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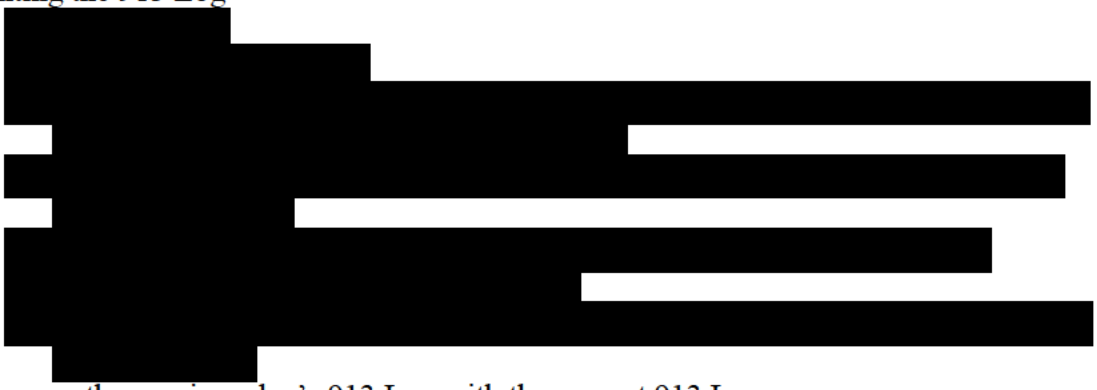
Section 1. Opening & Closing ITR (Intake, Transfer & Release)

A. Day Shift (begins by 0730)

1. Begin your shift by getting your keys form the storage unit in OPHU
2. Unlock all the doors in Main Clinic, including the MD offices *(Monday – Friday)*

B. Setting up ITR

1. Once you get to ITR, pull all MHR's (*Mental Health Referrals*) from CFMG ITR Office located on black clip on the wall.
2. Power up the computer and log in. Open all the programs you will need for the day (*email, ATIMS, CG, Appointment calendar in Excel, Insyst*).
3. Retrieve messages from the ITR Voicemail. Normally just hitting the VM button on the ITR phone will get you to the Voice Mail Prompt. [redacted] Then follow the prompts to retrieve messages. If the VM button is not working, call [redacted], then type [redacted]. Enter [redacted]. Then listen to prompts for retrieval.
4. Printing the 913 Log



5. Compare the <u>previous</u> day's 913 Log with the <u>current</u> 913 Log.
   a) Make sure that all handwritten notes about inmates, from the previous day, are reflected on the new 913. IE: inmates being placed on, or taken off, IOL/Safety Cell.
   b) If some inmates' names haven't transferred over to the new 913 Log, in the past 24 hours:
      - Check ATIMS to make sure the client was not released overnight.
      - If not, then call Classification Unit and tell them you are re-faxing the classification form.
      - 'Re-fax' Classification Form to the Classification Unit. Note the Class Deputy's name, time and date you re-faxed the form.
   c) If there are new inmates on the 913, then the ITR Clinician needs to determine how that inmate got on the 913 and if the inmate needs to be screened by AFBH.
      - Usually a Nurse or Deputy has started an IOL, or placed an inmate in a safety cell, and notified the On-Call Clinician. The On-Call Clinician should have left a message on the ITR phone informing ITR of the new IOL or S/C. Rarely, an IOL or S/C is started and AFBH is not notified for some reason.
      - If the client has not been screened, the day-time ITR Clinician needs to facilitate the screening of the inmate. The ITR clinician and the HU clinicians

should determine who will do a face to face suicide assessment once the inmate has been located.
- If the inmate is out to court (OTC), the PM clinician needs to do the screening upon the inmates return from court.

6. Start an ITR Activity Log (see below for instructions on how to start it).
7. If your shift happens after a shift that was not filled by a AFBH staff, you also need to change the out going voice message for the phones. Do this by:
    a) Log into the Voice Mail system
    b) Follow the prompts to turn off the "Out of Office Notice". The phone should alert you that the "Out of Office message" is on when you enter the Voice Mail system.
    c) If you need to, Record a new voice mail message. The standard message is written out and posted on the bulletin board. However, the original message should still be intact after deleting the "out of office" message.
    d) In case you have not done this yet, remove the sign saying AFBH is not on base from the window.

C. End of Shift

At end of your Shift, copy your ITR Activity Log and put it on top of the others hanging on the wall above the desk for the upcoming ITR Clinician to refer to.

Lastly, leave an end of shift voicemail on the ITR voice mail by calling [redacted]. Report if there are any:

- Safety Cells that were started or were continued,
- New IOL's you started,
- How many inmates were referred to ICC's,
- If anyone was 5150'd,
- If you were involved with any Post Release 5150s,
- Follow-ups: leave a "FYI" about any "New Books" who appeared agitated/fragile that may need to be followed up with on during the upcoming shift.
- If any inmates from JGP or a State Hospital has returned (or is returning).

D. Closing ITR in PM

In addition to the "at the end of shift" to do list, the PM ITR Clinician will:

- Take the entire day's paperwork from ITR and deliver it to the ITR slot in Clinic workroom. The Clerks will retrieve this paperwork the next morning for dissemination and processing of appointments.
- Leave an "End of Shift" message summarizing the shift & anything pending: IOLs, S/Cs, etc.
- Turn off the computer and lights and lock the door.

E. ITR Activity Log

The ITR Activity Log is a paper log that tracks what each ITR clinician does during their shift and is used by others to track down information about an inmate and their paperwork. The ITR

Activity Log should reflect all of the clinician's work for that shift. For example: Assessments done, MHRs addressed, Progress Notes, Class Forms, etc.

The Log has a spot for the inmate's name, PFN, Function, Outcome, Appointment date, Notes. At the bottom of the Log is a cheat sheet for different short hand codes to be used on the Log. In the note section, extra information can be written. Notes don't need to be "progress notes", as this information can be gathered from the progress notes or assessments you completed.

To help with communication:
It is very important that you stamp if an inmate is Pregnant, on IOL or in a Safety Cell on the your Log.
Highlight any new IOL's and/or Safety Cells initiated by anyone that day.

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Section 2. Screening of Inmates

A. The MHRs (Mental Health Referrals)

In ITR, the primary sources of MHRs are the ITR CFMG Nurses & ITR Classification Unit. MHRs come from other sources as well, for a list of other sources of MHRs, see "Origins of ITR MHRs" below.

1. ITR Nurses

Every Inmate who comes into custody gets a medical screening by the CFMG Nurses stationed in ITR. The majority of these Inmates pass through ITR and into the jail without getting AFBH's attention. When a Nurse feels that an inmate needs to be assessed by AFBH, the nurse will fill out a MHR. Usually these MHRs are put on the metal paper clamp, in the Nurse's office and are there for AFBH to pick them up. Be sure to check CFMG Office for new MHR's frequently (about every 15-20 minutes).

- ***Yellow Hold Signs.*** For some inmates, the nurse feels that the client needs to be assessed right away. In such cases, the nurse will fill-out a yellow "HOLD" sign and give it to ITR Nurse Deputy to place on cell door. Examples: the Nurse starts a client on IOL or the client appears psychotic.

2. ITR Deputies

ITR Deputies and ITR Classification Deputies will also submit MHRs on inmates' they are concerned about and/or are being classified as Mental. These inmates need to be assessed to help the Deputies decide on what classification is appropriate.

B. Researching the Mental Health Referral

It's 'best practice' to research the MHR prior to screening the inmate so one is aware of criminal charges and psychiatric history. To research a client, you need to use the following programs:

1. ATIMS

ATIMS is the Sheriff Department's electronic record keeping program. ATIMS provides important information like 1) date of arrest 2) criminal charges 3) court date/dept 4) bail amount 5) housing assignment 6) social security number 7) movement history and 8) Alias. See Appendix: ATIMS for instructions on how ATIMS works.

2. INSYST (aka PSP):

Provides a summary of a client's mental health history in Alameda County ***only.*** Insyst will show: 1) the service providers, 2) If the client is open with that service or not, 3) the range of dates the client was open, 4) how many services were provided and 5) when the most recent service date was, and 6) the primary diagnosis. See Appendix: Insyst for instructions on how Insyst works.

3. Clinicians Gateway (CG):

This is Alameda County Behavioral Health Client Services Electronic Health Record. By looking up a client in CG, you can see and read progress notes from past services provided by

AFBH and other BHCS agencies. CG will also give you a summary of past providers like Insyst does. CG will also allow you to see the client's complete diagnosis. See Appendix: Clinicians Gateway for instructions on how Clinicians Gateway works.

4. Catalyst:
Catalyst is CFMG's Medical and Medication Electronic Health Record. CFMG owns the software and AFBH has permission to access it. For medical information about a clients, in ITR, review the nurse's MHR first, and ask the nurses directly is an option as well. Catalyst will tell you what sort of medication the client is currently on, which is helpful for inmates already being seen by AFBH.

C. A Complete Initial Assessment includes *(see examples and Section: 13 Computers):*
1. a CG "CJ Assessment" or 324 Initial Screener (ie: the paper form, if the power is out).
2. a CG Classification Form
3. ATIMS print out
4. Insyst or CG print out
5. Medication Verification Form (if faxed)

D. Interviewing the client
After gathering your paperwork & reviewing background information:

1. Finding the inmate*:* On the table, near the Bubble, is a sheet which lists all the inmates and what cells they are in on it. This sheet is made in the early morning so maybe out of date when you review, but the sheet could tell you which cell the client is in currently.

You can also ask the Nurse Station Deputy, they usually know if the inmate has moved to the Transfer side or not.

Also look at the *white boards* that are next to each cell in ITR. The *white board* usually will indicate the classification of the inmate: A/S, PC, or Men. Often it will have a client's name listed as well. Sometimes it may give you additional information.

2. Finding a Deputy to open the door is the next task.
Things to know:
One Deputy needs to stay near the ITR Nursing station at all times to provide security and manage inmate flow in and out of the Nurses office. Asking this Deputy to open doors is not an option, most of the time. Once and awhile, a Deputy will do it, but they are going against their standing orders not to.

Usually you can find an extra Deputy in the Bubble, or Deputy workstation, which is across from the ITR Classification Desk. If you see a Deputy walking around the area, you can ask them as well.

The main thing to do is just ask the Deputies if they are free and if they can help you.

***3. Doing the interview**:*

- Sometimes the Deputy will call the inmate out of the cell. Ask the inmate to stand with their back against the wall. While interviewing the inmate, stand with your back towards the middle of the room, facing the inmate, about an arms + reach away.
- Sometimes the Deputy will ask the inmate to stay seated on the bench in the cell, when this happens go to the doorframe to talk to the inmate. Don't go into the cell.

The interview is intended to be quick and to the point. It is a challenge to get good information from the client to assess them, do it quickly, not disrupt the Deputies from their other duties too much, and be empathetic and supportive.

Once you have completed a screening, get the attention of the Deputy so they can place the inmate back into the cell she/he came from.

***4. Classifying the inmate**:*

After interviewing the inmate, reviewing the information gathered during your research and the inmate's MHR, and maybe gathered by speaking the Deputies, especially the classification Deputies, it's time to classify the inmate. See Section 10, Classification Assignments for more detail.

a) The basic choices are:

Mainline: most inmates live in a general population HU, which will be either Minimum (Blues) or Medium (Yellows) security settings. Inmates who take psychiatric medication and have a Mental History can stay in these HUs, if they can socialize with others with few problems.

Mental: is reserved for inmates who have a significant Mental Health history or problems and can't socialize with others well, will be classed Mental.

A/S or Administrative Segregation: is reserved for inmates who have a history of violence and/or a high level of disruptive behaviors. These inmates often don't socialize well with others.

P/C or Protective Custody: is reserved inmates who need to be protected from other inmates. EX: LGBT, gang drop outs, sex offenders.

Inmates in A/S or P/C could also be classed as Mental.

b) Submitting a Class form:

- Fill out a CG Class & Housing form.
- Either hand the Class form to the ITR Class Deputies (for inmates in ITR, on weekends, after 4pm or on Holidays) or Fax the form to Main Class (for inmates in the HU).

E. Security Issues

1. Sometimes Deputies will hesitate to open the cell doors for us. Ask if the Deputies have security concerns. If the risks are too high, you can interview client through the air vents and cuffing ports. Interviewing an inmate through the vent or cuffing portal is much harder due to the background sound, but is do able.

2. A Deputy should <u>always</u> be within visual range while screening an inmate.

3. Never leave an inmate unattended in booking.

4. Interviewing a client in the ITR AFBH office is not allowed per ACSO Management.

5. When you leave the office, be sure to lock the computer as well as the office door behind you.

6. ITR is a busy environment, be mindful of inmates movements and don't let inmates walk behind you.

7. Be aware of what and how the Deputies are acting around the inmates, for clues about safety. For example, if there is one inmate and multiple Deputies guarding him or her, it is an indication that the inmate is seen as a risk.

F. Other sources of ITR Mental Health Referrals (MHR's)

1. Family Members, Attorney's, etc*:* ITR Clinicians receive phone calls from parents, siblings, significant others, Lawyers, etc. inquiring about the status of an inmate (ie: when is the inmates court date, are they getting their psy meds?) and to report concerns (my son is suicidal, my son is not taking his meds, how come?). "See what to do" below.

Remember, AFBH cannot disclose mental health information without a Release of Information Authorization signed by the inmate, to speak to specific person or organization. However, the person calling AFBH about the status of inmate can impart as much information to AFBH as they wish.

The ITR clinician can direct the caller to access the ACSO website and use it to check on the person in question's status (See Below)

http://www.acgov.org/sheriff_app/inmateSearch.do

If the inmate has a AFBH Clinician, you can pass on the family member's contact information, and whatever information they give you, to that clinician so the Clinician can contact the family.

2. HU Deputies

ITR gets calls from the Mainline HU Deputies as well as from the Special Handling HUs.

- *Mainline* Deputies usually call about clients who are not functioning well in a mainline HU or are in crisis. The HU Deputy will usually ask that client's be assessed, which often leads to a client be reclassified as Mental. Sometimes HU Deputies will call to check when a client has an appointments.
- *Special Handling* HUs (1,2,8,9 & 24) Deputies will also call if they think a client needs to be assessed or is in crisis, and to check on when their next appointment is.

