective is to address organizational and system issues which may have led to the adverse event.

3. Clinical Peer Review is a mandated peer review of practitioner clinical practice annually. These reviews are conducted at each contract and county operated clinic site. The objective is to review the general clinical work of practitioners and programs which is not connected to an adverse event.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B 3 e**	**PAGES: 1**
	RELATED ORDERS:	
	ISSUED DATE: March 31, 2010	
	REVIEW DATE: March 3, 2017	
	REVISION DATE: February 14, 2013	
CHAPTER: Mental Health Program	**SUBJECT: Credentialing for AFBH psychiatrists**	

I. PURPOSE: To ensure that psychiatrists working for AFBH are credentialed and re-credentialed regularly.

II. POLICY: All AFBH psychiatrists are credentialed through the Alameda County Behavioral Health Care Services Network Office unit.

III PROCEDURE: The BHCS Network Office has a contract with a Credentialing Agency (currently MedVersant) which credentials and re-credentials every three years. The application and supporting documentation are sent to the provider and reviewed by Network Office for preparation and sent to MedVersant, which responds with a report. That report is reviewed by the Credentialing Committee, which includes Quality Assurance, to determine if the providers are accepted, denied, or pended.

1. Network Office sends a packet for credentialing to all AFBH psychiatrists at the time of hire and six months within the expiration of credentialing dates.
2. The individual psychiatrist completes the required paperwork and returns the packet to the Network Office as stated in the instructions.
3. When credentialing is complete, notices are sent to the individual psychiatrist and the AFBH Director.
4. Copies of the letters confirming credentialing are kept in the Network Office's employees' personnel files.
5. Failure to complete and submit any requested documentation may result in removal from the AFBH panel at BHCS' sole discretion.

Adult Forensic Behavioral Health Program

Job Titles

Administrative Support Manager
Behavioral Health Clinical Manager
Behavioral Health Clinical Supervisor
Behavioral Health Clinician 1 AND II
Director, Conditional Release & Criminal Justice Services
Mental Health Specialist
Physician III, Lead Psychiatrist
Physician III REG (Regular)
Physician III-SAN (Services as Needed)
Rehabilitation Counselor II
Specialist Clerk I
Supervising Clerk I

Revised/Reviewed 03/2017

Job titles eff. 4/15/10

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B-5-a	**PAGES:** 1 of 4
	RELATED ORDERS: ACA 4-ALDF-2A-52, 2A-56, 2A-66	
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: April 27, 2012	
CHAPTER: Mental Health Services	**SUBJECT: Special Management Inmates**	

I. **POLICY**:

A. Adult Forensic Behavioral Health (AFBH) provides all necessary mental health services to inmates housed in special management housing units who are referred for services. The goal is to assist inmates achieve as much stabilization as possible during their incarceration and to prevent self-harm.

B. CALIFORNIA FORENSIC MEDICAL GROUP staff conducts a mental health screen of all inmates during the receiving/booking process. Special management inmates identified as needing mental health services are referred to AFBH for assessment and ongoing treatment if indicated.

C. Inmates housed at the Glenn Dyer Detention Facility (GDDF) or now seen at GDDF and are no longer transported to Santa Rita Jail for treatment.

D. Mental health, medical, and substance abuse services are coordinated such that inmate management is appropriately integrated, health needs are met, and the impact of any of these conditions on each other is adequately addressed.

E. Adult Forensic Behavioral Health Services receive calls from family members and outside mental health providers to coordinate care and obtain collateral information to assist with the evaluation and treatment of the special housing inmate.

II. **PROCEDURE**:

1. TREATMENT SERVICES

a) Administrative Segregation inmates receive mental health screening during the receiving/intake process and a more in-depth screening during the health assessment. Positive screenings are forwarded to AFBH for further evaluation and treatment.

b) Adult Forensic Behavioral Health staff conduct assessments and triage; provide ongoing counseling, medication management services, crisis intervention, monitoring and

discharge planning services. Adult Forensic Behavioral Health staff collaborates with sheriff's staff on the classification of persons with serious mental illnesses and disabilities.

c) Treatment services include onsite or offsite crisis intervention, short-term individual counseling, monitoring of special management inmates and psychotropic medication management.

2. RECORDS, REFERRALS, & TREATMENT PLANS

a) Prior treatment records are requested as the need is identified.

b) Referrals from non-medical personnel including, but not limited to, custody staff and clergy, family members, community providers, and others interacting with the inmate at any time during his or her incarceration are accepted.

c) Treatment plans are developed for each inmate requiring mental health care. Discharge planning is part of the treatment plan.

3. .OBSERVATION AND INTERVENTION

a) Inmates are placed on Inmate Observation Logs (I.O.L.s) if, because of their mental illnesses, they are demonstrating confused, disorganized, self-injurious, or violent behaviors that require observations four times each hour. Inmates with increased risk for violence and increased risk for suicide (an identified plan and means) are placed in Safety Cells until they can be evaluated by mental health professionals.

b) Inmates who have been placed on I.O.Ls by mental health staff due to their serious mental illnesses or disorganized behaviors are observed four (4) times each hour on an irregular basis by sheriff's deputies. Inmate Observation Logs are kept with the inmate for documentation of observations and until the I.O.L. has been discontinued by AFBH.

c) Inmates at heightened risk for suicide (an identified plan and means) are placed in Safety Cells for their own protection. All garments that might be used for self-harm are removed. Adult Forensic Behavioral Health assesses the inmate within eight (8) hours and every 24 hours following placement in the Safety Cell and signs off on posted logs for all contacts. Adult Forensic Behavioral Health staff arranges for transfer to an acute psychiatric hospital if needed.

d) If an inmate has committed an overt act indicating suicide, he/she will be transported immediately to the nearest emergency room for treatment.

4. MEDICATIONS, CLOTHING, AND PERSONAL ITEMS:

a) All mentally ill inmates in special housing units receive their psychiatric medications as prescribed by the AFBH psychiatrists. Medications are dispensed by CALIFORNIA FORENSIC MEDICAL GROUP nurses.

b) All mentally ill inmates in special housing units are dressed in standard jail clothing.

c) All mentally ill inmates have access to basic personal items unless these items present a risk to the inmate or others.

5. COUNSELING SERVICES: Adult Forensic Behavioral Health provides mental health services to jail inmates who are evaluated and found to need these services, including special management inmates.

a) Adult Forensic Behavioral Health staff proactively deliver mental health services to mentally ill inmates in special housing units. This allows for identification and engagement of inmates who may not have been identified in booking as needing mental health attention.

b) There are dedicated AFBH staff (clinicians and psychiatrists) assigned to the special housing units to closely monitor inmates.

c) Visits occur several times a week, including cell checks for inmates who refuse to be seen or who are non-compliant with treatment.

d) Communication takes place between housing unit deputies, AFBH, and CALIFORNIA FORENSIC MEDICAL GROUP nurses. This allows for team building with deputies and minimization of mentally ill inmates who may have fallen through the cracks. Deputies alert staff when there is concern about an inmate's mental health condition or suicide risk.

Reviewed 11/2015

ALAMEDA COUNTY **BEHAVIORAL HEALTH CARE SERVICES** **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B 5 b 1	**PAGES:** 1 -9
	RELATED ORDERS: ACA 4-ALDF-4C-01, 4C-4C-06, 4C-07, 4C-08, 4C-09, 4C-19, 4C-22, 4C-23, 4C-24, 4C-27, 4C-28, 4C-30, 4C-31, 4C-32, 4C-33, 4C-34, 4C-37, 4C-38, 4C-40	
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 3, 2017	
	REVISION DATE: April 27, 2012	
CHAPTER: Mental Health Program	**SUBJECT:** **Access to Care – Mental Health Services**	

I. PURPOSE: To ensure that mental health services are available to inmates in the jail.

II. POLICY: Adult Forensic Behavioral Health (AFBH), a division of the Alameda County Behavioral Health Care Services (ACBHCS), provides all necessary mental health services in a timely manner so that inmates have unimpeded access to mental health services. The goal is to address the inmates' mental health needs, including prevention and education, to maximize their stability and encourage recovery while they are in the custody of the Alameda County Sheriff's Office (ACSO).

A. All inmates receive an initial mental health screen conducted by CALIFORNIA FORENSIC MEDICAL GROUP staff in the booking/intake section of the jail.

B. Inmates housed at the Glenn Dyer Detention Facility (GDDF) will receive treatment at GDDF and are no longer transported to SRJ for treatment. AFBH is onsite at GDDF Tuesday and Thursday's.

C. Mental health, medical, and substance abuse services are coordinated such that inmate management is appropriately integrated, health needs are met, and the impact of any of these conditions on each other is adequately addressed.

D. A more in-depth screening is conducted during the health assessment.

E. Positive screenings are forwarded to mental health professionals for further evaluation and treatment.

F. Adult Forensic Behavioral Health staff conduct assessments and triage; provide ongoing counseling, medication management services, crisis intervention, and discharge planning services.

G. Adult Forensic Behavioral Health collaborates with the Sheriff's Office on the classification of persons with serious mental illnesses and disabilities.

H. Treatment services include onsite or offsite crisis intervention, short-term individual and/or group therapy follow-up, monitoring of inmates in special housing areas, and psychotropic medication management.

I. Prior treatment records will be requested as the need is identified.

J. Referrals from non-medical personnel including, but not limited to custody staff and clergy, as well as others interacting with the inmate at any time during his or her incarceration are accepted.

K. Treatment plans are developed for each inmate requiring mental health care. Discharge planning is part of the treatment plan.

III. PROCEDURES:

1) ACCESS TO MENTAL HEALTH SERVICES: All inmates receive information during the booking/intake process on how to access mental health care.

   a) All inmates receive a copy of the ACSO's "Inmate Rules and Information" booklet.

   b) Inmates also receive this information through the inmate orientation video.

   c) Inmates are referred to AFBH if there are indications of need for further psychiatric assessment / ongoing treatment.

   d) Bilingual staff or language lines are used to assist inmates who are non-English speaking.

   e) Inmates seen by mental health staff in booking/intake are assessed and triaged for follow-up care.

   f) Self-referral forms are available to all inmates on their housing units.

   g) Inmates can ask the ACSO or CALIFORNIA FORENSIC MEDICAL GROUP staffs for a referral to mental health services, or in some housing units, ask AFBH staff directly.

2) CLINICAL SERVICES:

   a) Inmates are able to request mental health services on a daily basis.

   b) Inmates are screened for mental health treatment needs at intake and referred for mental health services.

   c) Once assigned to a housing unit, inmates can be referred by the ACSO or CALIFORNIA FORENSIC MEDICAL GROUP staff, or can submit a self-referral form. Health care request forms are readily available to all inmates on their housing units.

   d) Request for service forms are delivered by CALIFORNIA FORENSIC MEDICAL GROUP staff to the AFBH office and are triaged for priority. Appointments are given based on medical necessity and priority of needs.

   e) Mental health clinic appointments are available five (5) days a week.

   f) Inmates are seen by AFBH mental health professionals and/or psychiatrists.

3) CONTINUITY OF CARE:

a) Adult Forensic Behavioral Health provides continuity of care.

b) Referrals are made to community agencies to connect persons who have serious mental illnesses with appropriate treatment services when inmates are released from jail.

c) Community providers are contacted when inmates are admitted to the jail to inform them of the incarceration and to obtain recent clinical information including verification of psychiatric medications.

d). Information about inmates is provided to acute psychiatric hospitals when inmates are transferred there for involuntary treatment and stabilization.

4) REFERRALS TO ACUTE PSYCHIATRIC EMERGENCY SERVICES:

1. Inmates needing acute psychiatric hospitalization are transferred from the jail to the acute psychiatric inpatient unit for 24-hour acute care under the Welfare and Institutions Code 5150 hold (danger to self, danger to others, or gravely disabled due to mental illness).

2. Adult Forensic Behavioral Health clinicians:
   a. Evaluate inmates who may need acute psychiatric care
   b. Complete the necessary paperwork associated with the WIC 5150
   c. Arrange for the inmate to be transferred to the acute psychiatric hospital
   d. Secure transportation is provided by the ACSO or ambulance

3. A written list of referral sources is included with the Health Authority's list of referral sources. The list is reviewed and updated annually.

5) TRANSPORTATION:

1. Acutely mentally ill and/or suicidal inmates who require transportation from the jail to an acute psychiatric hospital are transported by the ACSO or ambulance in a timely manner.

2. Medical clearance and other clinical information required by the acute hospital is sent in a sealed package with the transportation unit or faxed directly to the acute facility.

6) TREATMENT PLAN:

1. Treatment plans for inmates with serious mental health problems are developed by AFBH staff in collaboration with AFBH psychiatrists who approve and sign off on the established treatment plan.

2. The plan identifies the mental health condition, treatment modalities, and degree of monitoring needed.

3. Adult Forensic Behavioral Health mental health professionals and psychiatrists work closely together on the treatment plans for inmates.

7) EMERGENCY SERVICES:

1. Emergency mental health services are available 24 hours a day by onsite AFBH staff or by mental health professionals who work on-call.

2. When needed, access to 24-hour acute psychiatric hospitalization is available by means of the WIC 5150 process (involuntary acute psychiatric hospitalization).

3. Inmates are transported to the designated acute psychiatric inpatient unit by the ACSO or by ambulance.

4. When there are no mental health staff onsite, a AFBH clinician is on-call and can be reached by the ACSO or CALIFORNIA FORENSIC MEDICAL GROUP by pager to assist with urgent mental health matters

5. A AFBH psychiatrist is on-call for consultation and to accommodate the continuity of psychotropic medications

8) OUTPATIENT HOUSING UNIT (OPHU) (Infirmary care):

1. Inmates with mental illnesses are generally not housed in the Outpatient Housing Unit unless they are placed there by CALIFORNIA FORENSIC MEDICAL GROUP for a medical condition that needs close supervision.

2. If a mentally ill inmate is housed in the OPHU, mental health staff will visit the inmate in that location as needed.

3. Inmates returning from acute psychiatric hospitals are temporarily housed in the OPHU until they can be assessed for stability by an AFBH Clinical Supervisor/ or designee and psychiatrist before being assigned to their housing units. This ensures readiness for return to custody and continuity of medications.

9) CHRONIC CARE:

a. .Inmates with serious and chronic mental illnesses such as Schizophrenia and Bipolar Disorder receive mental health services.

b. Adult Forensic Behavioral Health regularly monitors inmates in the special housing units.

c. The Mental health staff routinely talks to inmates. The ACSO, AFBH, and CALIFORNIA FORENSIC MEDICAL GROUP staffs conduct routine cell checks to ensure that the special inmates' needs are addressed.

d. Adult Forensic Behavioral Health psychiatrists also monitor mental health inmates in the OPHU and prescribe psychiatric medications.

e. When indicated, AFBH psychiatrists order lab tests by submitting lab request forms.

10) HEALTH SCREENS:

1. All inmates; newly booked or those that are transferred from the Glenn Dyer Detention Facility, are initially screened for medical and mental health conditions by CALIFORNIA FORENSIC MEDICAL GROUP in the booking/intake section of the jail.

2. Information is recorded on a CALIFORNIA FORENSIC MEDICAL GROUP medical screener form and a copy is provided to AFBH along with accompanying documentation of psychiatric medications on all referrals.

3. Referrals are made to AFBH by CALIFORNIA FORENSIC MEDICAL GROUP medical screeners for those persons identified as needing further mental health assessment by a mental health professional.

11) HEALTH APPRAISAL:

a. CALIFORNIA FORENSIC MEDICAL GROUP conducts History and Physicals (H&Ps) on inmates within 14 days of admission to the jail.

b. This evaluation includes a review of the inmate's mental status.

c. If inmates are identified as needing further mental health assessments, they are referred to AFBH via the CALIFORNIA FORENSIC MEDICAL GROUP referral form.

12) MENTAL HEALTH PROGRAM: The mental health program and its services are approved by the Health Authority. The mental health program is under the direction of the Director of Adult Forensic Behavioral Health Services, a division of Alameda County Behavioral Health Care Services. .

a. Adult Forensic Behavioral Health Services is responsible for providing mental health services to inmates in the custody of the ACSO. Adult Forensic Behavioral Health provides all mental health services following referrals by CALIFORNIA FORENSIC MEDICAL GROUP staff. These services include, but are not limited to:
    a. Mental health screening/assessment to determine need for treatment
    b. Mental health evaluation
    c. Crisis intervention
    d. Transfer to an acute inpatient psychiatric hospital when needed.
    e. Individual counseling
    f. Medication assessment and management
    g. Monitoring
    h. Referral
    i. Discharge planning
2. Services are provided in four areas of the jail: intake/booking, OPHU, the outpatient mental health clinic, and in the housing units.
3. Positive screens for mental health problems receive a referral to AFBH for a further assessment/screening by a mental health professional. CALIFORNIA FORENSIC MEDICAL GROUP refers inmates to AFBH for the detection, diagnosis and treatment of mental illness by a mental health professional.
4. Adult Forensic Behavioral Health staff provides crisis intervention services and the management of acute psychiatric episodes.
5. Adult Forensic Behavioral Health staff assess psychiatric emergencies, conduct assessments; make decisions as to level of care needed; process paperwork and otherwise

coordinate admission of acutely mentally ill inmates and/or suicidal inmates to the designated acute psychiatric inpatient facility.

6. Adult Forensic Behavioral Health provides ongoing monitoring and proactive mental health contacts with inmates with serious mental illnesses with the goal of maximizing stabilization and preventing de-compensation while inmates are in jail custody.
7. Inmates who are acutely mentally ill and/or suicidal, and cannot be safely and effectively treated in the jail, are sent out to acute psychiatric hospitals for stabilization via the WIC 5150, 72-hour emergency psychiatric evaluation process.
8. Adult Forensic Behavioral Health has dedicated staff assigned to the special needs housing units where they work collaboratively with the ACSO and CALIFORNIA FORENSIC MEDICAL GROUP in an effort to best address the mental health needs of inmates. For inmates who refuse treatment, AFBH staff continues to monitor their mental status, attempt to engage them in treatment, and initiate transfer to an acute hospital setting if needed.
9. All inmates whose mental health needs exceed the treatment capability of the jail are seen by AFBH who initiates transfers to the designated acute inpatient psychiatric hospital.
10. All inmates who participate in mental health services are provided with forms that document consent for treatment and consent for medications. If inmates refuse to sign consent forms, their refusal is documented. Monitoring of seriously mentally ill inmates who refuse treatment continues, despite refusal of services, to ensure their safety and need for transfer to an acute psychiatric facility.

13) MENTAL HEALTH SCREEN: All inmates receive a mental health screening in booking/intake mental health trained personnel. The screening includes inquiry into:

a) Suicidal ideation and history
b) If the inmate is receiving psychiatric medications and/or treatment for a psychiatric condition
c) History of psychiatric outpatient and/or inpatient mental health treatment
d) History of substance abuse treatment
e). Documentation of a current mental health complaint
f) The screener observes
    1. General appearance and behavior
    2. Evidence if abuse and/or trauma
    3. Current symptoms of psychosis; depression, anxiety, and/or aggression

ii. Disposition of inmate:
    1. cleared for general population
    2. Cleared for general population with referral for follow-up mental health assessment and treatment
    3. Referral to mental health services for emergency assessment and treatment.
    4. Referral to AFBH for further screening by a mental health professional.

14. MENTAL HEALTH APPRAISAL: All inmates receive a mental health appraisal by a qualified mental health person within 14 days as part of the H&P. This appraisal includes:

1. Assessment of current mental status and condition
2. Assessment of suicidal potential including risk factors for the individual
3. Assessment of dangerousness/violence potential and specific risk factors
4. Review of:

a. records of past inpatient and/or outpatient psychiatric treatment
b. history of treatment with psychotropic medications
c. history of other psychiatric services: counseling, psychotherapy, etc
d. educational history
e. history of sexual abuse, victimization, and predatory behavior
f. assessment of substance abuse and dependence

5. Referral to mental health services for further evaluation and/or treatment
6. Development of a treatment plan that includes recommendations for housing and program participation. Job assignments are handled by the sheriff's department.

15. MENTAL HEALTH REFERRALS: Referrals are triaged by AFBH mental health staff. Inmates referred for mental health treatment as a result of the screenings/need assessments done by a qualified mental health person, receive a comprehensive evaluation by a licensed or registered mental health professional within 14 days of the referral. Some inmates receive face-to-face assessments in the booking/intake section, some are given appointments and assessed in the AFBH clinic, and some are seen for assessments in their assigned housing units. The AFBH Intake, Transfer and Release service is generally staffed with mental health professionals seven days a week, sixteen hours each day.
See attached Policies and Procedures for sections B 5 b: 15, 15a, 15b, 15c, and 15d

The assessment includes:

1. Evaluation of the inmate's current psychiatric condition(s) and Mental Status Exam (MSE)
2. Observation of behavior
3. Psychiatric history including research and review of past treatment in Alameda County's Behavioral Health Care system and other treatment settings
4. Psychiatric treatment history including hospitalizations and outpatient treatment
5. Substance abuse history and current use
6. Psychiatric medication history and current need for medications
7. Suicide assessment including current risk factors
8. Assessment of intellectual functioning with attention to developmental disability
9. Assessment of post-partum depression or psychosis for female inmates
10. History of incarcerations and charges
11. Provisional diagnoses
12. History of victimization
13. History of aggressive behavior
14. History of head trauma
15. Disposition (treatment / management plan) for follow-up; classification input for special housing, prioritization for treatment services, transfer to acute care facility if treatment needs exceed the treatment capacity of the facility.

16. MENTAL ILLNESS AND DEVELOPMENTAL DISABILITY: Adult Forensic Behavioral Health identifies and evaluates inmates who are severely developmentally disabled or who suffer from severe mental illnesses. Whenever a Developmentally Disabled individual is identified by AFBH, the staffs notify the East Bay Regional Center. Adult Forensic Behavioral Health staff participates in the classification process for persons with serious mental illnesses and developmental disabilities by making recommendations to the ACSO's Classification Unit for special housing assignments.

1. All seriously mentally ill inmates and those with developmental disabilities who need protection and attention are placed in specialized housing units where mental health staff is assigned.

2. Only mental health staff can remove these special classification designations
3. Recommendations may also include placement in non-correctional facilities.

17. MANAGEMENT OF CHEMICAL DEPENDENCY:

1. The D.E.U.C.E. Program (Deciding, Education, Understanding, Counseling, and Evaluation) is available to inmates and provides focused education and group process activities designed to prevent further substance abuse and criminal activity that supports addiction is available to inmates.
2. A separate program for seriously mentally ill inmates, "Breaking the Chains," is available in the special housing units.
3. As part of mental health assessments, AFBH clinicians inquire about histories of substance use/abuse.
4. In addition to the programs mentioned above, AFBH addresses substance abuse issues in ongoing counseling sessions with inmates receiving mental health services.
5. A focus on substance abuse recovery is integrated into mental health treatment services.

18. PHARMACEUTICALS: When medically indicated, inmates are prescribed psychotropic medications by AFBH psychiatrists and monitored regularly for compliance, efficacy and side effects. These services are provided in the AFBH clinic, the OPHU, and in the housing units.

a. Adult Forensic Behavioral Health uses the formulary of BHCS. All medications, except those taken off the jail formulary due to health risks or abuse, are available for AFBH psychiatrists to prescribe.
b. There is a formalized method for psychiatrists to request non-formulary medications. Specific forms have been developed for this purpose.
c. Adult Forensic Behavioral Health psychiatrists prescribe only the psychiatric medications that are clinically indicated. The medications are regularly reviewed for compliance, efficacy and side effects; and adjustments are made as needed. Psychiatrists document their findings and recommendations in the inmates' AFBH clinical records. Medication renewals are evaluated by AFBH psychiatrists prior to refilling the medications.
d. Prescribing practices are monitored by the AFBH lead psychiatrist and the ACBHCS Medical Director's office in accordance with state and federal laws.
e. Medication procurement, receipt, distribution, storage, dispensing, administration, and disposal are managed by Maxor Pharmacy and California Forensic Medical Group.
f. Maxor Pharmacy is responsible for administering and managing the jail's pharmacy system.
g. Prescriptions written by AFBH psychiatrists are dispensed by Maxor Pharmacy.
h. Maxor pharmacy is responsible for distributing psychiatric medications to CALIFORNIA FORENSIC MEDICAL GROUP nurses in a timely manner.
i. CALIFORNIA FORENSIC MEDICAL GROUP is responsible for delivering the medications to inmates in a timely manner according to AFBH psychiatrists' orders.

19. SPECIAL NEEDS INMATES: The ACSO's Detention and Corrections administrative staff consults with AFBH prior to determining housing and program assignments, disciplinary actions, and transfers of inmates with serious mental illnesses or developmental disabilities.

Reviewed 03/2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-32**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: May, 2014	
Mental Health Program	**SUBJECT:** Inmate Use of AFBH Staff Telephones & Computers	

I PURPOSE: To ensure that Criminal Justice Mental Health staff (AFBH) understands that the Alameda County Sheriff's Office, for reasons of security, does not allow inmates to have access to staff telephones or computers

II POLICY: AFBH staff should not allow inmates to use staff telephones or computers. Inmates are not allowed to view or access computer screens, the internet, mainframe, or otherwise use AFBH computers. Per jail regulations, inmates have access to public telephones.

III PROCEDURES:

1. If an inmate requests to use a AFBH staff telephone or computer, inform the inmate that AFBH telephones and computers cannot be used by inmates.
2. Inform the inmate to use phones made available to them per the Sheriff's policy on access to public telephones.
3. If an inmate is unable to access a public phone, report this to the Sheriff's Office AFBH Liaison Sergeant for assistance.
4. For release planning or other mental health planning activities, AFBH staff may place calls to community providers, etc. on behalf of the inmate.
5. AFBH staff will document **all** contacts/phone calls in Clinical Gateway under Plan Development/or in the Plan portion of your CG note. In your CG note please make sure you include the following:
    1. Phone Number of where you are calling
    2. Name of the place/person (e.g.) Attorney's name/Case Manager
    3. Reason for the phone call.
6. Inmates are not allowed to look at the Computer Screen. Please ensure that you have the computer screen out of the inmates sight of vision

Reviewed: 11-2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-5 b 15 a)**	**PAGES: 1-2**
	RELATED ORDERS:	
	ISSUED DATE: March 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: February 15, 2013	
CHAPTER: Mental Health Program	**SUBJECT**: **Access to Care Pre-screening / Screening Triage**	

I. PURPOSE: To ensure that inmates who meet mental health treatment criteria are prioritized and receive prompt attention.

II POLICY: Referrals received by the ITR screener are reviewed for urgency and given a priority rating of Emergency, High, Medium or Low. Those rated Emergency are seen immediately. High priority referrals should be seen the same day that the referral is received. Medium priority cases are to be seen for initial screening within seven days. Low priority cases may be deferred for a longer period of time. Post-booking referrals are triaged by the Clinic or AFBH assigned housing unit staffs.

III DEFINITIONS: **/ PROCEDURE**

A. Emergency--handle now

These are referrals that indicate the person is grossly psychotic or actively suicidal and may need admission to the Psychiatric Inpatient Unit.

B. High--Screen on the same day referral received. Any patients in the High category who are <u>not</u> seen on the day the referral is received will be passed on to the next shift as High priority until seen. High priority includes any one of the following descriptors:

1. Safety Cell Placement
2. At risk for self harm
3. Serious and persistent mental illness as reflected in face sheet or by self-report or outside information: Schizophrenias, Bipolar Disorders, other Psychotic Disorders, Major Depression.
4. In serious emotional crisis (crying, screaming, mute) or acting out (head banging, threatening, kicking, etc.)
5. Housed in mental health housing (1, 2, 8, 9, 24)
6. Require medication continuity
7. Held in ITR for screening

C. Medium--See within 7 days of receipt

A combination of factors listed below:

1. History of mental health treatment
2. No serious symptomatology
3. No recent medication

4. Not housed in “mental” housing
5. Substance abuse on withdrawal protocol

D. Low—Schedule appointment for assessment.
A combination of the factors listed below:

1. No history or indication of mental health treatment
2. No symptomatology
3. No medication
4. Not housed in “mental” housing
5. Recent substance abuse history
6. Sleep problems

E. CRITERIA FOR MENTAL HEATLH TREATMENT

1. MEDICAL NECESSITY/ DIAGNOSIS

Serious and persistent mental illness or ***severe*** emotional disturbance, i.e., Schizophrenias, Schizoaffective Disorder, Bipolar Disorder, Major Depression, Psychotic Disorder NOS, etc. Substantial treatment history as indicated by BHCS face sheet or information from transferring facility.
Current acute psychiatric episode requiring mental health crisis intervention and stabilization.

2. MEDICAL NECESSITY/ FUNCTIONAL IMPAIRMENT

Substantial impairment in community or institutional functioning: problems understanding and cooperating with jail routine; problems maintaining a stable residence, ability to house properly and maintain cell environment; problems engaging in productive activities and daily responsibilities; problems maintaining health.

3. PSYCHIATRIC HISTORY

History of psychiatric hospitalizations, mental health treatment in other incarcerated or criminal justice settings, or a long history of outpatient mental health treatment.

4. SUBSTANCE ABUSE HISTORY

Dually diagnosed (mental illness and substance abuse) are generally accepted. If there are severe psychiatric symptoms, refer without waiting period. If it appears to be purely a substance abuse issue, defer with instructions to inmate to self-refer or ask nurse to make mental health referral after a few weeks.

5. DANGEROUS TO SELF OR OTHERS

Suicidal ideation, impulses. Danger to others because of a mental disorder.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-5 b 15 b)**	**PAGES: 1-3**
	RELATED ORDERS:	
	ISSUED DATE: March 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: September 1, 2015	
CHAPTER: Mental Health Program	**SUBJECT**: **Access to Care ITR Screener Duties & Responsibilities**	

I. PURPOSE: To standardize ITR screening duties to ensure tasks are consistently completed.

II POLICY: AFBH staff provides mental health screening and interventions in the booking section of the jail.

III PROCEDURE: The procedures required to meet the responsibilities of the ITR screening position are found below: Note: Consult P&P Section B 5 b 14 a) Criteria for Mental Health Treatment in determining eligibility for mental health treatment.

1. VOICE MAIL: Check the voice mail for new messages at the beginning and periodically throughout your shift.

2. E-MAIL: Check for new e-mail messages in Microsoft OUTLOOK.

3. FAXES – Check the FAX machine for incoming faxes. Families of mentally ill inmates may complete and fax the information form located on the BHCS, Sherriff's, and other websites to provide jail mental health staff with alerts, history, treatment needs, etc of their arrested mentally ill family members.

4. MENTAL HEALTH REFERRALS: Pick up referrals from CALIFORNIA FORENSIC MEDICAL GROUP Booking office at the beginning of the shift, and throughout the shift.

5. RESEARCH:
    a. Research all referrals in MAINFRAME for custody information. Print JPQP and JPQS screens. Write needed identification information onto the Initial Screening Form. Include CDC number for all persons who are parole violators.
    b. Research all referrals in INSYST for prior mental health history and print a face sheet. Note whether there is a CJ history and year of last visit, BHCS only, or NRF (No Record Found) on the Initial Screening form.
    c. Research all referrals in the REFERRAL DATABASE for previous contacts during this incarceration and note information on the Initial Screening forms (321 or 321a) or on progress notes.

6. SCREENING: (*See P&P B 5 b 15 a) Pre-Screening Triage*)
    a. Complete an Initial Screening form on all new and returning patients. ITR clinicians are strongly encouraged to open an episode in INSYST for individual's who is already in the system. However, ITR is not responsible for registering a client.
    b. Document suicide risk information on the Initial Screening forms.

7. SAFETY CELLS. (See P&P Section B 6 Safety Cells)
    a. Evaluate NEW Safety Cell placements as soon as possible and no longer than 8 hours post placement. It is the responsibility of ITR staff to attend to new safety cells Monday-Friday, 3:00 pm to 10:00 pm & Weekends 7:30 am to 10:00 pm. Housing unit clinicians are responsible for new safety cell placements and ongoing monitoring of safety cells Monday-Friday, 7:30-3:00
    b. Sign off completing all entries on posted Safety Cell logs.
    c. Complete Classification HU Recommendation form and contact Classification of disposition.
    d. Mental health staff must evaluate anyone in a Safety Cell within the first 8 hours of placement and once every 24-hours until the Safety Cell is discontinued.
    e. Keep a copy of all Safety Cell activity notes in the ITR office so the next shift person can review them and follow-up as necessary.

8. INMATE OBSERVATION LOG (IOL): (See P&P Section B 7 Suicide Prevention-IOLs)
    a. Obtain the current day's IOL list (913 log) from California Forensic Medical Group Medical Records every morning (including weekends).
    b. Compare the current list to the previous day's list and identify the new IOL listings.
    c. Research new listings to determine if they are active AFBH cases. If the IOL was initiated by AFBH staff, the ITR screener is not required to evaluate that person.
    d. Evaluate new IOL placements within 8-12 hours of initiation. ITR clinicians are responsible for attending to new IOL's Monday-Friday, 3:00 pm to 10:00 pm & weekends 7:30 am to 10:00 pm.
    e. Complete the following forms:
        1. Initial screening form if patient is not yet open to AFBH, or Progress Note (if open), including assessment for suicide risk.
        2. Classification Housing Unit Recommendation form

    Note: If the decision is to retain the IOL, advise the HU staff, and schedule the inmate for an appointment in the clinic within 7 days. AFBH staff is expected to notify ITR staff whenever they initiate an IOL.

9. ADMISSIONS TO THE PSYCHIATRIC INPATIENT UNIT (WIC 5150). See P&P Section B 6 b Admissions to Psychiatric Inpatient Unit.

10. RETURNS FROM THE PSYCHIATRIC INPATIENT UNIT – to ensure that inmates returning from the psychiatric inpatient units are sufficiently stable for incarceration and for continuity of medications, all returns are housed in the OPHU (Infirmary) until assessed and cleared by AFBH. This function is part of the jail's overall suicide prevention plan.
    a. All inmates returning from an acute care hospital are placed on IOLs by the sheriff's office upon arrival at the OPHU until mental health staff can conduct an evaluation. This is part of the facility's suicide prevention plan.
    b. Assess inmate in the OPHU and make appropriate clinical decision as to classification. Housing, IOL status, etc.
    c. If upon assessment it appears that the inmate has not recovered sufficient stability to be

managed in the jail, a new WIC 5150 may need to be initiated in order to return the inmate to an acute care hospital for further treatment and stabilization.

d. Contact AFBH psychiatrist to provide consultation and continuation of psychiatric medications begun at the hospital.
e. Process all accompanying paperwork / documentation.

11. POST-RELEASE 5150 – When an inmate is due to be released and is considered gravely disabled and / or at risk for harm to self or others due to a mental illness, conduct a post-release 5150 to John George Psychiatric Pavilion. Follow established WIC 5150 procedures..

12. SCHEDULING APPOINTMENTS.
    a. Schedule no more than ten (10) appointments on any given day, using Appointment Priority information found on back of Initial Screening forms. Inmates who will be housed in the special population housing units and who would benefit from a medication evaluation may be scheduled to see the psychiatrist prior to seeing the clinician. In these instances, please schedule an MD appointment first followed by a clinician appointment.
    b. Schedule for the Immediate Care Clinic (ICC) as appropriate (see P&P Section B 8 a Medication Continuity of Care and Medication Continuity on Weekends and Holidays)
    c. Schedule evaluated IOL's within seven (7) days of initial IOL evaluation.

13. MAINTAINING MEDICATION CONTINUITY OF CARE—Use procedures detailed in P&P Section B 8 a)

    Note: Obtain a copy of any verbal medication orders given by AFBH On-Call psychiatrist.

14. PAPERWORK:
    a. Complete ITR Assessment (Activity) Log.
    b. Make a copy of the completed Initial Screening form.
    c. Attach each individual's set of forms together with a paper clip. Gather forms in the following sequence:
        i. Initial Screening
        ii. Classification Housing Unit Recommendation form
        iii. Medication Verification forms (if any).
        iv. Copies of verbal medication orders (if any).
        v. Referral form, mainframe screens, and face sheet.
    d. Make a copy of the ITR Assessment (Activity) Log generated during the shift. Leave this copy on the desk for use by the next ITR Screener.
    e. Attach all the paperwork to the original copy of the ITR Assessment (Activity) Log and deliver to the AFBH Manager's Office.

15. HOLIDAY AND WEEKEND SHIFT CHECK-IN: On arrival on holiday and weekend shifts, check-in with the Watch Commander ([redacted]) and with CALIFORNIA FORENSIC MEDICAL GROUP nursing (ext[redacted]) to notify them of arrival.

16. ABSENCE or TARDINESS: If you are going to be absent or late for your shift:

a. Contact the AFBH Manager's line: **x47221** to report the absence ASAP before the start of your shift. The Clinic Manager attempts to arrange coverage. If unsuccessful, contact the following:
    Classification (or Watch Commander)
    PHS Nursing Supervisor
    ITR Nursing Office
    On-Call clinician (and changes the ITR Voice Mail)

Reviewed: 11-2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-5 b 15 a)**	**PAGES: 1-2**
	RELATED ORDERS:	
	ISSUED DATE: March 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: February 15, 2013	
CHAPTER: Mental Health Program	**SUBJECT**: **Access to Care Pre-screening / Screening Triage**	

I. PURPOSE: To ensure that inmates who meet mental health treatment criteria are prioritized and receive prompt attention.

II POLICY: Referrals received by the ITR screener are reviewed for urgency and given a priority rating of Emergency, High, Medium or Low. Those rated Emergency are seen immediately. High priority referrals should be seen the same day that the referral is received. Medium priority cases are to be seen for initial screening within seven days. Low priority cases may be deferred for a longer period of time. Post-booking referrals are triaged by the Clinic or AFBH assigned housing unit staffs.

III DEFINITIONS: **/ PROCEDURE**

A. Emergency--handle now

These are referrals that indicate the person is grossly psychotic or actively suicidal and may need admission to the Psychiatric Inpatient Unit.

B. High--Screen on the same day referral received. Any patients in the High category who are <u>not</u> seen on the day the referral is received will be passed on to the next shift as High priority until seen. High priority includes any one of the following descriptors:

1. Safety Cell Placement
2. At risk for self harm
3. Serious and persistent mental illness as reflected in face sheet or by self-report or outside information: Schizophrenias, Bipolar Disorders, other Psychotic Disorders, Major Depression.
4. In serious emotional crisis (crying, screaming, mute) or acting out (head banging, threatening, kicking, etc.)
5. Housed in mental health housing (1, 2, 8, 9, 24)
6. Require medication continuity
7. Held in ITR for screening

C. Medium--See within 7 days of receipt

A combination of factors listed below:

1. History of mental health treatment
2. No serious symptomatology
3. No recent medication

4. Not housed in “mental” housing
5. Substance abuse on withdrawal protocol

D. Low—Schedule appointment for assessment.
A combination of the factors listed below:

1. No history or indication of mental health treatment
2. No symptomatology
3. No medication
4. Not housed in “mental” housing
5. Recent substance abuse history
6. Sleep problems

E. CRITERIA FOR MENTAL HEATLH TREATMENT

1. MEDICAL NECESSITY/ DIAGNOSIS

Serious and persistent mental illness or ***severe*** emotional disturbance, i.e., Schizophrenias, Schizoaffective Disorder, Bipolar Disorder, Major Depression, Psychotic Disorder NOS, etc. Substantial treatment history as indicated by BHCS face sheet or information from transferring facility.
Current acute psychiatric episode requiring mental health crisis intervention and stabilization.

2. MEDICAL NECESSITY/ FUNCTIONAL IMPAIRMENT

Substantial impairment in community or institutional functioning: problems understanding and cooperating with jail routine; problems maintaining a stable residence, ability to house properly and maintain cell environment; problems engaging in productive activities and daily responsibilities; problems maintaining health.

3. PSYCHIATRIC HISTORY

History of psychiatric hospitalizations, mental health treatment in other incarcerated or criminal justice settings, or a long history of outpatient mental health treatment.

4. SUBSTANCE ABUSE HISTORY

Dually diagnosed (mental illness and substance abuse) are generally accepted. If there are severe psychiatric symptoms, refer without waiting period. If it appears to be purely a substance abuse issue, defer with instructions to inmate to self-refer or ask nurse to make mental health referral after a few weeks.

5. DANGEROUS TO SELF OR OTHERS

Suicidal ideation, impulses. Danger to others because of a mental disorder.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-5 b 15 c)**	**PAGES: 1-2**
	RELATED ORDERS:	
	ISSUED DATE: March 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: April 27, 2012	
CHAPTER: Mental Health Program	**SUBJECT**: **Access to Care Housing Unit - Post Booking Referrals**	

I. **PURPOSE:** To ensure that inmates have access to mental health services post-booking.

II POLICY: Adult Forensic Behavioral Health Services encourages and responds to requests for mental health assessment and treatment from jail personnel, community members, and inmates, at anytime during the incarceration period to provide access to care and crisis intervention, adhering to policies regarding Criteria for Mental Health Treatment and Priority Status.

III PROCEDURE

A. The AFBH Clerk:

1. Pick up housing unit referrals / treatment requests from CALIFORNIA FORENSIC MEDICAL GROUP Medical Records daily
2. Date stamp all paperwork
3. Sort by type of forms: i.e. Referrals from CALIFORNIA FORENSIC MEDICAL GROUP nursing, self-referrals, Inmate Information forms. Enter totals received in space provided on Housing Unit Referral Log. Other forms such as MARS, Medical Consults, etc. are handled separately.
4. In Mainframe, run JQCD to find custody status. Note if NIC (not in custody) with NIC date; set aside to be filed at a later time. If in custody, press F1 and print JPQS screen. Attach this printout to front of referral.
5. In Referral Database, press Search. Enter PFN number to determine if patient has been previously seen or referred during this incarceration.
   a. If found, note most recent information; match with prior referral or assessment. Forward to current therapist or bring to attention of OD as needed.
   b. If not found, continue research.
6. In INSYST, run Client Locator (CLIE LO) to determine if patient has a mental health history. Press Gold S to save number, then Ep Ma to check for current status.
   a. If open, match referral to chart, place in current therapist's box or bring to the attention of the OD as needed.
   b. If not open, print face sheet (press Gold S to save number, go back to Client Locator screen (CLIE LO), press Gold F, F6.
7. For the remaining referrals which research shows have not been seen or referred previously, locate prior CJ chart:
   a. If patient has a CJ history from the year 2009, pull chart from closed files and attach

referral to front of chart.

b. If patient has a CJ history from the period 2008 and prior, check Iron Mountain binders by date of last episode to determines if chart is in storage. Highlight name, note date requested, and obtain the control # at the bottom of page. Add name to the Iron Mountain Log so chart can be ordered.

8. After sorting referrals and determining case status, enter patient information into the Activity Database. If a patient's treatment has begun either in ITR or via 4011.6 or referral process, and given an appointment, do not log subsequent referrals. If patient was seen but had no return appointment, handle as new referral.
9. Take urgent referrals to the Clinic Manager.
10. Place referrals in alpha sorter to be reviewed by clinician.

B. AFBH Clinician Reviewer:
   1. Review each referral to determine whether client meets one of six criteria for treatment and need for services.
      a. Schedule an appointment to be seen in either clinic or housing unit.
      b. Prepare an Inmate Information form to be sent to inmate requesting more information if appropriate. No appointment will be given at this time. If the Inmate Information Form is returned and the client still does not meet criteria for treatment, send the client the Referral Response Form listing other options in the jail.
   2. Post appointments to Master schedule
   3. Return referrals to clerk for processing.

C. AFBH Clerk:
   1. Prepare charts for patients with appointments.
   2. Mail Inmate Information Forms and Referral Response Forms to inmates. Place paperwork in accordion file to await response.

Reviewed 11-2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-5 b 15 a)**	**PAGES: 1-2**
	RELATED ORDERS:	
	ISSUED DATE: March 2008	
	REVIEW DATE: March 3, 2017	
	REVISION DATE: February 15, 2013	
CHAPTER: Mental Health Program	**SUBJECT**: **Access to Care Pre-screening / Screening Triage**	

I. PURPOSE: To ensure that inmates who meet mental health treatment criteria are prioritized and receive prompt attention.

II POLICY: Referrals received by the ITR screener are reviewed for urgency and given a priority rating of Emergency, High, Medium or Low. Those rated Emergency are seen immediately. High priority referrals should be seen the same day that the referral is received. Medium priority cases are to be seen for initial screening within seven days. Low priority cases may be deferred for a longer period of time. Post-booking referrals are triaged by the Clinic or AFBH assigned housing unit staffs.

III DEFINITIONS: **/ PROCEDURE**

A. Emergency--handle now

These are referrals that indicate the person is grossly psychotic or actively suicidal and may need admission to the Psychiatric Inpatient Unit.

B. High--Screen on the same day referral received. Any patients in the High category who are <u>not</u> seen on the day the referral is received will be passed on to the next shift as High priority until seen. High priority includes any one of the following descriptors:

1. Safety Cell Placement
2. At risk for self harm
3. Serious and persistent mental illness as reflected in face sheet or by self-report or outside information: Schizophrenias, Bipolar Disorders, other Psychotic Disorders, Major Depression.
4. In serious emotional crisis (crying, screaming, mute) or acting out (head banging, threatening, kicking, etc.)
5. Housed in mental health housing (1, 2, 8, 9, 24)
6. Require medication continuity
7. Held in ITR for screening

C. Medium--See within 7 days of receipt

A combination of factors listed below:

1. History of mental health treatment
2. No serious symptomatology
3. No recent medication

4. Not housed in “mental” housing
5. Substance abuse on withdrawal protocol

D. Low—Schedule appointment for assessment.
A combination of the factors listed below:

1. No history or indication of mental health treatment
2. No symptomatology
3. No medication
4. Not housed in “mental” housing
5. Recent substance abuse history
6. Sleep problems

E. CRITERIA FOR MENTAL HEATLH TREATMENT

1. MEDICAL NECESSITY/ DIAGNOSIS

Serious and persistent mental illness or ***severe*** emotional disturbance, i.e., Schizophrenias, Schizoaffective Disorder, Bipolar Disorder, Major Depression, Psychotic Disorder NOS, etc. Substantial treatment history as indicated by BHCS face sheet or information from transferring facility.
Current acute psychiatric episode requiring mental health crisis intervention and stabilization.

2. MEDICAL NECESSITY/ FUNCTIONAL IMPAIRMENT

Substantial impairment in community or institutional functioning: problems understanding and cooperating with jail routine; problems maintaining a stable residence, ability to house properly and maintain cell environment; problems engaging in productive activities and daily responsibilities; problems maintaining health.

3. PSYCHIATRIC HISTORY

History of psychiatric hospitalizations, mental health treatment in other incarcerated or criminal justice settings, or a long history of outpatient mental health treatment.

4. SUBSTANCE ABUSE HISTORY

Dually diagnosed (mental illness and substance abuse) are generally accepted. If there are severe psychiatric symptoms, refer without waiting period. If it appears to be purely a substance abuse issue, defer with instructions to inmate to self-refer or ask nurse to make mental health referral after a few weeks.

5. DANGEROUS TO SELF OR OTHERS

Suicidal ideation, impulses. Danger to others because of a mental disorder.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES (BHCS) **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B 5 b 15 d)**	**PAGES: 1-2**
	RELATED ORDERS:	
	ISSUED DATE: March 2008	
	REVIEW DATE: March 3, 2017	
	REVISION DATE: June 29, 2011	
CHAPTER: Mental Health Program	**SUBJECT: Criteria for Mental Health Treatment**	

I. **PURPOSE:** To define criteria for mental heath treatment.

II. **POLICY:** AFBH provides mental health treatment to county jail inmates consistent with the Alameda County BHCS criteria for treatment and expectations of jail regulations and accreditations.

III. **PROCEDURE: / DEFINITIONS / GUIDELINES**

A. CRITERIA FOR MENTAL HEALTH TREATMENT (*SUMMARY)*

1. MEDICAL NECESSITY/ DIAGNOSIS

Serious and persistent mental illness or ***severe*** emotional disturbance, i.e., schizophrenias, schizoaffective disorder, bi-polar disorder, major depression, psychotic disorder NOS, etc. Substantial treatment history as indicated by BHCS face sheet or information from transferring facility.
Current acute psychiatric episode requiring mental health crisis intervention and stabilization.

2. MEDICAL NECESSITY/ FUNCTIONAL IMPAIRMENT

Substantial impairment in community or institutional functioning: problems understanding and cooperating with jail routine; problems maintaining a stable residence, ability to house properly and maintain cell environment; problems engaging in productive activities and daily responsibilities; problems maintaining health.

3. PSYCHIATRIC HISTORY

History of psychiatric hospitalizations, mental health treatment in other incarcerated or criminal justice settings, or a long history of outpatient mental health treatment.

4. SUBSTANCE ABUSE HISTORY

Dually diagnosed (mental illness and substance abuse) are generally accepted. If severe psychiatric symptoms, refer without waiting period. If appears to be purely a substance abuse issue, defer with instructions to inmate to self-refer or ask nurse to make mental health referral after a few weeks.

5. DANGEROUS TO SELF OR OTHERS; GRAVE DISABILITY

Suicidal ideation, impulses. Danger to others because of a mental disorder. Major difficulty in taking care of one's own personal needs, following instructions, etc. due to s serious metnal illness.

6. OTHER CONDITIONS:

AFBH staff receive referrals for mental health assessments / services initialed by nurses, sheriff's staff, court personnel, families, inmates themselves, etc. for a range of conditions, Referrals are triaged for urgency and assessments planned accordingly. .

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B 5 c**	**PAGES: 1**
	RELATED ORDERS: ACA: 4-ALDF-6B-08	
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 3, 2017	
	REVISION DATE: January 22, 2009	
CHAPTER: Fair Treatment of Inmates	**SUBJECT**: **Disabled Inmates**	

I. **PURPOSE**: To ensure that disabled inmates have access to mental health services in the jail.

II. **POLICY**: Inmates are treated fairly and are not discriminated against due to their physical or mental disabilities. Staff and inmates have access to an appropriately trained and qualified individual who is educated in the problems and challenges faced by inmates with physical and/or mental impairments, programs designed to educate and assist disabled inmates, and legal requirements for the protection of inmates with disabilities.

III. **PROCEDURE:**

A. Inmates who have identified physical disabilities such as visual and auditory impairments are referred to the Sheriff's Inmates Services Division for assistance with access to services and programs.

B. Inmates with serious mental impairments are referred to Adult Forensic Behavioral Health (AFBH) for access to mental health services.

C. At any time that a AFBH clinician suspects that an inmate may be developmentally disabled, the clinician must contact the Regional Center of the East Bay to determine eligibility and/or current status of the patient's case. ***510-383-1200,***
   - **Pursuant to Section 1057 of Title 15: Developmentally Disabled Inmates**. The health authority or designee shall contact the Regional Center on any inmate suspected or confirmed to be developmentally disabled for the purposes of diagnosis and/or treatment within 24 hours of such determination, excluding holidays and weekends. Contact the Regional Center @ (510) 383-1200. (See reverse of Initial Screening form.)

D. Adult Forensic Behavioral Health staffs provide mental health treatment for inmates with mental illnesses.

E. See other sections of the Policy and Procedure manual for the full scope of mental health services provided to inmates.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-6 a**	**PAGES: 1-2**
	RELATED ORDERS:	
	ISSUED DATE: March 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: September 1, 2015	
CHAPTER: Mental Health Program	**SUBJECT:** **Safety Cells**	

I PURPOSE: To ensure the safety of inmates who need special protection from self harm or harm to others.

II POLICY: Adult forensic behavioral health Services (AFBH) staff is actively involved in the protection of inmates via Safety Cell interventions. AFBH staff initiate, monitor, and recommend the discontinuance of Safety Cell placements. Safety Cell placements may be initiated by custody, medical, and AFBH staffs. When inmates are deemed to no longer be at risk, AFBH staff recommend discontinuation of Safety Cell by indicating this on the Safety Cell logs. However, the ultimate decision is with the facility Watch Commander.

NOTE: TO BE TRANSFERRED TO A SAFETY CELL, AN INMATE MUST BE DEEMED A DANGER TO SELF OR OTHERS.

III PROCEDURE: CALIFORNIA FORENSIC MEDICAL GROUP nursing or ACSO custody staffs will notify AFBH staff whenever an inmate has been placed in a Safety Cell. Instructions to CALIFORNIA FORENSIC MEDICAL GROUP and ACSO staff for obtaining emergency intervention are posted throughout the jail (see attached). AFBH is onsite from 0800-2300. Psychiatric services for crisis situations can be obtained by contacting the AFBH ITR screener at x [redacted] during those hours. *Between 2300-0800, On-Call staff is contacted at* [redacted]**.** After 3 beeps, enter return phone number followed by the # sign. AFBH *staff should respond ASAP, within 15 minutes. (See Section B19 of P&P for On-Call procedures.)*

- Safety Cell placements can be made by custody staff, nursing, or AFBH staffs. Mental heath staffs evaluate the inmate within 8 hours of placement in the Safety Cell. Thereafter, rechecks must be done every 24 hours.
- Jail policy prohibits maintaining an inmate in a Safety Cell over 72 hours. Any plan to extend the Safety Cell placement requires discussion with the Clinic Manager and the Watch Commander. The jail captain will be notified by custody staff on all Safety Cell placements that exceed 72 hours.
- When an inmate is placed in a Safety Cell, an Inmate Observation Log (IOL) is started. AFBH ITR clinicians or assigned AFBH housing unit staffs are responsible for monitoring the inmate's mental condition and the appropriateness of the placement as long as the inmate remains in the Safety Cell. A suicide risk assessment is part of all Safety-Cell evaluations.

- When a inmate is in the Safety Cell secondary to suicidal ideation only AFBH can sign an inmate out of the safety cell.

:

1. The AFBH ITR (booking) screener is notified via phone call whenever an inmate is placed in a Safety Cell and performs the following duties:
   A. Between the hours of 7:30 am – 3:00 pm, the ITR clinician will notify the HU clinicians immediately regarding the safety cell placement.
   B. Between the hours of 3:00 pm to 10:00 pm, the ITR clinician will:
      a) Researches and prints patient information:
      b) Insyst Face sheet
      c) AFBH Activity Database
      d) Mainframe information including custody status (JQCD/JQCS), movement history (JQMH), demographic data (JPQP)
2. The ITR screener or designated AFBH housing unit staff evaluates the inmate in the Safety Cell as soon as possible, within 8 hours of placement. Housing unit clinicians are responsible for new safety cell placement and ongoing assessments Monday-Friday, 7:30 am to 3:00 pm. ITR staff are responsible for new safety cell placements and ongoing monitoring Monday-Friday 3:00 pm to 10:00 pm. When notification is received by the On-Call clinician, he or she makes arrangements to have the inmate evaluated within 8 hours by either notifying the incoming ITR screener via voice mail or by making other arrangements with AFBH staff.
3. Determines whether to maintain or recommend discontinuation of the Safety Cell placement. **Initials and signs off on all Safety Cell logs.**
4. If hospitalization is indicated, see Section **B 6 b** of P&P for admission to the Psychiatric Inpatient Unit procedure.
5. Notifies Classification of the recommendation using the Classification Housing Unit Recommendation form.
6. Notifies the inmate's assigned clinician via phone call if the case is currently open.
7. Completes a Progress Note or Initial Screening as appropriate.

   Note: If there is any doubt about the appropriate disposition of a Safety Cell situation, contact the BHCS Clinical Supervisor or Clinical Manager.

Reviewed: 11- 2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-6 a**	**PAGES: 1-2**
	RELATED ORDERS:	
	ISSUED DATE: March 2008	
	REVIEW DATE: March 3, 2017	
	REVISION DATE: September 1, 2015	
CHAPTER: Mental Health Program	**SUBJECT:** **Safety Cells**	

I PURPOSE: To ensure the safety of inmates who need special protection from self harm or harm to others.

II POLICY: Adult forensic behavioral health Services (AFBH) staff is actively involved in the protection of inmates via Safety Cell interventions. AFBH staff initiate, monitor, and recommend the discontinuance of Safety Cell placements. Safety Cell placements may be initiated by custody, medical, and AFBH staffs. When inmates are deemed to no longer be at risk, AFBH staff recommend discontinuation of Safety Cell by indicating this on the Safety Cell logs. However, the ultimate decision is with the facility Watch Commander.

NOTE: TO BE TRANSFERRED TO A SAFETY CELL, AN INMATE MUST BE DEEMED A DANGER TO SELF OR OTHERS.

III PROCEDURE: CALIFORNIA FORENSIC MEDICAL GROUP nursing or ACSO custody staffs will notify AFBH staff whenever an inmate has been placed in a Safety Cell. Instructions to CALIFORNIA FORENSIC MEDICAL GROUP and ACSO staff for obtaining emergency intervention are posted throughout the jail (see attached). AFBH is onsite from 0800-2300. Psychiatric services for crisis situations can be obtained by contacting the AFBH ITR screener at x [redacted] during those hours. *Between 2300-0800, On-Call staff is contacted at* [redacted]**.** Safety Cell placements can be made by custody staff, nursing, or AFBH staffs. Mental heath staffs evaluate the inmate within 8 hours of placement in the Safety Cell. Thereafter, rechecks must be done every 24 hours.

- Jail policy prohibits maintaining an inmate in a Safety Cell over 72 hours. Any plan to extend the Safety Cell placement requires discussion with the Clinic Manager and the Watch Commander. The jail captain will be notified by custody staff on all Safety Cell placements that exceed 72 hours.
- When an inmate is placed in a Safety Cell, an Inmate Observation Log (IOL) is started. AFBH ITR clinicians or assigned AFBH housing unit staffs are responsible for monitoring the inmate's mental condition and the appropriateness of the placement as long as the inmate remains in the Safety Cell. A suicide risk assessment is part of all Safety-Cell evaluations.

:

1. The AFBH ITR (booking) screener is notified via phone call whenever an inmate is placed in a Safety Cell and performs the following duties:

   A. ***Between the hours of 7:30 am – 3:00 pm, the ITR clinician will notify the HU clinicians immediately regarding the safety cell placement. B.***
   B. ***After 3:00 pm and on the Weekend, ITR staff will be responsible for all safety cell placements and emergencies.***
2. The ITR screener or designated AFBH housing unit staff evaluates the inmate in the Safety Cell as soon as possible, within 8 hours of placement. Housing unit clinicians are responsible for new safety cell placement and ongoing assessments Monday-Friday, 7:30 am to 3:00 pm. ITR staff are responsible for new safety cell placements and ongoing monitoring Monday-Friday 3:00 pm to 10:00 pm. When notification is received by the On-Call clinician, he or she makes arrangements to have the inmate evaluated within 8 hours by either notifying the incoming ITR screener via voice mail or by making other arrangements with AFBH staff.
3. Determines whether to maintain or recommend discontinuation of the Safety Cell placement. **Initials and signs off on all Safety Cell logs.**
4. If hospitalization is indicated, see Section **B 6 b** of P&P for admission to the Psychiatric Inpatient Unit procedure.
5. Notifies Classification of the recommendation using the Classification Housing Unit Recommendation form.
6. Notifies the inmate's assigned clinician via phone call if the case is currently open.
7. Completes a Progress Note or Initial Screening as appropriate.

   Note: If there is any doubt about the appropriate disposition of a Safety Cell situation, contact the Clinic Manager.

Alameda County Behavioral Health Care Services
ADULT FORENSIC BEHAVIORAL HEALTH PROGRAM

ADMISSIONS TO PSYCHIATRIC INPATIENT UNIT

Procedure and Abbreviated Checklist (B 6 b1)

A. To admit patient to Psych Inpatient Unit, do the following:

1. Advise the Deputy responsible for care and custody of the inmate of the pending 5150.

2. Call CP-1 (x[redacted]) and advise staff of the pending 5150. (They will notify the Watch Commander and Admin Sgt. of the 5150 so that transfer deputies can be identified and assigned.)

3. Obtain a Jail and County Face Sheet on this inmate so as to be able to pass identifying information on to staff at the acute care unit when they ask for it.

5. Contact the Charge Nurse at JGPP PES and advise of the pending 5150- Call [redacted].)

6. Notify Classification (X[redacted] during normal duty hours or X[redacted] after regular business hours) and CP-1 (X[redacted]) and advise them of the 5150, confirm the name and PFN and destination of the inmate. (I.e. Santa Clara County Jail or JGPP).

7. Contact the Housing Unit Nurse. Advise the nurse of the pending 5150 and request medical clearance for transfer to the psychiatric in-patient care unit. If the housing unit nurse is not available, contact the CALIFORNIA FORENSIC MEDICAL GROUP Charge Nurse, X[redacted], or the Nursing Supervisor (x[redacted]), and make the same request. **IF MEDICAL CLEARANCE CANNOT BE OBTAINED AND PROVIDED, THE INMATE MUST GO TO HIGHLAND HOSPITAL (HACH), IN OAKLAND, FOR MEDICAL CLEARANCE TO BE OBTAINED BEFORE HE/SHE CAN BE ACCEPTED INTOTHE IN-PATIENT UNIT**. Other emergency hospital facilities may be used as well as HACH, but **medical clearance is mandatory.**

8. Complete the 5150 form. Include the inmate's PFN at the top of the page. Remove and retain the first green copy of the 5150 form for our records.

9. In coordination with the AFBH clerical staff, prepare the transfer packet. Use the Admission Checklist for Transfer to Santa Clara County Jail Acute Psychiatric Treatment Unit as a guide to ensure that all needed material and information is included in the transfer packet. Include the checklist in the transfer packet.
10. Enclose the transfer packet in a medical transfer envelope or a plain manila envelope. Address it to the receiving Acute Care Unit, and if medical is to be obtained, include in the address the phrase "via HACH for Medical Clearance." Deliver the transfer packet to CP-1 when ready for transfer. Place a photocopy of the 5150 form on the outside of the transfer envelope so that the copy may be entered into the inmate's record jacket
11. Contact an AFBH staff psychiatrist and request that any existing order for psychotropic medication be terminated so that there are no conflicts with medication issuance when the inmate returns to Santa Rita Jail.

12. Complete a new Assessment form on all 5150'd inmates. Prepare progress notes, etc. to document the actions you have taken.

13. Place the saved copy of the 5150 green sheet on top of the inmate's AFBH chart, insert the new notes, etc. and deliver the chart to clerical for processing.

Additional Information

John George PES
2060 Fairmont Drive
San Leandro, CA 94578

PES Charge Nurse: [redacted]

B 6 c Reviewed and revised March 3, 2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-6 b**	**PAGES: 1-3**
	RELATED ORDERS:	
	ISSUED DATE: March 31, 2010	
	REVIEW DATE: November 30, 2015	
	REVISION DATE: March 6, 2013	
CHAPTER: Mental Health Program	**SUBJECT**: **Admission to Psychiatric Inpatient Unit**	

I PURPOSE: To ensure that jail inmates who need acute psychiatric inpatient care are transferred to appropriate facilities.

II POLICY: Adult Forensic Behavioral Health Services AFBH) is responsible for hospitalizing inmates in Psychiatric Inpatient Units who are a danger to self or others or gravely disabled per Welfare and Institutions (WIC) Code 5150. Inmates needing inpatient hospitalization may be placed in a Safety Cell prior to their transfer to the inpatient unit to protect them from harm. (See Policy & Procedure for Safety Cells in Section B 6 a.). Medical clearance is required prior to admission. CALIFORNIA FORENSIC MEDICAL GROUP medical staff will evaluate the inmate and complete the medical clearance form prior to transport to the acute psychiatric unit. If the inmate refuses to cooperate with the medical clearance procedure at the jail, the inmate will need to be taken to the county hospital (Highland) or other medical hospital for medical clearance prior to transport to the acute unit.