G. Glen Dyer Detention Facility (GDDF)

CFMG Nurses or ACSO Deputies will call the ITR office for the following reasons: (See the "What to do" section below about documenting information).

Restraint Logs

When an inmate is placed into restraints, the Nurse or Deputy will call and informing AFBH of date/time it was started. This is primarily a FYI and we don't need to respond.

IOL's (suicide watch)

- When a GDDF ITR Nurse or Deputy has a concern about an inmate and they call to consult: Discuss their concerns and come to a decision if the client needs to be placed on IOL or not. The safer option is to have the inmate transferred to SRJ to be assessed by AFBH. See next bullet point for additional information.

- If a nurse or Deputy calls and says they are starting an inmate on IOL or after discussing the nurses concerns an IOL is required, the inmate needs to be transferred to SRJ because GDDF does not house inmates with this classifications. You will need to submit a *Classification Form* indicating that the inmate has been placed on IOL and given a Mental Status. The class form needs to be given to classification.

5150 from GDDF: If an inmate engages in suicidal behaviors, is articulating a plan & has the means to commit suicide or has recently attempted. GDDF Deputies will 5150 the inmate to JGP to be assessed and treated. When we are notified of these events, write a progress note and put a copy of the note in the Critical Information Binder and leave a copy on the desk so the next shift is aware of the situation. Also submit a *Classification Form* to the Classification.

H. "What to do" when people are calling to make Referrals

- Get the client's name, PFN, the caller's name and phone number, and gather any information the caller is willing to give you.
- Check ATIMS and print out the "one sheet". Note when the client came into custody.
- Check and print out CG or the Insyst system to get an overview of the inmate's clinical history and to see if client could have been getting psy meds within the last 30 days.
- Check Excel to see if the client is already scheduled for an appointment with AFBH.
- If no appointment is found in Excel, check the ITR Log of the shifts around the day the client came into custody to see if they were screened and if an appointment was made.
- If an appointment should have happened, you can check CG to see if the client was actually seen.
- If the inmate has not been open and has not been seen, write up a manual MHR, and assign the inmate an appointment.

HIPAA: If this is someone outside of the jail, we are unable to share information with them until we have a release of information (ROI). There is one exception, we can share information with other organization that are a part of BHCS without a ROI.

I. State Hospital Returns

The Primary State Hospitals are: Napa State, Metropolitan State, Coalinga State, Atascadero State and inmates can be returned from a State Hospitals at any time. The ITR Clinician should do an initial screening and bridge the inmate's meds.

J. "Out of Custody, New Book" Inmates coming from JGP

"Out of Custody, New Book" means they were not "In-custody" prior to them going to JGP. (See In-Custody 5150 returnees below) and who came directly to SRJ from JGP, via Police transportation. Often the Police took these inmates to JGP to be assesses and stabilized prior to

incarceration, because the client may have said they were suicidal or were acting in a bizarre manner. When JGP deems the inmate 'fit for incarceration", the inmate will be released from JGP and brought to SRJ by the arresting Police agency.

It is a ***high priority*** for the ITR clinician to assess these clients to make sure they are stable and safe enough for incarceration and appropriately classed. Nursing and Deputy Staff will start a client on an IOL if AFBH is not available to interview the inmate at the "Bubble". See "new IOL" procedure.

There are times when the inmate is still not stable enough to come into SRJ, and the client can be rejected at the Bubble. See "The Bubble" for that protocol.

JGP will usually send along their release documentation, which may or may not list an inmate's current psychiatric medications. Sometimes JGP will fax an assessment prior to, or shortly after, the inmate arrives to custody. If either the release documentation or the assessment indicates that the client has medications, follow the Bridge Med or ICC protocol.

If the inmate arrives without a Discharge Summary from JGP, or the JGP documentation in unclear if the client is on medication, the ITR Clinician should call JGP and ask for a copy of JGP's assessment and/or fax a Medication Verification form to JGP.

K. John George Pavilion (JGP) "In-Custody" 5150 Returnees

An "In Custody" 5150 Returnee is an inmate who was 5150'd from SRJ or GDDF and is returning from the hospital back into custody at SRJ.

"In Custody" 5150 Returnees will be held in OPHU until the inmate is screened by AFBH Management and psychiatrist that day or next business day. (ie: if they come back Thursday night, they are seen Friday morning. If they come back Friday night, Saturday, Sunday or Holiday, they are seen Monday morning or next business day).

When an inmate returns:

If the returnee returns during business hours:

- Call AFBH Management ([redacted]) who will do the assessment and set up Bridge Medications. Management is available to do this until 4 pm.

If the returnee comes back in the PM or Weekend Shift:

- Do an Assessment.
- Complete Classification Form initiating IOL on inmate and give "copy" to ITR Classification Unit.
- Obtain Psy Hospital's discharge packet, which is located in OPHU in the Black File "**Psych Returns**" on wall behind nurse's desk.
- Review the discharge packet and look for prescribed medication. If the inmate has medication, send the inmate to ICC or have the medication Bridged.
- Current AFBH Policy is the inmate remains on IOL in OPHU until cleared by AFBH Management & psychiatrist.

L. Prison and Jail Transfers

Inmates from the Prison system and other Jails will transferred to SRJ. Prisoners and Inmates from other facilities will come with transfer paperwork from their previous facility, which may include their psychiatric assessments and prescriptions. The ITR CFMG nurses will be receiving the paperwork and should attach copies of the paperwork on the inmate's MHR. When AFBH receives the inmate's MHR, follow standard protocol in assessing the inmate and bridging their medication.

M. Weekenders

AFBH does not treat Weekenders (inmates who serve their sentence of several weekends only) who have verified psychiatric medications. The reason is because the psychiatrist will not be able to see them in person to do a face to face interview, as the psychiatrist are required to do.

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Section 3. "Red Flags" & Special Circumstances that need extra attention

A. PC 187's (murder), PC 288's (pedofile), PC 261(rape), and other High Profile Cases:
AFBH keeps a close eye on this group of inmates usually starting an IOL and monitoring for a week or longer if they arrive to custody unstable and overwhelmed. Many cases with these criminal charges be *High Profile Cases* and have a *High Risk of Suicide*.

B. Post Partum-Depression
Some women suffer from Post Partum Depression after giving birth, and have a *Higher Risk of Suicide*, therefore evaluate female inmates about recent births, miscarriages and abortions and if this increased their level of depression and suicidal ideation.

C. Life Sentences and/or Long Sentences
The Classification Unit automatically places these inmates on Administrative IOL until they're seen by AFBH for suicide evaluation. The Classification Unit will alert AFBH of these inmates who need urgent evaluation. This task must be done same day to ensure inmate's safety.

D. ETOH, Opiate and Benzodiazepine Detox
Inmates who are on intoxicated on drugs can present as being very psychotic in ITR, when they first arrive. Inmates can be screaming, crying, talking nonsense, and pacing about the cell. The Deputies will usually leave these inmates in the cells across the hall from AFBH Office until they sober up. The Deputies will regularly monitor the inmate. It is also good idea for us to monitor them as well when we walk by. Usually, after several hours, the inmate will start to settle down as the drug or ETOH works it way out of their system.

ITR will also get calls about Inmates who, because they are in jail, are no longer using ETOH, Opioids, and Benzos, etc. and start acting bizarre (usually in the Housing Units (HU)). It is important to do an ETOH – Drug and ETOH use assessment focusing on length of use and quantity of use. (See "Special Circumstances" for additional information). Also check with CFMG to make sure that CIWA or COWS protocols have been started.

CIWA is for monitoring a client for ETOH withdraws.
COWS is for monitoring a client for Opioid and Benzos withdraws.

E. Suicide Attempt
If an inmate reports past suicide ask the Suicide Protocol Questions (see Special Circumstances: Documenting Suicide Attempts)

1. Date of the attempt suicide?
2. How did the inmate try to hurt themselves?
   EX: Item of clothing; bedding, towels, plastic bags, razor or pills?
3. What were the circumstances of the attempt?
   a. What lead them to make the decision to attempt suicide?
   b. Were they found? Did they stop themselves?
   c. How serious was the attempt? Did they require medical attention?

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Section 4. Scheduling Appointments on the ITR Appointment Log

The ITR Appointment Log has several rows for each HU and the clinic, with appointment slots for each day that HU or clinic sees inmates. Blacked out sections mean that for that day, the HU or Clinic is not seeing inmates.

After an inmate has been assessed, assign the client an appointment. Find an open appointment slot, either in the clinic if the inmate is in the Mainline Houses (HUs) or one of the special handling houses (HUs 1,2,8,9 & 24). Appointments can't be "next day" appointments because the clerks need time to open the client and prepare the TBA paperwork.

Inmates placed on IOL, need an appointment within the 7 days of the client being placed on IOL, so fit the inmate in. That sometimes that may mean writing an inmate as an "overflow", note "IOL" next to the name.

Overflows: As mentioned above, sometimes inmates need to be seen sooner then the closest open appointment slot. Remember, when we write extra appointments (more then the slots allotted), the clinician's managing a HU or the Clinic could be overwhelmed with appointments and will start triaging and having to reschedule the extra appointments. So if you feel someone really needs to be scheduled as soon as possible, you may want to reconsider the client's status. Should the client be on IOL? Should they be classed Mental vs being in Mainline??

Purging the ITR Appointment Log: due to the nature of Jails, inmate turn over can be high. So purging the ITR Appointment Log is a task that is helpful to do everyday because purging the Appointment Log can open up appointment slots. To purge the log, use ATIMS to run a "Location Assignment" (see ATIMS for a 'How to use ATIMS' for instructions) for each day to see if any inmates have been released (No longer In Custody or NIC). If you find that someone has been released, white the inmate's name off the Log.

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Section 5. The Bubble

All inmates are accepted into SRJ at the "Bubble". When a Police Officer brings the inmate into the jail, the Techs and Deputies will process the inmates belongs and take the inmates picture. During this process, the CFMG Nurses will do a brief medical screening.

If the Nurse or Deputies are concerned about an inmate's mental health, they will ask AFBH to assess the inmate at the Bubble. When an AFBH clinician assesses an inmate at the Bubble, you will be assessing the client's suicide risk, psychological stability, state of intoxication and the client's ability to be safe while at SRJ. AFBH has the clinical authority to refuse an inmate for incarceration if the inmate is actively suicidal or gravely psychotic.

Things to think about while you are assessing an inmate at the Bubble:

You could feel pressure when you are assessing an inmate at the Bubble, because the Police have driven out to Dublin expecting to leave the inmate at SRJ, and are often reluctant or upset to take the inmate to, or back to, JGP. So be aware of these pressures, and do your best assessment of the individual.

Be aware that individuals coming to jail don't want to come to jail and some "pre-book" individuals will "use" their (real or pretend) mental illness as a means to be sent to JGP. Some of these inmates believe that if they go to JGP, they won't have to come to SRJ. In most cases these individuals are only delaying their court process. The ITR Clinician will need to determine if the inmate's behavior is to avoid incarceration or if inmate is genuinely at risk for harm to self.

Also, there are times when the ITR Clinician will be called to the parking lot to assess a new book who's still in the police car or paddy wagon. The criteria is the same as it is at the Bubble.

It's good practice to enlist the ITR Sargent when you are on the fence about "not accepting" an inmate at the Bubble into custody.

If you reject an inmate at the Bubble, write a Progress Note with client's name, DOB, and PFN and leave it in the Critical Information Binder in AFBH ITR office and leave a verbal message for the upcoming ITR clinician.

If you accept the inmate at the Bubble, it is helpful and more efficient if you complete a CG assessment, or paper 324 Initial Screening if you are unable to open the client, assign the inmate follow up appointments, and leave a note for the following ITR clinician that the client needs to see the Nurse still the clinicians can merge the inmate's MHR with your assessment and help reduce redundant appointments and assessments.

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Section 6. IOL & Safety Cells

A. IOL (Intensive Observation Log):

1. What is IOL?

a) IOL indicates that the inmate is under close observation due to a safety concern (usually suicidal ideation).
b) IOL is part of an inmate's classification and shows up on the inmate's ATIMS file.
c) IOL stands for *the* "Log" (called the Intensive Observation Log) that the Deputies use to note their observations of the client. It is usually referred to as "the IOL Log".
d) When an inmate is on IOL, the Deputies are suppose to do an observation check of the inmates every 15 minutes and note, on the IOL log, what time they observed the inmate and what the inmate was doing.
e) When an inmate is on IOL, they are considered to *have a higher level of risk and security, so they **don't** get the following items: razors, underwear, socks, t-shirt, FISH kit or commissary.* Pod time is also limited to times when they are alone or with other inmates who are also on IOL. Inmates on IOL do get a Safety Blanket and their jail pants & shirt. *Female inmates* may or may not get underwear while on menses depending on the Deputy in HU while on suicide watch (IOL).

2. Who can start an IOL?

An IOL can be started by the Deputies, CFMG Nurses and AFBH clinicians (on base or on call).

A) If Deputy and Nursing staff start the IOL, they will usually notify the ITR clinician, or the On-call Clinician after hours. If CFMG or ACSO staff starts an IOL, they will start the paper Log.

Two things need to happen for an inmate to be "officially" on IOL:

- You need to submit a ***classification form*** to Classification, either in ITR or to Main Classification, depending on time of day, weekday or location of inmate. See "***Class Form"*** example.
- An ***Intensive Observation Log*** (the paper form) needs to have been started, double check that the Nurse or Deputies started one. See "***IOL Form"*** example.

B) If AFBH starts an IOL:

- After the clinician has assessed an inmate, and decides that the inmate should be on an IOL, the clinician should: Complete an IOL form, inform the Deputy in the area you are working in (ex: the ITR Nurse Deputy or the Transfer side Deputy) that you are starting the IOL, and if you are in ITR bring some tape and tape the IOL sheet to the inmate's cell door. If you are out at a HU, remember to bring a long an extra IOL form to fill out.
- If the IOL was started by the HU Deputy, the Deputies will have started the Log, so the clinician, based on their assessment of the inmate, will either continue or discontinue the IOL.
- To continue the IOL: the clinician will note time they saw the inmate, their initials and "Cont. IOL" in the descriptive line; and put their initials and last name in a box at the bottom of the sheet. See example of how it should look.