III PROCEDURE:

AFBH Clinician:

1. Evaluates inmate and determines need for psychiatric inpatient treatment, in consultation with assigned clinician/psychiatrist if appropriate.
2. Completes WIC 5150 form and other documentation (Initial Screening, Assessment, Progress Note, etc.)
3. Obtains the signature of an authorized ACSO staff on the 5150 document.
4. Notifies Clinic Manager of WIC 5150. Include information regarding special circumstances.
5. Consults Abbreviated Checklist (attached) and makes notifications as required.
6. Notifies Clerk of WIC 5150.

AFBH Clerical staff:

1. Prepare transfer packet:
    a. Copies of the Initial Screening, Assessment, and Progress Notes since Initial Screening (this incarceration only)
    b. ***Original*** WIC 5150 (copy to chart, copy to PHS)
    c. ***Original*** CALIFORNIA FORENSIC MEDICAL GROUP Medical Transfer Sheet (copy to chart)
    d. ***Original*** CALIFORNIA FORENSIC MEDICAL GROUP Medical Clearance (copy to chart)

e. Others documents specified on the *Admission Checklist for Transfer to Santa Clara County Custody Acute Psychiatric Treatment Unit* (see attached).

2. Prepares transfer envelope with the following information written on front of envelope: patient name, PFN#, To: (specify Psychiatric Inpatient Unit, i.e. Santa Clara or John George Psychiatric Pavilion). If patient requires medical clearance by a medical emergency room or hospital, specify "via medical facility."
3. Delivers the sealed transfer envelope to CP-1 to accompany patient to PIU.
4. Completes data input in INSYST. Referral out code is:
    a. John George PP =01016
    b. Santa Clara Co. = 47001.
5. Holds chart in clinic, pending discharge from PIU.

Special Circumstances:

- **Patients admitted to John George Psychiatric Pavilion:** When Santa Clara County PIU is unable to accept the patient; JGPP will be used as an alternative treatment facility. The Clinic Manager is responsible for monitoring bed space at Santa Clara County inpatient unit 8A, and arranges transfer from JGPP when indicated.
- **Mental health screening prior to booking:** ASCO policy and the law prevents the jail from accepting into custody individuals who are acutely psychiatrically ill or suicidal until they have been cleared by a psychiatric emergency service (PES). Prior to booking, the ITR screener may be asked to assess a detainee for acute psychiatric conditions. Our recommendation regarding the necessity for admission to PES should be given to the booking officer.
- **Medical treatment prior to admission to Psychiatric Inpatient Unit:** If there is an unresolved medical issue the patient will have to be taken to a medical facility prior to admission to the psychiatric inpatient unit. Prepare admission packet as required. Note on envelope "To: (specify PIU) via Medical Emergency Facility". If the patient is admitted to the medical facility, that facility may have to generate a new WIC 5150 in order to secure acute psychiatric treatment. The WIC 5150 is only good for 8 hours.
- **Admission to Psychiatric Inpatient Unit during On-Call hours:** The AFBH On-Call clinician will determine by telephone consultation whether an immediate WIC 5150 is necessary or the patient can wait for evaluation by an on-site clinician. If immediate WIC 5150 is necessary, the clinician will assist the ACSO and CALIFORNIA FORENSIC MEDICAL GROUP staff in completing documents necessary for admission.
- **Glenn Dyer Detention Facility Inmates:** If an inmate housed at Glenn Dyer Detention Facility (GDDF - north county) is determined to be at risk for suicide or otherwise in need of emergency mental health attention, staff at GDDF should contact AFBH for consultation on the most appropriate intervention. If AFBH staff determine the inmate needs to be sent to the acute psychiatric facility, ACSO deputies will complete the 5150 documents and transport the inmate to John George Psychiatric Pavilion.

AFBH contact numbers:

ITR Screening [redacted]

Note: AFBH is on site from 0800-2300. Psychiatric services for crisis situations can be obtained by contacting the AFBH ITR screener at x.[redacted] during those hours. ***Between 2300-0800****, On-Call staff is contacted at* [redacted]***.*** *After 3 beeps, enter return number followed by the # sign. . AFBH staff should respond ASAP, within 15 minutes.*

Reviewed 11/2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-6 c**	**PAGES: 1**
	RELATED ORDERS:	
	ISSUED DATE: February 19, 2014	
	REVIEW DATE: November 15, 2015	
	REVISION DATE: March 8, 2016	
CHAPTER: Mental Health Program	**SUBJECT Discharges from Psychiatric Inpatient Unit / Use of OPHU**	

I PURPOSE: To ensure that inmates who return from psychiatric inpatient units as a result of AFBH ACSO 5150s are assessed for safety and psychiatric stability, and to provide for continuity of care.
Note: AFBH has requested that John George Psychiatric Pavilion not return inmates to the jail on weekends or holidays.

II POLICY: Adult Forensic Behavioral Health Services (AFBH) staff provides assessments, monitoring, and continuity of medications to inmates returning to jail from Psychiatric Inpatient Units as a result of AFBH / ACSO 5150s. Returning inmates are housed in the Outpatient Housing Unit (OPHU) on an IOL (Inmate Observation Log) initiated by the sheriff's office until assessed and cleared for regular housing or returned to the hospital by a AFBH supervisor and AFBH psychiatrist.

III PROCEDURE:

A. The Sheriff's Office (ACSO) initiates an IOL on all inmates returning from an acute psychiatric hospital stay as a result of a AFBH / ACSO initiated 5150

B. The inmate is placed in an OPHU cell to be assessed and cleared by a AFBH manager and psychiatrist. Although most inmates will be assessed and cleared on the same day, some may need to stay in the OPHU for up to three days to allow time for transition back to incarceration and / or to allow time for AFBH staff to review records and conduct a risk assessment. The IOL remains in place during this time.

C. If an inmate is placed on a 5150 for a serious suicide attempt (Hanging//Cutting) The Inmate will remain on an IOL for at least seven days, after they return from the hospital.

D. If an inmate is to be held in the OPHU beyond one day, AFBH psychiatrists will
   a. Provide California Forensic Medical Group with written orders regarding the plan for the specific inmate including directions for dispensing psychiatric medications and any ongoing nursing tasks needed, such as taking vitals daily. California Forensic Medical Group will provide whatever medical services are needed per usual protocols.
   b. Enter a note in Catalyst and into the inmate's OPHU hardcopy chart documenting the specific plan for monitoring, indicating who will clear the inmate
   For example "hold inmate in OPHU on IOL for three days for suicide risk monitoring. To be cleared by AFBH manager and psychiatrist."

E. The available AFBH Manager does the following:
   1. Receives notification of impending discharge by Psychiatric Inpatient Unit via phone and/or fax.

2. Receives notification from ACSO or California Forensic Medical Group of arrival of inmate to the OPHU.
3. With a AFBH psychiatrist, reviews all information known about the inmate, and, as soon as possible, conducts an evaluation that includes both a mental status appraisal and a suicide risk assessment (a specific form is available for this assessment).
4. With the psychiatrist, makes a joint decision / recommendation to:
    a. Clear the inmate for general housing
    b. Continue or discontinue the IOL.
    c. Continue the inmate's stay in the OPHU (up to three days) for further observation and assessment
    d. Initiate re-hospitalization.
5. If the inmate is cleared for general housing, arranges for transfer of inmate and advises Sheriff's Classification staff by phone ([redacted]) and by faxing the Housing / Classification form.

F. **<u>Weekends, nights, holidays or when no AFBH manager or psychiatrist is onsite</u>.**

<u>Note</u>: There are no AFBH managers or psychiatrists' onsite on weekends, nights, or holidays. AFBH ITR clinicians are generally onsite daily from 7:00 am until 11:00 pm and psychiatrists are On-Call weekdays until 11:00 pm and weekends and holidays until 9:00 pm. When there is no AFBH manager and psychiatrist onsite, the following procedures will occur:

1. The AFBH ITR clinician is notified of the inmate's return from the hospital.
2. A AFBH ITR clinician makes daily checks on the inmate in the OPHU, documenting the assessments as per AFBH documentation procedures. .
3. The AFBH ITR clinician does not discontinue the IOL or clear the inmate for general housing.
4. The inmate is to be held in the OPHU until an assessment by a AFBH manager and psychiatrist can occur.
5. The AFBH ITR clinician obtains a bridge medication order from the On-Call AFBH psychiatrist for continuation of psychiatric medications.
6. The AFBH ITR staff requests that the On-Call psychiatrist give a verbal order to the California Forensic Medical Group nurse at [redacted] who enters the order in the inmate's OPHU chart.
7. The AFBH psychiatrist documents his or her contact per AFBH documentation procedures for all On-Call notes, entering the contact on his or her On-Call log identifying the name of the nurse to whom the order was given.
8. If the inmate is returned from the hospital when there are no AFBH ITR staff onsite, (generally between 11:00 pm and 7:30 am), the inmate should be held in the OPHU and a message left at x[redacted] for AFBH to follow-up. Or, for assistance, contact the AFBH On-Call Clinician at [redacted] (dial the number and after three (3) beeps, enter your return phone number followed by the # sign).
9. On the next regular workday (M-F except for holidays), the inmate will be assessed by a AFBH manager and psychiatrist and a decision made as to next steps.

G. If an inmate is held in the OPHU per AFBH doctor's orders, the AFBH psychiatrist will provide a Discharge Order to release the inmate from the OPHU.

Reviewed and revised 03/2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-6 d**	**PAGES: 1**
	RELATED ORDERS:	
	ISSUED DATE: August 26, 2010	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: February 13, 2013	
CHAPTER: Mental Health Program	**SUBJECT: Glenn Dyer Psychiatric Emergencies Admission to Psychiatric Inpatient Unit**	

I PURPOSE: To ensure that inmates housed at Glenn Dyer Detention Facility (GDDF – north county jail) who need acute psychiatric inpatient care are transferred to an appropriate facility.

II POLICY: Adult Forensic Behavioral Health Services (AFBH) is on site at GDDF on **Monday's and Thursday's from 0800-1600)** In the event that an inmate at GDDF becomes suicidal or otherwise experiences a psychiatric emergency, when AFBH is offsite, AFBH staff provide consultation and direction to GDDF sheriff's staff via pager, to the most appropriate intervention. Alameda County Sheriff's Office staff (ACSO) do not countermand instructions given by mental health professionals.

III PROCEDURE: for GDDF inmates at risk for suicide or needing emergency psychiatric attention, **(WHEN AFBH IS OFF SITE)**

1. GDDF sheriff's staff contacts the AFBH ITR office at Santa Rita Jail or the AFBH On-Call clinician for consultation to determine the most appropriate intervention.
2. **AFBH contact numbers:**

   From 0800-2300 AFBH is onsite at SRJ. Psychiatric consultation for crisis situations can be obtained by contacting the AFBH ITR screener at **x.** [redacted] during those hours.
   a) ***Between 2300-0800****, AFBH On-Call staff is contacted at* **x**[redacted]*. AFBH staff should respond ASAP, within 15 minutes.*
3. AFBH staff consults with sheriff's and nursing staffs to determine the degree of risk and the most appropriate intervention to protect the safety of the inmate.
4. If AFBH staff determines the inmate needs to be sent to the acute psychiatric facility, GDDF sheriff's staff will complete the 5150 documents and transport the inmate to John George Psychiatric Pavilion (JGPP).
5. Sheriff's staff are not to countermand directions given by mental health professionals..
6. Pending transport to JGPP, the inmate should be housed in a GDDF Safety Cell **not to exceed 8 hours**.
7. **Note: GDDF inmates determined to be at risk for suicide are not to be transferred from a Safety Cell at GDDF to a Safety Cell at SRJ.**

Reviewed 11/2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-6 e**	**PAGES: 1**
	RELATED ORDERS:	
	ISSUED DATE: October 14, 2011	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: April 30, 2012	
CHAPTER: Mental Health Program	**SUBJECT: Inmates Detoxing from Alcohol or Certain Other Drugs**	

I PURPOSE: To ensure that inmates who may be withdrawing from alcohol and / or other drugs get the appropriate medical attention. Detoxing from alcohol and / or certain other drugs can constitute a medical emergency as well as create a behavioral management problem in the jail.

II POLICY: AFBH staffs participate in the identification and referral of inmates who may be detoxing and need medical attention. AFBH staff in booking (ITR) and elsewhere in the jail consult with AFBH psychiatrists who may refer to California Forensic Medical Group physicians for initiation of Detox protocols if indicated.

III PROCEDURE:

1. When a AFBH clinician suspects that an inmate may be detoxing from alcohol or other drugs, he or she contacts the AFBH psychiatrist – either Onsite or On Call. .See below for information and possible symptoms of detox for various substances).
2. The AFBH psychiatrist obtains information from the clinician and determines if the inmate may need a medical intervention for withdrawal.
3. The AFBH psychiatrist contacts the California Forensic Medical Group physician – either onsite on On-Call -- to discuss the case.
4. The California Forensic Medical Group physician initiates withdrawal protocols if indicated.

Note: California Forensic Medical Group provides AFBH with updated schedules of California Forensic Medical Group physicians on a regular basis.

- Withdrawal signs vary by substance:
  - **Alcohol withdrawal** may show up from 4 hours to 7 days) or so after the reduction or cessation of heavy use as sweating, rapid pulse, hand tremor, insomnia, nausea or vomiting, transient hallucinations of visions, voices, or touch, agitation, anxiety, delirium, grand mal seizures. Symptoms usually peak during the second day, improving markedly by the fourth or fifth day.
  - **Benzodiazepine withdrawal syndrome**—(**benzo withdrawal)**—is the cluster of symptoms which appear when a person who has taken benzodiazepines long term and has developed benzodiazepine dependence stops taking benzodiazepine drug(s) or during dosage reductions. Benzodiazepine withdrawal is similar to alcohol withdrawal syndrome and barbiturate withdrawal syndrome[1] and can in severe cases provoke life threatening withdrawal symptoms such as seizures.[2] Severe and life threatening symptoms are mostly limited to abrupt or over-rapid dosage reduction from high doses.[3] A protracted withdrawal syndrome may develop in a proportion of individuals with symptoms such as anxiety, irritability, insomnia and sensory

disturbances. In a small number of people it can be severe and resemble serious psychiatric and medical conditions such as schizophrenia and seizure disorders.[4] A serious side effect of benzodiazepine withdrawal is suicide.[5]
Chronic exposure to benzodiazepines causes physical adaptations in the brain that counteract the drug's effects. This is known as a tolerance and physical dependence. When the drug is removed or dosage reduced in an individual physically dependent on benzodiazepines, numerous withdrawal symptoms both physical and psychological may appear and will remain present until the body reverses the physical dependence by making adaptions to the drug-free environment and thus returning the brain to normal function.[8] Generally, the higher the dose and the longer a benzodiazepine is used and the more rapidly a benzodiazepine is discontinued, the more likely severe withdrawal symptoms will occur. However, severe withdrawal symptoms can still occur during gradual dose reduction or from relatively low doses.[9]In certain selected patient groups the occurrence of withdrawal symptoms is as high as 100%, whereas in unselected patient groups more than 50% of subjects are able to discontinue benzodiazepines with mild or even no withdrawal symptoms at all. Withdrawal symptoms may persist for weeks or months after cessation of benzodiazepines. In a smaller subset of patients withdrawal symptoms may continue at a sub acute level for many months or even a year or more. Long term use of benzodiazepines may lead to withdrawal like symptoms emerging despite a constant therapeutic dose. Correctly attributing previously misdiagnosed withdrawal symptoms such as anxiety to the withdrawal effects of benzodiazepines, individualized taper strategies according to withdrawal severity, the addition of alternative strategies such as reassurance and referral to benzodiazepine withdrawal support groups increase the success rate of withdrawal.[10][11] Withdrawal symptoms can resemble psychiatric symptoms which doctors often interpret as evidence for the need of benzodiazepines which in turn leads to withdrawal failure and reinstatement of benzodiazepines, often to higher doses.[4]

- **Amphetamine withdrawal** develops within a few hours to several days after cessation or reduction in heavy use and generally involves unpleasant mood, fatigue, vivid and unpleasant dreams, insomnia or hypersomnia, increased appetite with rapid weight gain, either hyperactivity or lethargy, depression which can involve suicidality. Acute withdrawal generally lasts several days, but depression can last weeks.
- **Cocaine withdrawal** appears very similar to amphetamine withdrawal.
- **Hallucinogen** flashbacks are a recurrence of the perceptual disturbances experienced during earlier intoxications, when the person is no longer intoxicated.
- **Opioid withdrawal** begins within 6 – 12 hours of the last dose for heroin, or within 2 – 4 days for methadone, and is characterized by complaints of anxiety, restlessness, and an “achy feeling” that may be in the back and legs, craving for the drug, irritability, increased sensitivity to pain, unpleasant mood, nausea or vomiting, muscle aches, teary eyes or runny nose, dilated pupils, goosebumps, increased sweating, diarrhea, yawning, fever, insomnia. Acute symptoms usually last up to seven days; less acute symptoms can last for weeks to months, and include anxiety, unpleasant mood, loss of interest in things, insomnia, and drug cravings.

Reviewed 11-2015

Alameda County Behavioral Health Care Services
ADULT FORENSIC BEHAVIORAL HEALTH PROGRAM

Attention all ACSO and CALIFORNIA FORENSIC MEDICAL GROUP staff:

PSYCHIATRIC EMERGENCIES

Notify AFBH immediately when the following occur:

IOL Initiations
Safety Cell Placements
Sexual Assaults
Suicide attempts and fatalities
WIC 5150 situations
Death notifications

Between 8am-11p creener:

X [redacted]

Between 11pm-8am, contact the On-Call clinician: [redacted]

After 3 beeps, enter return phone number followed by the # sign

Psychiatric Emergency Flyer Rev. 11/2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-6 g**	**PAGES: 1**
	RELATED ORDERS:	
	ISSUED DATE: February 19,2014	
	REVIEW DATE: November 20, 2015	
	REVISION DATE March 4, 2014	
CHAPTER: Mental Health Program	**SUBJECT: Communication among jail staffs: Use of OPHU for Suicide Risk Monitoring when needed for longer than one day.**	

I. PURPOSE: At times, inmates returning to jail as a result of AFBH 5150s to psychiatric hospitals may still be at risk for suicide or may be too decompensated for placement in the jail. The option of a brief stay (up to three days) in the OPHU for selected inmates provides an opportunity to assess and monitor them before clearing them for general jail housing. It is important that all staffs support these plans and that clear communication takes place between mental health (AFBH), medical (California Forensic Medical Group), and sheriff's staffs regarding this use of the OPHU. All staffs involved with these OPHU cases need to be informed of the care plans and carry out their respective tasks.

II POLICY: As a clinical decision, a AFBH manager and psychiatrist may initiate a plan to have an inmate held in the OPHU for a brief time (up to three days) following psychiatric hospitalization to allow time for further assessment and monitoring. The AFBH manager and psychiatrist will communicate the plan to the California Forensic Medical Group OPHU staff.
(Please see AFBH Policy and Procedure B 6 c for more specific details).

III PRODEDURE: When an inmate returns to jail from a psychiatric hospital as a result of a AFBH / ACSO 5150 the inmate may be held in the OPHU for up to three days for monitoring and continued evaluation as follows:

1. During **regular workdays**:
    a. A AFBH manager and psychiatrist determine that an inmate may be at continued risk and they initiate an OPHU monitoring plan.
    b. The AFBH psychiatrist completes a AFBH Doctors' Orders form and provides it to California Forensic Medical Group's OPHU staff.
    c. The AFBH psychiatrist enters a note in Catalyst and into the inmate's OPHU chart documenting the specific plan for monitoring, indicating who will clear the inmate
        For example "hold inmate in OPHU on IOL for three days for suicide risk monitoring. To be cleared by AFBH staff".
2. AFBH ITR clinicians monitor the inmate daily and report to the AFBH manager and psychiatrist.
3. The AFBH psychiatrist provides a Doctors' Discharge order when the inmate is ready for release from the OPHU.
4. On **weekends, holidays, or evenings**
    If the inmate is returned from the hospital when no AFBH manager or psychiatrist are onsite:
    a) The onsite AFBH ITR staff will assess the inmate and contact the On-Call AFBH psychiatrist, if needed, who will give a verbal order to a California Forensic Medical Group nurse at [redacted] who can enter the order in the inmate's OPHU chart.

b) The AFBH psychiatrist documents his or her contact per AFBH documentation procedures for all On-Call notes, entering the contact on his or her On-Call log identifying the name of the nurse to whom the order was given.

c) If the inmate is returned from the hospital when there are no AFBH staff onsite, the inmate should be held in the OPHU and a message left for AFBH ITR staff (at x[redacted]) to follow-up..

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B-7	**PAGES:** 1 of 7
	RELATED ORDERS: ACA 4-ALDF-4C-32. 4C-33	
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: September 1, 2015	
	REVISION DATE: March 8, 2016	
CHAPTER: Protection From Harm	**SUBJECT: Suicide Prevention and Intervention**	

I. **PURPOSE:** to ensure a comprehensive suicide prevention program within the Alameda County jails.

II. **POLICY**: California Forensic Medical Group Health, Adult forensic behavioral health (AFBH), and Sheriff's Office staff are expected to be familiar with the Santa Rita Jail/Glenn Dyer Jail Suicide Prevention/Intervention Program. California Forensic Medical Group Health, AFBH, and Sheriff's Office staff will participate effectively in all aspects of suicide prevention from the time of arrival of each inmate throughout the continuum of incarceration and discharge back into the community. The California Forensic Medical Group Health/AFBH collaborative Suicide Prevention Program is an ongoing process based on research, skills, education, training and practice. All efforts will be made to avert suicidal gestures and attempts in the facility through ongoing surveillance and watchful monitoring on the part of medical, mental health, and correctional personnel.

III. **PROCEDURE**:

A. All suicide statements, threats, or gestures are taken seriously.

B. Inmates have the availability to request mental health services at anytime.

C. The California Forensic Medical Group Health/AFBH Collaborative Suicide Prevention Program includes the following elements:

1. Training
2. Identification
3. Prevention
4. Assessment and referral
5. Evaluation
6. Housing
7. Monitoring
8. Communication
9. Intervention
10. Notification
11. Reporting
12. Review
13. Critical incident debriefing

D. TRAINING: Suicide prevention/intervention training is part of orientation for all new employees. California Forensic Medical Group Health, AFBH, and Sheriff's Office staffs receive annual training on suicide prevention/intervention. To assist with meeting this need, California Forensic Medical Group Health provides a Continuing Education Self-Study Packet on Suicide Prevention. Adult forensic behavioral health conducts annual suicide prevention training for mental health staff and for Sheriff's Office staffs pursuant the Sheriff's Office training schedule.

The objective of training includes:

a. Understanding risk factors for suicidal behavior in the jail setting
b. Identification and awareness of the signs and symptoms of inmates at risk for suicide
c. Awareness of intervention techniques
d. Understanding of the importance of careful observation and documentation of observations
e. The understanding that suicidality can occur at anytime
f. Responding to suicidal and depressed inmates.
g. Communication among California Forensic Medical Group Health, AFBH and Sheriff's Office staffs
h. Informing inmates of mental health services and using the referral process.
i. Monitoring and follow-up procedures for inmates who make suicide attempts.

E. Medical and Sheriff's Office personnel assigned to specialized mental health housing areas work collaboratively with the mental health staff on an ongoing basis in reviewing suicide risk factors and on the management of the suicidal inmate.

F. IDENTIFICATION:

1. Receiving Screening - The receiving screening is the first (and most important) opportunity to assess each inmate's potential for suicide by asking specific questions regarding current suicidal ideations and history of previous attempts. The screening tool addresses, but is not limited to the following areas:

   a. Previous suicide attempts
   b. Past and/or current psychiatric treatment
   c. Psychotropic medication use
   d. Alcohol and/or drug use
   e. Current thoughts related to suicide
   f. Family history of psychiatric illness, substance abuse, and suicide
   g. Previous hospital stays required by a physician or psychiatrist

2. Health Assessment - additional screening occurs at the time of the health assessment. The patient receives a mental health evaluation as part of the health assessment. The mental health assessment includes an assessment for suicide risk.

3. Patients who are identified as being at risk for suicide at any time by medical or custody personnel are placed on an observation log for suicide watch, placed in a safety cell, and referred for mental health services.

G. ASSESSMENT AND REFERRAL:

1. Any deputy sheriff or medical personnel may initiate a safety cell placement upon receiving information that alerts them to potential suicide risk.

2. Upon recognition that an inmate is at risk for suicide, the inmate is placed in a safety cell for monitoring until the inmate can be further assessed by a mental health professionals.

3. Health staff request that the Sheriff's Office staff make arrangements for housing and safety cell placements.

4. Only upon a face-to-face assessment by a mental health professional will the safety cell placements and Intensive Observation Logs (IOLs) be discontinued.

5. The Sheriff's Office is notified if an inmate, identified with suicide potential, is scheduled for release from the detention facility. Adult forensic behavioral health and the Sheriff's Office will make arrangements for transport to an acute psychiatric hospital for evaluation.

H. EVALUATION AND RESPONSE

1. An evaluation, conducted by a qualified mental health professional, designates the individual's level of suicide risk, level of supervision needed; and if a need exists, transfer to an inpatient mental health facility or program.

   Note: Glenn Dyer Detention Facility Inmates: If an inmate housed at Glenn Dyer Detention Facility (GDDF) is determined to be at risk for suicide or otherwise in need of emergency mental health attention, contact AFBH staff at GDDF on **(Monday's and Thursday's from 0800-1600) When AFBH is offsite: c**ontact Mental Health staff (AFBH) for consultation on the most appropriate intervention. If AFBH staff determines the inmate needs to be sent to the acute psychiatric facility, ACSO deputies will complete the 5150 documents and transport the inmate to John George Psychiatric Pavilion.
   N**ote: GDDF inmates determined to be at risk for suicide are not to be transferred from a Safety Cell at GDDF to a Safety Cell at SRJ.**

   AFBH contact numbers:

   ITR Screening [redacted]

   Note: AFBH is onsite from 0800-2300. Psychiatric services for crisis situations can be obtained ~by contacting the AFBH ITR screener at x [redacted] during those hours. ***Between 2300-0800****, On-Call staff is contacted at x*[redacted]*. AFBH staff should respond ASAP, within 15 minutes.*

2. Inmates are reassessed regularly to identify any change in condition indicating the need for a change in supervision level or required transfer or commitment.

3. The evaluation will include procedures for periodic follow-up assessment after the individual is discharged from suicide precautions.

I. HOUSING:

1. Inmates with suicidal risk are housed in special housing units and Safety Cells where higher levels of observation are available.

2. Inmates placed in Safety Cells are given modesty garments to avoid being stripped naked and to prevent humiliation and depression. These modesty garments cannot be used for self-harm.

J. MONITORING: There are two levels of monitoring for inmates with suicidal risk:

1. Safety Cells: Inmates who are at heightened risk for suicide (an identified plan and means) or demonstrating self-injurious behavior are placed in Safety Cells under intensive observation. Mental health professionals evaluate these inmates within the first eight (8) hours of placement and at least daily thereafter while on suicide watch, not to exceed seventy-two (72) hours without notifying the Watch Commander and/or recommending discontinuing the Safety Cell placement or arranging for transfer of the inmate to an acute psychiatric facility. These observations are documented in the inmate's health record and recorded on the logs.
   Note: Inmates at GDDF needing a Safety Cell level of interventions need to be taken to the acute psychiatric hospital on a WIC 5150 for evaluation.

3. Inmate Observation Logs (IOLs) / Close Observation:
   The IOL intervention is used for inmates who verbalize current thoughts of suicide, but who do not express a specific plan or means to harm themselves. In addition, inmates with histories of suicide attempts, who are determined to be at risk, may be kept on IOLs until a mental health clinician, in consultation with a colleague, psychiatrist, or supervisor, determines that it is safe to remove the special watch. Inmates with mental illnesses who demonstrate bizarre, violent, or self-injurious behaviors that require observation a minimum of four times an hour, may be placed on IOLs. Certain items of bedding and clothing, as well as razors, are removed to prevent use of these items for self harm."

   This watch requires observation at staggered / random intervals every 15 minutes. The inmate must be in full sight of the deputy sheriffs when the checks are performed. The supervision is documented on a log which stays with the inmate if he or she is moved. Mental health staffs are required to conduct an in person assessment of inmates on IOLs within the first 8 hours of placement and every 7 days thereafter, and make recommendations to continue or discontinue the IOL status.
4. Discontinuation of an IOL:

.

   a. If an inmate is 5150'd for a serious suicide attempt, (Cutting/Hanging) They will remain on an IOL for seven days, after their discharge from the hospital.
   b. To discontinue an IOL, clinicians are required to consult with a colleague, psychiatrist or supervisor.
   c. Upon being removed from an IOL inmates are placed on AFBH's schedule to be seen on a regular basis.

L. Upon being removed from a Safety Cell, inmates are placed on AFBH's schedule to be seen on a regular basis, and at a minimum of:
   1. Once within 72 hours following the discontinuation of the suicide watch
   2. Weekly for a minimum of 2 weeks, then
   3. Monthly until periodic evaluations are felt to be appropriate

Sheriff Office and medical staffs are trained in risk factors for suicide. When AFBH staff members are notified of inmates with risk factors, such as those listed below, AFBH will conduct evaluations for suicidal risk:

1. Placement into segregation
2. Serious interpersonal conflicts or stressors such as death of a close family member/friend
3. Negative event(s) involving the legal process

M. COMMUNICATION:

1. An inmate may report suicidal ideation to health care personnel, a mental health professional, or Sheriff's Office staff. A major component of a successful suicide prevention program is effective and timely inter-departmental communication. Health care personnel, mental health professionals, and Sheriff's Office staff are aware of the communication process to be followed when an inmate is identified as being potentially suicidal. It is important to remember that any deputy sheriff or medical personnel may initiate placing an inmate on suicide watch.

2. Sheriff's Office personnel are informed of inmates identified as potentially suicidal to ensure that they are appropriately housed and observed.

3. Appropriate staff are notified when an inmate is removed from suicide watch and reassigned to general population housing. Adult forensic behavioral health makes the clinical decision to remove an inmate from suicide watch. Adult forensic behavioral health provides follow-up for inmates removed from suicide watch until AFBH determines the inmate no longer needs such monitoring.

4. An inmate's suicide status is considered when transporting to court, an outside appointment, another facility, or upon release. .

N. INTERVENTION:

1. Suicide gestures and attempts are considered serious. Health staff should respond appropriately and notify mental health staff of all incidents.

2. Every effort is made to stabilize and/or resuscitate an inmate who has attempted suicide while emergency medical support is summoned for immediate transport if necessary.

3. All healthcare providers and nurses are trained in CPR and resuscitation of suicide attempts. Resuscitation equipment necessary to conduct CPR is readily available.

O. NOTIFICATION:

1. AFBH Administrator or designee is notified of all suicide attempts and inmates placed on suicide watch. This occurs through the use of the Inter-departmental Classification forms.

2. The health and/or mental health staff notify, via the Classification form, the supervising Sheriff's Office staff on duty and additional Sheriff's Office staff as necessary to ensure proper housing and monitoring.

3. The AFBH Administrator or designee will ensure that the Facility Administrator and the Mental Health Site Medical Director are informed of any suicide. All suicide attempts are reviewed at the jail's monthly Suicide Prevention Committee. .

P. REPORTING:

1. The Sheriff's Office will document the completion of suicide watches (logs).

2. Health personnel and/or mental health professionals provide the AFBH Administrator or designee with a daily report of patients on suicide watch and the names of patients released from suicide watch within the previous twenty-four (24) hours.

3. Adult forensic behavioral health personnel document thorough notes in the inmate's mental health record initially and daily while the patient is on suicide watch.

4. Completed suicides and suicide attempts which result in hospitalization are required to be reported to the California Forensic Medical Group Health Patient Safety Committee.