- If AFBH did not start the IOL, then an AFBH clinician will need to assess the client within 8 hours from the start of the IOL.
- If the IOL was started at night, an AFBH clinician will need to do an assessment in the morning.
- If the inmate is at Court, the PM ITR staff will need to assess the inmate on the PM shift.

3. Discontinuing an IOL:

a) Only AFBH can discontinue an IOL.
b) Do an Assessment of the inmate's suicide risk as part of your determination if they should stay on IOL or not.
c) If the inmate does not meet criteria to be on IOL, consult with a fellow AFBH clinician and review the inmate's case. If you both agree that the client can come off IOL, then you can discontinue the IOL, otherwise the client will remain on IOL until they are assessed by a HU Clinician.
d) The HU Deputies should have an IOL form which you will need to discontinue. To discontinue an IOL,
    - **Write your name in the "Terminated by" box, as well as the time and date that you terminated the IOL.**
    - **In the main observation section, note the time that you terminated the IOL. The main observation section is where the Deputies have been logging each 15 minute observation. If the Log is not caught up, ask the Deputies to get it caught up first.**
    - **In the lines after your name, run a line diagonally across those sections.**
    - **Lastly, on the bottom, write your initials and your full name. See the example.**
e) Once you get back to the office, fax a Classification form to Main Classification Unit, or ITR Class Unit on weekends, discontinuing the IOL. See example.
f) If there is an Classification sheet in the Critical Information Binder, remove that sheet, staple the new class form to the front of it, and store the sheet in the bottom draw in the front of the other classification forms.
g) Lastly, note that the inmate's IOL status was discontinued by you (or HU Clinician) on the 913 log.

4. GDDF IOL's:

Any inmates started on IOL at GDDF will be transferred to SRJ- asap. Once the inmate arrives, the ITR Clinician should do a Suicide Assessment and set up an appointment. ACSO usually will keep these inmates in ITR until seen by AFBH the next business day.

5. Out to Court:

Sometimes an inmate will be taken to court after being started on IOL, and the morning ITR clinician is unable to see the inmate. The inmate will need a face-to-face assessment upon return from court later that day.

6. Additional Information:

a) If an IOL is started by a Nurse or Deputy during business hours, ITR or the HU clinician will be notified and the ITR and HU Clinician should discuss who should assess the inmate. It is important to have a verbal conversation between the clinicians so it is clear who is doing the assessment and submitting the class form.

b) From 1 hour before a HU clinician's shift ends to 11:30pm, the ITR usually will be the one addressing a new IOL.

c) Between 11:30 pm until 7:30 am, the Nurses and Deputies will page the AFBH On-call Clinician to start a new IOL. The next morning, the ITR clinician will need to coordinate with the HU Clinician to make sure the inmate is assessed and the class form is completed.

d) If an inmate is housed in a Mainline house, such as 33, they will be moved either to 1,2,8 or 9 for the male inmates; or 24 D, E or F for the female inmates.

e) ITR clinicians should make a copy of the Classification form, which starts the IOL, and your progress note and put them both in the IOL section of the Critical Information Binder. Then write the inmate's name, PFN, "IOL", name of clinician who started IOL & date the IOL started on the 913 Log.

f) When the HU clinicians start an IOL, they should fax a copy of the Class form to AFBH's ITR office. It is helpful if they include their progress note about why the IOL was started.

g) When scheduling TBAs for inmates on IOL, make the appointment within 7 days, on a day that the HU clinicians are scheduled to see clients but on a day the inmate is at court. Be aware that inmates must be evaluated by AFBH at a minimum, once every 7 days.

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B. Safety Cells

1. What is a Safety Cell?

HUs 1, 2, 8, 9 and 24 each has a specially padded cell, which is called "the Safety Cell" or S/C for short. While in the Safety Cell, the inmate will only get a Safety Garment (something like a toga) and Safety Blanket. The Safety Cell does not have a toilet fixture, instead it has a grated hole in the floor and the inmate does not get toilet paper. All food is served on floppy tray. The S/C is a very inhospitable place to do time in.

2. Criteria

Inmate is placed in the Safety Cell if they endorse having suicidal ideation and have an *active plan and/or has made an attempt* to kill him/herself or if they are having homicidal ideation and have a plan to harm someone else or have engaged in violent behaviors towards others.

3. Limits of the Safety Cell

Due to the intensity and deprivation that inmates experience within the Safety Cells, an inmate ***cannot*** be in the Safety Cell for more then ***72 hours***. If the inmate has been in the Safety Cell, and is still endorsing suicidal or homicidal ideation and has a plan, after 72 hours, the inmate needs to be 5150'd immediately.

4. What AFBH must do:

a) AFBH needs to interview the inmate in the Safety Cell within 8 hours of their placement in the safety cell and then at least once every 24 hour period afterwards. Monday through Friday, the ITR Clinician needs to coordinate with the HU Clinicians to make sure an inmate in a Safety Cell is interviewed each day.

b) When you go to a HU to assess an inmate, check in with the Deputies and ask how the inmate has been behaving, have they been eating or drinking, etc. This information can help you with your assessment if the inmate being released from the Safety Cell is appropriate.

c) When assessing an inmate in the Safety Cell, the Clinician is trying to assess if the client can be safe and is no longer actively suicidal or homicidal, so the focus of the interview should be on safety.

d) If the inmate is not safe enough to be released from the Safety Cell, make sure you sign the Safety Cell log at the HU, noting the time you interviewed the inmate, that you are from AFBH and that the Safety Cell should be continued. (see Safety Cell Log example)

e) If the inmate is safe enough to come out of the Safety Cell, you need to:

- Discontinue the Safety Cell on the Safety Cell log by putting your name in the Termination box, and the time and date you terminated the Safety Cell. (see Safety Cell Log example)
- Usually, when someone is released from a Safety Cell, they are downgraded to IOL status. Bring a blank IOL sheet with you to fill it out. *note: there are exceptions to this rule, see below.
- Once back at the ITR office, submit a Classification Form to either (Main or ITR Class on weekends) updating inmate's status from being in the safety cell to being on IOL.

f) Write a progress note outline the interaction had with the inmate and your decision regarding releasing or keeping the client in the S/C.
g) In ITR, print a copy of your note and attach it on top of all the previous information for the client in the ITR Critical Information Binder.

7. Supervision
Most of the time, it is clear if you should remove or keep an inmate in the Safety Cell. If it is unclear or you have questions about what to do, seek clinical supervision.

8. Who can end a Safety Cell
Only AFBH has the authority to discontinue a Safety Cell. However, there are times when the Watch Commander at SRJ can remove an inmate from a Safety Cell to transfer the inmate to another facility or release the inmate from custody. In such cases, ACSO should do a Post Release 5150 Assessment.

9. GDDF & Safety Cells
GDDF does not have Safety Cells. If the GDDF nurse calls the ITR clinician reporting an inmate is endorsing suicidal ideation, has a plan and/or is engaging in suicidal behaviors, please direct GDDF's CFMG Nurse & Sergeant to 5150 inmate to JGP due to being suicidal. The inmate ***should not*** come directly to SRJ if a Safety Cell is indicated.

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Section 7. 913 Log & the ITR Critical Information Binder

A. 913 Log (ATIMS' Intense Observation Log)

The 913 Log is a log that shows all inmates on IOL or in a Safety Cell. The 913 Log is printed each morning by the ITR Clinician. The morning ITR clinician will compare yesterday's 913 Log with today's 913 log to check that today's Log is accurate.

To print a 913 Log:

a) Open ATIMS

Check the 913 for the following:

1. An I/M was on yesterday's 913, but no longer appears on the Log.

a) Check ATIMS to see if the client was released. See "Using ATIMS".
b) Check the previous day's 913 Log to see if there is a hand written note indicating a change to the client's status. EX: Doe, John: d/c IOL Mouton 12/29/14.
c) If there is no note on the previous 913, try looking up the inmate in CG to review the client's progress notes to see if the clinician had change the client's status. EX: Jane Doe's IOL was ended by Oakes on 12/29/14.

2. An Inmate has a handwritten note on the previous 913, but the new 913 does not reflect the changed indicated in the note.

Check ATIMS to see what the inmate's current status is.

a) If the inmate's status reflects what the old 913's handwritten note states, then *just write a handwritten note on the new 913* reflecting that status.
b) If the inmate has been released, write NIC and the date of their release on the old 913 log.
c) If the inmate is still in custody, but their status has not been changed in ATIMS.
    - Call Classification, tell them that you are refaxing a Class form; the class form should be in the Critical Information Binder.
    - Write the Classification Deputy or Tech's name you spoke with, as well as the date and time on the Class form and re-fax it to Classification.
    - Then make a note on the new 913 Log so it is accurate.

3. If there is a new inmate on today's 913

a) If the On-call Clinician started the inmate on IOL or S/C, they should have left ITR a message, so check the voice mail if you have not done so already.
b) Then check the previous day's ITR Clinician's Activity Log to see if one of those clinicians started the inmate on IOL or S/C.

c) If that does not resolve the issue, then look the inmate up in ATIMS and the Insyst/PSP systems to see:
    - When the inmate came into custody and which HU they are residing in.
    - If they are open to AFBH
d) Then check CG and see if there is a progress explaining why the inmate is on the 913 Log.
e) Assuming you don't fine an explanation, then you will need to coordinate a face-to-face suicide assessment with the inmate within 8 hours by AFBH.
    - Call and email the HU Clinician(s) informing them that a new IOL is in their HU and ask if they are able to screen that inmate.
    - If they are unable to set up the assessment, then the ITR Clinician will need to assess the inmate.
f) Sometimes, new IOL inmates' are out to court (OTC) and will need to be screened upon returning from court usually in the evening.

B. Critical Information Binder

Critical Information Binder contains progress notes, class forms, 5150 Reports, etc., on acute inmates at SRJ. The Binder is broken up into 5 sections to help us find and track this information. The Sections are: S/C, IOL, FYI, Mentals reclassified as Mainline, 5150s.

1. When you add an inmate's information to the Binder: put the Class form on top of the assessment or progress note. Stable and 3 hole punch the documents. Then place the new document on top of the section you are adding it to.

2. If you have a follow up contact with an inmate on IOL or in the S/C, stable your progress note on top of the inmate's previous documentation in the Binder. This will help the clinicians who come after you know what has happened up to this point.

3. If an inmate is 5150'd, make a copy of the 5150 sheet, the Brief Assessment and the Classification Form and add it to the 5150 section of the Binder.

4. If an "arrestee" is not accepted at the Bubble, write a progress note about why the inmate was not accepted into SRJ and place a copy of your note in the FYI section of the Binder.

5. Some inmates classified as Mental will be reclassified Mainline, sometimes against the inmate's wishes. This usually happens when an inmate does not meet criteria to be in the Mental HU and sometimes is manipulating or taking advantage of other inmates in the Mental HU. To prevent inmates trying to manipulate the situation, these particular inmates are kept in this section. If an inmate was formerly in HU9 for instance, double check to make sure the inmate is not trying to act out to get back to HU9.

6. The Critical Information Binder needs to be cleaned out regularly. It is a good idea, at the end of your shift to spend some time cleaning it out. To clean it out, use ATIMS' "Location Assignment" function to see which inmates are still in custody and still on IOL or in the S/C.

The IOL section is usually the most cluttered section of the Critical Information Binder, so focus on that section first.

C. ITR Clinician's Activity Log

At the beginning of your ITR shift, start an ITR Clinician's Activity Log to track what work you do. All clinical assessments, progress notes and MHRs that are processed need to be logged and accounted for on an ITR Activity Log. Throughout the ITR Shift, be sure to keep your ITR Activity Log updated and current while noting & highlighting any new IOL's and/or Safety Cells initiated by anyone that day.

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Section 8. Psychiatric Medication Verifications

Some inmates, when they come to SRJ, say they have been taking psychotropic medications. This is usually noted on the MHR the CFMG Nurse submits to AFBH.

A. How to verify Medication

1. When you print out the inmate's PSP history from CG or Insyst, look to see if they have an open provider that they have seen in the last mouth or two. IF they do, try the following:
    a) Look at CG to see if there is a Progress Note from a Psychiatrist or Physician's Assistant prescribing the inmate's medication.
    b) If there is no CG progress note and the inmate has open services with an agency, fax a "Medication Verification" form to the agency in question, asking that they can verify the inmate's medication.

2. When interviewing an inmate, who says they take psychotropic medications, ask them:
    a) Which pharmacy they go to, to get their medications refilled. Ask for the street address and cross street to help you find the right pharmacy.
    b) Ask the inmate when they picked up their medication last.
    c) Ask the inmate to sign the Medication Verification form.
    d) Fax a "Medication Verification" form to the pharmacy in question, asking that they verify the inmate's medication.

3. Researching: If the inmate or their PSP shows that they have open services:
    a) Look at "The List" on the ITR wall. "The List" lists pharmacies and agencies that we frequently send med verifications to. Usually, you will find the agency's name, address, phone number and fax number. "The List" is a living document, so if you find that an agency's phone or fax number has changed or you gather that information for a new entity, send it to the *"The List Zar"* so the list can be updated.
    b) Google: With the information that you have gathered from the inmate or their PSP history, try googling to get the agency or pharmacy's fax number. Often you can find the phone number and you will have to call and ask for the pharmacy's fax number.

B. Medication Bottles

Sometimes inmates have their medication bottles with them when they come to SRJ. The procedure is for the CFMG Nurses to verify these medications and write up a list of current medications. This list will be included in the inmate's MHR. Client's medication go into their "belongings" that the inmate deposits at the Bubble. We don't have access to the inmate's belongings.

C. Kaiser Pharmacy

Kaiser does not usually respond to faxed med verifications in a timely manner but will verify meds over the phone.