5. Suicide attempts require a California Forensic Medical Group Health *Suicide / Attempted Suicide Review Form* and a California Forensic Medical Group Health *Sentinel Event Comprehensive Review Form* to be completed and submitted to the Patient Safety Committee within three (3) business days of the attempted suicide. Completed suicides also require a California Forensic Medical Group Health *Mortality Review Form* to be submitted.

6. See the AFBH Manual for internal mental health administrative reporting process.

Q. REVIEW:

1. The California Forensic Medical Group Health Corporate Director of Mental Health Services will receive notification of all completed suicides and suicide attempts resulting in hospitalization from the California Forensic Medical Group Health Patient Safety Committee. The Corporate Director of Mental Health Services may contact the facility Health Service Administrator to expedite a prompt teleconference review of the incident.

2. Personnel involved in the event participate in the review process.

3. A report of the review should be documented. The purpose of the review is quality improvement; therefore all documentation pertaining to the review should be marked "Confidential."

4. The report is submitted to the California Forensic Medical Group Health Patient Safety Committee and the California Forensic Medical Group Health Regional Medical Director.

5. See the AFBH Manual for internal mental health administrative reviewing process.
6. Multidisciplinary review of suicide attempts, suicides, and other incidents may be reviewed at periodic facility meetings, i.e., monthly MAC Meeting, and/or Suicide Prevention Meeting. All suicides are reviewed by the Mortality Review Committee. Discussion and corrective action shall be taken as deemed appropriate.

R. CRITICAL INCIDENT DEBRIEFING: Successful suicides and suicide attempts are extremely traumatic for other inmates and all staff. Adult forensic behavioral health professionals offer counseling and are available to anyone who may have been affected by a suicide and who may need help in adjusting to the situation. Support may be provided individually or in a group setting. An informal meeting of involved or concerned staff members is conducted promptly so that concerns, feelings, and suggestions for improvement can be vocalized. It is important that during the course of these discussions that the *Name, Blame, & Shame* mentality be avoided.

S. TRAINING in Risk Assessment :

1. Predisposing factors to suicide:
    a. *recent* excessive use of alcohol, drugs
    b. recent losses: family, friends, spouse; job; home; money
    c. severe guilt, shame
    d. same sex rape or threats of it
    e. mental illness
    f. poor health
    g. emotional breaking point
    h. gender issues
    i. cultural issues
2. High risk periods:
    a. First 24-72 hours of jail
    b. intoxication and when sobering up
    c. waiting for trial
    d. sentencing
    e. impending release
    f. holidays
    g. Inmate birthday
    h. darkness
    i. decreased staff supervision: weekends, nights shift changes, holidays
    j. bad news of any kind
3. Critical times to observe suicidal signs and symptoms:
    a. at arrest
    b. during transportation to jail and from court
    c. at booking
    d. throughout confinement with previous history of suicide risk
    e. sentencing, returning from court
4. Warning signs and symptoms:
    a. depression, paranoia
    b. expresses strong guilt or shame over offense
    c. talks about/threatens suicide
    d. under the influence
    e. prior suicide attempt, especially recent attempt and/or history of mental illness
    f. severe agitation or aggressiveness
    g. hopelessness, helplessness, no hope for future
    h. fear of what will happen to him/her
    i. mood or behavior changes: may act calm once decision to suicide is mad
    j. dwelling on the past
    k. giving away things, packing
    l. attention seeking gestures – take all gesture seriously
    m. Paranoid delusions or hallucinations: voices telling him to kill self. Ask what voices are saying

n. Depression: the best suicide indicator
o. Delusions; persecution, feeling controlled, grandiose
p. Hallucinations: audio or visual

5. Additional risk factors:
    a. Minor arrest history or first arrest **(however, victims of suicides in large urban jails are often arrested for violent offenses and are dead within 1-4 months)**
    b. persons with high status in the community
    c. prior suicide by close family member or loved one
    d. facing serious charges and long prison term
    e. third strike
    f. prior same sex rape
    g. prior jail suicide or recent attempt
    h. harsh attitude of deputies
    i. prior experience with pain/suffering; drug/alcohol withdrawal
    j. Special housing unit
6. Current / recent stresses:
    a. loss or threat of loss of loved one
    b. recent job loss or failure
    c. divorce, separation, break-up
    d. rejection by peers
    e. serious financial loss
    f. discovery of major health problem
    g. victim or threatened regarding same sex rape
    h. committed heinous crime or revolting sex crime

Reviewed 9-1

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B-7	**PAGES:** 1 of 7
	RELATED ORDERS: ACA 4-ALDF-4C-32. 4C-33	
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: September 1, 2015	
	REVISION DATE: March 8, 2016	
CHAPTER: Protection From Harm	**SUBJECT: Suicide Prevention and Intervention**	

I. **PURPOSE:** to ensure a comprehensive suicide prevention program within the Alameda County jails.

II. **POLICY**: California Forensic Medical Group Health, Adult forensic behavioral health (AFBH), and Sheriff's Office staff are expected to be familiar with the Santa Rita Jail/Glenn Dyer Jail Suicide Prevention/Intervention Program. California Forensic Medical Group Health, AFBH, and Sheriff's Office staff will participate effectively in all aspects of suicide prevention from the time of arrival of each inmate throughout the continuum of incarceration and discharge back into the community. The California Forensic Medical Group Health/AFBH collaborative Suicide Prevention Program is an ongoing process based on research, skills, education, training and practice. All efforts will be made to avert suicidal gestures and attempts in the facility through ongoing surveillance and watchful monitoring on the part of medical, mental health, and correctional personnel.

III. **PROCEDURE**:

A. All suicide statements, threats, or gestures are taken seriously.

B. Inmates have the availability to request mental health services at anytime.

C. The California Forensic Medical Group Health/AFBH Collaborative Suicide Prevention Program includes the following elements:

1. Training
2. Identification
3. Prevention
4. Assessment and referral
5. Evaluation
6. Housing
7. Monitoring
8. Communication
9. Intervention
10. Notification
11. Reporting
12. Review
13. Critical incident debriefing

D. TRAINING: Suicide prevention/intervention training is part of orientation for all new employees. California Forensic Medical Group Health, AFBH, and Sheriff's Office staffs receive annual training on suicide prevention/intervention. To assist with meeting this need, California Forensic Medical Group Health provides a Continuing Education Self-Study Packet on Suicide Prevention. Adult forensic behavioral health conducts annual suicide prevention training for mental health staff and for Sheriff's Office staffs pursuant the Sheriff's Office training schedule.

The objective of training includes:

a. Understanding risk factors for suicidal behavior in the jail setting
b. Identification and awareness of the signs and symptoms of inmates at risk for suicide
c. Awareness of intervention techniques
d. Understanding of the importance of careful observation and documentation of observations
e. The understanding that suicidality can occur at anytime
f. Responding to suicidal and depressed inmates.
g. Communication among California Forensic Medical Group Health, AFBH and Sheriff's Office staffs
h. Informing inmates of mental health services and using the referral process.
i. Monitoring and follow-up procedures for inmates who make suicide attempts.

E. Medical and Sheriff's Office personnel assigned to specialized mental health housing areas work collaboratively with the mental health staff on an ongoing basis in reviewing suicide risk factors and on the management of the suicidal inmate.

F. IDENTIFICATION:

1. Receiving Screening - The receiving screening is the first (and most important) opportunity to assess each inmate's potential for suicide by asking specific questions regarding current suicidal ideations and history of previous attempts. The screening tool addresses, but is not limited to the following areas:

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   g. Previous hospital stays required by a physician or psychiatrist

2. Health Assessment - additional screening occurs at the time of the health assessment. The patient receives a mental health evaluation as part of the health assessment. The mental health assessment includes an assessment for suicide risk.

3. Patients who are identified as being at risk for suicide at any time by medical or custody personnel are placed on an observation log for suicide watch, placed in a safety cell, and referred for mental health services.

G. ASSESSMENT AND REFERRAL:

1. Any deputy sheriff or medical personnel may initiate a safety cell placement upon receiving information that alerts them to potential suicide risk.

2. Upon recognition that an inmate is at risk for suicide, the inmate is placed in a safety cell for monitoring until the inmate can be further assessed by a mental health professionals.

3. Health staff request that the Sheriff's Office staff make arrangements for housing and safety cell placements.

4. Only upon a face-to-face assessment by a mental health professional will the safety cell placements and Intensive Observation Logs (IOLs) be discontinued.

5. The Sheriff's Office is notified if an inmate, identified with suicide potential, is scheduled for release from the detention facility. Adult forensic behavioral health and the Sheriff's Office will make arrangements for transport to an acute psychiatric hospital for evaluation.

H. EVALUATION AND RESPONSE

1. An evaluation, conducted by a qualified mental health professional, designates the individual's level of suicide risk, level of supervision needed; and if a need exists, transfer to an inpatient mental health facility or program.

   Note: Glenn Dyer Detention Facility Inmates: If an inmate housed at Glenn Dyer Detention Facility (GDDF) is determined to be at risk for suicide or otherwise in need of emergency mental health attention, contact AFBH staff at GDDF on **(Monday's and Thursday's from 0800-1600) When AFBH is offsite: c**ontact Mental Health staff (AFBH) for consultation on the most appropriate intervention. If AFBH staff determines the inmate needs to be sent to the acute psychiatric facility, ACSO deputies will complete the 5150 documents and transport the inmate to John George Psychiatric Pavilion.
   N**ote: GDDF inmates determined to be at risk for suicide are not to be transferred from a Safety Cell at GDDF to a Safety Cell at SRJ.**

   AFBH contact numbers:

   ITR Screening [redacted]

   Note: AFBH is onsite from 0800-2300. Psychiatric services for crisis situations can be obtained ~by contacting the AFBH ITR screener at x [redacted] during those hours. ***Between 2300-0800****, On-Call staff is contacted at x*[redacted]*. AFBH staff should respond ASAP, within 15 minutes.*

2. Inmates are reassessed regularly to identify any change in condition indicating the need for a change in supervision level or required transfer or commitment.

3. The evaluation will include procedures for periodic follow-up assessment after the individual is discharged from suicide precautions.

I. HOUSING:

1. Inmates with suicidal risk are housed in special housing units and Safety Cells where higher levels of observation are available.

2. Inmates placed in Safety Cells are given modesty garments to avoid being stripped naked and to prevent humiliation and depression. These modesty garments cannot be used for self-harm.

J. MONITORING: There are two levels of monitoring for inmates with suicidal risk:

1. Safety Cells: Inmates who are at heightened risk for suicide (an identified plan and means) or demonstrating self-injurious behavior are placed in Safety Cells under intensive observation. Mental health professionals evaluate these inmates within the first eight (8) hours of placement and at least daily thereafter while on suicide watch, not to exceed seventy-two (72) hours without notifying the Watch Commander and/or recommending discontinuing the Safety Cell placement or arranging for transfer of the inmate to an acute psychiatric facility. These observations are documented in the inmate's health record and recorded on the logs.
   Note: Inmates at GDDF needing a Safety Cell level of interventions need to be taken to the acute psychiatric hospital on a WIC 5150 for evaluation.

3. Inmate Observation Logs (IOLs) / Close Observation:
   The IOL intervention is used for inmates who verbalize current thoughts of suicide, but who do not express a specific plan or means to harm themselves. In addition, inmates with histories of suicide attempts, who are determined to be at risk, may be kept on IOLs until a mental health clinician, in consultation with a colleague, psychiatrist, or supervisor, determines that it is safe to remove the special watch. Inmates with mental illnesses, who demonstrate bizarre, violent, or self-injurious behaviors that require observation a minimum of four times an hour, may be placed on IOLs. Certain items of bedding and clothing, as well as razors, are removed to prevent use of these items for self harm."

   This watch requires observation at staggered / random intervals every 15 minutes. The inmate must be in full sight of the deputy sheriffs when the checks are performed. The supervision is documented on a log which stays with the inmate if he or she is moved. Mental health staffs are required to conduct an in person assessment of inmates on IOLs within the first 8 hours of placement and every 7 days thereafter, and make recommendations to continue or discontinue the IOL status.
4. Discontinuation of an IOL:

.

   a. If an inmate is 5150'd for a serious suicide attempt, (Cutting/Hanging) The Inmate will remain on an IOL for seven days, after their discharge from the hospital.
   b. To discontinue an IOL, clinicians are required to consult with a colleague, psychiatrist or supervisor.
   c. Upon being removed from an IOL inmates are placed on AFBH's schedule to be seen on a regular basis.

L. Upon being removed from a Safety Cell, inmates are placed on AFBH's schedule to be seen on a regular basis, and at a minimum of:
   1. Once within 72 hours following the discontinuation of the suicide watch
   2. Weekly for a minimum of 2 weeks, then
   3. Monthly until periodic evaluations are felt to be appropriate

Sheriff Office and medical staffs are trained in risk factors for suicide. When AFBH staff members are notified of inmates with risk factors, such as those listed below, AFBH will conduct evaluations for suicidal risk:

1. Placement into segregation
2. Serious interpersonal conflicts or stressors such as death of a close family member/friend
3. Negative event(s) involving the legal process

M. COMMUNICATION:

1. Any Inmate who makes a serious suicide attempt (Hanging/Cutting) and you are the first clinician to respond, you must send out an all AFBH email alerting staff to the situation. In you email please include the following information:

a. Inmates Name
b. PFN
c. Describe the attempt
d. Whether the inmate required immediate medical attention/or was sent out for medical clearance
e. Current Status (Safety Cell, 5150?)

2. An inmate may report suicidal ideation to health care personnel, a mental health professional, or Sheriff's Office staff. A major component of a successful suicide prevention program is effective and timely inter-departmental communication. Health care personnel, mental health professionals, and Sheriff's Office staff are aware of the communication process to be followed when an inmate is identified as being potentially suicidal. It is important to remember that any deputy sheriff or medical personnel may initiate placing an inmate on suicide watch.
3. Sheriff's Office personnel are informed of inmates identified as potentially suicidal to ensure that they are appropriately housed and observed.
4. Appropriate staff are notified when an inmate is removed from suicide watch and reassigned to general population housing. Adult forensic behavioral health makes the clinical decision to remove an inmate from suicide watch. Adult forensic behavioral health provides follow-up for inmates removed from suicide watch until AFBH determines the inmate no longer needs such monitoring.

4. An inmate's suicide status is considered when transporting to court, an outside appointment, another facility, or upon release. .

N. INTERVENTION:

1. Suicide gestures and attempts are considered serious. Health staff should respond appropriately and notify mental health staff of all incidents.

2. Every effort is made to stabilize and/or resuscitate an inmate who has attempted suicide while emergency medical support is summoned for immediate transport if necessary.

3. All healthcare providers and nurses are trained in CPR and resuscitation of suicide attempts. Resuscitation equipment necessary to conduct CPR is readily available.

O. NOTIFICATION:

1. AFBH Administrator or designee is notified of all suicide attempts and inmates placed on suicide watch. This occurs through the use of the Inter-departmental Classification forms.

2. The health and/or mental health staff notify, via the Classification form, the supervising Sheriff's Office staff on duty and additional Sheriff's Office staff as necessary to ensure proper housing and monitoring.

3. The AFBH Administrator or designee will ensure that the Facility Administrator and the Mental Health Site Medical Director are informed of any suicide. All suicide attempts are reviewed at the jail's monthly Suicide Prevention Committee. .

P. REPORTING:

1. The Sheriff's Office will document the completion of suicide watches (logs).

2. Health personnel and/or mental health professionals provide the AFBH Administrator or designee with a daily report of patients on suicide watch and the names of patients released from suicide watch within the previous twenty-four (24) hours.

3. Adult forensic behavioral health personnel document thorough notes in the inmate's mental health record initially and daily while the patient is on suicide watch.

4. Completed suicides and suicide attempts which result in hospitalization are required to be reported to the California Forensic Medical Group Health Patient Safety Committee.

5. Suicide attempts require a California Forensic Medical Group Health *Suicide / Attempted Suicide Review Form* and a California Forensic Medical Group Health *Sentinel Event Comprehensive Review Form* to be completed and submitted to the Patient Safety Committee within three (3) business days of the attempted suicide. Completed suicides also require a California Forensic Medical Group Health *Mortality Review Form* to be submitted.

6. See the AFBH Manual for internal mental health administrative reporting process.

Q. REVIEW:

1. The California Forensic Medical Group Health Corporate Director of Mental Health Services will receive notification of all completed suicides and suicide attempts resulting in hospitalization from the California Forensic Medical Group Health Patient Safety Committee. The Corporate Director of Mental Health Services may contact the facility Health Service Administrator to expedite a prompt teleconference review of the incident.

2. Personnel involved in the event participate in the review process.

3. A report of the review should be documented. The purpose of the review is quality improvement; therefore all documentation pertaining to the review should be marked "Confidential."

4. The report is submitted to the California Forensic Medical Group Health Patient Safety Committee and the California Forensic Medical Group Health Regional Medical Director.

5. See the AFBH Manual for internal mental health administrative reviewing process.
6. Multidisciplinary review of suicide attempts, suicides, and other incidents may be reviewed at periodic facility meetings, i.e., monthly MAC Meeting, and/or Suicide Prevention Meeting. All suicides are reviewed by the Mortality Review Committee. Discussion and corrective action shall be taken as deemed appropriate.

R. CRITICAL INCIDENT DEBRIEFING: Successful suicides and suicide attempts are extremely traumatic for other inmates and all staff. Adult forensic behavioral health professionals offer counseling and are available to anyone who may have been affected by a suicide and who may need help in adjusting to the situation. Support may be provided individually or in a group setting. An informal meeting of involved or concerned staff members is conducted promptly so that concerns, feelings, and suggestions for improvement can be vocalized. It is important that during the course of these discussions that the *Name, Blame, & Shame* mentality be avoided.

S. TRAINING in Risk Assessment :

1. Predisposing factors to suicide:
   a. *recent* excessive use of alcohol, drugs
   b. recent losses: family, friends, spouse; job; home; money
   c. severe guilt, shame
   d. same sex rape or threats of it
   e. mental illness
   f. poor health
   g. emotional breaking point
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2. High risk periods:
   a. First 24-72 hours of jail
   b. intoxication and when sobering up
   c. waiting for trial
   d. sentencing
   e. impending release
   f. holidays
   g. Inmate birthday
   h. darkness
   i. decreased staff supervision: weekends, nights shift changes, holidays
   j. bad news of any kind
3. Critical times to observe suicidal signs and symptoms:
   a. at arrest
   b. during transportation to jail and from court
   c. at booking
   d. throughout confinement with previous history of suicide risk
   e. sentencing, returning from court
4. Warning signs and symptoms:
   a. depression, paranoia
   b. expresses strong guilt or shame over offense
   c. talks about/threatens suicide
   d. under the influence

e. prior suicide attempt, especially recent attempt and/or history of mental illness
f. severe agitation or aggressiveness
g. hopelessness, helplessness, no hope for future
h. fear of what will happen to him/her
i. mood or behavior changes: may act calm once decision to suicide is mad
j. dwelling on the past
k. giving away things, packing
l. attention seeking gestures – take all gesture seriously
m. Paranoid delusions or hallucinations: voices telling him to kill self. Ask what voices are saying
n. Depression: the best suicide indicator
o. Delusions; persecution, feeling controlled, grandiose
p. Hallucinations: audio or visual

5. Additional risk factors:
   a. Minor arrest history or first arrest **(however, victims of suicides in large urban jails are often arrested for violent offenses and are dead within 1-4 months)**
   b. persons with high status in the community
   c. prior suicide by close family member or loved one
   d. facing serious charges and long prison term
   e. third strike
   f. prior same sex rape
   g. prior jail suicide or recent attempt
   h. harsh attitude of deputies
   i. prior experience with pain/suffering; drug/alcohol withdrawal
   j. Special housing unit
6. Current / recent stresses:
   a. loss or threat of loss of loved one
   b. recent job loss or failure
   c. divorce, separation, break-up
   d. rejection by peers
   e. serious financial loss
   f. discovery of major health problem
   g. victim or threatened regarding same sex rape
   h. committed heinous crime or revolting sex crime

Reviewed 9-1

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B 8 a 1)	**PAGES: 1**-2
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: March 6, 2013	
Continuity of Care	**SUBJECT: Medications: Weekdays**	

I PURPOSE: To ensure that inmates who are booked into the jail on weekdays are able to receive continuation of their psychiatric medications.

II POLICY: Adult forensic behavioral health (AFBH) provides continuity of psychiatric medications for individuals booked into the jail when criteria are met. Written verification of medications is required. Prescriptions must have been ordered within the past 30 days and medications must have been taken by the individual within the past 7 days. AFBH intake screeners arrange same day or next day medication evaluations in the Immediate Care Clinic (ICC) for inmates / patients booked into Santa Rita jail accompanied by written documentation of psychotropic medications. On-Call psychiatrists are available for consultation regarding written verified medications on weekends and holidays.

PROCEDURE:

A. The AFBH ITR Screener performs the following tasks: :
   1. Receives mental health referral from California Forensic Medical Group with copy of medication documentation.
   2. Evaluates patient and completes Initial Screening form. Determines if patient needs immediate psychiatric evaluation and notes that on screening form.
   3. Calls x[redacted] to add patient to next Immediate Care Clinic (ICC). Identify yourself as the ITR screener and leave a message with the following information: Patient name, PFN#, Birthdate.
   4. Identifies paperwork for these patients by attaching the goldenrod **Special Handling** flyer to the top of the client's paperwork.
   5. Schedules patients screened by 1:30 pm to today's ICC. **Take paperwork directly to Intake clerk.**
   6. Schedules patients screened <u>after</u> 1:30 pm for tomorrow's (or next workday) ICC. Put paperwork in Intake clerk's mailbox.
   7. When medication is unconfirmed, ITR mental health screeners will use the Consent to Obtain Medication Verification form, signed by the inmate, to obtain documentation of current psychiatric medication. An effort will be made to fax the request to the prescribing provider in the community. Patients without written verified orders will be scheduled routinely.

B. Intake Clerk performs the following tasks:
   1. Expedites processing of paperwork marked with **Special Handling** notice
   2. Pulls/orders/makes record as needed.
   3. Processes Initial Screening paperwork and complete data input.
   4 Prepares chart for ICC (Assessment form, Treatment Consent form, Client Registration form, **and Progress Note**).
   4. Clips ICC flyer to top of chart and delivers to 4011.6 desk in clinic by 4:00pm on date of appointment.

C. 4011.6/ICC Clerk performs the following tasks:
   1. .Picks up messages from 4011.6/ICC phone (x.).
   2. Posts information to 4011.6 log. Separates 4011.6's from ICC patients on log.

D. The Psychiatrist performs the following tasks: :
   1. Gives priority to evaluation of ICC patients.
   2. Evaluates for medications, completes appropriate documents (progress notes, med order, medication consent form, lab orders, etc.). **Schedules for follow up TBA and MD appointment.**
   3. Gives chart directly to clerk for processing.

E. The 4011.6/ICC Clerk performs the following tasks:
   1. Makes two copies of med order: Delivers original and one copy to pharmacy; one copy to chart.
   2. Processes chart according to established procedures (post appointments, organize chart forms, data input, etc.)

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B-8-a 2)	**PAGES: 1-2**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 3, 2017	
	REVISION DATE: March 6, 2013	
Continuity of Care	**SUBJECT: Medications: Weekends and Holidays**	

I PURPOSE To ensure that inmates who are booked into the jail on weekends and holidays are able to receive continuation of their psychiatric medications.

II POLICY: Adult forensic behavioral health Services (AFBH) will ensure continuity of psychiatric medications for inmates who are booked into Santa Rita County Jail on weekends and holidays for whom verification (written documentation) of psychiatric medications is obtained. On-Call psychiatrists are available for consultation. Documented medication is given priority by ITR screeners.

III PROCEDURE

A. For inmates booked between the hours of **9:00am – 9:00pm** on weekends and holidays:

AFBH Booking ITR) Screener:

1. Receives the Mental Health Referral from CALIFORNIA FORENSIC MEDICAL GROUP Health ITR (Booking) nurses with a copy of medication documentation.
2. Whenever possible, accesses the Clinician's Gateway electronic health record of the individual to verify mediciaons prescribed at other provider sites within the Alameda County Behavioral Health Care Services provider network.
3. Conducts a psychiatric screening, and, if indicated, contacts the On-Call AFBH psychiatrist by AFBH cell phone to consult regarding the need for continuity of medications. Paperwork from previous shift is held until the On-Call psychiatrist is available.

AFBH On-Call Psychiatrist:

1. Collaborates with the AFBH screener and the ITR CALIFORNIA FORENSIC MEDICAL GROUP nurse and, based on reliable information, makes a decision to either:
    - give a verbal order to the CALIFORNIA FORENSIC MEDICAL GROUP nurse to continue the medications as written or
    - have the inmate wait until regular working hours for a face-to-face assessment or
    - go to the jail site if the need is urgent to assess the inmate by a face-to-face interview to determine what, if any, medication(s) is needed and order the medication.

B. For inmates booked between the hours of **9:00pm – 9:00am** on weekends and holidays:

In the event of an urgent matter encountered by CALIFORNIA FORENSIC MEDICAL GROUP nurses during these hours, the AFBH ITR screener or AFBH On-Call clinician should be contacted for assistance.

Reviewed 03/2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B 8 a 3)**	**PAGES: 1-2**
	ISSUED DATE November 9, 2009	
	REVIEW DATE **November 20, 2015**	
	REVISION DATE: March 6, 2013	
SUBJECT: Continuity of Care `	**Medications** **Verified / Bridge**	

I. PURPOSE To ensure that persons booked into the jail who meet criteria for verified medications receive orders for continuation of psychiatric medications as soon as possible.

II POLICY: AFBH will continue psychiatric medications for persons entering the jail when criteria are met for verification of medications. To provide continuity of care and for the safe use of psychotropic medications, careful attention to the verification process is required. The intent is to provide continuation of medications for those inmates who have been continuously prescribed and taking legitimate regimens of psychiatric medications prior to entering the jail.

III PROCEDURE:

1**. Medication verification** For medications to be continued at the time a person enters the jail ("bridged "or referred to the Immediate Care Clinic, ICC), there must be written verification that meets the following specific criteria.

a) Written verification: the AFBH ITR (intake) worker obtains written verification of medications by contacting treatment providers, electronic medical records, pharmacies, or reviewing documents that accompany the inmate.
b) Current prescription: the intake worker verifies that the prescription is current: written or refilled within thirty (30) days.
c) Use for 7 days: the intake worker verifies that the person has been taking the medications for the past 7 days.
d) Transfer documents: the intake worker reviews all written transfer documents that list medications and verifies that medications listed are current and have been taken within the past 7 days.

2. **Non-formulary medications:** Note: To ensure continuity of care for persons who enter the jail and have been consistently taking legitimate regimens of non-formulary mediciaons, brief bridge orders are provided until there can be a face-to-face evaluation and change to alternative formulary medications by a AFBH psychiatrist, as follows:

a) The number of days of the bridge order will depend on the number of days between the order and the following second business day ICC clinic. The ITR clinician schedules the inmate for the ICC clinic on the second business day following the weekend / holiday weekend. .
b) During weekdays and weeknights: If there is verification of non-formulary medications per the above criteria, the individual should be scheduled for the next ICC appointment and no bridge medications requested.

c) During weekends and holidays, the ITR worker calls the On-Call psychiatrist who will decide whether to order bridge medications.
    - If the medication(s) is bridged, it will be for the number of days determined to be necessary by the prescribing physician taking into consideration matters that might interfere with the timely face to face assessment of the individual post booking. .

3. **Regular work days up to 1:30 pm**: the ITR worker schedules new inmates with verified medications for the evening ICC clinic, providing documentation of medication verification.
4. **After-hours:** weekends & holidays (9:00am to 9:00pm) and evenings (up to 11:00 pm), the intake worker contacts the On-Call AFBH psychiatrist and provides the MD with the verification information.
5. **On-Call psychiatrist**: the psychiatrist on-call confirms that the medications are verified and documents in the progress note the specific verification information. He/she authorizes a "Bridge Order" for up to 14 days (see exception for non-formulary meds above), directing the jail medical nurse [redacted] to write a medication order for the pharmacy.
    a) During after-hours, the ITR intake worker may call the On-Call psychiatrist for consultation regarding any questions about inmate care
    b) The On-Call psychiatrist writes a progress note on all consultations provided to ITR staff.
    c) In urgent or atypical situations, the On-Call psychiatrist will use his or her best medical judgment in authorizing psychotropic medications that do not meet the above "verified medications criteria" The rationale for all decisions authorizing bridge medications and/or urgent medications must be documented in the Physician's note.
6. The nurse submits the order to the pharmacy.
7 The nurse enters the order in the jails' electronic medical record. .
8 The psychiatrist writes a progress note and turns it in or faxes it to the AFBH clinic the next day. Progress notes are placed in the ITR tray in the AFBH clinic to be reviewed and filed in the chart.
9. The AFBH ITR worker schedules the client for further assessment at ICC, the clinic, or Housing Unit per scheduling protocols. .

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B 8 a 4)**	**PAGES: 2**
	ISSUED DATE March 14, 2011	
	REVIEW DATE November 20, 2015	
	REVISION DATE: March 6, 2013	
SUBJECT: Continuity of Care `	**Medications** **Transfers between GDDF and SRJ**	

I. PURPOSE to ensure that inmates who are transferred between the Glenn Dyer Detention Facility (GDDF) and Santa Rita Jail (SRJ) receive their psychiatric medications without disruption.

II POLICY: AFBH psychiatrists provide psychiatric medication services for inmates housed at both the GDDF and SRJ facilities; however, these facilities use different pharmacies to dispense medications. Prescriptions cannot be transferred between pharmacies. Each pharmacy must have its own prescription on file. To provide continuity of care, AFBH psychiatrists will re-order prescriptions for inmates transferred between the two facilities.

III PROCEDURE: When inmates who are taking psychiatric medications are transferred between the GDDF and SRJ facilities, they will need to have their prescriptions reordered for the receiving facility's pharmacy. AFBH psychiatrists will reorder the prescriptions.

NOTE: It is an American Correctional Association (ACA) accreditation standard and a CALIFORNIA FORENSIC MEDICAL GROUP Health policy that inmates transferred between facilities have a medical review upon arrival at the receiving facility prior to being housed to determine if their health status is stable and they are suitable for incarceration at the new site.

A. Transfers to SRJ: from GDDF

1. When an inmate arrives at SRJ as a transfer from GDDF, ACSO Records deputies notify CALIFORNIA FORENSIC MEDICAL GROUP booking nurses and deliver the inmate to the booking (ITR) section of the jail.
2. CALIFORNIA FORENSIC MEDICAL GROUP ITR nurses conduct medical reviews on incoming transferred inmates. If psychiatric medications are listed on the Transfer forms, the nurses notify AFBH ITR workers, indicating that psychiatric medication orders need to be continued via new medication orders / prescriptions.
3. CALIFORNIA FORENSIC MEDICAL GROUP ITR nurses provide AFBH ITR staff with all relevant documentation including medication orders.
4. The AFBH ITR worker contacts the AFBH On-Duty psychiatrist or AFBH Supervisor and requests that a new order be processed for the SRJ Maxtor Pharmacy.
5. During AFBH hours of operation, the prescriptions can be reordered by the AFBH On-Duty MD, any other available AFBH psychiatrist, or the On-call psychiatrist.
6. If an inmate is transferred on weekdays between the hours of 11:00 pm and 8:00 am and on weekends or holidays between 9:00 pm and 9:00 am, the matter will be handled by the morning AFBH ITR worker.

7. When there are no AFBH psychiatrists onsite (late evenings, weekends, holidays), the AFBH ITR worker contacts the AFBH On-Call psychiatrist for bridge meds.
8. The new prescriptions are processed per established procedures at SRJ.
9. GDDF inmates arriving at SRJ who have been receiving psychiatric medications should already have future appointments in place, and they can be followed-up by their assigned psychiatrist during their incarceration at SRJ.