1. If the inmate says they get medication from Kaiser, ask them for their Kaiser Medical Records number. If they don't have their Kaiser number, get the inmate's birthdate, home address, phone number, family members names and/or doctor they see. The clerks at Kaiser will use this personal data to help verify they have the right patient.

2. You do not need a release of information form if you are requesting mediation information by phone for the jail, but if asked to provide one, there are Kaiser Release of information forms in the ITR office.
3. Kaiser uses an electronic record system, and the pharmacist should be able to review the inmate's records, no matter which office the inmate goes to.
4. Hours:
   Weekdays: 8am to 8pm; Weekends: 8am to 6pm. The call center may not be available on holidays.

Weekdays:
Pharmacy Call Center: [redacted] Follow prompts to speak directly to customer service.

Weekends:
Saturday: [redacted] Follow prompts to speak directly to customer service.
Sunday: S. San Francisco: [redacted]
Oakland:

D. Transfers
Sometimes clients are coming from other institutions (JGP, State Hospital, another Jail, etc.) and have a prescription from those institutions. The prescription will be included in their transfer paperwork. Make sure you get a copy of this paperwork for AFBH's files. In such cases, refer the inmate to ICC or do Bridge Meds.

E. Receiving Verification
Sometimes your clinician's have sent in medication verifications the day before and the agency or pharmacy sends us a reply. If during your shift, you receive medication verifications:

a) Check to see if the inmate is still in custody.
b) Check to see if the inmate has already seen psychiatrist and been started on psychotropic medications. Sometimes agencies are slow in responding to our med verifications.
c) If the inmate is still in custody and not on meds, then refer to the ICC or do Bridge Meds.

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F. Criteria for ICC and Bridge Medications
An inmate is considered to be currently on psychiatric Medication if:

- They have a Doctor or Psychiatrist who is prescribing them psychotropic medication, that is verified in writing from the prescriber or the pharmacy.
- They have had their prescriptions refilled within the last 30 days or got enough medication so they should have had enough medication over the last 30 days. (ie: they take 1 pill a day and got 60 pills 40 days ago).
- The inmate says they have been taking their medication within the last 14 days.

One exception to this rule is an inmate, who was on psy meds while at SRJ and was recently released. In these cases, the inmate getting psy meds while at SRJ qualifies as verified Medication as long as they were 1) released within the last 14 days or 2) release within the last 30 days and there is verification that they were provided release medications ***and*** picked up the release medications.

*Consult with the MD if there are any questions.

G. ICC (*Immediate Care Clinic*)

ICC happens Monday through Friday, around 2:00pm. During ICC, the AFBH Psychiatrists will meet with inmates who have ***verified medication the meet the criteria*** *(see below).* The psychiatrists will give the inmate an initial prescription for medication and set a follow up appointment with a psychiatrist (and therapist if this is not already done). The inmate's ICC packet needs to be submitted to the clerks by 1:00 PM on the day the inmate needs to be seen.

H. Bridge Medications

After the ICC cut off time of 1:00pm, or on the weekends, if an inmate's medication is verified and meets criteria, the inmate's meds can be **Bridged** by the on-call psychiatrist. Bridging means that the inmate's medication will be continued for up to 14 days until they can be seen by a psychiatrist.

You will need the following the inmate's:

a) Name, PFN, date of birth, if the inmate has any allergies or medical conditions, plus pertinent information such as inmate is on IOL, in a S/C, has recent 5150s
b) Where and when the inmate last got their medication
c) What the medication is
d) Who prescribed it or who is verifying the medication
e) Dosage, quantity and frequency of the medication

1. Then call the On Call MD during the On Call Hours:
    a) Monday thru Friday 7pm thru 11pm,
    b) Holiday's 9am to 9pm,
    c) Sat & Sun- 9am to 9pm.
2. If the On Call MD is away from the phone when you call, leave a message, and they will call you back as soon as they are able.
3. It usually works best if you save the verified meds and make one call vs call each time you get verified meds.
    a) Write a progress note for each inmate who is bridged or is not bridged.
    b) Note that you spoke with the On-Call MD to bridge the inmate's medication
    c) Whether or not the MD agreed to bridge the medication, list the name and doses of the medication to be bridged, and/or any other instructions from the MD (ie: set up ICC for non-formulary meds)
    d) How many days the Bridge Meds will be good for (usually 14 days, but sometimes 7 days if the medication is not usually prescribed at SRJ);
    e) Make an appointment for the inmate to see a Clinician and Psychiatrist. Remember to schedule an appointment with the psychiatrist well before the medication expires just in case the inmate is at court for instance.

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Section 9. 5150s

There are two types of 5150s that occur at SRJ. They are: ***In-custody 5150s*** and ***Post Release 5150s***. The difference between these two are as follows:

A. In-Custody 5150s

In custody 5150s are inmates who are in-custody when they are 5150'd. By "in-custody" we mean that they were booked into the jail and have not been released yet from the jail. In-Custody Inmates will usually return to SRJ after they are discharged from JGP.

When an inmate is "In-Custody", AFBH is responsible to determine if the client meets 5150 criteria and preparing the 5150 paperwork. Technically, a Deputy could write the 5150 paperwork but they usually defer to AFBH. At GDDF, the Deputies will do the 5150s because AFBH does not usually have staff on base.

When the inmate goes to JGP, 2 Deputies will provide security for the inmate at JGP for the time the inmate is at there.

B. Post-release 5150s

Post-release 5150s are those inmates, who are being released from SRJ and are assessed in ITR by the Deputies for *Suicidal or Homicidal ideation and Grave Disability*, just prior to being allowed to leave the jail. Due to the fact that the inmate is now technically "out of custody" and AFBH no longer has the authority to 5150 the inmate.

Sometimes the Deputies will ask for assistance with doing the Post-Release 5150s, which AFBH is willing to do, but the Deputies are responsible for making the final determination and writing the 5150 paperwork, not AFBH.

Sometimes a HU or CAP clinician will determines that an inmate needs to assessed and potentially 5150'd at release. The clinician will generate a "Post-Release 5150" notification. The Notification will be printed on blue paper and one copy will be placed on the inmate's jacket and one copy posted in the ITR office, on the Post-Release 5150 clip.

The inmate's "jacket" is stored in the ACSO ITR Records office.

C. How to do a 5150

About JGP: JGP is a crisis psychiatric hospital. The policy is that they must assess everyone who is brought to their facility. Often they will assess them and provide some treatment, and the inmate will be returned, sometimes within the day.

Follow the step-by-step 5150 process, a copy of this protocol is posted on the wall in ITR.

Once you've determined an inmate needs to go 5150, please do the following to get things in motion.

1) Call JGP @ [redacted], ask to speak to Charge Nurse, and inform them of a 5150 coming their way. You don't need their permission to 5150 to JGPP.

2) Call CP-1 [redacted] ASAP to inform them of the 5150. Ask the Tech in CP-1 to contact **ACSO Records and Watch Commander** to inform them of the 5150**.**

3) Call the HU Nurse ([redacted]) or the Pill Room Nurse at [redacted] and request Nursing Staff to complete the following forms **a) Medical Clearance Form b) Medical Transfer Form—** these forms are mandatory. If the nurse isn't able to get the Med Clearance then the inmate must go to Highland Hospital for Med Clearance prior to 5150 transport. This must be clearly articulated to CP-1 Staff as ACSO is doing the transport. Ask the nurse to drop off the medical forms to CP-1, by a certain time.

4) Clearly notify the Housing Unit Deputies of your intention to 5150 inmate due to whatever reason: GD, harm to self and/or harm towards others. Does the client need to be in Safety Cell if this is the case?

5) Start Preparing the 5150 Packet

a) 5150 Green Sheet (original x 3 goes with 5150 packet) and 1 Green Sheet to AFBH Record for scanning purposes.

b) Classification Form—Notify Classification @ [redacted] of 5150 by faxing (#3 on Fax Machine) a Class Form about the 5150. Put a copy of the Classification form in the 5150 packet.

c) Write a Progress Note in CG about 5150: circumstances leading up to 5150 and current symptom/behavior warranting involuntary hospitalization. Print this progress note for 5150 Packet.

d) Print out the ATIMS Booking Summary for 5150 Packet

e) Provide Progress Notes and Medication Notes from CG for the past 1-2 weeks for 5150 packet-copies only.

f) Ask the Psychiatrist to 'discontinue' inmates' psychiatric medication due to 5150.

g) Make copies of the 5150 Green Sheet and the Medical forms for AFBH's charts and for the 5150 section of the ITR Important Information Binder

h) Put your work go into a 8x11" envelope and label the outside of the packet with the client's name, PRN, 5150 to JGP, and date. Then give the 5150 packet envelope to CP1.

6) ALERT AFBH Manager of all 5150's done at SRJ or GDDF by AFBH or ACSO via EMAIL. **7)** Give one of the original green 5150 sheets and medical forms to Barb for scanning into CG.

Sections 10. HU *(Housing Units)*

A. Background Information

SRJ has a number of Housing Units, each of which houses different classes of inmates.

- HU 1 & 2: houses inmates classified A/S or Administrative Segregation (pronounced: Ad Seg); some of which also are classified as Mental.
- HU 8: houses inmates classified PC or Protective Custody. The holds inmates that are A/S as well as Mainline.
- HU 9: houses inmates with a Mental Classification.
- HU24: houses female inmates with Mainline classifications (Pods A,B,C); Mental (Pod D) and A/S (Pods E & F), which can also have a Mental Classification.
- HU 3, 4, 6, 7: are all male, mainline units (usually Max Yellows).
- HU 21: female Mainline unit, which is a mixed classification unit. C Pod in HU21, will hold P/C inmates, as well as Mental overflow inmates. In the past, 21 has had males on one side, females on the other.
- HU 22, Mainline units
- HU 23: PC minimum
- HU 31, 32, 33, 34, 35: Mainline units housing Blues or minimum security.
- OPHU: or "the infirmary", which houses inmates that need medical attention. OPHU also has three Safety Cells.

AFBH has one or more clinicians and MH specialist supporting HU 1, 2, 8, 9 & 24 D, E & F pods. Clinician's in the Clinic see inmates from the other HUs and cover the inmates in OPHU.

B. Classification Assignments:

AFBH plays a very critical role in assessing and suggesting a classification status for an inmate. Each classification status has a set of rules related to it.

Classification	What is it?	Who starts?	Who stops?
IOL: Intensive Observation Log	Inmates who need close observation	ACSO, AFBH, CFMG	only AFBH
Safety Cell	Inmates in the S/C, who are actively suicidal and have a plan	ACSO, AFBH	AFBH Watch Commander * see note below.
Mental	Inmates with a MH symptoms, and who can not house in Mainline Housing	ACSO, AFBH	only AFBH
Restraint Log	Inmates who are aggressive, who have been placed in restraints, and are observed by the Deputies.	ACSO AFBH must sign off on the Log in ITR.	only ACSO
Administrative Log	Inmates who are acting out in some manner, who are isolated and placed in the ISO cell	ACSO	only ACSO

Medical Observation Log	Inmate has a medical condition that is being monitored, usually in OPHU	only CFMG	only CFMG
Administrative Segregation (Ad Seg)	Inmates having charges or behaviors that indicate they are a serious risk to harm others. (*See below)	ACSO	ACSO
Protective Custody (P/C)	Gang drop outs, Sexual Minority/(LGBTQI), Sexual Offenders (pedophile, rapist)	ACSO	ACSO
Pregnant	For women who passed the pregnancy test.	ACSO, CFMG	Only after they have the child, or abort or lose the fetus
Mainline	Main Population of the jail, that have none of the above classifications.	ACSO	ACSO

*The Watch Commander can discontinue a Safety Cell for the following reasons: a) To transfer the inmate to another facility b) Court order to release inmate from custody. If Watch Commander releases an inmate being held in a Safety Cell, *then ACSO needs to assess inmate for Post Release 5150.*

C. Most Common Classification Combinations

The combination of the various classifications above will result in different Housing Unit placements.

HUs	**Classifications Combos**	**Results in**	**Notes**
HU's 1, 2, 8 (male) 24 F Pod (female)	Mental + P/C	Ad Seg	
HU 24 F Pod	Preg + Mental	Ad Seg	
HU's 1, 2, 8, 24 E & F Pod	Ad Seg	Ad Seg	
HU-9 A Pod (male), HU-24 D Pod(female)	Mental + IOL	Mental	overflow mental inmates will go to other HU's because of high demand and lack of space in 9A & 24D
HU8 (males)& HU24 E pod (females)	P/C	P/C	PC= LGBTQ, gang drop outs, sex offenders: pedophiles, rapists
HU 3, 4, 6, 7,	Mainline, Max	"Yellows"	
HU 22, 25, 31, 32, 33, 34, 35	Mainline, Minimum	"Blues"	

HU 21(Female)	Mixed	Yellows, P/C, Orange (Surenas) and overflows of Mental (Greens) and A/S (Reds)	
HU 23	Minimum	P/C	

D. SRJ also will house PC 3056's, Parole Violators, Federal Inmates, Out of County Inmates.

- Parole Violation = 3056 charge code
- Federal Inmate = U charge code. Federal inmates often have one PFN that identified them when they were at SRJ but were not a Federal inmate. When an inmate comes into custody at SRJ as a Federal inmate, the inmate will be assigned a new PFN.
- OOC Inmate = This code is for inmates that are from other counties, that have contracted with SRJ to handle their overflow. (ex: San Mateo County, Santa Cruz County).

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Section 11. Communication with the HU Clinicians

A. Handling new IOLs and S/Cs

The ITR clinician needs to be in communication with the HU clinicians as well as the Clinic Clinicians when there are inmates in safety cells, new IOLs or new admissions to OPHU.

It is best for the ITR clinician to send an email and voice message to the clinician, and a email to management staff, if you don't speak directly with the clinician over the phone. The ITR Clinician and HU Clinicians should discuss who can cover any particular situation. IE: an inmate was started on IOL by the on-call clinician in HU9.

The ideal is for the ITR clinician to be in ITR 100% of the time, but sometimes HU clinicians get overwhelmed with appointments for the day, and need support. So it is good to work as a team and support each other.

In addition, if a S/C or IOL is started in the HU, at the end of the HU Clinician's day (about an hour before the clinician is scheduled to go home), ITR will need to cover these emergencies.

B. FYIs

On the weekends or at night, if the ITR clinician intervenes with an inmate who is already open with AFBH, it is helpful for the ITR Clinician send an email to the HU clinician about the situation, so the HU clinician can stay informed.

As an example:
"I saw Doe, Jane XXX111 75XXXXX, at HU24. She was saying she was having S/I, no plan, and I started her on an IOL. I assessed her last night. I schedule you an appointment for: 01/03/15."

ITR Training Manual

Section 12. Communication and working with the Deputies

When working with Deputies, our goal is to work collaboratively with them. Things to remember about The Deputies: They are professionals. They have professional code of conduct and procedures they are supposed to work by. They are members of a quasi-military organization with a chain of command. Some Deputies are brand new Deputies are still learning the ropes, while other Deputies have years of experience and know SRJ inside out.

A. In ITR

Check in with the Deputies about an inmate you are going to interview, because:

1. The Deputies may know an inmate from previous incarcerations and may know the inmate's baseline behaviors.
2. The Deputies may have security concerns around an inmate. For instance, the inmate had been aggressive during some stage of booking.
3. The Deputies have been interacting with the inmate and may have some observations about his current behaviors/mood.
4. Once you are done interviewing an inmate: Tell the Deputy assisting you "thank you" and check in with the Deputy about what you think your classification recommendations are going to be.

B. In the HUs

1. When you arrive to the HU, check in with the HU Tech, letting them know who you are, why you are in the HU and then ask where the Deputy is.
2. Check in with the HU Deputy, inform them why you are at the HU (if they did not call you), and ask them what they know about the inmate.

C. Radio or Military Alphabet

The Deputies usually use a "radio alphabet" or "military alphabet" when they tell you an inmate's PFN. Using a Radio Alphabet is helpful because it reduces miscommunication when saying things like a PFN, which is a combination of letters, but is not a word. Here is one to learn.

A = Adam	M = Mary
B = Boy	N = Nora
C = Charlie	O = Ocean
D = David	P = Paul
E = Edward	S = Sam
F = Frank	T = Tom
G = George	U = Union
H = Henry	V = Victor
I = Ida	W = William
J = John	X = X-ray
K = King	Y = Yellow
L = Larry	Z = Zebra

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Section 13. Computers

A. Excel Appointment Calendar

1. To search for an inmate in the Excel Appointment Calendar, click the Find Button (has a pair of binoculars, upper right).
2. A new window will appear, which has a field to enter information. In that space enter the inmate's PFN.
3. Click the "find all" button. This will give you a complete list of recent or future appointments.
4. Start at the bottom of the list, and work your way up the list, to see when the inmate has their next appointment clinician and/or psychiatrist.
5. The appointment calendar also will list the inmate's "client number" (usually a 7 digit number). You can use this number to search Clinician's Gateway (CG).

B. Clinician's Gateway (CG)

CG will let you review all of the inmate's progress notes in CG, from AFBH as well as some outside providers. Looking at CG can be helpful in getting an inmate's medication verified as well. CG will also let you review the various diagnoses a inmate may have been given by various providers.

1. To search for an inmate's history: The best way is to use the inmate's "client number" [redacted]

2. You can search for a person by their name, to search by name, enter the inmate's last name then first name. No commas between names and then click search.
* Be aware that the name ATIMS uses to identify the inmate may not match the County's system or the name the inmate uses currently.

3. How to do Assessments and Classification forms.

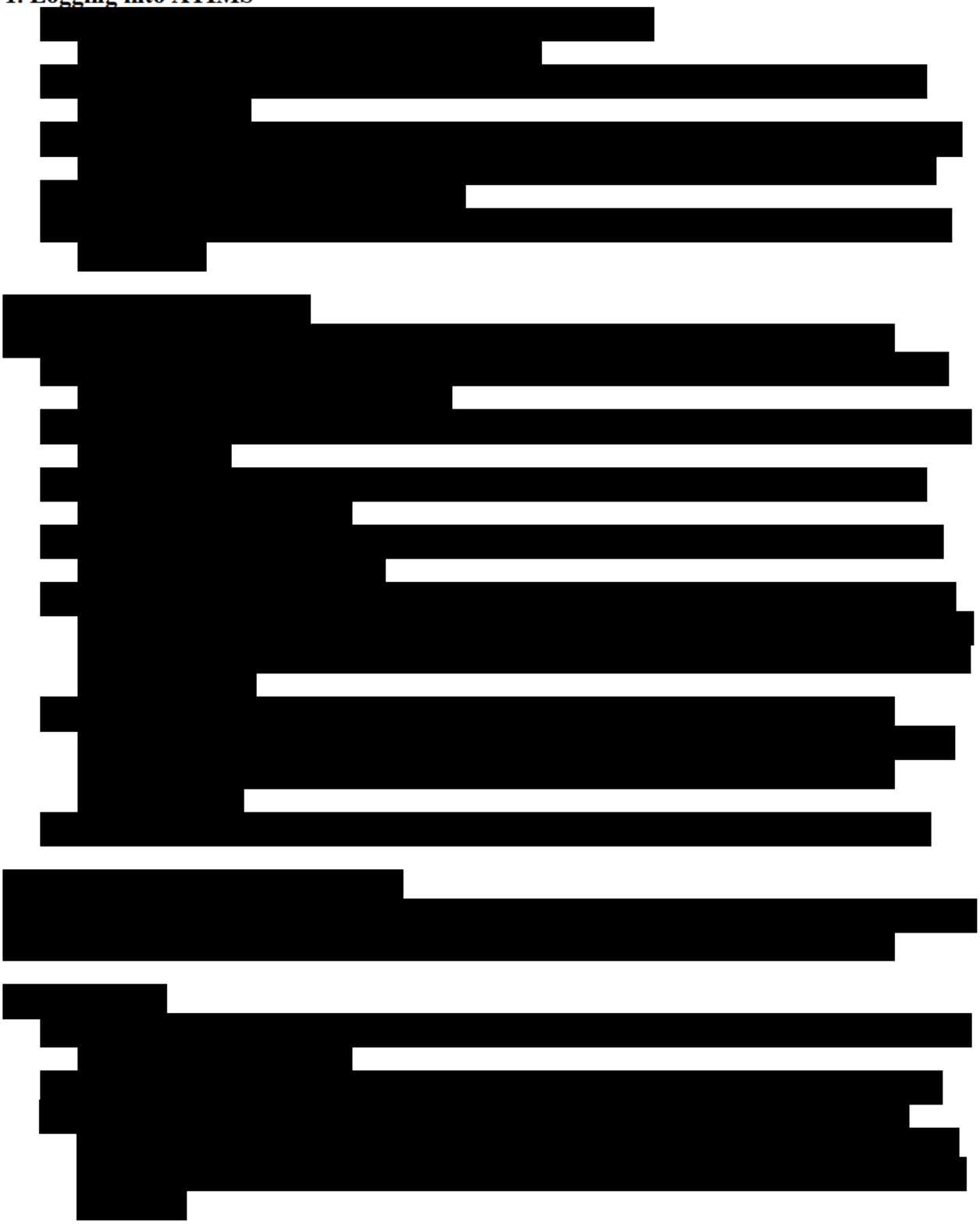
C. Insyst

Insyst is another tool you can use to find inmate's history of psychiatric services. We also use Insyst to open up an inmate to services.

1. Begin by logging into Insyst:

D. ATIMS

1. Logging into ATIMS



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Section 14. How to use the phone messaging system

A. To listen to voice mail

1. While using the speaker or handset, push the "VM" button.
2. At the prompt, enter [redacted]
3. The prompts will ask you if want to listen to the new voice mail. Enter "1" twice.
4. Listen to the message. Voice Mail won't let you delete a message until you listen to it completely.
5. Then choose one:

B. To change the main ITR greeting

1. While using the speaker or handset, push the "VM" button.
2. At the prompt, enter [redacted]
3. The prompts will give you several choices, choose: "Phone Manager Options" number "4"
4. Then choose "change your Standard Greeting", number "4".
5. The voice mail system will record the standard ITR message. An example of the Standard Greeting is on the bulletin board.
6. When you are done, punch "*" to stop the recording.
7. Then follow the prompts.

C. To set up the Out of office greeting

1. While using the speaker or handset, push the "VM" button.
2. At the prompt, enter [redacted]
3. The prompts will give you several choices, choose: "Phone Manager Options" number "4".
4. The prompts will give you several choices, choose "change your 'Out of Office Greeting', number "6".
5. The voice mail system will then record the "Out of the Office Greetings". An example of the Out of Office Greeting is also on the bulletin board.

D. Turning off the "Out of Office Greeting"

1. While using the speaker or handset, push the "VM" button.
2. At the prompt, enter [redacted]
3. The Voice Mail system will alert you that the Out of Office Greeting is on and ask you if you wish to delete it or keep it.
4. Press "4" to cancel the Out of Office Greeting.

Section 15. Other Tasks

[redacted]

C. Where to get supplies

Pens, Paper, tape, etc. are stored in the Max Muster office. There is a set of shelves that hold documents. On the top shelf, under all the documents, is a brass key to the cabinet in which the supplies are located.

Section 16. Special Circumstances

A. Documenting On Base Suicide Attempt

Please document the following when charting on an inmate who engaged in a suicide attempt or self-injurious behaviors.

1. What did they use?
    a. Item of clothing
    b. bedding, towels
    c. plastic bags
    d. razor
    e. pills

2. Circumstances
    d. how did it come to your attention
    e. how were they found
    f. how serious was it?
    g. did they require medical attention
    h. date, time, housing unit

3. Email a report to Joan, Sharmaine, Yvonne and the entire AFBH team

B. Alcohol Withdraw

Alcohol Withdrawal: things to remember
About 50% of alcohol (ETOH) dependent patients have clinically significant symptoms of withdrawal.

ETOH withdrawal starts within 6 to 24 hours after the last drink or significant decrease in use. Withdraws can start while the inmate is still intoxicated for heavy, long-term alcoholics.

The withdrawal maybe short-lived (less then 5 days) and require minimal or no medical intervention, or it maybe severe and require hospitalization, with severity increasing over the first 48 to 72 hours of abstinence.

Psychological symptoms can last for weeks to months, and include: dysphoria, sleep disturbance and anxiety.

Section 17. Security

AFBH **does *not*** give inmates the bagged lunches in ITR. The deputies use the "*bag lunches*" as a behavior modification tool in the booking process, especially when dealing with uncooperative inmates. If an inmate complains about not getting fed or asks for a lunch, AFBH can let the Deputies know the inmate's request.

If Deputies are searching of inmates near the ITR office, do not walk by Deputy or inmates until you gain the attention of the Deputy and are waved through.

Section 20. Other Information

A. AFBH's CAP

The Court Advocacy Project (CAP) is a Mental Health Service Act -funded program. The court mental health staffs work closely with jail and community mental health providers. The CAP Program is intended to help break the circular pattern of arrest, incarceration, and institutionalization. Overwhelming evidence has demonstrated that active participation in a range of community-based services can greatly assist individuals struggling with mental illnesses to achieve wellness and recovery and remain out of hospitals and jails. CAP Clinicians do the following:

- **Identify and Connect** defendants with mental illnesses to treatment services while in jail and R**efer** to community treatment for post release follow up.
- **Involve** community treatment providers in the court process for their clients and notify them of court status to ensure continuity of care
- **Assist** Judges, Public Defenders, DA's & Probation in understanding mental illnesses and treatment resources
- **Identify** underlying issues leading to recidivism; i.e. Housing, Benefits, Medical Issues, Substance Abuse, etc
- **Advocate** for specialty mental health treatment, such as hospitalization for acutely ill, suicidal, and gravely disabled individuals
- **Assist** family members in navigating the courts and the mental health system of care

B. Taxi Vouchers in ITR

How does ITR get brought into these situations?

ITR Clinician does assist fragile inmates out to the Clock in front of the jail to send them on their way to a drug program, EB-FACT/Tract, B&C, etc., . The trick with coordination is the following:

Colloborate very closely with Release Deputy about when to bring inmate down to ITR for release process. It's generally takes about 20 minutes so call the taxi about 45 minutes before the release process begins.
In the end, the clinician meets inmate up at CP-11 (Main Lobby) and walks inmate to front of jail @ Clock with Taxi Voucher in hand.
The taxi driver must sign the voucher and give you a copy of voucher for billing purposes. It's very easy to demonstrate.

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Appendix: Terms: quick look up

Bridge Meds = an inmate with an verified prescription, gets their medication continued for 7 to 14 day until they see the psychiatrist.
GDDF = Glen Dyer Detention Facility
HU = Housing Unit
ICC = Immediate Care Clinic
ICC protocol = what qualifies as "verified" medication and when and how to refer an inmate to ICC.
IOL = Intensive Observation Log
ITR = Intake, Transfer and Release
JGP = John George Pavillion
MHR = Mental Health Referral
New Book = an individual, arrested in the community, who has just arrived to SRJ or GDDF
NIC = No longer In Custody
OPHU or "the infirmary" = the on-base Medical hospital
OTC/OTA = Out to Court/Out to Appointment
S/C = Safety Cell
913 Log = ATIMS' Intensive Observation Log report (see ATIMS)

Examples:

CG Assessment
Class Form
IOL Sheet
Safety Cell Sheet
MH Referral
Handwritten Progress Note
5150 Packet and the pieces within
Daily Log
Scenarios with Step by Step process
Santa Rita Jail's Phone list: Cheat sheet and full list.
Procedures:
Information:
ITR Activity Log

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Extra Material

Appendix: Documenting Suicide Attempts:
Appendix: ASCO Website
Appendix: ATIMS
Appendix: Alcohol Withdraw

Section 17: ITR Dos and Don'ts

The *primary* mission in ITR is to establish 'Continuity of Treatment/Care' for the mentally ill new book/inmate. Hence, the ITR Clinician is to try to verify psychiatric medications for immediate bridge meds.

two primary sources: the CFMG Nurses and the Sheriff Deputies.