B. Transfers to GDDF from SRJ

1. Whenever an inmate is being considered for transfer from SRJ to GDDF, the ACSO notifies CALIFORNIA FORENSIC MEDICAL GROUP .
2. If the inmate is receiving psychiatric medications and/or other AFBH services, CALIFORNIA FORENSIC MEDICAL GROUP consults with the AFBH Supervisor to determine if it is appropriate to transfer the inmate.
3. AFBH makes its recommendation based on the severity of the inmate's mental condition and whether placement at GDDF would compromise the inmate's stability and/or AFBH's ability to monitor the inmate.
4. If AFBH approves the transfer, a new prescription for psychiatric medications is ordered by the AFBH On-Duty psychiatrist.
5. The new prescription is given to CALIFORNIA FORENSIC MEDICAL GROUP and it accompanies the inmate's chart to GDDF.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B-8-b 1)	**PAGES:** 1 of 3
	RELATED ORDERS: ACA 4-ALDF-5B-13, 5B-18	
	ISSUED DATE: January 10, 2008	
	REVIEW DATE March 3, 2017	
	REVISION DATE: February 2, 2010	
CHAPTER: Mental Health Program	**SUBJECT: Continuity of Care** **Discharge Planning / Community Connections**	

I. **PURPOSE**: Whenever possible, to ensure that inmates are referred for follow-up services upon release from jail.

II. **POLICY**: All inmates held for 30 days or longer, who will be released to the community, are provided with preparation for release that includes referral to and/or information about community resources

III. **PROCEDURE**:

A. DISCHARGE PLANNING / CONTINUITY OF CARE: When Adult forensic behavioral health (AFBH) staff have advanced notice of an inmate's date of release, a referral for follow-up outpatient treatment is made to the Alameda County Behavioral Health Care Services ACCESS Program or to the inmate's previous community mental health services provider.

1. On a consistent basis, AFBH advocate for the assignment of community case managers for persons with serious mental illnesses who are in need of comprehensive community care.

2. Inmates with less severe mental health conditions are referred to the ACCESS program or other community providers.

3. If there is a community provider already in place, AFBH staff coordinates care with the provider while the inmate is in custody and upon release.

4. AFBH staff work closely with court mental health advocates (AFBH Court Advocacy Program, CAP), the FACT (Forensic Assertive Community Treatment) team, and the Behavioral Health Court (BHC) in coordinating treatment plans and release plans for persons in custody with serious mental illnesses.

5. Adult forensic behavioral health receives information from family members and involves family with the consent of the inmate.

6. Discharge medications – for inmates who received psychotropic medications while incarcerated, the AFBH clinician faxes the prescription to the inmate's local (county-pay) community pharmacy. In some cases, a ten-day supply of medications is provided directly to

the inmate on release.

7. Taxi vouchers are available for use in ensuring that mentally ill inmates arrive at their intended discharge locations.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-8-b 2)**	**PAGES: 1-2**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: March 1, 2010	
Continuity of Care	**SUBJECT: Medications: Discharge Medications**	

I PURPOSE To ensure that inmates released from Santa Rita Jail are provided with access to release psychiatric medications for continuity of care.

II POLICY: Adult forensic behavioral health Services (AFBH) provides inmates who are being released into the community with a 10-day supply of discharge medications. Medication is either provided to the inmate at the time of his release from Intake, Transfer and Release (ITR), or the inmate is provided with instructions to pick up his medications at a county-pay pharmacy near his destination. No more than 10-days of medications are provided. In general, the method using county-pay pharmacies is the preferred one.

III PROCEDURE: Discharge Medication Orders and the Treatment Continuity Agreement will be processed in the following manner:

1. The clinician determines the need to provide a ***prescription*** to a County-pay pharmacy **or a *10-day supply*** of psychotropic medications and will arrange an appointment in the community for follow up treatment if necessary. Appointment information will be noted on the Treatment Continuity Agreement.
   A. ***Prescription*** for 10-day supply:
      1. The clinician prepares top section of Treatment Continuity Agreement.
      2. The psychiatrist completes the bottom section of the Treatment Continuity Agreement noting name of medication/dose/frequency, signs the form, and obtains patient's signature. A copy of this form is given to the patient, and the original will be kept in the chart.
      3. The psychiatrist completes a Discharge Medication Prescription Form 313-PH-OO for a 10 day Rx that is faxed to a County-pay pharmacy selected by clinician and patient. A list of participating pharmacies is available in MD office and the BHCS Pharmacy Manual.
      4. The clinician writes pharmacy address and phone on the Discharge Medication Prescription Form.
      5. The clinician faxes the prescription to the designated County-pay pharmacy.
   B. **Ten (10) day supply** of medications:
      1. The clinician prepares top portion of Treatment Continuity Agreement.

2. The psychiatrist completes the bottom section of the Treatment Continuity Agreement noting name of medication/dose/frequency, signs the form, and obtains patient's signature. A copy of this form is given to the patient, and the original will be kept in the chart.
3. The psychiatrist completes the CALIFORNIA FORENSIC MEDICAL GROUP Physician's Order form for a lO-day supply of medications and clearly notes these are DISCHARGE MEDICATIONS.
4. A copy of the Treatment Continuity Agreement is given to the patient.
5. The Discharge Medication order is given to the clerk for processing.
6. The clerk:
    a. Posts patient's name to the Discharge Medication Log.
    b. Makes two additional copies of the Treatment Continuity Agreement to be distributed in the following manner: Original to chart, copy for booking jacket, and copy for **ITR** nurse.
    c. Delivers two copies of the Treatment Continuity Agreement to **ITR** prior to the patient's release date (2-3 days if possible). Clerk goes to ITR, locates patient's booking jacket, affixes the yellow ALERT label to the front, and puts one copy of the Treatment Continuity agreement in the jacket. The second copy is given to the **ITR** nurse.

NOTE: Just prior to release, the Pharmacy will package the patient's medications and deliver them to the **ITR** nurse. The medications are given to the patient when processed for release.

Reviewed 11/2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-9**	**PAGES: 1-2**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: March 28, 2013	
Mental Health Program	**SUBJECT: Assessments** **Consent for Treatment, Freedom of Choice**	

I PURPOSE: To ensure that Adult forensic behavioral health Services (AFBH) provides mental health assessments and follows regulations with regard to Consent for Treatment and Freedom of Choice.

ASSESSMENTS

II POLICY: Adult forensic behavioral health Program (AFBH) is responsible for screening and assessing each client referred for mental health services. Inmates receive their first post-booking assessment in either the AFBH clinic or on the housing units.

III PROCEDURE:

Clerical staff:

1. Prepares chart for appointment; includes blank Assessment form, Consent for Treatment form, and Client Registration (when needed).
2. Places in TBA (to be assigned) slots for next day appointment.

Clinical staff:

1. Evaluates patient.
2. Completes Assessment form. Note on the Individual Staff Log.
3. Determines if client requires medications and consults with or schedules appointment with psychiatrist if appropriate.
4. Determines if client requires ongoing services and notes return appointment, i.e. RTC to see Therapist/MD on_____(date) or "No further treatment necessary."
5. Documents findings in clinical record.
6. Subsequent visits are recorded on Progress Notes, noting date, duration of visit, and location code (8 for jail). See Progress Notes Section.

Psychiatrist:

1. Conducts a Medication Interview (Service Code 361) with the client.
2. Orders medication as appropriate.

Clerical staff:

1. Processes chart according to established procedures (see Clerical Procedure manual).

CONSENT FOR TREATMENT/FREEDOM OF CHOICE

I POLICY: Behavioral Health Care Services requires the Consent for Treatment / Freedom of Choice form be signed by the client when it is determined the client will participate in ongoing treatment.

II PROCEDURE: This form is reviewed and discussed with client at the time of Assessment. The client is asked to sign verifying that the information is understood. The therapist also signs. If the client refuses to sign, but is in need of ongoing treatment, the therapist will note that the client refused and make a return appointment.

Reviewed 10-2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-10**	**PAGES: 1-3**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 8, 2017	
	REVISION DATE: January 13, 2016	
Mental Health Program	**SUBJECT: PC 4011.6 Court Orders**	

PURPOSE: To comply with the appropriate use of PC 4011.6 Court Orders. See copy of statute section below.

POLICY: Adult forensic behavioral health Program (AFBH) has responsibility to perform evaluations ordered by the Court under Penal Code Section 4011.6. These reports are confidential, are for the judge only, and are kept in a sealed file in the court case record.

PROCEDURE

Courts may order PC 4011.6s either with a "Written Report Required" or with "No Written Report Required" by checking the appropriate box at the bottom of the court order document. When "No Written Report Required" is indicated, the court is simply alerting AFBH about a defendant who may be suffering from some type of mental illness or distress. Often, AFBH has already assessed the individual for mental health services. When the court indicates "Written Report Required", AFBH evaluates the defendant and submits a report to the court using the form "RESPONSE TO COURT REQUEST FOR WIC 5150 EVALUATION (PENAL CODE 4011.6).

1. The designated AFBH clerk enters **ALL** orders on the 4011.6 log on the "G" Drive.
2. When "No Written Report Required" is indicated, the AFBH manager checks to see if the individual is already open to AFBH for services and alerts the primary clinician or schedules an initial assessment within 24-48 hours of receipt of the order.
3. When "Written Report Required" is indicated, the orders are processed as follows:
    a) Inmates are brought to Santa Rita Jail AFBH Clinic location or assessed in their Housing unit if the inmate is housed on a special population housing unit.
    b) The AFBH manager or the assigned clinician, researches the case, assesses the individual to determine if the individual meets Welfare and Institutions Code 5150 criteria, and completes the paperwork.
    c) "Written Report" is due at the time of the next court date, usually noted on the court order.
    d) Clerical staff
        1. Obtains chart or prepares new chart.
        2. Upon completion of the 4011.6 evaluation, processes per established procedures (see Clerical Procedure Manual).
    e) Clinical staff:

1. Reviews patient's history.
2. Evaluates patient.
3. Contacts any treatment personnel, relatives, etc. from whom you may get information helpful in understanding patient's condition/situation.
4. Determines treatment plan and takes appropriate action (ie. Refer for MD medication evaluation, schedule follow-up, 5150, etc.)
5. Completes Response to Court Request for W&I Code 5150 Evaluation pursuant to PC 4011.6 located in the 4011.6 folder on the G drive.
    i. Completed forms should be saved as the patient's last name, PFN and date form was completed.
6. Completes appropriate clinical forms (Assessment, Progress Notes, etc.). Refers to psychiatrist if necessary for medication evaluation.
7. Provide the designated clerk with a copy of the completed Response to Court Request for W&I Code 5150 Evaluation and a copy of the completed CG progress note for the clerks to process and return to the court.

Note: Keep in mind that this is a formal report. Value judgments, opinions have no place—professional judgments only. The main issue is always the psychiatric condition. Do not make placement or felony competency recommendations, or offer opinions on dangerousness. Penal Code 1368 evaluations (Incompetent to Stand Trial) are beyond our current scope of practice.

- PC 4011.6. In any case in which it appears to the person in charge of a county jail, city jail, or juvenile detention facility, or to any judge of a court in the county in which the jail or juvenile detention facility is located, that a person in custody in that jail or juvenile detention facility may be mentally disordered, he or she may cause the prisoner to be taken to a facility for 72-hour treatment and evaluation pursuant to Section 5150 of the Welfare and Institutions Code and he or she shall inform the facility in writing, which shall be confidential, of the reasons that the person is being taken to the facility. The local mental health director or his or her designee may examine the prisoner prior to transfer to a facility for treatment and evaluation. Upon transfer to a facility, Article 1 (commencing with Section 5150), Article 4 (commencing with Section 5250), Article 4.5 (commencing with Section 5260), Article 5 (commencing with Section 5275), Article 6 (commencing with Section 5300), and Article 7 (commencing with Section 5325) of Chapter 2 and Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code shall apply to the prisoner. Where the court causes the prisoner to be transferred to a 72-hour facility, the court shall forthwith notify the local mental health director or his or her designee, the prosecuting attorney, and counsel for the prisoner in the criminal or juvenile proceedings about that transfer. Where the person in charge of the jail or juvenile detention facility causes the transfer of the prisoner to a 72-hour facility the person shall immediately notify the local mental health director or his or her designee and each court within the county where the prisoner has a pending proceeding about the transfer. Upon notification by the person in charge of the jail or juvenile detention facility the court shall forthwith notify counsel for the prisoner and the prosecuting attorney in the criminal or juvenile proceedings about that transfer. If a prisoner is detained in, or remanded to, a facility pursuant to those articles of the Welfare and Institutions Code, the facility shall transmit a report, which shall be confidential, to the person in charge of the jail or juvenile detention facility or judge of the court who caused the prisoner to be taken to the facility and to the local mental health director or his or her designee, concerning the condition of the prisoner. A new report shall be transmitted at the end of each period of confinement provided for in those articles, upon conversion to voluntary status, and upon filing of temporary letters of conservatorship. A prisoner who has been transferred to an inpatient facility pursuant to this section may convert to voluntary inpatient status without obtaining the consent of the court, the person in charge of the jail or juvenile detention facilty, or the local mental health director. At the beginning of that conversion to voluntary status, the person in charge of the facility shall transmit a report to the person in charge of the jail or juvenile detention facility or judge of the court who caused the prisoner to be taken to the facility, counsel for the prisoner, prosecuting attorney, and local mental health director or his or her designee. If the prisoner is detained in, or remanded to, a facility pursuant to those articles of the Welfare and Institutions Code, the time passed in the facility shall count as part of the prisoner's sentence. When the prisoner is detained in, or remanded to, the facility, the person in charge of the jail or juvenile detention facility shall advise the professional person in charge of the facility of the expiration date of the prisoner's sentence. If the prisoner is to be released from the facility before the expiration date, the professional person in charge shall notify the local mental health director or his or her designee, counsel for the prisoner, the prosecuting attorney, and the person in charge of the jail or juvenile detention facility, who shall send for, take, and receive the prisoner back into the jail or juvenile detention facility. A defendant, either charged with or convicted of a criminal

offense, or a minor alleged to be within the jurisdiction of the juvenile court, may be concurrently subject to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code). If a prisoner is detained in a facility pursuant to those articles of the Welfare and Institutions Code and if the person in charge of the facility determines that arraignment or trial would be detrimental to the well-being of the prisoner, the time spent in the facility shall not be computed in any statutory time requirements for arraignment or trial in any pending criminal or juvenile proceedings. Otherwise, this section shall not affect any statutory time requirements for arraignment or trial in any pending criminal or juvenile proceedings. For purposes of this section, the term "juvenile detention facility" includes any state, county, or private home or institution in which wards or dependent children of the juvenile court or persons awaiting a hearing before the juvenile court are detained.

Reviewed 3/2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-11**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 8, 2017	
	REVISION DATE: June 25, 2012	
Mental Health Program	**SUBJECT: State Hospital Boarders**	

I PURPOSE: To ensure continuity of psychiatric care for persons transferred to jail from state hospitals for court proceedings.

II POLICY: Adult forensic behavioral health Services (AFBH) evaluates and continues treatment of all inmates transferring to Alameda County from state hospitals (Napa, Atascadero, Patton, etc.). AFBH is notified of expected patients by written report from the state hospital and by ACSO Transportation which is responsible for transporting the inmates to the AFBH clinic.

Inmates are evaluated, psychiatric medications prescribed, and placed in Special Housing Units at Santa Rita Jail on the date of their arrival. Housing will be coordinated with ACSO Classification. Civil commitments (PC 2970's and WIC 5008h) are to be housed in Mental housing.

AFBH clinicians are responsible for continuity of care for these patients. Monitoring will be regular until the inmate demonstrates adjustment to jail routine and continuing psychiatric care.

III PROCEDURE

1. ACSO Transportation faxes prior notification of the arrival of the inmate to the Conditional Release Program (CONREP) and the AFBH clinic.
2. Inmate is evaluated and an Assessment completed during the evening clinic. Medications are continued. Medication changes are to be avoided if possible.
3. If the inmate arrives after 7:00pm, the evening ITR clinician will obtain Bridge medications from the AFBH On-Call psychiatrist.
4. A call is made to Classification to arrange housing in Behavioral Health Unit.
5. All state hospital boarders are housed in the Special Housing Units where AFBH staff is assigned. Monitoring of patients is performed by AFBH staff with special attention to maintaining the patients' stability and continuity of care to the extent possible.
6. If patients refuse to cooperate with treatment, stop medications, and decompensate, AFBH staff should notify the AFBH Director and/or CONREP supervisor who can work with the courts in an effort to expedite the patients' return to state hospital.
7. Clinicians assigned to Special Housing Units should be aware of any state hospital boarders on their units and the boarders' specific legal class designations.

Note: For brief explanation of Legal Status Codes, see attached Legal Classes document.

Reviewed 3/2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-12**	**PAGES: 1-2**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: June 25, 2012	
Mental Health Program	**SUBJECT: State CDCR Parolees**	

I PURPOSE: To ensure continuity of psychiatric care for California Department of Corrections and Rehabilitation (CDCR) parolees housed in Alameda County jails.

II POLICY: The Alameda County Sheriff's Office (ACSO) provides care and custody for CDCR parolees whose parole has been revoked and who are serving their revocation time (up to 180days) in county jail per AB109, implemented October 1, 2011.

III PROCEDURE Adult forensic behavioral health (AFBH), is the designated mental health service provider for all inmates in the care and custody of the ACSO. CDCR inmates often come into custody without accompanying documentation of their medical and psychiatric history. Efforts should be made to obtain such information, especially information on medications, dosages, etc. See AFBH policy on Verified Medications. B 8 a 3). Also, see below for leads on securing the necessary information.

Information may be obtained from:

Parole Outpatient Clinics (POC) and related numbers

Oakland Parole Outpatient Clinic
(510) 577-7596
(510) 577-2407
(510) 883-6664

San Francisco Parole Outpatient Clinic
1 (415) 557-7045

Region II
Oakland Parole Outpatient Clinic
(510) 622-4701 (recording)
(510) 622-4781 (main number)

San Francisco Parole Outpatient Clinic
(415) 597-5848

San Leandro Parole Office
1651 Alvarado St.
San Leandro, CA 94577
1-(510) [redacted]

San Jose Parole Office
1 (408) [redacted]
1 (408) [redacted]

Redwood City Parole
1 (650) [redacted]

1- (650) [redacted]

Santa Clara County Jail
1 (408) [redacted]

Reviewed 11/2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-13**	**PAGES: 1-2**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 8, 2017	
	REVISION DATE: March 6, 2013	
Mental Health Program	**SUBJECT: Federal Inmates**	

I PURPOSE: To ensure that Federal Inmates in the custody of the Alameda County Sheriff's Office, (ACSO) per the contract held between the ACSO and the US Marshall's Office, have access to the same jail-based mental health services as all other inmates.

II POLICY: The ACSO provides in-house care and custody for a specified number of Federal inmates, including those from the Immigration and Customs Enforcement (I.C.E.) agency per its contract with the US Marshalls Office. The jail's mental health services provider, Criminal Justice Mental Health (AFBH) provides jail- based (in-house) mental health services to federal inmates consistent with its policies and procedures for other inmates. AFBH / BHCS is not responsible for acute inpatient care of federal inmates.

III PROCEDURE

1. Federal inmates are screened for mental health service needs at the time of booking by California Forensic Medical Group nurses.

2. Federal inmates needing further psychiatric assessment, care, and monitoring are referred to AFBH per established referral procedures.

3. All appointments for mental health services for federal inmates take place at Santa Rita Jail.

4. Federal inmates housed at GDDF (Glenn Dyer Detention Facility) who need enhanced mental health services are transferred to the Santa Rita Jail facility unless it is determined by AFBH that their psychiatric conditions can be safely managed at GDDF.

5. AFBH does not provide federal court-ordered psychiatric evaluations for federal inmates. If such orders inadvertently reach AFBH, they are forwarded to the ACSO Contract Liaison Sergeant, who will communicate with federal officials.

6. **HOSPITALIZATIONS:**
   a) If it is determined by AFBH staff that a federal inmate is in need of acute, hospitalization, will be assessed by AFBH and placed on a 51510 and sent to JGP for further assessment and monitoring.

b) It will be the decision of the US Marshalls as to whether they wish to have the inmate transferred to an inpatient psychiatric hospital ***at their cost***, or remove the inmate from the Alameda County jail facility for placement elsewhere.

7. Additional information regarding federal inmates may be obtained from:
   a) Federal Marshall
      United States Marshall's Office
      450 Golden Gate Ave, Room 20-005
      San Francisco, CA 94102
      (415) 436-7677
   b) San Francisco County Jail
      850 Bryant Street, 7th floor
      San Francisco, CA
      (415) 553-1852
      Medical (415) 553-9546
      Medical Records (415) 553-1568

Reviewed 11/2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIROAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-14**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: April 8, 2013	
Mental Health Program	**SUBJECT: Clinicians' Progress Notes**	

I PURPOSE: To ensure that all clinical interventions are documented and signed off in the inmate's mental health electronic record, Clinician's Gateway

II POLICY: Progress Notes are written to document all clinical contacts and interventions provided by Adult forensic behaviroal health (AFBH) staff to inmate/patients using the BHCS electronic health record, Clinician's Gateway. All documentations are consistent with the standards set by the BHCS Quality Assurance Office (See enclosed guidelines).

III PROCEDURE:

1. All AFBH staff are trained on the use of the BHCS electronic health record, Clinician's Gateway.
2. All sections of the electronic note should be completed. Including information related to
    a. Current issues being addressed that are consistent with the diagnosis.
    b. Mental status including suicide risk, and symptoms of mental illness
    c. Clinical interventions and response.
    d. Goals and Objectives
    e. Plan for ongoing care
    f. Disposition (i.e. return to clinic, no further treatment necessary, admission to inpatient)

4. For specific handwritten notes, each note must end with the clinician's signature, name, and title. Use rubber stamp when available.

5. Clinicians complete an Episode Update form at any time during the episode if the patient is transferred to another therapist or to the MD only or if there is a change of diagnosis (when it is apparent that a diagnosis needs to be changed for clinical accuracy, the clinican completes and submits the appropriate episode form to the clerical staff so that the diagnosis can be changed in the official BHCS data base.

6. No ***White Out*** is to be used in records. If a mistake is made on a handwritten record, cross out the error and enter the correction.

7. The Progress Note is printed out and forwarded to CALIFORNIA FORENSIC MEDICAL GROUP Health Medical Records at the completion of each face-to-face service.

Reviewed 11-15

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES (BHCS) **ADULT FORENSIC BEHAVIORAL HEALTH (AFBH)** **POLICY AND PROCEDURE**	**NUMBER: B-14 a**	**PAGES: 1-2**
	ISSUED DATE: August 17, 2012	
	REVIEW DATE: March 8, 2017	
	REVISION DATE: April 8, 2013	
Mental Health Program	**SUBJECT: Electronic Mental Health Record: Clinician's Gateway**	

I PURPOSE: To ensure that documentation of mental health clinical notes are entered into Clinician's Gateway, the BHCS / AFBH electronic health record for jail mental health services.

II POLICY: In 2012 AFBH transitioned from hardcopy records to the use of electronic record keeping for mental health services using the BHCS system, Clinician's Gateway (CG). All clinical staffs are expected to enter their clinical notes in the electronic record. Some standard BHCS templates for notes are used by AFBH staffs, and other, customized templates developed specifically for jail mental health services, are used for various other entries.

III PROCEDURE:

1. All AFBH staffs have been trained in the use of Clinician's Gateway by BHCS Information Systems staff and have been given Clinician's Gateway manuals.
2. It is the expectation that every effort should be used by AFBH staff to document client care in CG.
3. All notes / entries are required to identify the following information:
   - Diagnostic code on each note
   - Date
   - Amount of Time
   - Location of service
   - Service Type

3. All notes and medication orders are entered electronically
   a. Psychiatrists use the physician's assessment and medication note forms
   b. Psychiatrists also use Corazon's ER, Catalyst, to list and order psychotropic medications
   c. Clinicians use the clinician's progress note and other AFBH clinical forms that have been specifically formatted for AFBH
4. The clinician fills in the formatted boxes that contain
   a. Current issues being addressed that are consistent with the diagnosis.
   b. Mental status including suicide risk and symptoms of mental illness
   c. Clinical interventions and response.
   d. Goals and Objectives
   e. Plan for ongoing care
   f. Disposition (i.e. return to clinic, no further treatment necessary, admission to inpatient, etc).

5. Each progress note must denote the type of service provided using BHCS established service codes. Each note must contain the clinician's signature, name, and title. This is done electronically.
6. Clinicians complete an Episode Update form at any time during the episode if the patient is transferred to another therapist or to the MD only or if there is a change of diagnosis (when it is apparent that a diagnosis needs to be changed for clinical accuracy, the clinican completes and submits the appropriate episode form to the clerical staff so that the diagnosis can be changed in the official BHCS data base.
7. Psychiatrists enter the psychiatric diagnosis on the master problem list in CFMG Health's ER. Catalyst. .
8. After documentation of each service, the progress note is printed out and given to California Forensic Medical Group Health for the inmate's medical record..
9. AFBH clerical staffs provide support by scanning documents, etc.

Reviewed 3/2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH (AFBH)** **POLICY AND PROCEDURE**	**NUMBER: B-14 b**	**PAGES: 1**
	ISSUED DATE: August 17, 2012	
	REVIEW DATE March 8, 2017	
	REVISION DATE:	
Mental Health Program	**SUBJECT: BHCS Clinical Record Documentation Standards**	

I PURPOSE: To ensure that all documentation of mental health clinical notes is consistent with the BHCS Clinical Record Documentation Standards.

II POLICY: AFBH clinicians and psychiatrists document all of their clinical contacts / interventions in inmates' mental health records. The content of all notes is consistent with BHCS' Clinical Record Documentation Standards

III PROCEDURE:

1. All AFBH staffs have been provided with the BHCS Clinical Record Documentation Standards and have been provided with materials on the agency's 2012 Medi-Medi Documentation Training compiled by the BHCS Quality Assurance Office. See included copy of the PowerPoint presentation.
2. All AFBH psychiatrists have been provided with the BHCS Medical Director's "*Guidelines for Psychotropic Medications Practices*". See included copy.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-15**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: April 5, 2010	
Mental Health Program	**SUBJECT: Program Forms**	

I PURPOSE: To provide standardization of record keeping and interagency communication through the use of approved forms.

II POLICY: AFBH staffs use approved program forms for documentation of clinical services, clerical entries and tasks, data entry, and interagency communication.

III PROCEDURE Program forms generated by Adult forensic behavioral health (AFBH), Behavioral Health Care Services (BHCS), CALIFORNIA FORENSIC MEDICAL GROUP Health, and Alameda County Sheriff's Office (ACSO) are listed in the attached document with information about their purpose and distribution.

1. All forms used by AFBH staff are available in the AFBH clinic.
2. Please see attached document (Communication of Information) for information about how information is maintained, the source of the information, the use of the information, and the distribution of information.

Reviewed 11-2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES (BHCS) **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-16 a b c d**	**PAGES: 1-2**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 8, 2017	
	REVISION DATE: April 8, 2013	
Mental Health Program	**SUBJECT: Psychotropic Medications**	

I PURPOSE: To identify the guidelines for AFBH psychiatric practices regarding the prescription of psychotropic medications. The BHCS Medical Director's office has established guidelines for psychiatric medication practices and documentation standards which have been distributed to all AFBH psychiatrists.

II POLICY**:** Adult forensic behavioral health Services (AFBH) psychiatrists are responsible for evaluating inmates and prescribing appropriate psychiatric medications. Alameda County Behavioral Health Care Services (BHCS) has developed a formulary of psychiatric medications judged appropriate for use in a jail setting. AFBH psychiatrists are provided with the formulary and a form for requesting non-formulary medications (see attached). All AFBH psychiatrists are familiar with the BHCS Medication and Pharmacy Users Guide.

For continuity of patient care, all AFBH psychiatrists assist their colleagues by providing coverage during times of absence. Duties include writing medication orders for inmates being released from custody and refilling prescriptions for inmates whose orders are about to expire or have expired. (*Please see memo and the attached Business and Professions Code 2242 that permits this practice.)* See P&P Sections **8 a** and **8 b** for information regarding medication continuity of care.

Psychiatric medications are tracked and dispensed by California Forensic Medical Group Health nursing staff who report medication problems to the AFBH clinic as needed. *(See California Forensic Medical Group Health policy on AFBH med refusals attached.)*

New psychotropic medication orders may be written for up to 60 days, but the patient must be seen by the psychiatrist within 30 days. Renewals of psychotropic medications on stable patients may be ordered for as long as 90 days. A clinician should see all patients a minimum of every 30 days for monitoring.

III PROCEDURES: All AFBH psychiatrists follow the practice guidelines for the prescription of psychiatric medications; ordering lab work; monitoring medication effects, compliance, and side effects; and documenting their decisions in accordance with the standards set forth in the BHCS Medical Director's Psychiatric Guidelines for all BHCS psychiatrists.

A. Physician's Orders

The psychiatrist

1. Evaluates patient
2. Enters the prescription in the electronic health record.

3. Enters the medication orders into California Forensic Medical Group Health's EHR, Catalyst, following procedures for ordering medications.
4. Electronically faxes the prescription to Maxor pharmacy.
5. Prints out the prescription – one copy goes to California Forensic Medical Group nursing for the MAR and another copy for the AFBH mental health record.
6. Writes a Progress Note in patient's record every time a client is seen or medication is changed using the appropriate service codes. .

B. Medication Consent Form

The psychiatrist:

1. Explains the information included on the Medication Consent form (see Sample A) to each client receiving medications. Each medication must be listed on the form. ***A new form must be completed when a new medication is added to the patient's course of therapy.*** Client and MD signatures are required. Original is scanned into the record, and a copy to California Forensic Medical Group Health Medical Records.
2. Provides a copy of the Drug Information sheet specific to the prescribed medication (information sheets are located in the MD desk drawer).

C Requests for Lab Work

the psychiatrist:

1. Follows the BHCS Medical Director's practice guidelines
2. Determines when lab work is required and orders the lab work electronically. @ https://brli.careevlove.com
    a) For inmates already in the system (bio reference system), search by Name/PFN for lab results and to 'reorder' lab work.
    b) For inmates NOT in the system: 'manually ADD' their names to the system (full name/PFN) in order to request lab work and retrieve results.
3. Prims out the lab order and submits it to the lab dept.
4. When results are received: reviews and writes a Progress Note documenting the review, evaluation, and further action, if any.

D Medical Consults

The psychiatrist:

1. Completes an Internal Consultation form on clients requiring medical consultation to determine medical condition (see Sample D).
2. Notes on Physician's Orders the type of consultation requested, i.e. "California Forensic Medical Group Health should evaluate for seizure disorder."
3. Writes Progress Note to document the request for medical consult.

The clerk:

1. Makes one copy for chart.
2. Posts Medical Consult Log.
3. Delivers form to California Forensic Medical Group Health Medical Director.
4. Pulls chart and gives to MD for review when results are returned.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B-16-e	**PAGES:** 1 of 2
	RELATED ORDERS: ACA 4-ALDF-4D-17	
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: June 27, 2012	
CHAPTER: Health Services Staff	**SUBJECT:** Involuntary Administration of Psychotropic Medications	

I. PURPOSE: To establish guidelines for the use of involuntary psychotropic medications.

II. POLICY: Adult Forensic Behavioral Health (AFBH) follows policies developed for the emergency use of *forced* psychotropic medications as governed by the laws applicable in the State of California. The policies on forced psychotropic medication require physician authorization prior to use and specifics of when, where, and how the psychotropic medication may be forced. Forced psychotropic medication is not used to control behavior or as a disciplinary measure. Adult Forensic Behavioral Health provides all Mental Health Services for facilities operated by the Alameda County Sheriff's Office. There are protocols for why, when, where, and how emergency/involuntary medication shall be administered.

III. DEFINITIONS:

A. WELFARE AND INSTITUTIONS CODE (W&I) 5008 (m): "Emergency" means a situation in which action to impose treatment over the person's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient 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.

B. WELFARE AND INSTITUTIONS CODE 5332(e): In the case of an emergency, as defined in subdivision (m) of Section 5008, a person detained pursuant to Section 5150, 5250, 5260, or 5270.15 may be treated with antipsychotic medication over his or her objection prior to a capacity hearing, but only with antipsychotic medication that is required to treat the emergency condition, which shall be provided in the manner least restrictive to the personal liberty of the patient. It is not necessary for harm to take place or become unavoidable prior to intervention.

C. EMERGENCY MEDICATIONS: Welfare and Institutions Code 5008(m) authorizes psychiatrists to prescribe psychotropic medications for emergencies for the preservation of life or the prevention of seriously bodily harm to self or others. *(Title 15, Section 1217, Psychotropic Medication)*

IV. PROCEDURE:

A. Forced psychotropic medications are used by AFBH in psychiatric emergencies as defined by California Welfare and Institutions Code Sections 5008(m) and 5332(e).

B. Emergency medication is appropriate when a patient becomes an imminent danger to self or others as a result of mental disease, defect, or disorder, and will not cooperate physically with the process of admission to acute care.

C. It is not necessary for harm to take place or become unavoidable prior to emergent treatment.

D. Adult Forensic Behavioral Health shall be notified if any inmate needs emergency psychiatric care.

E. In all cases, the psychiatrist will evaluate the situation and determine that less restrictive measures have been tried and have been unsuccessful in mitigating the emergency.

F. If a psychiatrist determines that emergency medications are needed, psychotropic medications shall be provided in the manner least restrictive to the personal liberty of the patient.

G. Emergency psychiatric medications must be ordered by a AFBH physician. Documentation in the chart must include: the inmate's condition, the threat posed, the reason for forcing the medication, other treatment modalities attempted, and treatment plan goals for less restrictive treatment alternatives as soon as possible.

H. The use of emergency / involuntary medication will be authorized by a AFBH psychiatrist. The psychiatrist will specify the type of medication to be used, the dose, and the duration. Only short-acting medication will be used on an emergency/involuntary basis. The goal is to prevent harm to the inmate and/or staff in an emergency situation;

I. Emergency medication administration may continue only as long as the psychiatric emergency exists. Hospitalization should be undertaken if appropriate

J. Treatment plans for less restrictive interventions will be identified and implemented as soon as possible following the emergency.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B-16-f	**PAGES:** 1 of 3
	RELATED ORDERS: ACA 4-ALDF-2B-03, 4D-21	
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: June 27, 2012	
CHAPTER: Protection From Harm	**SUBJECT:** Use of Physical and Chemical Restraints	

I. **PURPOSE:** To address the use of restraints and the limited use of forced psychotropic medications in the jail setting.

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II. **POLICY**:

Four and five point restraints are not authorized for use in the Santa Rita Jail or the Glenn Dyer Detention Facility. Adult forensic behavioral health staff follow policies developed for the emergency use of forced psychotropic medications as governed by the laws applicable in the State of California. The policy on forced psychotropic medication requires physician authorization prior to use and specifies when, where, and how the psychotropic medication may be forced. Forced psychotropic medications are administered under the procedures listed in Policy B 16 e Involuntary Administration of Psychotropic Medications. Adult forensic behavioral health staff initiate involuntary acute psychiatric hospitalization per WIC 5150 when an inmate meets criteria for a 72 hour psychiatric emergency evaluation.

III. **DEFINITIONS**:

A. WELFARE AND INSTITUTITIONS CODE 5150: When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation. Such facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer, member of the attending staff, or professional person, and stating that the officer, member of the attending staff, or professional person has probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled. If the probable cause is based on the statement of a person other than the officer, member of the attending staff, or professional person, such person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false.

B. WELFARE AND INSTITUTIONS CODE 5150.05(a): When determining if probable cause exists to take a person into custody, or cause a person to be taken into custody, pursuant to Section 5150, any person who is authorized to take that person, or cause that person to be taken,

into custody pursuant to that section shall consider available relevant information about the historical course of the person's mental disorder if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a danger to others, or to himself or herself, or is gravely disabled as a result of the mental disorder.

C. WELFARE AND INSTITUTIONS CODE 5008(m): Authorizes psychiatrists to prescribe psychotropic medications for emergencies for the preservation of life or the prevention of seriously bodily harm to self or others. Emergency means a situation in which action to impose treatment over the person's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient 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.

D. WELFARE AND INSTITUTIONS CODE 5332(e): In the case of an emergency, as defined in subdivision (m) of Section 5008, a person detained pursuant to Section 5150, 5250, 5260 or 5270.15 may be treated with antipsychotic medication over his or her objection prior to a capacity hearing, but only with antipsychotic medication that is required to treat the emergency condition, which shall be provided in the manner least restrictive to the personal liberty of the patient. It is not necessary for harm to take place or become unavoidable prior to intervention.

III. PROCEDURE:

A. Inmates who are dangerous to themselves or others as a result of a mental disorder are managed by initial confinement to a Safety Cell with assessment by AFBH within eight (8) hours. If necessary, the inmate is transferred to the designated acute psychiatric hospital on an involuntary commitment pursuant to Section 5150 of the Welfare and Institutions Code.

B. Emergency involuntary psychiatric medication is rarely used. Psychotropic medication can be used in an emergency situation when it is needed to protect the inmate from harm to self or others in the process of transferring the inmate to an acute hospital on an involuntary commitment.

C. Forced psychotropic medication is not used to control behavior or as a disciplinary measure.

D. Forced psychotropic medications are used by AFBH in psychiatric emergencies as defined by California Welfare and Institutions Code Sections 5008(m) and 5332(e)*.

E. Emergency medication is appropriate when a patient becomes an imminent danger to self or others as a result of mental disease, defect, or disorder, and will not cooperate physically with the process of admission to acute care.

F. It is not necessary for harm to take place or become unavoidable prior to emergent treatment.

G. AFBH shall be notified if any inmate needs emergency psychiatric care.

H. Emergency medication administration may continue only as long as the psychiatric emergency exists. Hospitalization should be undertaken if appropriate.

I. Psychotropic medications shall be provided in the manner least restrictive to the personal liberty of the patient.

J. In all cases, the psychiatrist will evaluate the situation and determine that less restrictive measures have been tried and have been unsuccessful in mitigating the emergency.

K. Emergency psychiatric medications must be authorized and ordered by a AFBH physician. Documentation in the chart must include: the inmate's condition, the threat posed, the reason for forcing the medication, other treatment modalities attempted, and treatment plan goals for less restrictive treatment alternatives as soon as possible.

L. The psychiatrist will specify the type of medication to be used, the dose, and the duration. Only short-acting medication will be used on an emergency/involuntary basis. The goal is to prevent harm to the inmate and/or staff in an emergency situation.

M. The inmate will be monitored for adverse reactions and side effects.

N. Treatment plans for less restrictive interventions will be identified and implemented as soon as possible following the emergency.

O. An after-incident review will be completed.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES (BHCS) ADULT FORENSIC BEHAVIORAL HEALTH POLICY AND PROCEDURE	**NUMBER: B 16 h**	**PAGES: 1**
	RELATED ORDERS:	
	ISSUED DATE: : June 29, 2011	
	REVIEW DATE March 8, 2017	
	REVISION DATE:	
CHAPTER: Mental Health Program	**SUBJECT: Request for Non-formulary Medications**	

I PURPOSE: To provide access to non-formulary medications when there is justification for such use.

II POLICY: AFBH provides access to non-formulary medications if needed.

III PROCEDURE:

1. A "Santa Rita Non-Formulary Request Form" is to be completed by the physician (see attached).
2. The form is to be attached to the medication prescription and sent to the pharmacy.
3. The pharmacist will dispense the medication and will forward the completed form to the Office of the Medical Director.
4. State Hospital "boarders" and 1372s (competent to stand trial) who return to the jail for their legal proceedings will be continued on non-formulary medications to maintain stability and continuity of care. .

Note: No medication will be dispensed by the pharmacy without the accompanying Non-Formulary Request Form. If one has not been provided, the pharmacy will contact the prescribing physician if he/she is onsite, and, if not, the covering physician will complete the form if the medication is to be dispensed.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES (BHCS) **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-16 i**	**PAGES: 1**
	ISSUED DATE: January 30, 2012	
	REVIEW DATE: March 8, 2017	
	REVISION DATE:	
Mental Health Program	**SUBJECT: Urgent "STAT" Psychotropic Medications**	

I PURPOSE: To ensure that there is a process fo**r** urgent, **STAT**, psychotropic medications for inmates in acute distress.

II POLICY: Adult forensic behavioral health Services (AFBH) clinicians and psychiatrists identify and provide interventions with urgent psychiatric medications (STAT) for inmates in acute distress.

III PROCEDURES: AFBH interventions for inmates in acute distress:

1. The AFBH clinician and / or psychiatrist identify and assess the inmate who appears to be in acute distress.
2. The psychiatrist is contacted – either on site or On-Call.
3. The psychiatrist determines what urgent STAT medication is needed.
4. If the inmate is still in booking (ITR), the psychiatrist contacts the booking nurse and gives an order for the STAT medication.
5. If the inmate is in a housing unit, the psychiatrist contacts the charge nurse and gives the STAT order.

Reviewed 11/2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-17 1,2,3,4,5,**	**PAGES: 1-20**
	RELATED ORDERS: Title 15	
	ISSUED DATE: March 14, 2010	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: April 9, 2013	
CHAPTER: Mental Health Program	**SUBJECT: Mandatory Reporting**	

I. **PURPOSE:** To ensure that AFBH mental health clinicians (mandatory reporters) fulfill their legal duty to report when required to do so.

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II **POLICY:** Adult forensic behavioral health Services staff is aware of mandatory reporting requirements as prescribed by law and regulations and reports cases involving suspected **Child Abuse, Developmental Disability, Pregnant/Post-partum females, Elder and Dependent Adult Abuse, and Duty to Protect / Warn** (threats of harm) per Tarasoff.

III PROCEDURE: Adult forensic behavioral health staffs are bound by state and federal laws (WIC 5328 and HIPAA) to protect the confidentiality of mental health services / information except when required by law to report specific information and perform specific actions. *All mandatory reporting notifications are to be documented in the clinical record of the mental health client.*

1. SUSPECTED CHILD ABUSE REPORT

All AFBH clinicians are required to submit a Suspected Child Abuse Report to the appropriate agency whenever there is evidence to suggest that a child has been abused, pursuant to **Penal Code Section 11166** (See Appendix)

Instructions for completion are included on the reverse of the reporting form.

Submit the entire report to the agency that has jurisdiction for handling such reports (i.e. Alameda County Children's Protective Services). Do not separate copies except for the last copy yellow) for AFBH chart (the yellow copy is often illegible; make a copy of the original for the chart as well).

2. DEVELOPMENTAL DISABILITY

A. At any time that a AFBH clinician suspects that an inmate may be developmentally disabled, the clinician must contact the Regional Center of the East Bay to determine eligibility and/or current status of the patient's case. ***510-383-1200***
Section 1057 of Title 15 (See Appendix).

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3. PREGNANT/POST-PARTUM FEMALES

A. During assessment, the clinician determines if the female inmate is currently pregnant. If so, referral to OB-GYN will be initiated.
B. If the female is post-partum within the past year, she will be evaluated for symptoms of post-partum depression or psychosis.

Section 1207.5 of Title 15 (see Appendix).

4. ELDER and DEPENDENT ADULT ABUSE

California law mandates that certain individuals report known or suspected instances of elder or dependent adult abuse. Failure to do so is a crime. Senate Bill 2199 (Chapter 946, Statutes of 1998) broadened and redefined “abuse of an elder or dependent adult,” expanded the definition of “mandated reporters” and added “abandonment, isolation, financial abuse, and neglect” to the list of reportable crimes.

Reports of elder adults (age 65 and older) and dependent adults (disabled adults aged 18 - 64) who are unable to meet their own needs or are victims of abuse, neglect, or exploitation should be made as follows:

- To Your County Adult Protective Services (APS) agency. The Web site of the California Department of Social Services (CDSS) lists the county APS offices in all 58 counties. County APS agencies investigate reports of abuse of elders and dependent adults who live in private homes and hotels, or hospitals and health clinics, when the abuser is not a staff member. From the CDSS Web site, follow the “Report Abuse" link to find county APS information. www.dss.cahwnet.gov/cdssweb/

- To the Licensing and Certification Program of the California Department of Health Services (DHS). DHS Licensing and Certification oversees health facilities such as nursing homes. If you do not want to discuss the problem with anyone in the nursing home, and you believe the nursing home is not or has not protected your rights or the rights of others, you may call the Department of Health Services, Licensing and Certification District Office. The telephone number of the office should be posted in nursing homes and also listed in the "Licensing and Certification," "Nursing Home Residents Rights Fact Sheets" section of the DHS Web site.
  http://www.cdph.ca.gov/programs/Pages/LnC.aspx

- To the Long-Term Care Ombudsman's Office of the California Department of Aging or local Ombudsman Programs statewide. The Ombudsman handles reports of abuse that occur in a nursing home, a board and care home, a residential facility, or a long-term care facility. Local Ombudsman Program phone numbers are posted in care facilities and local and state program phone numbers are available at the Department of Aging Web site.
  www.aging.ca.gov

- To the California Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, which works to protect patients from abuse or neglect in nursing homes and other long-term care facilities. To report elder abuse, contact the Attorney General's toll-free hotline at (800) 722-

0432
http://ag.ca.gov/bmfea

- To any local law enforcement agency.

5. DUTY to PROTECT / WARN (TARASOFF)

Civil Code Section 43.92 *(see Appendix)* and subsequent judicial rulings establish a duty to warn and protect anytime a psychotherapist is reasonably convinced that a client has communicated an active, serious threat of physical violence against a reasonably identifiable victim or victims, regardless of how or from whom the psychotherapist learns of the threat. The key is whether the psychotherapist actually believes that a client has made a credible threat. The duty to warn and protect is discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims *and* to a law enforcement agency.

Ewing v. Goldstein is a recent California appeals court decision that extended the interpretation of the Tarasoff warning law. **The court expanded the definition of Civil Code § 43.92 to "include family members** as persons covered within the statute who, upon communication to a therapist of a serious threat of physical violence against a reasonably identifiable victim, would trigger a duty to warn." The court states in *Goldstein:* "The intent of the statute is clear. A therapist has a duty to warn if, and only if, the threat which the therapist has learned - whether from the patient **or a family member** - actually leads him or her to believe the patient poses a risk of grave bodily injury to another person." The expanded duty from now on applies to credible threats received from the patient, or the patient's family, however, the court made clear that its decision did not go beyond "family members

If a psychotherapist issues a Tarasoff warning, an incident report need *not* be filed, but chart documentation must include: (a) identification of the person reporting the threat and the exact statement made; (b) if the client is the reporter and is available, mental status assessment and disposition of client; (c) if the client is not the reporter, client's whereabouts if known; (d) name of the intended victim(s) and when notified, or description of the attempt to notify; (e) name of the law enforcement official notified; and (f) follow-up notes of the outcome of the situation.

If a *possible* threat has been made or reported to a psychotherapist, but the psychotherapist decides *not* to issue a warning, either because the report of a threat is not believed or the threat itself is not deemed to be serious, then the psychotherapist shall document in the client's clinical record the facts and reasoning that led to the decision *not* to issue a warning. Consultation is advisable and should be documented.

Psychotherapist, for purposes of this Code Section, is defined in ***Evidence Code Section 1010 subdivisions (a) through (m), appended to this policy*** *(see Appendix).*

In addition, ***Welfare and Institutions Code Section 8105(c)*** *(see Appendix)* requires that licensed psychotherapists report immediately to local law enforcement agencies the identity of a person who has communicated to the licensed psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

Psychotherapist, for purposes of this Code Section, is defined in ***Evidence Code Section 1010 subdivisions (a) through (e), appended to this policy.***

Furthermore, any clerk, administrator, or other employee of a clinic or clinical practice who becomes aware of any serious threat of physical violence made by a client of that clinic or clinical practice should immediately notify that client's psychotherapist or, if they are unavailable, any available psychotherapist.

APPENDIX

Penal Code Section 11166

11166. (a) Except as provided in subdivision (d), and in Section 11166.05, a mandated reporter shall make a report to an agency specified in Section 11165.9 whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter shall make an initial report to the agency immediately or as soon as is practicably possible by telephone and the mandated reporter shall prepare and send, fax, or electronically transmit a written followup report thereof within 36 hours of receiving the information concerning the incident. The mandated reporter may include with the report any nonprivileged documentary evidence the mandated reporter possesses relating to the incident.

(1) For purposes of this article, "reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. "Reasonable suspicion" does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any "reasonable suspicion" is sufficient. For the purpose of this article, the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse.

(2) The agency shall be notified and a report shall be prepared and sent, faxed, or electronically transmitted even if the child has expired, regardless of whether or not the possible abuse was a factor contributing to the death, and even if suspected child abuse was discovered during an autopsy.

(3) Any report made by a mandated reporter pursuant to this section shall be known as a mandated report.

(b) If after reasonable efforts a mandated reporter is unable to submit an initial report by telephone, he or she shall immediately or as soon as is practicably possible, by fax or electronic transmission, make a one-time automated written report on the form prescribed by the Department of Justice, and shall also be available to respond to a telephone followup call by the agency with which he or she filed the report. A mandated reporter who files a one-time automated written report because he or she was unable to submit an initial report by telephone is not required to submit a written followup report.

(1) The one-time automated written report form prescribed by the Department of Justice shall be clearly identifiable so that it is not mistaken for a standard written followup report. In addition, the automated one-time report shall contain a section that allows the mandated reporter to state the reason the initial telephone call was not able to be completed. The reason for the submission of the one-time automated written report in lieu of the procedure prescribed in subdivision (a) shall be captured in the Child Welfare Services/Case Management System (CWS/CMS). The department shall work with stakeholders to modify reporting forms and the CWS/CMS as is necessary to accommodate the changes enacted by these provisions.

(2) This subdivision shall not become operative until the CWS/CMS is updated to capture the information prescribed in this subdivision.

(3) This subdivision shall become inoperative three years after this subdivision becomes operative or on January 1, 2009, whichever occurs first.

(4) On the inoperative date of these provisions, a report shall be submitted to the counties and the Legislature by the Department of Social Services that reflects the data collected from automated one-time reports indicating the reasons stated as to why the automated one-time report was filed in lieu of the initial telephone report.

(5) Nothing in this section shall supersede the requirement that a mandated reporter first attempt to make a report via telephone, or that agencies specified in Section 11165.9 accept reports from mandated reporters and other persons as required.

(c) Any mandated reporter who fails to report an incident of known or reasonably suspected child abuse or neglect as required by this section is guilty of a misdemeanor punishable by up to six months confinement in a county jail or by a fine of one thousand dollars ($1,000) or by both that imprisonment and fine. If a mandated reporter intentionally conceals his or her failure to report an incident known by the mandated reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until an agency specified in Section 11165.9 discovers the offense.

(d) (1) A clergy member who acquires knowledge or a reasonable suspicion of child abuse or neglect during a penitential communication is not subject to subdivision (a). For the purposes of this subdivision, "penitential communication" means a communication, intended to be in confidence, including, but not limited to, a sacramental confession, made to a clergy member who, in the course of the discipline or practice of his or her church, denomination, or organization, is authorized or accustomed to hear those communications, and under the discipline, tenets, customs, or practices of his or her church, denomination, or organization, has a duty to keep those communications secret.

(2) Nothing in this subdivision shall be construed to modify or limit a clergy member's duty to report known or suspected child abuse or neglect when the clergy member is acting in some other capacity that would otherwise make the clergy member a mandated reporter.

(3) (A) On or before January 1, 2004, a clergy member or any custodian of records for the clergy member may report to an agency specified in Section 11165.9 that the clergy member or any custodian of records for the clergy member, prior to January 1, 1997, in his or her professional capacity or within the scope of his or her employment, other than during a penitential communication, acquired knowledge or had a reasonable suspicion that a child had been the victim of sexual abuse that the clergy member or any custodian of records for the clergy member did not previously report the abuse to an agency specified in Section 11165.9. The provisions of Section 11172 shall apply to all reports made pursuant to this paragraph.

(B) This paragraph shall apply even if the victim of the known or suspected abuse has reached the age of majority by the time the required report is made.

(C) The local law enforcement agency shall have jurisdiction to investigate any report of child abuse made pursuant to this paragraph even if the report is made after the victim has reached the age of majority.

(e) Any commercial film and photographic print processor who has knowledge of or observes, within the scope of his or her professional capacity or employment, any film, photograph, videotape, negative, or slide depicting a child under the age of 16 years engaged in an act of sexual conduct, shall report the instance of suspected child abuse to the law enforcement agency having jurisdiction over the case immediately, or as soon as practicably possible, by telephone and shall prepare and send, fax, or electronically transmit a written report of it with a copy of the film, photograph, videotape, negative, or slide attached within 36 hours of receiving the information concerning the incident. As used in this subdivision, "sexual conduct" means any of the following:

(1) Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex or between humans and animals.

(2) Penetration of the vagina or rectum by any object.

(3) Masturbation for the purpose of sexual stimulation of the viewer.

(4) Sadomasochistic abuse for the purpose of sexual stimulation of the viewer.

(5) Exhibition of the genitals, pubic, or rectal areas of any

person for the purpose of sexual stimulation of the viewer.

(f) Any mandated reporter who knows or reasonably suspects that the home or institution in which a child resides is unsuitable for the child because of abuse or neglect of the child shall bring the condition to the attention of the agency to which, and at the same time as, he or she makes a report of the abuse or neglect pursuant to subdivision (a).

(g) Any other person who has knowledge of or observes a child whom he or she knows or reasonably suspects has been a victim of child abuse or neglect may report the known or suspected instance of child abuse or neglect to an agency specified in Section 11165.9. For purposes of this section, "any other person" includes a mandated reporter who acts in his or her private capacity and not in his or her professional capacity or within the scope of his or her employment.

(h) When two or more persons, who are required to report, jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

(i) (1) The reporting duties under this section are individual, and no supervisor or administrator may impede or inhibit the reporting duties, and no person making a report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established provided that they are not inconsistent with this article.

(2) The internal procedures shall not require any employee required to make reports pursuant to this article to disclose his or her identity to the employer.

(3) Reporting the information regarding a case of possible child abuse or neglect to an employer, supervisor, school principal, school counselor, coworker, or other person shall not be a substitute for making a mandated report to an agency specified in Section 11165.9.

(j) A county probation or welfare department shall immediately, or as soon as practicably possible, report by telephone, fax, or electronic transmission to the law enforcement agency having jurisdiction over the case, to the agency given the responsibility for investigation of cases under Section 300 of the Welfare and Institutions Code, and to the district attorney's office every known or suspected instance of child abuse or neglect, as defined in Section 11165.6, except acts or omissions coming within subdivision (b) of Section 11165.2, or reports made pursuant to Section 11165.13 based on risk to a child which relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse, which shall be reported only to the county welfare or probation department. A county probation or welfare department also shall send, fax, or electronically transmit a written report thereof within 36 hours of receiving the information concerning the incident to any agency to which it makes a telephone report under this subdivision.

(k) A law enforcement agency shall immediately, or as soon as practicably possible, report by telephone, fax, or electronic transmission to the agency given responsibility for investigation of cases under Section 300 of the Welfare and Institutions Code and to the district attorney's office every known or suspected instance of child abuse or neglect reported to it, except acts or omissions coming within subdivision (b) of Section 11165.2, which shall be reported only to the county welfare or probation department. A law enforcement agency shall report to the county welfare or probation department every known or suspected instance of child abuse or neglect reported to it which is alleged to have occurred as a result of the action of a person responsible for the child's welfare, or as the result of the failure of a person responsible for the child's

welfare to adequately protect the minor from abuse when the person responsible for the child's welfare knew or reasonably should have known that the minor was in danger of abuse. A law enforcement agency also shall send, fax, or electronically transmit a written report thereof within 36 hours of receiving the information concerning the incident to any agency to which it makes a telephone report under this subdivision.

Section 1057 of Title 15:

Developmentally Disabled Inmates

. . The health authority or designee shall contact the Regional Center on any inmate suspected or confirmed to be developmentally disabled for the purposes of diagnosis and/or treatment within 24 hours of such determination, excluding holidays and weekends. Contact the Regional Center @ (510) 383-1200.

Section 1207.5 of Title 15:

Special Mental Disorder Assessment

An additional mental health screening will be performed, according to written procedures, to women who have given birth within the past year and are charged with murder or attempted murder of their infants. Such screening will be performed at intake and if the assessment indicates postpartum psychosis, a referral for further evaluation will be made.

Civil Code Section: 43.92.

(a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to warn of and protect from a patient's threatened violent behavior or failing to predict and warn of and protect from a patient' s violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

(b) There shall be no monetary liability on the part of, and no cause of action shall arise against, a psychotherapist who, under the limited circumstances specified above, discharges his or her duty to warn and protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.

Evidence Code Section 1010

As used in this article, “psychotherapist” means a person who is, or is reasonably believed by the patient to be:

a) A person authorized to practice medicine in any state or nation who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry.
b) A person licensed as a psychologist under Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.
c) A person licensed as a clinical social worker under Article 4 (commencing with Section 4996) of Chapter 14 of Division 2 of the Business and Professions Code, when he or she is engaged in applied psychotherapy of a non-medical nature.
d) A person who is serving as a school psychologist and holds a credential authorizing that service issued by the state.
e) A person licensed as a marriage and family therapist under Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.
f) A person registered as a psychological assistant who is under the supervision of a licensed psychologist or board certified psychiatrist as required by Section 2913 of the Business and Professions Code, or a person registered as a marriage and family therapist intern who is under the supervision of a licensed marriage and family therapist, a licensed clinical social worker, a licensed psychologist, or a licensed physician certified in psychiatry, as specified in Section 4980.44 of the Business and Professions Code.
g) A person registered as an associate clinical social worker who is under the supervision of a licensed clinical social worker, a licensed psychologist, or a board certified psychiatrist as required by Section 4996.20 or 4996.21 of the Business and Professions Code.
h) A person exempt from the Psychology Licensing Law pursuant to subdivision (d) of Section 2909 of the Business and Professions Code who is under the supervision of a licensed psychologist or board certified psychiatrist.
i) A psychological intern as defined in Section 2911 of the Business and Professions Code who is under the supervision of a licensed psychologist or board certified psychiatrist.
j) A trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, who is fulfilling his or her supervised practicum required by subdivision (b) of Section 4980.40 of the Business and Professions Code and is supervised by a licensed psychologist, board certified psychiatrist, a licensed clinical social worker, or a licensed marriage and family therapist.

k) A person licensed as a registered nurse pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, who possesses a master's degree in psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing.
l) An advanced practice registered nurse who is certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code and who participates in expert clinical practice in the specialty of psychiatric-mental health nursing.
m) A person rendering mental health treatment or counseling services as authorized pursuant to Section 6924 of the Family Code.

Welfare and Institutions Code Section 8105 (c)

(c) A licensed psychotherapist shall immediately report to a local law enforcement agency the identity of a person subject to subdivision (b) of Section 8100. Upon receipt of the report, the local law enforcement agency, on a form prescribed by the Department of Justice, shall immediately notify the department of the person who is subject to subdivision (b) of Section 8100.

Welfare and Institutions Code Section 8100(b)(1)

A person shall not have in his or her possession or under his or her custody or control, or purchase or receive, or attempt to purchase or receive, any firearms whatsoever or any other deadly weapon for a period of six months whenever, on or after January 1, 1992, he or she communicates to a licensed psychotherapist, as defined in subdivisions (a) to (e), inclusive, of Section 1010 of the Evidence Code, a serious threat of physical violence against a reasonably identifiable victim or victims. The six-month period shall commence from the date that the licensed psychotherapist reports to the local law enforcement agency the identity of the person making the communication. The prohibition provided for in this subdivision shall not apply unless the licensed psychotherapist notifies a local law enforcement agency of the threat by that person. The person, however, may own, possess, have custody or control over, or receive or purchase any firearm if a superior court, pursuant to paragraph (3) and upon petition of the person, has found, by a preponderance of the evidence, that the person is likely to use firearms or other deadly weapons in a safe and lawful manner.

Welfare and Institutions Code Section 5328 (Confidentiality and Exceptions)

All information and records obtained in the course of providing services under Division 4 (commencing with Section 4000), Division 4.1 (commencing with Section 4400), Division 4.5 (commencing with Section 4500), Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7100), to either voluntary or involuntary recipients of services shall be confidential. Information and records obtained in the course of providing similar services to either voluntary or involuntary recipients prior to 1969 shall also be confidential. Information and records shall be disclosed only in any of the following cases:

(a) In communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. The consent of the patient, or his or her guardian or conservator shall be obtained before information or records may be disclosed by a professional person employed by a facility to a professional person not employed by the facility who does not have the medical or psychological responsibility for the patient's care.

(b) When the patient, with the approval of the physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist, who is in charge of the patient, designates persons to whom information or records may be released, except that nothing in this article shall be construed to compel a physician, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family. Nothing in this subdivision shall be construed to authorize a licensed marriage and family therapist to provide services or to be in charge of a patient's care beyond his or her lawful scope of practice.

(c) To the extent necessary for a recipient to make a claim, or

for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which he or she may be entitled.

(d) If the recipient of services is a minor, ward, or conservatee, and his or her parent, guardian, guardian ad litem, or conservator designates, in writing, persons to whom records or information may be disclosed, except that nothing in this article shall be construed to compel a physician, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family.

(e) For research, provided that the Director of Mental Health or the Director of Developmental Services designates by regulation, rules for the conduct of research and requires the research to be first reviewed by the appropriate institutional review board or boards. The rules shall include, but need not be limited to, the requirement that all researchers shall sign an oath of confidentiality as follows:

_____
Date

As a condition of doing research concerning persons who have received services from ____ (fill in the facility, agency or person), I, ____, agree to obtain the prior informed consent of such persons who have received services to the maximum degree possible as determined by the appropriate institutional review board or boards for protection of human subjects reviewing my research, and I further agree not to divulge any information obtained in the course of such research to unauthorized persons, and not to publish or otherwise make public any information regarding persons who have received services such that the person who received services is identifiable.

I recognize that the unauthorized release of confidential information may make me subject to a civil action under provisions of the Welfare and Institutions Code.

(f) To the courts, as necessary to the administration of justice.

(g) To governmental law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families.

(h) To the Senate Committee on Rules or the Assembly Committee on Rules for the purposes of legislative investigation authorized by the committee.

(i) If the recipient of services who applies for life or disability insurance designates in writing the insurer to which records or information may be disclosed.

(j) To the attorney for the patient in any and all proceedings upon presentation of a release of information signed by the patient, except that when the patient is unable to sign the release, the staff of the facility, upon satisfying itself of the identity of the attorney, and of the fact that the attorney does represent the interests of the patient, may release all information and records relating to the patient except that nothing in this article shall be construed to compel a physician, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family.

(k) Upon written agreement by a person previously confined in or otherwise treated by a facility, the professional person in charge of the facility or his or her designee may release any information, except information that has been given in confidence by members of the person's family, requested by a probation officer charged with the evaluation of the person after his or her conviction of a crime

if the professional person in charge of the facility determines that the information is relevant to the evaluation. The agreement shall only be operative until sentence is passed on the crime of which the person was convicted. The confidential information released pursuant to this subdivision shall be transmitted to the court separately from the probation report and shall not be placed in the probation report. The confidential information shall remain confidential except for purposes of sentencing. After sentencing, the confidential information shall be sealed.

(l) Between persons who are trained and qualified to serve on multidisciplinary personnel teams pursuant to subdivision (d) of Section 18951. The information and records sought to be disclosed shall be relevant to the prevention, identification, management, or treatment of an abused child and his or her parents pursuant to Chapter 11 (commencing with Section 18950) of Part 6 of Division 9.