It's 'best practice' to research the MHR prior to screening the inmate so you are aware of the I/M's criminal charges and psychiatric history.

To get a snap shot, look up the client in ATIMS and print out the second page of their booking summary. Then check the Insyst(PSP) and/or CG for the client's mental health history.
ATIMS: is the ACSO's Inmate tracking program. It gives you a summary of the inmate's charges, status: such as being A/S or IOL, what HU, pod and cell they are in, court date, release date, and charges.
Insyst(PSP) and CG: will give you a list of the client's current providers, if any, as well as past providers, the number of services provided and date of last service provided for each provider. The advantage of CG is it gives you the full names of programs. Insyst gives you a more condensed version of the same information. For example: John Doe (create a sample and explain)….

Review the MHR provide by the CFMG Nurse and/or Deputy. What did they see when they interviewed the client? How did the Inmate answer their questions?

The Interview:
Bring the Paperwork you may need.

These inmates need to be screened by AFBH ASAP so the Deputies can keep inmates moving through ITR on a timely basis and before the inmate is moved out to the house. Sometimes ITR Nurse will call you to notify you that they have placed someone on Hold.

Additional information:
Sometimes you screen an inmate prior to the client being seen by the Nurses. Try to merge your paperwork with the Nurse's MHR or leave a note for the upcoming ITR shift, so the paperwork can be merged. This helps reduce double booking of appointments. If you do see and assess a client, but the Nurse's paperwork has not arrived to you, complete the assessment and make an appointment for the client. Make a note for the upcoming clinician, so they can merge paperwork together.

Note: The ITR clinician is not to sign any admitting documents either from Booking deputies or CFMG during booking process. If clinician determines clt remains at high risk for incarceration (specific suicide plan/means, psychotic, disoriented, incoherent, very agitated) then AFBH has authority to send clt back to John George Pavilion for ongoing psychiatric stabilization.

Sometimes client's come to the ITR clinician's attention, but can't be assessed for some reason, but based on the information you have received, you think they need to see AFBH. Examples a HU Deputy calls and says that a inmate reports having a psy meds, but is not having struggling in their HU and is not in crisis. In such a case, schedule the client for the clinic and make a hand written MHR.

Clinical Supervision: When an inmate goes into the Safety Cell, leave a message with the Clinical Supervisor. Consult with Clinical Supervisor if the inmate's presentation, behaviors are atypical or your needing additional support around what to do with the client. There are times when an inmate may be hiding out in the S/C. In such cases the clinician needs to discuss case with Supervisor.

Any clinical interventions by AFBH *should* be communicated to the ITR deputies and Booking Sergeant. It is also prudent for AFBH to be in collaboration with CFMG Nurses for continuity of information. The clinician must collaborate/consult with AFBH Supervisor regarding any critical clinical decisions pertaining to an inmate.

- **ITR Etiquette**

  a) AFBH does *not* give inmates the bagged lunches in ITR. The deputies use the "*bag lunches*" as a behavior modification tool in the booking process especially when dealing with uncooperative inmates. AFBH should take the posture of "inquiring" into such a matter and not demanding this from deputies.
  b) The same posture is held when asking a deputy for assistance when screening an inmate. The clinician "asks" the booking deputies if they are "available" to help with taking out an inmate from a cell for an initial mental health screening.
  c) Any clinical interventions by AFBH *should* be communicated to the ITR deputies and Booking Sergeant. It is also prudent for AFBH to be in collaboration with CFMG Nurses for continuity of information. The clinician must collaborate/**consult with AFBH Supervisor regarding any critical clinical**

decisions pertaining to an inmate. No decision or clinical intervention is done in isolation in ITR or in the jail at large.

Psychiatrically Stable
No drug detox rule provided the inmate meets #1, #2 & #3 above. Do not call the on-call MD for drug detox/intoxication if the inmate is otherwise stable.

Please see ICC Protocol in ITR office. Criteria: Must have written confirmed psych meds to use the ICC mechanism.

1. Clinician can't take verbal med lists over the phone unless there's an identified Rx #, Date within past 30 days, MD, Pharmacy, Date of Issue, Refills.

ITR Clinician contacts On Call MD for verified medications that come through ITR in 'hard copy' form only.

*BRIDGE Meds:
On Friday, Saturday, Sunday –Bridge inmates that would normally go to ICC
On Sun-Thurs: Bridge "Acceptable" confirmations, if it's a "Questionable" confirmation, you can put on ICC for Dr. Thomas to review.
Call the On-Call MD if: Psychiatrically unstable, meds confirmed, and ITR Nurse can get dose.

This section needs to be reviewed, and updated at least or tossed.

ICC, BRIDGE MED, URGENT INTERVENTION & VERIFIED MED POLICY:

General Guidelines:
1. Call the on-call MD if you have a situation that you feel needs MD consultation.
2. Call the on-call MD to bridge all confirmed medications (DEFINED BELOW).
3. Do not call the MD to bridge medications which do not meet the definition of Confirmed.

Call for URGENT INTERVENTION if the following:
Psychiatrically unstable or in emotional crisis
Concern for risk to self or others
May or may not have psych history
It's a situation where if we didn't have a Doctor Available, you'd be considering a 5150.

*Confirmed Medications:
Acceptable:
1. A treating doctor's written report.
2. Faxed records from the pharmacy where meds were obtained (not verbal confirmation).
3. Medication bottles only if current AND the labels indicate dates and prescribing physician.
Copy of label should appear in chart, NOT simply transcribed information.
ALSO:

Must have been taken within 14-days
Must have been prescribed the meds for at least 14-days

Questionable:
4. Medical Records from a hospital or other treatment facility. E.g. an outpatient clinic. May be acceptable if these records are current and are dated, and clearly show that medication has been prescribed for greater than 14 days prior to incarceration. Emergency room or recent clinic records which show only that the patient claims to be taking medications are not adequate verification for bridge or ICC.

Definitely not adequate for Bridge Meds or ICC:
5. Verbal report by an individual should be accepted cautiously if no other information is available.
6. Claims of unusual medications or medications often abused, i.e. tranquilizers as the only medicine being taken.
7. Claims of medication use when there appears to be no evidence of medical necessity.

Other important information if available:
Date of prescriptions and expiration dates
When the medications were last taken and the length of time when these medications had been taken

DEFINITION OF CONTINUITY OF CARE FOR CONFIRMED MEDICATIONS

There is a Valid prescription for the medications within the last 30-days.
The medications must have been taken within 14-days.
Must have been taking the medications for more than 14-days.
No drug detox rule provided the inmate meets #1, #2 & #3 above.
Do not call the on-call MD for drug detox/intoxication if the inmate is otherwise stable.
Consult with the MD if there are any questions.

CONFIRMED MEDICATIONS

Acceptable:
A treating doctor's written report.
Faxed records from the pharmacy where meds were obtained (not verbal confirmation)
Medication bottles only if current AND the labels indicate dates and prescribing physician (attempt to copy if possible)
Questionable:
Medical Records from a hospital or other treatment facility. e.g. an outpatient clinic. May be acceptable if these records are current and dated, and clearly show that medication has been prescribed for greater than 14-days prior to incarceration. Emergency room or recent clinic records which show only that the patient claims to be taking medications are not adequate verification for bridge or ICC.

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(SHEET)

ALAMEDA COUNTY SHERIFFS OFFICE

[redacted]

06/29/2016 14:00:06 [redacted]

Inmate Name	DOB	Age	Number	Site #
(NAME)	[redacted]	[redacted]	(PFN)	

Race	Hair	Eyes	Height	Weight	Marital Status
[redacted]					

SSN	DLN	Place Of Birth	Illegal
	CA	[redacted]	☐

FBI	CII	Alien Number	Housing	Classification
[redacted]	[redacted]		24 D 01	MENTAL MIN

Home Address	City, State, Zip	Home Phone
[redacted] STREET.	[redacted]	

Business Address	City, State, Zip	Business Phone

Employer	Occupation

[redacted]	First Known Name
	(NAME)

Booking Type	Booking Date/Time	Booking Officer	Booking Agency
DA WARRANT	[redacted]	OFFICER, A 10000	ALAMEDA COUNTY SHERIFFS OFFICE

Book Status	Arrest Date/Time	Arresting Officer	Arresting Agency
	[redacted]	HEIST, MARTIN, OFFICER, B	BERKELEY PD

Arrest Location	Case #/ Site Book. #	Billing Agency
[redacted]		BERKELEY PD

Court Docket #	Arraignment Date	Court
[redacted]		WILEY W. MANUEL COURTHOUSE

Booking Bail Amount	Booking Bail Type
$[redacted]	

...unts	Type	Qual	Section	Description	Bail	Status
1	F		148(D)	ATT RMV/ETC F/ARM:PO/ETC	0.00	
1	M		148(A)(1)	OBSTRUCT/ETC PUB OFCR/ETC	0.00	

Consecutive/Concurrent	Start Date	Release Date	Amended	Manual	Anytime Release
UNSENT					

Sent. Days	Credits Served	Days Stayed	Credits	Fine Days	Actual Days To Serve
	0				

Sentence Type	Findings	Description

[redacted] EXAMPLE of SUMMARY

ALAMEDA COUNTY SHERIFFS OFFICE
ACTIVE INMATE SUMMARY

06/29/2016 14:01

NAME : (NAME) NUM : (PFN)

A[redacted] INCARCERATION INCARCERATION NAME : (NAME)

DATE IN: [redacted] SCHD REL: TIME SERVED TO DATE: [redacted]

BOOKING #: [redacted]

ARREST DATE: [redacted]
ARREST LOC: [redacted]
ARREST OFFICER: HEIST, MARTIN
ORIG AGENCY:
ARREST AGENCY: BERKELEY PD
CASE NUM:
DOCKET:

BOOK TYPE: DA WARRANT
BOOK DATE: [redacted]
REC OFFICER: [redacted]
STATUS:
COURT: WILEY W. MANUEL COURTHOUSE
CLEAR REASON:

BOOK BAIL: $[redacted]
SENTENCED: UNSENT
LEN DAYS:
SCHD CLEAR:
CLEAR DATE:

BOOKING NOTES:

SCHED COURT: [redacted]

CHARGE DETAILS

COUNT	TYPE	QUALIFIER	SECTION	STATUTE	DESCRIPTION	STATUS	NOTES	BAIL
1	F		148(D)	PC	ATT RMV/ETC F/ARM:PO/ETC			0.00
1	M		148(A)(1)	PC	OBSTRUCT/ETC PUB OFCR/ETC			0.00

BAIL SUMMARY

BOOKING NUMBER	COURT DOCKET	STATUS	SENT	ACTIVE BAIL	NON ACTIVE BAIL
[redacted]	[redacted]	ACTIVE	UNSENT	$[redacted]	

GRAND TOTAL BAIL BAIL SET: 1 OF 1 BOOKINGS $[redacted]

[redacted]

ALAMEDA COUNTY SHERIFFS OFFICE
ACTIVE INMATE SUMMARY

06/29/2016 14:01

Image Not Available

NAME: (NAME) NUM: (PFN)

DOB: [redacted] AGE: [redacted]
RACE: [redacted] SEX:
HT: [redacted] WT:
HAIR: [redacted] EYES

PERSON DESCRIPTOR:

ALWAYS ALERTS:
MENTAL
INTENSE OBSERVTN LOG
ACTIVE ALERTS:
DIET ALERTS:
ASSOCATION:
KEEP SEPARATE:

CUR HOUSING:
SRJ 24 D 01
CLASSIFY:
MENTAL MIN

SSN: DLN: [redacted] DOC: CII: FBI: ALIEN: OTHER:

FKN: (NAME)
MONIKER:
AKA: AKA:
AKA:

HOME ADDRESS: [redacted] WORK ADDRESS: EMPLOYER: CONTACT:
OCCUPATION:

ITR VIRTUAL PSYCHIATRIC EXAMINER

PHS ☐SRJ ☐GDDF

Request for Mental Health Triage

R/O Drug Toxicity, Alcohol Withdrawal, Head Injury, Etc. Before Making a Mental Health Triage Request

PHS MR #

Patient Name: DOE (Last) JOHN (First) (MI)

Birthdate: 01/01/61

Sex: ☒Male ○Female

Ethnicity:

PFN #: ABC 123

Date: 01/04/15 Time: 12:00

CDC #:

Referring Person: DEP. SMITH

From: ☒ITR ○HU #: ○OPHU ○Other:

☐ **HISTORY OF PSYCHIATRIC TREATMENT**

Diagnosis:

Clinic/MD:

Phone:

Last Contact:

☒ **BIZARRE BEHAVIOR**

Describe:

☐ **SIGNS / SYMPTOMS OF DEPRESSION**

Describe:

☐ **INTENSIVE OBSERVATION LOG (IOL)**

Date /Time Started:

☐ **SAFETY CELL** (contact CJMH immediately see * below)

Date /Time Started:

On-call staff notified (date/time):

☐ **PSYCHIATRIC MEDICATIONS** (Name/Dose/Frequency

Date of last dose:

☐ Patient Report

☐ Verified (list name/dose/frequency above

Are meds in SRJ property? ○Y ○N

If so, name of Tech obtaining info from bottles:

Prescription #:

Prescribing MD:

Pharmacy Issuing:

Pharmacy Phone #:

Date of Issue on Bottles:

ADDITIONAL INFORMATION/COMMENTS: [redacted]

SUBSTANCE ABUSE HISTORY? ○Yes ○No Currently under the influence? ○Yes ○No

Substances used [redacted] Last used: [redacted]

Withdrawal protocol started? ○Yes ○No

For which substance(s)?