(m) To county patients' rights advocates who have been given knowing voluntary authorization by a client or a guardian ad litem. The client or guardian ad litem, whoever entered into the agreement, may revoke the authorization at any time, either in writing or by oral declaration to an approved advocate.

(n) To a committee established in compliance with Section 4070.

(o) In providing information as described in Section 7325.5. Nothing in this subdivision shall permit the release of any information other than that described in Section 7325.5.

(p) To the county mental health director or the director's designee, or to a law enforcement officer, or to the person designated by a law enforcement agency, pursuant to Sections 5152.1 and 5250.1.

(q) If the patient gives his or her consent, information specifically pertaining to the existence of genetically handicapping conditions, as defined in Section 125135 of the Health and Safety Code, may be released to qualified professional persons for purposes of genetic counseling for blood relatives upon request of the blood relative. For purposes of this subdivision, "qualified professional persons" means those persons with the qualifications necessary to carry out the genetic counseling duties under this subdivision as determined by the genetic disease unit established in the State Department of Health Services under Section 125000 of the Health and Safety Code. If the patient does not respond or cannot respond to a request for permission to release information pursuant to this subdivision after reasonable attempts have been made over a two-week period to get a response, the information may be released upon request of the blood relative.

(r) When the patient, in the opinion of his or her psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies as the psychotherapist determines is needed for the protection of that person or persons. For purposes of this subdivision, "psychotherapist" means anyone so defined within Section 1010 of the Evidence Code.

(s) (1) To the designated officer of an emergency response employee, and from that designated officer to an emergency response employee regarding possible exposure to HIV or AIDS, but only to the extent necessary to comply with provisions of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (P.L. 101-381; 42 U.S.C. Sec. 201).

(2) For purposes of this subdivision, "designated officer" and "emergency response employee" have the same meaning as these terms are used in the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (P.L. 101-381; 42 U.S.C. Sec. 201).

(3) The designated officer shall be subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV results. Further, the designated officer shall inform the exposed emergency response employee that the employee is also subject to the confidentiality requirements specified in Section 120980, and

may be personally liable for unauthorized release of any identifying information about the HIV test results.

(t) (1) To a law enforcement officer who personally lodges with a facility, as defined in paragraph (2), a warrant of arrest or an abstract of such a warrant showing that the person sought is wanted for a serious felony, as defined in Section 1192.7 of the Penal Code, or a violent felony, as defined in Section 667.5 of the Penal Code. The information sought and released shall be limited to whether or not the person named in the arrest warrant is presently confined in the facility. This paragraph shall be implemented with minimum disruption to health facility operations and patients, in accordance with Section 5212. If the law enforcement officer is informed that the person named in the warrant is confined in the facility, the officer may not enter the facility to arrest the person without obtaining a valid search warrant or the permission of staff of the facility.

(2) For purposes of paragraph (1), a facility means all of the following:

(A) A state hospital, as defined in Section 4001.

(B) A general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, solely with regard to information pertaining to a mentally disordered person subject to this section.

(C) An acute psychiatric hospital, as defined in subdivision (b) of Section 1250 of the Health and Safety Code.

(D) A psychiatric health facility, as described in Section 1250.2 of the Health and Safety Code.

(E) A mental health rehabilitation center, as described in Section 5675.

(F) A skilled nursing facility with a special treatment program for chronically mentally disordered patients, as described in Sections 51335 and 72445 to 72475, inclusive, of Title 22 of the California Code of Regulations.

(u) Between persons who are trained and qualified to serve on multidisciplinary personnel teams pursuant to Section 15610.55, 15753.5, or 15761. The information and records sought to be disclosed shall be relevant to the prevention, identification, management, or treatment of an abused elder or dependent adult pursuant to Chapter 13 (commencing with Section 15750) of Part 3 of Division 9.

(v) The amendment of subdivision (d) enacted at the 1970 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the preexisting law.

(w) This section shall not be limited by Section 5150.05 or 5332.

(x) (1) When an employee is served with a notice of adverse action, as defined in Section 19570 of the Government Code, the following information and records may be released:

(A) All information and records that the appointing authority relied upon in issuing the notice of adverse action.

(B) All other information and records that are relevant to the adverse action, or that would constitute relevant evidence as defined in Section 210 of the Evidence Code.

(C) The information described in subparagraphs (A) and (B) may be released only if both of the following conditions are met:

(i) The appointing authority has provided written notice to the consumer and the consumer's legal representative or, if the consumer has no legal representative or if the legal representative is a state agency, to the clients' rights advocate, and the consumer, the consumer's legal representative, or the clients' rights advocate has not objected in writing to the appointing authority within five business days of receipt of the notice, or the appointing authority, upon review of the objection has determined that the circumstances on which the adverse action is based are egregious or threaten the health, safety, or life of the consumer or other consumers and without the information the adverse action could not be taken.

(ii) The appointing authority, the person against whom the adverse

action has been taken, and the person's representative, if any, have entered into a stipulation that does all of the following:

(I) Prohibits the parties from disclosing or using the information or records for any purpose other than the proceedings for which the information or records were requested or provided.

(II) Requires the employee and the employee's legal representative to return to the appointing authority all records provided to them under this subdivision, including, but not limited to, all records and documents from any source containing confidential information protected by this section, and all copies of those records and documents, within 10 days of the date that the adverse action becomes final except for the actual records and documents or copies thereof that are no longer in the possession of the employee or the employee's legal representative because they were submitted to the administrative tribunal as a component of an appeal from the adverse action.

(III) Requires the parties to submit the stipulation to the administrative tribunal with jurisdiction over the adverse action at the earliest possible opportunity.

(2) For the purposes of this subdivision, the State Personnel Board may, prior to any appeal from adverse action being filed with it, issue a protective order, upon application by the appointing authority, for the limited purpose of prohibiting the parties from disclosing or using information or records for any purpose other than the proceeding for which the information or records were requested or provided, and to require the employee or the employee's legal representative to return to the appointing authority all records provided to them under this subdivision, including, but not limited to, all records and documents from any source containing confidential information protected by this section, and all copies of those records and documents, within 10 days of the date that the adverse action becomes final, except for the actual records and documents or copies thereof that are no longer in the possession of the employee or the employee's legal representatives because they were submitted to the administrative tribunal as a component of an appeal from the adverse action.

(3) Individual identifiers, including, but not limited to, names, social security numbers, and hospital numbers, that are not necessary for the prosecution or defense of the adverse action, shall not be disclosed.

(4) All records, documents, or other materials containing confidential information protected by this section that has been submitted or otherwise disclosed to the administrative agency or other person as a component of an appeal from an adverse action shall, upon proper motion by the appointing authority to the administrative tribunal, be placed under administrative seal and shall not, thereafter, be subject to disclosure to any person or entity except upon the issuance of an order of a court of competent jurisdiction.

(5) For purposes of this subdivision, an adverse action becomes final when the employee fails to answer within the time specified in Section 19575 of the Government Code, or, after filing an answer, withdraws the appeal, or, upon exhaustion of the administrative appeal or of the judicial review remedies as otherwise provided by law.

5328.01. Notwithstanding Section 5328, all information and records made confidential under the first paragraph of Section 5328 shall also be disclosed to governmental law enforcement agencies investigating evidence of a crime where the records relate to a patient who is confined or has been confined as a mentally disordered sex offender or pursuant to Section 1026 or 1368 of the Penal Code and the records are in the possession or under the control of any state hospital serving the mentally disabled, as follows:

(a) In accordance with the written consent of the patient; or

(b) If authorized by an appropriate order of a court of competent

jurisdiction in the county where the records are located compelling a party to produce in court specified records and specifically describing the records being sought, when the order is granted after an application showing probable cause therefor. In assessing probable cause, the court shall do all of the following:

(1) Weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

(2) Determine that there is a reasonable likelihood that the records in question will disclose material information or evidence of substantial value in connection with the investigation or prosecution.

(3) Determine that the crime involves the causing of, or direct threatening of, the loss of life or serious bodily injury.

(4) In granting or denying a subpoena, the court shall state on the record the reasons for its decision and the facts which the court considered in making such a ruling.

(5) If a court grants an order permitting disclosure of such records, the court shall issue all orders necessary to protect, to the maximum extent possible, the patient's privacy and the privacy and confidentiality of the physician-patient relationship.

(6) Any records disclosed pursuant to the provisions of this subdivision and any copies thereof shall be returned to the facility at the completion of the investigation or prosecution unless they have been made a part of the court record.

(c) A governmental law enforcement agency applying for disclosure of patient records under this subdivision may petition the court for an order, upon a showing of probable cause to believe that delay would seriously impede the investigation, which requires the ordered party to produce the records forthwith.

(d) Records obtained by a governmental law enforcement agency pursuant to this section shall not be disseminated to any other agency or person unless such dissemination relates to the criminal investigation for which the records were obtained by the governmental law enforcement agency. The willful dissemination of any record in violation of this paragraph shall constitute a misdemeanor.

(e) If any records obtained pursuant to this section are of a patient presently receiving treatment at the state hospital serving the mentally disabled, the law enforcement agency shall only receive copies of the original records.

5328.02. Notwithstanding Section 5328, all information and records made confidential under the first paragraph of Section 5328 shall also be disclosed to the Youth Authority and Adult Correctional Agency or any component thereof, as necessary to the administration of justice.

5328.05. (a) Notwithstanding Section 5328, information and records may be disclosed when an older adult client, in the opinion of a designee of a human service agency serving older adults through an established multidisciplinary team, presents signs or symptoms of elder abuse or neglect, whether inflicted by another or self-inflicted, the agency designee to the multidisciplinary team may, with the older adult's consent, obtain information from other county agencies regarding, and limited to, whether or not a client is receiving services from any other county agency.

(b) The information obtained pursuant to subdivision (a) shall not include information regarding the nature of the treatment or services provided, and shall be shared among multidisciplinary team members for multidisciplinary team activities pursuant to this section.

(c) The county agencies which may cooperate and share information under this section shall have staff designated as members of an

established multidisciplinary team, and include, but not be limited to, the county departments of public social services, health, mental health, and alcohol and drug abuse, the public guardian, and the area agencies on aging.

(d) The county patient's rights advocate shall report any negative consequences of the implementation of this exception to confidentiality requirements to the local mental health director.

5328.06. (a) Notwithstanding Section 5328, information and records shall be disclosed to the protection and advocacy agency established in this state to fulfill the requirements and assurances of the federal Protection and Advocacy for the Mentally Ill Individuals Amendments Act of 1991, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of people with mental disabilities, including people with mental illness, as defined in Section 10802(4) of Title 42 of the United States Code.

(b) Access to information and records to which subdivision (a) applies shall be in accord with Division 4.7 (commencing with Section 4900).

5328.1. (a) Upon request of a member of the family of a patient, or other person designated by the patient, a public or private treatment facility shall give the family member or the designee notification of the patient's diagnosis, the prognosis, the medications prescribed, the side effects of medications prescribed, if any, and the progress of the patient, if, after notification of the patient that this information is requested, the patient authorizes its disclosure. If, when initially informed of the request for notification, the patient is unable to authorize the release of such information, notation of the attempt shall be made into the patient's treatment record, and daily efforts shall be made to secure the patient's consent or refusal of authorization. However, if a request for information is made by the spouse, parent, child, or sibling of the patient and the patient is unable to authorize the release of such information, the requester shall be given notification of the patient's presence in the facility, except to the extent prohibited by federal law.

(b) Upon the admission of any mental health patient to a 24-hour public or private health facility licensed pursuant to Section 1250 of the Health and Safety Code, the facility shall make reasonable attempts to notify the patient's next of kin or any other person designated by the patient, of the patient's admission, unless the patient requests that this information not be provided. The facility shall make reasonable attempts to notify the patient's next of kin or any other person designated by the patient, of the patient's release, transfer, serious illness, injury, or death only upon request of the family member, unless the patient requests that this information not be provided. The patient shall be advised by the facility that he or she has the right to request that this information not be provided.

(c) No public or private entity or public or private employee shall be liable for damages caused or alleged to be caused by the release of information or the omission to release information pursuant to this section.

Nothing in this section shall be construed to require photocopying of a patient's medical records in order to satisfy its provisions.

5328.15. All information and records obtained in the course of providing services under Division 5 (commencing with Section 5000),

Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7000), to either voluntary or involuntary recipients of services shall be confidential. Information and records may be disclosed, however, notwithstanding any other provision of law, as follows:

(a) To authorized licensing personnel who are employed by, or who are authorized representatives of, the State Department of Health Services, and who are licensed or registered health professionals, and to authorized legal staff or special investigators who are peace officers who are employed by, or who are authorized representatives of the State Department of Social Services, as necessary to the performance of their duties to inspect, license, and investigate health facilities and community care facilities and to ensure that the standards of care and services provided in such facilities are adequate and appropriate and to ascertain compliance with the rules and regulations to which the facility is subject. The confidential information shall remain confidential except for purposes of inspection, licensing, or investigation pursuant to Chapter 2 (commencing with Section 1250) of, and Chapter 3 (commencing with Section 1500) of, Division 2 of the Health and Safety Code, or a criminal, civil, or administrative proceeding in relation thereto. The confidential information may be used by the State Department of Health Services or the State Department of Social Services in a criminal, civil, or administrative proceeding. The confidential information shall be available only to the judge or hearing officer and to the parties to the case. Names which are confidential shall be listed in attachments separate to the general pleadings. The confidential information shall be sealed after the conclusion of the criminal, civil, or administrative hearings, and shall not subsequently be released except in accordance with this subdivision. If the confidential information does not result in a criminal, civil, or administrative proceeding, it shall be sealed after the State Department of Health Services or the State Department of Social Services decides that no further action will be taken in the matter of suspected licensing violations. Except as otherwise provided in this subdivision, confidential information in the possession of the State Department of Health Services or the State Department of Social Services shall not contain the name of the patient.

(b) To any board which licenses and certifies professionals in the fields of mental health pursuant to state law, when the Director of Mental Health has reasonable cause to believe that there has occurred a violation of any provision of law subject to the jurisdiction of that board and the records are relevant to the violation. This information shall be sealed after a decision is reached in the matter of the suspected violation, and shall not subsequently be released except in accordance with this subdivision. Confidential information in the possession of the board shall not contain the name of the patient.

5328.2. Notwithstanding Section 5328, movement and identification information and records regarding a patient who is committed to the department, state hospital, or any other public or private mental health facility approved by the county mental health director for observation or for an indeterminate period as a mentally disordered sex offender, or for a person who is civilly committed as a sexually violent predator pursuant to Article 4 (commencing with Section 6600) of Chapter 2 of Part 2 of Division 6, or regarding a patient who is committed to the department, to a state hospital, or any other public or private mental health facility approved by the county mental health director under Section 1026 or 1370 of the Penal Code or receiving treatment pursuant to Section 5300 of this code, shall be forwarded immediately without prior request to the Department of Justice. Except as otherwise provided by law, information automatically reported under this section shall be restricted to name, address, fingerprints, date of admission, date of discharge,

date of escape or return from escape, date of any home leave, parole or leave of absence and, if known, the county in which the person will reside upon release. The Department of Justice may in turn furnish information reported under this section pursuant to Section 11105 or 11105.1 of the Penal Code. It shall be a misdemeanor for recipients furnished with this information to in turn furnish the information to any person or agency other than those specified in Section 11105 or 11105.1 of the Penal Code.

5328.3. (a) When a voluntary patient would otherwise be subject to the provisions of Section 5150 of this part and disclosure is necessary for the protection of the patient or others due to the patient's disappearance from, without prior notice to, a designated facility and his or her whereabouts is unknown, notice of the disappearance may be made to relatives and governmental law enforcement agencies designated by the physician in charge of the patient or the professional person in charge of the facility or his or her designee.

(b) (1) When an involuntary patient is gravely disabled, as defined in subparagraph (B) of paragraph (1) of subdivision (h) of Section 5008, and the patient has disappeared from a designated facility, or is transferred between state hospitals, notice of the disappearance or transfer shall be made to the court initially ordering the patient's commitment pursuant to Section 1370 of the Penal Code, the district attorney for the county that ordered the commitment, and governmental law enforcement agencies designated by the physician in charge of the patient or the professional person in charge of the facility or his or her designee. This notice shall be made within 24 hours of the patient's disappearance or transfer from the facility.

(2) A designated facility shall not permit the release of an involuntary patient who is gravely disabled, as defined in subparagraph (B) of paragraph (1) of subdivision (h) of Section 5008, without prior written authorization of the court pursuant to paragraph (2) of subdivision (d) of Section 5358. The court may approve the pending release without a hearing unless a party notified pursuant to subdivision (d) of Section 5358 objects to the pending release within 10 days after receiving notice. This paragraph does not apply to the transfer of persons between state hospitals.

5328.35. The State Department of Mental Health shall develop policies and procedures no later than 30 days after the effective date of the Budget Act of 1998, at each state hospital, to notify Members of the Legislature who represent the district in which the state hospital is located, local law enforcement, and designated local government officials in the event of a patient escape or walkaway.

5328.4. The physician in charge of the patient, or the professional person in charge of the facility or his or her designee, when he or she has probable cause to believe that a patient while hospitalized has committed, or has been the victim of, murder, manslaughter, mayhem, aggravated mayhem, kidnapping, carjacking, robbery, assault with intent to commit a felony, arson, extortion, rape, forcible sodomy, forcible oral copulation, unlawful possession of a weapon as provided in Section 12020 of the Penal Code, or escape from a hospital by a mentally disordered sex offender as provided in Section 6330 of the Welfare and Institutions Code, shall release information about the patient to governmental law enforcement agencies.

The physician in charge of the patient, or the professional person in charge of the facility or his or her designee, when he or she has probable cause to believe that a patient, while hospitalized has

committed, or has been the victim of assault or battery may release information about the patient to governmental law enforcement agencies.

This section shall be limited solely to information directly relating to the factual circumstances of the commission of the enumerated offenses and shall not include any information relating to the mental state of the patient or the circumstances of his or her voluntary or involuntary admission, commitment, or treatment.

This section shall not be construed as an exception to or in any other way affecting the provisions of Article 7 (commencing with Section 1010) of Chapter 4 of Division 8 of the Evidence Code.

5328.5. Information and records described in Section 5328 may be disclosed in communications relating to the prevention, investigation, or treatment of elder abuse or dependent adult abuse pursuant to Chapter 11 (commencing with Section 15600) and Chapter 13 (commencing with Section 15750), of Part 3 of Division 9.

5328.6. When any disclosure of information or records is made as authorized by the provisions of Section 11878 or 11879 of the Health and Safety Code, subdivision (a) or (d) of Section 5328, Sections 5328.1, 5328.3, or 5328.4, the physician in charge of the patient or the professional person in charge of the facility shall promptly cause to be entered into the patient's medical record: the date and circumstances under which such disclosure was made; the names and relationships to the patient if any, of persons or agencies to whom such disclosure was made; and the specific information disclosed.

5328.7. Signed consent forms by a patient for release of any information to which such patient is required to consent under the provisions of Sections 11878 or 11879 of the Health and Safety Code or subdivision (a) or (d) of Section 5328 shall be obtained for each separate use with the use specified, the information to be released, the name of the agency or individual to whom information will be released indicated on the form and the name of the responsible individual who has authorization to release information specified. Any use of this form shall be noted in the patient file. Patients who sign consent forms shall be given a copy of the consent form signed.

5328.8. The State Department of Mental Health, the physician in charge of the patient, or the professional person in charge of the facility or his or her designee, shall, except as otherwise provided in this section, release information obtained in the course of providing services under Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7100), to the coroner when a patient dies from any cause, natural or otherwise, while hospitalized in a state mental hospital. The State Department of Mental Health, the physician in charge of the patient, or the professional person in charge of the facility or his or her designee, shall not release any notes, summaries, transcripts, tapes, or records of conversations between the patient and health professional personnel of the hospital relating to the personal life of the patient which is not related to the diagnosis and treatment of the patient's physical condition. Any information released to the coroner pursuant to this section shall remain confidential and shall be sealed and shall not be made part of the public record.

5328.9. If at such time as a patient's hospital records are required by an employer to whom the patient has applied for employment, such records shall be forwarded to a qualified physician or psychiatrist representing the employer upon the request of the patient unless the physician or administrative officer responsible for the patient deems the release of such records contrary to the best interest of the patient.

If the physician or administrative officer responsible for a patient deems the release of such records contrary to the best interest of the patient, he shall notify the patient within five days. In the event that the disclosure of the patient's records to the patient himself would not serve his best interests, the physician or administrative officer in question shall render formal notice of his decision to the superior court of the county in which the patient resides.

5329. Nothing in this chapter shall be construed to prohibit the compilation and publication of statistical data for use by government or researchers under standards set by the Director of Mental Health.

5330. (a) Any person may bring an action against an individual who has willfully and knowingly released confidential information or records concerning him or her in violation of this chapter, or of Chapter 1 (commencing with Section 11860) of Part 3 of Division 10.5 of the Health and Safety Code, for the greater of the following amounts:

(1) Ten thousand dollars ($10,000).

(2) Three times the amount of actual damages, if any, sustained by the plaintiff.

(b) Any person may bring an action against an individual who has negligently released confidential information or records concerning him or her in violation of this chapter, or of Chapter 1 (commencing with Section 11860) of Part 3 of Division 10.5 of the Health and Safety Code, for both of the following:

(1) One thousand dollars ($1,000). In order to recover under this paragraph, it shall not be a prerequisite that the plaintiff suffer or be threatened with actual damages.

(2) The amount of actual damages, if any, sustained by the plaintiff.

(c) Any person may, in accordance with Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, bring an action to enjoin the release of confidential information or records in violation of this chapter, and may in the same action seek damages as provided in this section.

(d) In addition to the amounts specified in subdivisions (a) and (b), the plaintiff shall recover court costs and reasonable attorney's fees as determined by the court.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-18**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 8, 2017	
	REVISION DATE: April 5, 2010	
Mental Health Program	**SUBJECT: Officer of the Day (OD) Duties**	

I PURPOSE: To provide AFBH coverage during weekdays for duties not otherwise covered by AFBH assignments.

II POLICY: AFBH staff members may be assigned Officer of the Day duties to ensure that specific daily tasks are covered.

III PROCEDURE Samples of duties include but are not limited to the following:

1. Answer phone inquiries.
2. Handle emergencies
3. Triage and assign new cases (termed "TBAs"—to be assigned).
4. Check arrival of patients and note time on copy of ACSO clinic log.
5. Provide consultation to deputies, CALIFORNIA FORENSIC MEDICAL GROUP Nursing staff, AFBH staff.
6. Review referrals for urgent problems.
7. Answer phones in clerk's absence
8. See clients as necessary in the clinic, ITR, and/or Housing Units.
9. Provide back-up coverage in absence of other clinicians.
10. Check next clinic day schedule to determine if clinic is overloaded and reschedule patients as needed.

Reviewed 3/2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B-19	**PAGES:** 1-2
	RELATED ORDERS: 4-ALDF-4C-08	
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: August 13, 2012	
CHAPTER: Mental Health Program	**SUBJECT:** On-Call Duties	

I. PURPOSE: To ensure that there is 24-hour coverage by mental health staff.

II. POLICY: Adult Forensic Behavioral Health Services (AFBH) is responsible for providing 24-Hour psychiatric emergency response and consultation to staff at Alameda County jails. On-call mental health staff is available to respond to psychiatric emergencies during "non-business" hours. This policy meets the Alameda County Sheriff's Office (ACSO) policy that requires immediate notification of the following: psychiatric emergencies; safety cell placements, sexual assaults, suicide attempts and fatalities, death notifications, and WIC 5150 situations which may require admission to the Psychiatric Inpatient Unit.

AFBH also provides an on-call psychiatrist on weekends and holidays from 9:00 am to 9:00pm and weeknights until 11:00 pm. Duties include maintaining continuity of care / medications for newly booked inmates.

AFBH staffs perform On-call duties daily. On-call coverage is assigned to cover shifts when no mental health staff is onsite. On-call staff will only respond to pages during their assigned periods of coverage. The AFBH manager creates a monthly schedule of On-call coverage and notifies all staff and, specifically, ITR Screening staff of any changes made to the schedule.

III. PROCEDURE:

A. ON-CALL CLINICIANS:

1. Respond as quickly as possible (no later than 15 minutes of the page).
2. Gather information
    a. Date and time of call
    b. Caller's name
    c. Inmate's name, PFN, and date of birth
    d. Housing Unit location
    e. Reason for call
    f. Current medication, if known
3. Assess the situation
4. Advise the caller of the recommended course of action: (Eg. Start IOL. Initiate Safety Cell, WIC 5150. Etc.) In some instances, additional information may be needed before determining a course of action. Additional information may be available from custodial or medical staffs
5. See WIC 5150 responsibilities below for admission to Psychiatric Inpatient Unit
6. Follow-up with staff on patient's condition, as needed

7. Complete a Progress Note: Include information gathered in #2 above, a summary of the situation and plan
8. Notify the ITR Screening Office at ([redacted]) of all On-call contacts
9. ITR Screening staff will assess all situations reported by the On-call staff and will consult Clinic manager ([redacted]) when needed
10. Instruct California Forensic Medical Group medical staff/ACSO to initiate an Intensive Observation Log (IOL) on any suicide attempt or gesture (an IOL is automatically initiated whenever an inmate is placed into a Safety Cell)
11. The On-call Progress Note is completed and turned into the designated clerical staff who will scan the document into the client's electronic mental health record. If there is no AFBH record and no action is necessary, originals will be filed in alphabetical file located in the clerical office.
12. On-call staff will maintain a log of all On-call contacts during each shift.
13. <u>WIC 5150 RESPONSIBILITIES:</u>
    a) During On-call hours, the ACSO is responsible for completion of the WIC 5150
    b) Provide consultation to the referring nurse/ACSO regarding the WIC 5150 process. ***ANY SERIOUS SUICIDE ATTEMPT OR GESTURE REQUIRING MEDICAL CARE REQUIRES A WIC 5150 ADMISSION.***
    c) The patient must be medically cleared prior to being sent to the Psychiatric Inpatient Unit. ***ADMISSION TO THE PSYCHIATRIC INPATIENT UNIT CANNOT TAKE PLACE WITHOUT MEDICAL CLEARANCE***.
       Clearance may be obtained:
       1) by California Forensic Medical Group medical staff, or
       2) by the medical hospital where inmate has been taken for treatment / medical clearance
    d) If the person requires medical attention/treatment (hospital emergency room, Santa Rita Jail's Out-Patient Housing Unit), the initiation of the WIC 5150 should begin subsequent to the medical clearance being issued.
    e) If an inmate is offsite, the ACSO is responsible for completing the WIC 5150 form. The inmate will be transported directly from the offsite location to the Psychiatric Inpatient Unit with medical clearance in place.
    f) Notify the Psychiatric Inpatient Unit of the WIC 5150 admission that is underway.
    g) Advise the unit whenever a WIC 5150 is awaiting medical treatment or clearance before being admitted.
    h) See P&P Section B 6 b: Admissions to Psychiatric Inpatient Unit for more information.
    i) Once medically cleared, inmates may be transported to:
       1. John George Psychiatric Pavilion (JGPP).

    j) Appropriate security procedures ensure the immediate transfer of inmates
    k) Inmates may be transported by Paramedics Plus Ambulance Co. or by ACSO staff

C. ON-CALL PSYCHIATRIST:

1. Collaborates with, and provides consultation to, the AFBH screener and the ITR California Forensic Medical Group nurse, assesses the inmate, and, based on reliable information, makes a decision to either;
    a) Give a verbal order to the California Forensic Medical Group nurse to continue the verified medications as written, order medications, or
    b) Have the inmate wait until regular working hours for a face-to-face assessment, or
    c) Go to the jail site if the need is urgent to assess the inmate by a face-to-face interview to determine what, if any, medication(s) is needed and order the medication.

Reviewed 11-14

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-20**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: August 14, 2012	
Mental Health Program	**SUBJECT: Outpatient Housing Unit OPHU**	

I PURPOSE: To deliver mental health services to inmates when they are housed in the Outpatient Housing Unit (OPHU).

II POLICY: It is the responsibility of Adult forensic behavioral health (AFBH) to provide services to patients with mental illnesses who are housed in the Out-Patient Housing Unit (OPHU). Patients must be either seen by the assigned M.D. or assigned therapist on a ***daily*** basis.

All patients returning from the Psychiatric Inpatient Unit will be held in the OPHU until seen by AFBH staff. (See P&P Section 17.B. Discharges from Psychiatric Inpatient Unit.)
Note: All inmates returning from an acute psychiatric inpatient unit are to be placed on an IOL (Inmate Observation Log) by the sheriff's office to protect them form self harm until they can be cleared by AFBH.

III PROCEDURE:

1. The AFBH Clinic Manager will be notified by CALIFORNIA FORENSIC MEDICAL GROUP when an inmate housed in the OPHU requires or is receiving psychiatric services. The Clinic Manager routes the referral to the appropriate clinician.

2. The assigned clinician will see the patient on days when the patient is not seen by the psychiatrist and document the visit with a progress note. The copy of the progress note must be left in the medical chart in the OPHU.

3. The psychiatrist will see the patient at least once per week and document visit on a progress note. The copy of the progress note is to be left in the medical chart in OPHU.

4. Psychiatric medication orders are processed using California Forensic Medical Group's electronic health record.

5. On weekends and holidays, the ITR screener will see patients in OPHU and write a progress note as described above.

Reviewed and revised 11-2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-21 a**	**PAGES: 1-2**
	ISSUED DATE: October 6, 2011	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: November 14, 2013	
Mental Health Program	**SUBJECT: Management of Inmate Complaints Regarding ACSO Conduct**	

I PURPOSE: To provide AFBH staff with a reporting procedure when they receive inmate complaints of alleged mistreatment by ACSO staff.

II POLICY: AFBH staff advise inmates who complain of alleged abuse by ACSO staff about reporting methods and AFBH reporting requirements.

III PRODEDURE: AFBH staff performs the following actions when an inmate reports an incident of alleged abuse / assault by an ACSO staff member:

a) If an inmate tells AFBH staff that he or she has been sexually assaulted by an ACSO staff, AFBH staff follows the steps below:
   1. Tell the inmate that, for his or her own safety, as well as for the safety of other inmates, this must be reported immediately to the ACSO who will conduct an investigation.
   2. Ask the inmate to sign a BHCS consent form for release of information to report the alleged assault. Indicate on the release form that the release is solely for the purpose of reporting the alleged assault. It is not consent to report the inmate's mental health information.
   3. Immediately notify:
      a) the AFBH supervisor if the supervisor is on site
      b) the AFBH supervisor will notify the AFBH Liaison Sergeant, Lieutenant, Watch Commander or ITR Sergeant.
      c) If no AFBH supervisor is available and / or on weekends, nights, holidays contact the Watch Commander through CP-1, x[redacted].
   4. The only information the AFBH staff discloses is the circumstances of the alleged assault. No mental health information about the inmate is released.
   5. If the inmate refuses to sign for disclosure of the reported assault, inform the inmate that AFBH staff must report it as it involves a safety matter.
   6. AFBH staff completes an Incident Report (see attached form) and gives it to the AFBH supervisor.
   7. The AFBH supervisor retains a copy and forwards the original to the ACSO Watch Commander.
   8. AFBH staff enters a note in the inmate's mental health record documenting the disclosure and action taken.
   9. The ACSO will conduct an investigation.

b) For all other inmate reports of alleged physical assault (non-sexual) by ACSO staff:

1. Inform the inmate that this needs to be reported to the ACSO.
2. Instruct the inmate to complete a grievance form. Inmates know to give the grievance form to a deputy that will submit it properly.
    a) All inmates receive a copy of the submitted grievance form with a tracking number.
    b) The ACSO must follow specific timelines in processing grievance complaints.
    c) Some grievances will be handled by the jail's Grievance Unit; others will be turned over to the ACSO Internal Affairs division.
3. If the inmate wants AFBH to report the complaint, ask the inmate to sign a BHCS consent form for release of information to report the alleged assault. Indicate on the release form that the release is solely for the purpose of reporting the alleged assault. It is not consent to report the inmate's mental health information.
4. The only information the AFBH staff discloses is the circumstances of the alleged assault. No mental health information about the inmate is released.
5. AFBH staff completes an Incident Report (see attached form) and gives it to the AFBH supervisor.
6. The AFBH supervisor retains a copy and forwards the original to the ACSO Liaison Sergeant or Watch Commander.
7. AFBH staff enters a note in the inmate's mental health record documenting the disclosure and action taken.
8. The ACSO will conduct an investigation.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-21 b**	**PAGES: 1-2**
	ISSUED DATE: October 6, 2011	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: November 14, 2013	
Mental Health Program	**SUBJECT: Management of Inmate Complaints Regarding Assaults by other Inmates**	

I PURPOSE: To provide AFBH staff with the reporting procedure when they receive inmate complaints of alleged assaults by other inmates.