# of days protocol ordered?

1. **Research in Insyst:** ○Prior CJ History ○BHCS History only (No CJ hx) ○No Record Found (NRF)
2. **Research in Mainframe:** Arrest date: Next court date: Release date:

Charges: Bail: HU:

3. **Priority Status:** ○URGENT ○HIGH ○MEDIUM ○LOW
4. **Additional Information/Comments:**

4. **Appointment Date:** ☐ Does not meet criteria

Reviewed By:

Signature

Print/Stamp

Date & Time

*Between 0800 - 2100 contaact ITR screener @ x 46905

*Between 2100 - 0800 call On-Call pager @ x 53200, enter pager #5098

ALAMEDA COUNTY SHERIFF'S OFFICE
INMATE OBSERVATION LOG (P&P 8.12)

DATE: [redacted]

FACILITY (please circle one): SRJ GEDDF

CLOSE : *Logged within 30 minutes* (Ad-Seg / DI / PC / ISO),

INTENSIVE: *Logged within 15-minutes* (Acute Suicide Risk or Medical/Psychiatric)

INMATE'S NAME: DOE, JOHN

PFN: ABC 123

HOUSE: 9 POD: CELL:

INITIATED BY: DEPT SMITH

DATE/TIME STARTED: [redacted]

REASON: SUICIDAL THOUGHTS.

APPROVED BY W/C *(name)*:

MED STAFF NOTIFIED *(name)*: JONES

PSYCH STAFF NOTIFIED *(name)*: HARRIS

DATE/TIME *W/C NOTIFIED*:

TERMINATED BY:

DATE/TIME *TERMINATED*:

REMARK CODES: 1) Sleeping 2) Dining *T-Taken R-Refused* 3) *Talking* 4) *Awake in Bed* 5) *Reading/Writing* 6) *On Telephone* 7) Other, explain

TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES
12:00	DS	1									
12:15	DS	1									
12:30	DS	1									
12:45	DS	1									
1:00	DS	2									

EXAMPLE OF WHAT YOU FIND AT THE HU

INITIAL	NAME	INITIAL	NAME	INITIAL	NAME	INITIAL	NAME
DS	SMITH						

ROUTING (ALL COMPLETED LOGS): SRJ 1) Compliance Sergeant 2) Classification File GEDDF 1) Night Team Supervisor 2) Watch Commander 3) Classification File PD 474 (Rev. 2/6/13)

REVIEWED BY: DATE:

ALAMEDA COUNTY SHERIFF'S OFFICE
INMATE OBSERVATION LOG (P&P 8.12)

TO DISCONTINUE IOL

DATE: [redacted]

FACILITY (please circle one): SRJ GEDDF

CLOSE : *Logged within 30 minutes* (Ad-Seg / DI / PC / ISO),

INTENSIVE: *Logged within 15-minutes* (Acute Suicide Risk or Medical/Psychiatric)

INMATE'S NAME: DOE, JOHN

PFN: ABC 123

HOUSE: 9 POD: CELL:

INITIATED BY: DEPT SMITH

DATE/TIME STARTED: [redacted]

REASON: SUICIDAL THOUGHTS.

APPROVED BY W/C (*name*):

MED STAFF NOTIFIED (*name*): JONES

PSYCH STAFF NOTIFIED (*name*): HARRIS

DATE/TIME *W/C NOTIFIED*:

TERMINATED BY: OAKES

DATE/TIME TERMINATED: [redacted]

REMARK CODES: 1) Sleeping 2) Dining *T-Taken R-Refused* 3) Talking 4) Awake in Bed 5) Reading/Writing 6) On Telephone 7) Other, explain

TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES
12:00	DS	1									
12:15	DS	1									
12:30	DS	1									
12:45	DS	1									
1:00	DS	2									
1:05	JEO	D/C IOL									

INITIAL: DS NAME: SMITH | INITIAL: NAME: | INITIAL: NAME: | INITIAL: JEO NAME: OAKES

INITIAL: NAME: | INITIAL: NAME: | INITIAL: NAME: | INITIAL: NAME:

INITIAL: NAME: | INITIAL: NAME: | INITIAL: NAME: | REVIEWED BY:

ROUTING (ALL COMPLETED LOGS): SRJ 1) Compliance Sergeant 2) Classification File GEDDF 1) Night Team Supervisor 2) Watch Commander 3) Classification File PD 474 (Rev. 2/5/10)

ALAMEDA COUNTY SHERIFF'S OFFICE
INMATE OBSERVATION LOG (P&P 8.12)

TO CONTINUE IOL

DATE: [redacted]

FACILITY (please circle one): SRJ GEDDF

CLOSE : *Logged within 30 minutes* (Ad-Seg / DI / PC / ISO),

INTENSIVE: *Logged within 15-minutes* (Acute Suicide Risk or Medical/Psychiatric)

INMATE'S NAME: DOE, JOHN

PFN: ABC 123

HOUSE: 9 POD: CELL:

INITIATED BY: DEPUTY SMITH

DATE/TIME STARTED: [redacted]

REASON: SUICIDAL THOUGHTS.

APPROVED BY W/C *(name)*:

MED STAFF NOTIFIED *(name)*: JONES

PSYCH STAFF NOTIFIED *(name)*: HARRIS

DATE/TIME *W/C NOTIFIED*:

TERMINATED BY:

DATE/TIME *TERMINATED*:

REMARK CODES: 1) Sleeping 2) Dining *T-Taken R-Refused* 3) *Talking* 4) *Awake in Bed* 5) *Reading/Writing* 6) *On Telephone* 7) Other, explain

TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES
~~12:00~~											
12:00	DS	1									
12:15	DS	1									
12:30	DS	1									
12:45	DS	1									
1:00	DS	2									
1:05	JEO	CONT. IOL									

INITIAL: DS NAME: SMITH | INITIAL: NAME: | INITIAL: NAME: | INITIAL: JEO NAME: OAKES

INITIAL: NAME: | INITIAL: NAME: | INITIAL: NAME: | INITIAL: NAME:

INITIAL: NAME: | INITIAL: NAME: | INITIAL: NAME: | REVIEWED BY: DATE:

ROUTING (ALL COMPLETED LOGS): SRJ 1) Compliance Sergeant 2) Classification File GF 1) Night Team Supervisor 2) Watch Commander 3) Classification File PD 1) Team

ALAMEDA COUNTY SHERIFF'S OFFICE
INMATE OBSERVATION LOG (P&P 8.12)

IF YOU START IOL

DATE: [redacted]

FACILITY (please circle one): SRJ GEDDF

CLOSE : *Logged within 30 minutes* (Ad-Seg / DI / PC / ISO),

INTENSIVE: *Logged within 15-minutes* (Acute Suicide Risk or Medical/Psychiatric)

INMATE'S NAME: DOE, JOHN

PFN: ABC123

HOUSE: ITR POD: CELL:

INITIATED BY: OAKES

DATE/TIME STARTED: [redacted]

REASON: SUICIDAL THOUGHTS

APPROVED BY W/C *(name)*:

MED STAFF NOTIFIED *(name)*: JONES

PSYCH STAFF NOTIFIED *(name)*: OAKES

DATE/TIME *W/C NOTIFIED*:

TERMINATED BY:

DATE/TIME TERMINATED:

REMARK CODES: 1) Sleeping 2) Dining *T-Taken R-Refused* 3) Talking 4) Awake in Bed 5) Reading/Writing 6) On Telephone 7) Other, explain

TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES	TIME	INITIAL	REMARK CODES
12:00	JEO	START IOL									

INFORM THE ITR NURSE YOU ARE STARTING AN IOL AND GET THERE NAME OR ASK THEM TO SIGN THE LOG.

INITIAL:	NAME:	INITIAL:	NAME:	INITIAL:	NAME:	INITIAL: JEO	NAME: OAKES
INITIAL:	NAME:	INITIAL:	NAME:	INITIAL:	NAME:		
INITIAL:	NAME:	INITIAL:	NAME:	INITIAL:	NAME:	INITIAL:	NAME:

ROUTING (ALL COMPLETED LOGS): SRJ 1) Compliance Sergeant 2) Classification File GEDDF 1) Night Team Supervisor 2) Watch Commander 3) Classification File PD-474 (Rev. 3/5/12)

REVIEWED BY: DATE:

SLIDING TO SAFETY CELL

ALAMEDA COUNTY SHERIFF'S OFFICE

INTENSIVE OBSERVATION LOG SAFETY CELL (P&P 8.12)

SAFETY CELL

DATE: [redacted] **FACILITY (please circle one):** SRJ GEDDF		**LOG TYPE: INTENSIVE/SAFETY CELL:** *Logged each 15 minutes* (Acute Suicide Risk or Medical/Psychiatric) Security checks are to be made within 15 minutes of the Log observation
INMATE'S NAME: DOE, JOHN	**PFN:** ABC123	**HOUSE:** 9 ~~POD~~ ~~CELL~~
INITIATED BY: OAKES	**DATE/TIME STARTED:** [redacted]	**REASON:** SUICIDAL THOUGHTS/PLAN
APPROVED BY W/C *(name)*:	**MED STAFF NOTIFIED *(name)*:** JONES	**PSYCH STAFF NOTIFIED *(name)*:** OAKES
DATE/TIME *W/C NOTIFIED*:	**TERMINATED BY :** OAKES	**DATE/TIME NOTIFIED** [redacted]

DEPUTY OBSERVATIONS

TIME	INITIALS	COMMENTS
6:00	DS	1
6:15	DS	1
6:30	DS	1
6:45	DS	1
7:00	DS	5
7:15	DS	5
7:30	DS	4
7:45	DS	4
8:00		

DEPUTY OBSERVATIONS

TIME	INITIALS	COMMENTS

MEDICAL/MENTAL HEALTH STAFF

TIME	INITIALS	COMMENTS
8:00	JEO	D/C S/A, CONT. IOL

W/C OR W.S. APPROVAL (Notify Medical/Mental Health)

TIME	INITIALS	COMMENTS

REMARK CODES:

1) Sleeping *2) Dining*

3) Exercising *4) Awake Lying Down*

5) Awake Standing

6) W/C-every 8 hours after initial approval

7) CJMH-initial 8 hours, cont'd-24 hours, *72 hrs. max*

8) *Corizon - Immediately, every 8 hours* of placement

Note: Fluids Offered & Taken (FT) or Fluids Refused (FR)

AND B=Breakfast; L= Lunch D=Dinner when "Dining"

ADDITIONAL COMMENTS:

INITIAL: DS NAME: [illegible]	INITIAL: NAME:	INITIAL: NAME:	INITIAL: JEO NAME: OAKES
INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:
INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:
INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:	REVIEWED BY: DATE:

ROUTING (ALL COMPLETED LOGS): 1) Night Team Supervisor 2) Watch Commander [illegible]ssification File

PD-474 (Rev. 09/[illegible]11)

CONTINUING IN SAFETY CELL

ALAMEDA COUNTY SHERIFF'S OFFICE
INTENSIVE OBSERVATION LOG SAFETY CELL (P&P 8.12)

DATE [redacted]	FACILITY (please circle one): SRJ GEDDF	LOG TYPE: INTENSIVE/SAFETY CELL: *Logged each 15-minutes* (Acute Suicide Risk or Medical/Psychiatric) Security checks are to be made within 15 minutes of the last observation
INMATE'S NAME: DOE, JOHN	PFN: ABC 123	HOUSE: 9 ~~POD:~~ ~~CELL:~~
INITIATED BY: OAKES	DATE/TIME STARTED: [redacted]	REASON: SUICIDAL THOUGHT/PLAN
APPROVED BY W/C *(name)*:	MED STAFF NOTIFIED *(name)*: JONES	PSYCH STAFF NOTIFIED *(name)*: OAKES
DATE/TIME *W/C NOTIFIED*:	TERMINATED BY :	DATE/TIME NOTIFIED:

DEPUTY OBSERVATIONS

TIME	INITIALS	COMMENTS
6:00	DS	1
6:15	DS	1
6:30	DS	1
6:45	DS	1
7:00	DS	5
7:15	DS	5
7:30	DS	3
8:00		

DEPUTY OBSERVATIONS

TIME	INITIALS	COMMENTS

MEDICAL/MENTAL HEALTH STAFF

TIME	INITIALS	COMMENTS
8:00	JEO	CONT- S/C, STILL SUICIDAL.

W/C OR W/S APPROVAL (Notify Medical/Mental Health)

TIME	INITIALS	COMMENTS

REMARK CODES:

1) Sleeping *2) Dining*
3) Exercising *4) Awake Lying Down*
5) Awake Standing

6) W/C-every 8 hours after initial approval
7) CJMH-initial 8 hours, cont'd-24 hours, *72 hrs. max*
8) *Corizon - Immediately, every 8 hours* of placement

Note: Fluids Offered & Taken (FT) or Fluids Refused (FR) AND B=Breakfast; L= Lunch D=Dinner when "Dining"

ADDITIONAL COMMENTS:

INITIAL: DS NAME: [illegible]	INITIAL: NAME:	INITIAL: NAME:	INITIAL: JEO NAME: OAKES
INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:
INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:
INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:	REVIEWED BY: DATE:

ROUTING (ALL COMPLETED LOGS): 1) Night Team Supervisor 2) Watch Commander [illegible]ssification File

PD-474 (Rev. 09/[illegible]11)

SAFETY CELL

STARTING A SAFETY CELL LOG.