II POLICY:

1. AFBH staff makes reports of complaints received from inmates regarding allegations of sexual abuse by other inmates.
2. AFBH staff advises inmates on ways to report allegations of physical assaults by other inmates.

III PRODEDURE: Complaints received by AFBH staff from inmates alleging assaults by other inmates are handled as follows:

a) In the case of an alleged sexual assault on an inmate by another inmate:
   1. Tell the inmate that for his or her own safety, as well as for the safety of other inmates, this must be reported immediately to the ACSO who will conduct an investigation.
      a) The ACSO participates in the Federal program to end sexual abuse of inmates.
      b) The ACSO investigates and reports any sexual assaults to the Federal Government as part of the Prison Rape Elimination Act.
   2. The inmate may report this to the ACSO directly. In addition, AFBH reports this to the ACSO.
   3. Ask the inmate to sign a BHCS consent form for release of information to report the assault.
   4. Immediately notify the AFBH supervisor and/or the Watch Commander.
   5. The only information disclosed is the circumstances of the assault. No mental health information about the inmate is released.
   6. If the inmate refuses to sign for disclosure of the assault, inform the inmate that AFBH needs to make a report as it is a safety matter.
   7. AFBH staff completes an Incident Report (see attached form) and gives it to the AFBH supervisor.
   8. The AFBH supervisor retains a copy and forwards the original to the ACSO Liaison Sergeant or Watch Commander.
   9. The AFBH staff enters a note in the inmate's mental health record documenting the disclosure and action taken.
   10. The ACSO will conduct an investigation.

11. AFBH staff will offer counseling for the inmate-victim of the assault.

b) In the case of all other complaints / allegations of assaults committed by other inmates:

1. Instruct the inmate to notify the ACSO and/or complete a grievance form. Inmates know to give the grievance form to a deputy that will submit it properly.
    a. All inmates receive a copy of the submitted grievance form with a tracking number.
    b. The ACSO must follow specific timelines in processing grievance complaints.
    c. Grievances will be handled by the jail's Grievance Unit.
3. If the inmate wants AFBH to report the complaint, ask the inmate to sign a BHCS consent form for release of information to report the alleged assault. Indicate on the release form that the release is solely for the purpose of reporting the alleged assault. It is not consent to report the inmate's mental health information.
4. The only information the AFBH staff discloses is the circumstances of the alleged assault. No mental health information about the inmate is released.
5. AFBH staff completes an Incident Report (see attached form) and gives it to the AFBH supervisor.
6. The AFBH supervisor retains a copy and forwards the original to the ACSO Liaison Sergeant or Watch Commander.
7. AFBH staff enters a note in the inmate's mental health record documenting the disclosure and action taken. .
8. The ACSO will conduct an investigation.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-21 d**	**PAGES: 1-3**
	ISSUED DATE April 30, 2013	
	REVIEW DATE: November 20, 2015	
	REVISION DATE:	
Mental Health Program	**SUBJECT: PREA (Prison Rape Elimination Act)**	

I PURPOSE: To ensure that AFBH staff are familiar with and trained in the requirements set forth in the Federal law entitled PREA (Prison Rape Elimination Act). Please see relevant PREA standards below.

II POLICY:

PREA (Prison Rape Elimination Act) was passed into law on May 17, 2012. This is the first Federal law to address sexual abuse in detention facilities. Per this law, there is a zero tolerance for sexual abuse in a detention setting. Specific training and duties are prescribed by this law, including mental health referrals.

AFBH, the mental health services provider in the Alameda County jails, participates in crisis intervention and accepts referrals made for mental health evaluations consistent with a community level of care. AFBH does not specialize in the treatment of sex offenders, but will evaluate all referred individuals and will assess them for mental health conditions and treatment needs.

II PRODEDURE:

A. Training

I. Specialized training: Medical and mental health care
PREA standard: 115.35.
In 2013, the facility (Sheriff's Office) will provide the initial"Train the Trainers" on June 21, 2013. AFBH individuals trained at this event will then train other AFBH mental health practitioners to ensure that all staff are trained in

(a) How to detect and assess signs of sexual abuse and sexual harassment;
(b) How to preserve physical evidence of sexual abuse;
(c) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and
(d) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

II. Documentation: The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.

(a) AFBH staff will receive training certificates
(b) AFBH staff will sign, versifying participation in training

(c) Verification of training will be provided to the Sheriff's Office.
(d) Subsequent to the implementation year (2013), PREA training will be incorporated into the annual ACSO Civilian training for all staff who work in the jail.

B. Screening for risk of victimization and abusiveness.

PREA standard 115.41: to be conducted by the Sheriff's Office

I. The Sheriff's Office will conduct initial screenings as follows**:**

(a) All inmates shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other inmates or sexually abusive toward other inmates.

(b) Intake screening shall ordinarily take place within 72 hours of arrival at the facility.

(c) Such assessments shall be conducted using an objective screening instrument.

(d) The intake screening shall consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization:

(1) Whether the inmate has a mental, physical, or developmental disability;
(2) The age of the inmate;
(3) The physical build of the inmate;
(4) Whether the inmate has previously been incarcerated;
(5) Whether the inmate's criminal history is exclusively nonviolent;
(6) Whether the inmate has prior convictions for sex offenses against an adult or child;
(7) Whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
(8) Whether the inmate has previously experienced sexual victimization;
(9) The inmate's own perception of vulnerability; and
(10) Whether the inmate is detained solely for civil immigration purposes.

(e) The initial screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing inmates for risk of being sexually abusive.

(f) Within a set time period, not to exceed 30 days from the inmate's arrival at the facility, the facility will reassess the inmate's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.

(g) An inmate's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness.

(h) Inmates may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section.

(i) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates.

C. Medical and mental health screenings; history of sexual abuse.

PREA standard 115.81

(a) If the screening pursuant to § 115.41 indicates that a **prison inmate has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, s**taff shall ensure that the inmate is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.

(b) If the screening pursuant to § 115.41 indicates that a prison i**nmate has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the**

community, staff shall ensure that the inmate is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening.

(c) If the screening pursuant to § 115.41 indicates that a **jail inmate has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community**, staff shall ensure that the inmate is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.

(d) AFBH staff will evaluate inmates offered a follow-up mental health meeting to determine if the inmate is in need of mental health treatment and will be offered treatment to the extent that resources and expertise are available.

D. Confidentiality

1. Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.
2. AFBH staff shall obtain informed consent from inmates before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the inmate is under the age of 18.

E Access to emergency medical and mental health services.
PREA standard 115.82

(a) Inmate victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

(b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders shall take preliminary steps to protect the victim pursuant to § 115.62 and shall immediately notify the appropriate medical and mental health practitioners.

(c) Inmate victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate (**Medical).**

(d) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

F. **Ongoing medical and mental health care for sexual abuse victims and abusers.**
PREA standard 115.83
Referrals to AFBH:

(a) The facility can refer inmates to AFBH for mental health evaluation and, as appropriate, treatment to all inmates who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

(b) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

(c) AFBH will provide such victims with mental health services consistent with the community level of care.

(d) Inmate victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests **(Medical).**

(e) If pregnancy results from the conduct described in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services **(Medical).**

(f) Inmate victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate **(Medical).**

(g) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-21**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: April 7, 2010	
Mental Health Program	**SUBJECT: Incident Report**	

I PURPOSE: To provide a formal means for AFBH staff to report any unusual events or incidents for the attention of AFBH management for review and action, if needed. .

II POLICY: AFBH staff fill out incident report forms and forward them to AFBH management when there is an unusual event or incident that requires the attention of program managers.

III PRODEDURE: An incident report is completed and forwarded to a AFBH Supervisor and/or the Director to document unusual events or circumstances. See attached form.

Reviewed 11-2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-22**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: April 9, 2013	
Mental Health Program	**SUBJECT: Inmate Grievance Process**	

I PURPOSE: Inmates have the right to submit grievances and have them reviewed and responded to by AFBH management.

II POLICY: Adult forensic behavioral health Services AFBH) management staff review and respond to grievances regarding inmates' psychiatric treatment through the Alameda County Sheriff's Office (ACSO) grievance procedure.

III PROCEDURE: Grievances filed against AFBH are forwarded to the designated AFBH Supervisor / Manager who will review and respond to the grievance in writing and take appropriate action.

A. The AFBH manager / supervisor researches the complaint identified in the grievance and completes the response with explanation and/or plan of correction if needed.
B. Distribution:
    1. Original to ACSO
    2. Copy to AFBH Director for review.
C. The AFBH Director reviews all grievances, initials the copies, intervenes if needed, and files the copies.
D. A grievance log is kept by AFBH management staff.
    1. For each grievance received, the reviewing AFBH supervisor enters the grievance information on the log kept in the AFBH Grievance Log "G" drive.
    2. The grievance log is periodically printed out for review by jail auditors.
    3. A copy is provided to California Forensic Medical Group Health as part of AFBH's quarterly CQI report.

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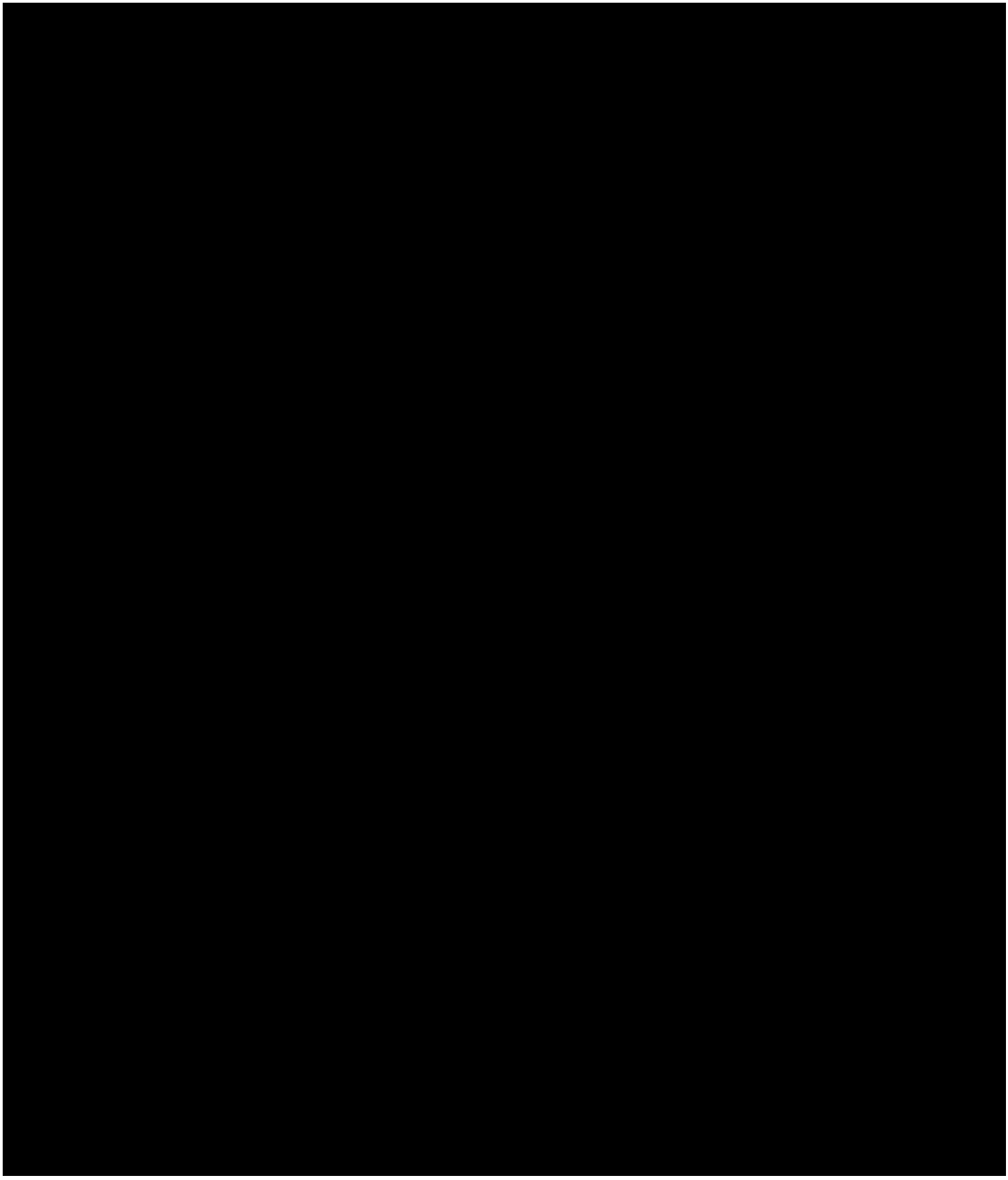
Reviewed 11-2105

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-24**	**PAGES: 1-2**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 8, 2017	
	REVISION DATE: April 7, 2010	
Mental Health Program	**SUBJECT: Insyst Database**	

I PURPOSE: To provide instructions for AFBH staff on how to access the Insyst database for information relevant to their work.

II POLICY: Adult Forensic Behavioral Health Services (AFBH) staff use the Insyst Database to access relevant information in order to carry out their assigned tasks.

[redacted]



Reviewed 3/2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-25**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 8, 2017	
	REVISION DATE: April 7, 2010	
Mental Health Program	**SUBJECT: BHCS Intra-agency Client Messages**	

I PURPOSE: AFBH is part of the broader Alameda County Behavioral Health Care Services system of care, and, as such, is able to participate in a communication system (INSYST) to alert other providers as to the specific needs of clients should those clients come into contact with their programs.

II POLICY: Adult Forensic Behavioral Health (AFBH) clinicians complete a Client Message form whenever it is necessary to alert other Behavioral Health Care Service providers to important information regarding a client. The instructions for completion are included on the form.

III PROCEDURE:

1. The clinician completes the Client Message input form.
2. The clerk inputs the information into the INSYST system (see attached for input instructions). The system automatically generates two copies that are printed the day after input.

   Any provider with an open episode will automatically receive a copy of the message. Client messages automatically print whenever a face sheet is requested.

   For further information see the INSYST User's Manual and the INSYST Reports Manual.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-26 a, b**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20, 2015	
	REVISION DATE: April 9, 2013	
Mental Health Program	**SUBJECT: Confidentiality / Release of Protected Health Information / Subpoena**	

I PURPOSE: To provide AFBH staff with the laws and guidelines related to the protection and release of confidential mental health information

II POLICY: Adult Forensic Behavioral Health (AFBH) staff adhere to all laws, regulations, and Alameda County Behavioral Health Care Services Agency policies regarding the confidentiality of mental health records and for all inmates/patients receiving mental health treatment.

III PROCEDURE:

1. AFBH adheres to the State of California Welfare and Institutions Code section (WIC) 5328 and the Federal Health Insurance Portability and Accountability Act (HIPAA) regulations. See the Alameda County Behavioral Health Care Services HIPAA manual for detailed information.
2. See attachments for further information on Behavioral Health Care Services policy and WIC 5328.
3. The disclosure of limited information in correctional settings is allowed to protect the inmate and staff from harm.
4. Disclosures must be with the written consent of the individual or by court order signed by a judge.
    a. Consent must be on authorized BHCS Release of Information forms (large font - see enclosed copy) .
    b. Confidentiality for the individual continues to extend after death.
5. Requests for copies of records and subpoenas for records are handled by the BHCS Office of Management Services.
    a. Subpoenas- must be signed by a judge.
    b. AFBH clerical staffs coordinate the release of copies of records with the BHCS Office of Management Services' designee per AFBH clerical procedures.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-27**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 8, 2017	
	REVISION DATE: June 28, 2011	
Mental Health Program	**SUBJECT: ACSO Security Site Clearance**	

I PURPOSE: To ensure that CJMH staff are aware of the ACSO policy on site clearance for entry into the jail.

II POLICY: Adult forensic behavioral health (CJMH) will adhere to the Alameda County Sheriff's Office (ACSO) regulations regarding site clearance for their employees, case managers, court-appointed evaluators, and other outside mental health staff./ visitors.

PROCEDURE: See attached Security Site Clearance form.

1. Form must be completed by the person seeking access to the jail.
2. Form is submitted to ACSO Classification (Fax [redacted]).
3. CJMH is notified when the person has been cleared. Arrangements can then be made for jail entrance.
4. The ACSO requests that visitors be directed to visit inmates using the jail's regular visiting procedures. Directions can be found on the sheriff's website: www.alamedacountysheriff.org.
5. If a visitor will be entering the jail, CJMH prepares a memo and distributes it. . See sample.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-28**	**PAGES: 1-12**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: November 20., 2015	
	REVISION DATE: August 20, 2012	
Mental Health Program	**SUBJECT: Commonly Used Terms and Approved Abbreviations**	

I PURPOSE: To ensure uniformity in understanding and use of terms and abbreviations.

II POLICY: Adult Forensic Behavioral Health (AFBH) may use commonly used and approved abbreviations in filling out forms and in clinical notes.

III DEFINITIONS:

COMMONLY USED TERMS & ABBREVIATIONS

AB 109	State legislation: Criminal Justice Realignment started Oct. 2011. Some prisoners released to county probation department; new 3 NON arrestees serve time in county jails; as well as revoked parolees serve their time in county jails for up to 180 days.
ACA	American Correctional Association
ACBHCS	Alameda County Behavioral Health Care Services
ACCESS	BHCS point of admission for all county mental health services 1-800-491-9099
ACSO	Alameda County Sheriff's Office
Ad Seg	Administrative Segregation
BHC	Alameda County Behavioral Health Court
BHCS	Behavioral Health Care Services
CAP	AFBH Court Advocacy Project
Catalyst	California Forensic Medical Group Health's electronic health record
CDCR	California Department of Corrections and Rehabilitation
CG	Clinician's Gateway – the BHCS electronic health record
AFBH	Adult Forensic Behavioral Health
COE	Court-Ordered Evaluation
CONREP	Conditional Release Program
California Forensic Medical Group	The jail's healthcare provider
CSC	Community Support Center (county case management teams)

DA	District Attorney
D / Ch	Discharge
D/C	Discontinue
Dx	Diagnosis
FACT	Forensic Assertive Community Treatment Team, a program of EBCRP
FSP	Full Service Partnership (case management under MHSA)
GDDF	Glenn Dyer Detention Facility
HX	History
HOST	Homeless Outreach and Stabilization Team, a program of Bonita House
HU	Housing Unit
ICC	Immediate Care Clinic
I.C.E.	Immigration and Customs Enforcement
IMQ	Institute for Medical Quality
IOL	Inmate Observation Log (formerly 913 suicide watch, Intensive Observation Log).
I / S	Initial Screening
ISO –cell	Isolation Cell
IST	Incompetent to Stand Trial
ITR	Intake, Transfer, and Release (Booking)
JGPP	John George Psychiatric Pavilion
MDO	Mentally Disordered Offender PC 2960, PC 2970
MHR	Mental Health Referral
MSE	Mental Status Exam
MHSA	California's Mental Health Services Act of 2004 (Prop 63)
MURPHY or MurCon	Murphy Conservatorship WIC 5008 (h)(1)(B)
NGI or NGRI	Not Guilty by Reason of Insanity PC 1026
NIC	Not in custody
3 NONS	Under AB 109 beginning October 2011 anyone convicted of a 3 NON felony (non-serious, non-violent, non-sexual) serves the sentence in the county jail and not prison.
OD	Officer of the Day / On Duty
OPHU	Out Patient Housing Unit
OTA	Out to appointment
PC	Penal Code
P/C	Protective Custody
PC 1368, 70 Etc.	Incompetent to stand trial proceedings and commitments for felonies and misdemeanors
PC 1370.01	Misdemeanant IST
PC 1370.1	Developmentally Disabled IST
PC 1370	Felony IST
PC 1372	Restored to competence and reedy to proceed
PC 4011.6	PC section pertaining to inmates referred by the Court for mental health evaluation
PC 4011.8	PC section pertaining to inmates requesting mental health evaluation and treatment
PD	Public Defender
PHS	PHS Correctional Healthcare – former jail healthcare provider
RTC	Return to clinic
Rx	Prescription
S/C	Safety Cell
SSI	Supplemental Security Income

SVP	Sexually Violent Predator WIC 6600
SX	Symptoms
TAY	Transition Age Youth ages 18-24
TBA	To be assigned
TRACT	Transitional Assertive Community Treatment team (assigned to the BHC)
Tx	Treatment
UTT	Unable to transport
WIC	Welfare and Institutions Code

Reviewed and revised 11/2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-30**	**PAGES: 1-2**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 8, 2017	
	REVISION DATE: August 9, 2012	
Mental Health Program	**SUBJECT: Language Capability / Translators**	

I PURPOSE: To ensure that non-English or limited English speaking and hearing-impaired inmates are able to communicate with mental health staffs with the assistance of translation services.

II POLICY: AFBH staffs use translation services when needed to assist inmates experiencing communication problems due to language or hearing barriers. Translation assistance may be provided by phone or in person.

III PROCEDURE:

1. For **phone translator:**

Note: Effective March 25, 2012 new language line Interpretive Services by LIONBRIDGE

a. Call: 1-800-965-0421

b. Enter [redacted]

c. Press:

1 for Spanish
2 for Mandarin
3 for Cantonese
4 for Vietnamese
5 for Farsi Dari
6 for Russian
7 for Cambodian
8 for Korean
9 for Arabic
10 or *All Other Languages or to Connect with an Operator*

d. Hold for Operator

e. To make arrangements to use the Language Line

1) Any AFBH staff may access the Lionbridge Language Line to assist with client interviews
2) For phone access, all interviews must take place in the AFBH clinic when space can be made available.
3) The clinician contacts the AFBH manager to request use of the Language Line.
4) The clinic manager and clinician select the best day for the interview.
5) The clinic manager coordinates the scheduling of the room / date for interview with AFBH clerical staffs and clinic deputies.

6) The AFBH manager informs the clinician of the date and time
7) Housing Unit clinicians have the option of transferring the inmate to the clinic for ongoing services.
   a) If the Housing Unit clinician wants the inmate to be transferred to the clinic, he or she indicates this to the AFBH manager. The AFBH manager arranges for the inmate to be seen by a AFBH clinic staff, or the manager will conduct the interviews.
   b) If the Housing Unit clinician wants to remain the primary clinician and conduct interviews using Language Line services, he or she indicates this to the AFBH manager and, together, they schedule a time for the clinic interview(s) to take place.

2. For **face-to-face translator:**

Interpreters Unlimited: http://www.interpretersunlimited.com/california-interpreter-translator.php
Click on the "In-Person Interpretation" link on the left side of the page, then scroll down and click on the "submit a request link"

Scheduling hours: 6:00 am to 5:00 pm PST, Monday to Friday.

Phone: (800) 726-9891 or (800) 821-9999

Fax: (800) 726-9822 or (858) 451-7499

Email: info@iugroup.com

3. For **sign language** translator call:

Hired Hands ([redacted])
http://www.hiredhandsasl.com/
The phone number and email link are listed on the homepage.

AFAF Translations [redacted]
http://www.afaftranslations.com/
The phone number and email link are listed on the homepage.

4. The following information is needed by the translating services:
   A. Date and time of interview
   B. Location of interview:
      AFBH at Santa Rita Jail
      5325 Broder Blvd.
      Dublin, CA 94568
      Contact person: AFBH Clerk [redacted]
   C. Name of patient
   D. Language needed

5. All translators entering the jail must have a security clearance form on file in Classification. Contact Classification at ( ) to verify. If clearance is needed, fax or email blank Site Security Clearance to the interpreting service with instructions to complete and fax to SRJ Classification at FAX #: ( ). Ask Classification to notify us when interpreter is cleared.

6. For patients needing ongoing translation services at future appointments, complete the Appointment for Translator form and attach to chart. Once arranged, the clerk will fax a copy to the Lobby as notification to expect translator.

Reviewed 03/2017

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-31**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: March 8, 2017	
	REVISION DATE: April 7, 2010	
Mental Health Program	**SUBJECT:** Training of Sheriff's Personnel	

I PURPOSE: To advance the knowledge of sheriff's personnel in understanding mental illnesses and suicide risk and prevention.

II POLICY: AFBH staff participates in the training of sheriff's personnel in understanding the signs and symptoms of mental illnesses and procedures for suicide prevention.

III PROCEDURE: See attached training outlines. Also see P&P B 7 Suicide Prevention Program.

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-32**	**PAGES: 1**
	ISSUED DATE: January 10, 2008	
	REVIEW DATE: February 11, 2014	
	REVISION DATE: February 24, 2015	
Mental Health Program	**SUBJECT:** Inmate Use of AFBH Staff Telephones & Computers	

I PURPOSE: To ensure that Adult forensic behavioral health staff (AFBH) understands that the Alameda County Sheriff's Office, for reasons of security, does not allow inmates to have access to staff telephones or computers

II POLICY: AFBH staff should not allow inmates to use staff telephones or computers. Inmates are not allowed to view or access computer screens, the internet, mainframe, or otherwise use AFBH computers. Per jail regulations, inmates have access to public telephones.

III PROCEDURES: If an inmate requests to use a AFBH staff telephone or computer, inform the inmate that AFBH telephones and computers cannot be used by inmates.

1. Inform the inmate to use phones made available to them per the Sheriff's policy on access to public telephones.
2. If an inmate is unable to access a public phone, report this to the Sheriff's Office AFBH Liaison Sergeant for assistance.
3. For release planning or other mental health planning activities, AFBH staff may place calls to community providers, etc. on behalf of the inmate.
4. AFBH staff will document **all** (collateral, contacts/phone calls in Clinical Gateway under Plan Development/or in the Plan portion of your CG noted. In your CG note please make sure you include the following:
    1. Phone Number of where you are calling
    2. Name of the place/person (e.g.) Attorney's name/Case Manager
    3. Reason for the phone call.
5. Inmates are not allowed to look at the Computer Screen. Please ensure that you have the computer screen out of the inmates sight of vision

Revised 02/ 2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-33**	**PAGES: 1**
	ISSUED DATE: June 7, 2010	
	REVIEW DATE: March 8, 2017	
	REVISION DATE:	
Mental Health Program	**SUBJECT: Court Advocacy Project (CAP) Referrals to Immediate Care Clinic (ICC)**	

I PURPOSE: To ensure that inmates identified in court by the AFBH Court Advocacy Project (CAP) staff have timely access to psychiatric assessments and medications. The goal is to provide medications at the earliest possible time to facilitate stability and readiness for release to community placements.

II POLICY: During the AFBH Immediate Care Clinic (ICC), Adult forensic behavioral health (AFBH) psychiatrists assess, and, if indicated, prescribe psychotropic medications for inmates referred by the AFBH Court Advocacy Project (CAP) staff.

III PROCEDURE

1. As part of release planning and accessing community placements, the CAP staff identifies and refers inmates needing assessment and medications to the AFBH Immediate Care Clinic (ICC).
2. Inmates are scheduled for ICC by AFBH clerical staffs.
3. The AFBH ICC psychiatrist assesses the inmate and prescribes medications when indicated and completes all paperwork as with any other ICC assessment.

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ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-34**	**PAGES: 1**
	ISSUED DATE: June 28, 2010	
	REVIEW DATE: November 20, 2015	
	REVISION DATE:	
Mental Health Program	**SUBJECT: Staff Reporting of Unexpected Absences**	

I PURPOSE: To provide AFBH employees an easy means to let managers know when unexpected absences from work occur. This will allow managers to assign staffing for coverage as needed.

II POLICY: Whenever a AFBH employee has an unexpected absence, he or she will let AFBH managers know by leaving a message on the designated AFBH Absence Reporting Line.

III PROCEDURE

1. When an unexpected absence occurs AFBH staff calls the Absence Reporting Line [redacted] and leaves a message explaining the reason for the absence and estimated time off, if known.
2. AFBH managers check the messages left on the line each morning and throughout the day. Messages are forwarded on to the appropriate supervisor for recording and staffing adjustments, etc.

Reviewed 11-14

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER: B-35**	**PAGES: 1**
	ISSUED DATE: May 7, 2013	
	REVIEW DATE: November 20, 2015	
	REVISION DATE:	
Mental Health Program	**SUBJECT: Reporting of BHCS / AFBH Client Death**	

I PURPOSE: To ensure that AFBH staff are aware of the BHCS requirement to report all deaths of clients receiving BHCS / AFBH mental health services.

II POLICY: All deaths of clients who have been receiving BHCS / AFBH services are reported to the BHCS Quality Assurance Office.

III PROCEDURE

1. When AFBH staff learn of the death of a client who has been receiving BHCS / AFBH services, staff report the death to the BHCS QA Office using the enclosed form.
2. Directions for submitting the form are listed on the form.

Reviewd:11/2015

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES **ADULT FORENSIC BEHAVIORAL HEALTH** **POLICY AND PROCEDURE**	**NUMBER:** B 37	**PAGES: 1**
	ISSUED DATE: March 4, 2014	
	REVIEW DATE: November 20, 2015	
	REVISION DATE:	
Mental Health Program	**SUBJECT: Death Notifications**	

I. PURPOSE: To distinguish between two different types of Death Notifications, and to ensure that Adult Forensic Behavioral Health staff (AFBH) understand how Death Notifications are handled and by whom.

II. POLICY: AFBH follow specific procedures for death notifications.
There are two different kinds of death notifications**.**

1. When AFBH staff learn of a client's death, staff notifies his or her supervisor and complete a BHCS a death report which is forwarded to the BHCS Quality Assurance Office. See P&P 35.
2. If a relative or other significant person in a AFBH client's life dies, the procedures below are followed.

III. PROCEDURES:

A. Death Notification of Family Member to In-Custody Inmate

1. When AFBH staff learn that an inmate's family member has died or is near death, staff contact ACSO and the Chaplain's Office as soon as possible, notifying them of the death so they can provide notification to the inmate.
2. AFBH is not responsible for imparting Death Notifications to inmates. This is done by the Chaplain's Office and ACSO Staff, often times in tandem. Additionally, AFBH Staff can accompany the Chaplain or Deputy when such information is imparted. In this way, AFBH may do an on-site suicide evaluation immediately following disclosure.
3. AFBH will do a suicide evaluation following the Chaplain's and ACSO meeting with the inmate to ensure safety and to provide more emotional support for the bereaved inmate.
4. AFBH staff document the intervention with a progress note.

B. Death Notification of Inmate Suicide at either SRJ or GDDF

1. When AFBH staff learns of the death of an inmate by suicide, the AFBH staff notifies the Clinic Manager right away.
2. The AFBH Manager notifies the AFBH Director.
3. If the deceased inmate had been receiving AFBH services, the supervisors for the involved clinicians are contacted (either at home or work) and informed of the suicide.
4. The primary clinician, or designee, completes the BHCS **Provider Report of Client Death** form and mails it to Quality Assurance Administrator, 2000 Embarcadero Cove, Ste 400, Oakland, CA 94606, (510) [redacted].

5. ASM and Clinic Manager will locate electronic health record and make copies as indicated for the Coroner.
6. AFBH is not to give any part of the AFBH clinical record to ACSO or the Coroner's Office without a Court order or Release of Information to ascertain chart.