ALAMEDA COUNTY SHERIFF'S OFFICE
INTENSIVE OBSERVATION LOG SAFETY CELL (P&P 8.12)

DATE: 01/01/15	FACILITY (please circle one): SRJ GEDDF	LOG TYPE: INTENSIVE/SAFETY CELL: *Logged each 15-minutes* (Acute Suicide Risk or Medical/Psychiatric) Security checks are to be made within 15 minutes of the Last observation
INMATE'S NAME: DOE, JOHN	PFN: ABC123	HOUSE: 9 ~~POD~~ ~~CELL~~
INITIATED BY: OAKES	DATE/TIME STARTED: [redacted]	REASON: SUICIDAL PLAN
APPROVED BY W/C *(name)*:	MED STAFF NOTIFIED *(name)*: JONES	PSYCH STAFF NOTIFIED *(name)*: OAKES
DATE/TIME *W/C NOTIFIED*:	TERMINATED BY:	DATE/TIME NOTIFIED:

DEPUTY OBSERVATIONS

TIME	INITIALS	COMMENTS

DEPUTY OBSERVATIONS

TIME	INITIALS	COMMENTS

MEDICAL/MENTAL HEALTH STAFF

TIME	INITIALS	COMMENTS
12:00	JEO	START S/C

W/C OR W/S APPROVAL (Notify Medical/Mental Health)

TIME	INITIALS	COMMENTS

SAFETY CELL

REMARK CODES:

1) Sleeping *2) Dining*

3) Exercising *4) Awake Lying Down*

5) Awake Standing

6) W/C-every 8 hours after initial approval

7) CJMH-initial 8 hours, cont'd-24 hours, *72 hrs. max*

8) *Corizon - Immediately, every 8 hours* of placement

Note: Fluids Offered & Taken (FT) or Fluids Refused (FR)

AND B=Breakfast; L= Lunch D=Dinner when "Dining"

ADDITIONAL COMMENTS:

INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:	INITIAL: JEO NAME: OAKES
INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:
INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:
INITIAL: NAME:	INITIAL: NAME:	INITIAL: NAME:	REVIEWED BY: DATE:

ROUTING (A) COMPLETED LOGS): 1) Night Team Supervisor 2) Watch Commander ssification File

PD-474 (Rev. 0. 11)

ALAMEDA COUNTY Behavioral Health Care Services

& Housing Rec (CJ)		Service Number:	[redacted]
Provider:	81142 CRIMINAL JUSTICE MHS SNTA RITA	Service Date:	
Procedure:	581 Plan Development	Dup Reason Code:	
Client:	[redacted] NAME	Location:	Correctional Facility
Emergency:	No Pregnant: No	Number in Group:	1
Primary Clinician:	15380 Oakes, Jonathan, MFT,	Med Compliant?	N/A Side Effects? N/A
Recommendation		Staff Time:	0 hr(s). 20 min(s).
		Record Stamp:	[redacted] PM

CRIMINAL JUSTICE MENTAL HEALTH PROGRAM

Santa Rita Jail, [redacted]

To: ACSO Classification. Attn: TECH HALL
From: CJMH
Re: Classification & Housing Recommendation

Client Name: **PFN#:** [redacted] **HU Location:** 24
Booking Name:
This client's mental health status was evaluated on (date) [redacted] @ (time) [redacted] AM

☑ ACSO logs have been signed, initialed and dated.

The recommendation is: ☐ Ad-Seg ☐ P/C
(select all that apply)

IOL	Intensive Observation Log: Respond ASAP within 8 hours of initiation, then every seven days (or more often) for duration of IOL. When CJMH responds to an IOL, on the first contact, always circle "initiate" IOL.	○ Initiate	○ Continue	● Discontinue	○ N/A
Safety Cell	Respond ASAP within 8 hours of initiation, then within 24 hours each day thereafter, not to exceed 72 hours. Consult supervisor/Watch Commander if need exceeds 72 hours.	○ Initiate	○ Continue	○ Discontinue	● N/A
Mental Status		○ Initiate	● Continue	○ Discontinue	○ N/A
Ints	Restraints: Must respond ASAP within 8 hours, then within every 8 hours until restraints removed.	☐ Evaluation of behavior-- Report results to Classification			
	☐ Regional Center Client	☐ Regional Center Notified			

Housing (select one and explain in Comments)

○ A. Cleared for Mainline
○ B. House in Behavioral Health Housing Unit (HU9)
○ C. House in **Ad Seg** (explain reason below)
○ D. 5150 to ○ JGP or ○ [redacted]
● E. If female, house in HU24 (select one)
○ Ad Seg or ● Mental Pod

Justification (select all that apply and provide rationale in Comments)

☑ Stable ☐ Assaultive ☐ Agitated ☐ Suicidal ☐ Hx. of assault ☑ Cooperative
☐ Homicidal ☐ Threatening ☐ No longer suicidal ☐ Other:

Comments:
CLIENT REPORTED THAT SHE IS NOT SUICIDAL AND IS FEELING STABLE.

Distribution:

1. Day shift, 7 days/week, **fax to Main Classification** [redacted]
   Faxed on (date) [redacted] @ (time) [redacted]
2. Evening/Night shift, 7 days/week, give a copy to ITR Classification deputy. Given to (name):
3. Clinic/HU generated class forms, fax a copy to ITR Screening Office [redacted]

Electronically Signed By

15380 - Oakes, Jonathan, MFT — Marriage/Family Counselor

(NAME) [redacted]
Printed On [redacted]
ELECTRONIC PROTECTED HEALTH INFORMATION

(STARTING AN IOL IN ITR)

Alameda County Behavioral Health Care Services

CRIMINAL JUSTICE MENTAL HEALTH PROGRAM

Santa Rita Jail

[redacted]

Date: [redacted]

To: ACSO Classification. Attn: CLASS KEY

From: CJMH

Re: Classification & Housing Recommendation

Inmate Name: DOE, JOHN **PFN#:** ABC123 **HU Location:** ITR

This inmate's mental health status was evaluated on [redacted] (date) (time) The recommendation is:

☒ **ACSO logs have been signed, initialed and dated.**

(circle all that apply) ☐ **Ad-Seg** ☐ **P./C**

IOL	Intensive Observation Log: Respond ASAP within 8 hours of initiation, then every seven days (or more often) for duration of IOL. When CJMH responds to an IOL, on the first contact, always circle "initiate" IOL.	(Initiate)	Continue	Discontinue	N/A
Safety Cell	Respond ASAP within 8 hours of initiation, then within 24 hours each day thereafter, not to exceed 72 hours. Consult supervisor/Watch Commander if need exceeds 72 hours.	Initiate	Continue	Discontinue	(N/A)
Mental Status		(Initiate)	Continue	Discontinue	N/A
[illegible]nts	Restraints: Must respond ASAP within 8 hours, then within every 8 hours until restraints removed.	Evaluation of behavior-- Report results to Classification			

Housing (check one and explain in Comments)

- ☐ A. Cleared for Mainline
- ☒ B. House in Behavioral Health Housing Unit (HU9)
- ☐ C. House in **Ad Seg** (explain reason below)
- ☐ D. If female, house in HU24 (check one) ☐ ***Ad Seg*** **or** ☐ ***Mental Pod***

Justification (circle all that apply and provide rationale in Comments):

Stable *Assaultive* *Agitated* (*Suicidal*) *Hx. of assault*

Cooperative *Homicidal* *Threatening* *No longer suicidal* *Other*

Comments: CLIENT SAID [redacted]

Signature: [signature] LMFT **Title:** Jonathan Oakes, LMFT Behavioral Health Clinician II Staff # 15380

Distribution:

1. Original to chart
2. Day shift, 7 days/week, **fax to Main Classification** [redacted] Faxed on (dat[redacted]
3. Evening/Night shift, 7 days/week, give a copy to ITR Classification deputy. Given to (name):
4. Clinic/HU generated class forms, fax a copy to ITR Screening Office [redacted]
5. Fax to Director [redacted]

CSI HOLDING AN IOL FOR CLIENT IN THE HOUSE)

Alameda County Behavioral Health Care Services

CRIMINAL JUSTICE MENTAL HEALTH PROGRAM

Santa Rita Jail

[redacted]

Date: [redacted]

To: ACSO Classification. Attn: CLASS KEY

From: CJMH

Re: Classification & Housing Recommendation

Inmate Name: DOE, JOHN **PFN#:** ABC123 **HU Location:** 9

This inmate's mental health status was evaluated on [redacted] (date) (time) The recommendation is:

☒ **ACSO logs have been signed, initialed and dated.** ☐ **Ad-Seg** ☐ **P./C**

(circle all that apply)

IOL	Intensive Observation Log: Respond ASAP within 8 hours of initiation, then every seven days (or more often) for duration of IOL. When CJMH responds to an IOL, on the first contact, always circle "initiate" IOL.	(Initiate)	Continue	Discontinue	N/A
Safety Cell	Respond ASAP within 8 hours of initiation, then within 24 hours each day thereafter, not to exceed 72 hours. Consult supervisor/Watch Commander if need exceeds 72 hours.	Initiate	Continue	Discontinue	(N/A)
Mental Status		(Initiate)	Continue	Discontinue	N/A
R[illegible]nts	Restraints: Must respond ASAP within 8 hours, then within every 8 hours until restraints removed.	Evaluation of behavior-- Report results to Classification			

Housing (check one and explain in Comments)

- ☐ A. Cleared for Mainline
- ☒ B. House in Behavioral Health Housing Unit (HU9)
- ☐ C. House in **Ad Seg** (explain reason below)
- ☐ D. If female, house in HU24 (check one) ☐ ***Ad Seg*** **or** ☐ ***Mental Pod***

Justification (circle all that apply and provide rationale in Comments):

Stable *Assaultive* *Agitated* (*Suicidal*) *Hx. of assault*

Cooperative *Homicidal* *Threatening* *No longer suicidal* *Other:* _____

Comments: CLIENT SAID [redacted]

Signature: [signature] LMFT **Title:** Jonathan Oakes, LMFT Behavioral Health Clinician II Staff # 15380

Distribution:

1. Original to chart
2. Day shift, 7 days/week, **fax to Main Classification** [redacted] Faxed on (date) [redacted]
3. Evening/Night shift, 7 days/week, give a copy to ITR Classification deputy. Given to (name):
4. Clinic/HU generated class forms, fax a copy to ITR Screening Office [redacted]
5. Fax to Director [redacted]

(STOPPING THE DOC CLIENT WILL STAY IN A MENTAL HOUSE)

Alameda County Behavioral Health Care Services

CRIMINAL JUSTICE MENTAL HEALTH PROGRAM

Santa Rita Jail

[redacted]

Date: [redacted]

To: ACSO Classification Attn: CLASS KEY

From: CJMH

Re: Classification & Housing Recommendation

Inmate Name: DOE, JOHN **PFN#:** ABC123 **HU Location:** 9

This inmate's mental health status was evaluated on [redacted] (date) (time) The recommendation is:

☒ **ACSO logs have been signed, initialed and dated.**

(circle all that apply) ☐ **Ad-Seg** ☐ **P./C**

IOL	Intensive Observation Log: Respond ASAP within 8 hours of initiation, then every seven days (or more often) for duration of IOL. When CJMH responds to an IOL, on the first contact, always circle "initiate" IOL.	Initiate	Continue	Discontinue	N/A
Safety Cell	Respond ASAP within 8 hours of initiation, then within 24 hours each day thereafter, not to exceed 72 hours. Consult supervisor/Watch Commander if need exceeds 72 hours.	Initiate	Continue	Discontinue	N/A
Mental Status		Initiate	Continue	Discontinue	N/A
[illegible]nts	Restraints: Must respond ASAP within 8 hours, then within every 8 hours until restraints removed.	Evaluation of behavior-- Report results to Classification			

Housing (check one and explain in Comments)

- ☐ A. Cleared for Mainline
- ☒ B. House in Behavioral Health Housing Unit (HU9)
- ☐ C. House in **Ad Seg** (explain reason below)
- ☐ D. If female, house in HU24 (check one) ☐ ***Ad Seg*** or ☐ ***Mental Pod***

Justification (circle all that apply and provide rationale in Comments):

Stable *Assaultive* *Agitated* *Suicidal* *Hx. of assault*
Cooperative *Homicidal* *Threatening* ~~*No longer suicidal*~~ *Other:*

Comments: CLIENT SAYS [redacted]

[redacted]

Signature: [signature] LMFT **Title:** Jonathan Oakes, LMFT
Behavioral Health Clinician II
Staff # 15380

Distribution:

1. Original to chart
2. Day shift, 7 days/week, fax to Main Classification [redacted] Faxed on (date) [redacted]
3. Evening/Night shift, 7 days/week, give a copy to ITR Classification deputy. Given to (name):
4. Clinic/HU generated class forms, fax a copy to ITR Screening Office [redacted]
5. Fax to Director [redacted]

Classification Housing Recommendation Rev 2/24/10

(SITTING IN SAFETY CELL)

Alameda County Behavioral Health Care Services

CRIMINAL JUSTICE MENTAL HEALTH PROGRAM

Santa Rita Jail

[redacted]

Date: [redacted]

To: ACSO Classification. Attn: CLASS KEY

From: CJMH

Re: Classification & Housing Recommendation

Inmate Name: DOE, JOHN **PFN#:** ABC123 **HU Location:** 9

This inmate's mental health status was evaluated on [redacted] The recommendation is:

☒ **ACSO logs have been signed, initialed and dated.**

(circle all that apply) ☐ **Ad-Seg** ☐ **P./C**

IOL	Intensive Observation Log: Respond ASAP within 8 hours of initiation, then every seven days (or more often) for duration of IOL. When CJMH responds to an IOL, on the first contact, always circle "initiate" IOL.	(Initiate)	Continue	Discontinue	N/A
Safety Cell	Respond ASAP within 8 hours of initiation, then within 24 hours each day thereafter, not to exceed 72 hours. Consult supervisor/Watch Commander if need exceeds 72 hours.	(Initiate)	Continue	Discontinue	N/A
Mental Status		(Initiate)	Continue	Discontinue	N/A
R[redacted]nts	Restraints: Must respond ASAP within 8 hours, then within every 8 hours until restraints removed.	Evaluation of behavior-- Report results to Classification			

Housing (check one and explain in Comments)

- ☐ A. Cleared for Mainline
- ☒ B. House in Behavioral Health Housing Unit (HU9)
- ☐ C. House in **Ad Seg** (explain reason below)
- ☐ D. If female, house in HU24 (check one) ☐ ***Ad Seg*** **or** ☐ ***Mental Pod***

Justification (circle all that apply and provide rationale in Comments):

Stable *Cooperative* (*Assaultive* *Homicidal*) *Agitated* *Threatening* (*Suicidal*) *No longer suicidal* *Hx. of assault* *Other:*

Comments: CLIENT REPORTED [redacted]

Signature: [redacted] **Title:** Jonathan Oakes, LMFT
Behavioral Health Clinician I
Staff # 15380

Distribution:

1. Original to chart
2. Day shift, 7 days/week, **fax to Main Classification** [redacted] Faxed on (date) [redacted]
3. Evening/Night shift, 7 days/week, give a copy to ITR Classification deputy. Given to (name):
4. Clinic/HU generated class forms, fax a copy to ITR Screening Office [redacted]
5. Fax to Director [redacted]

(ENDING SAFETY CELL, CONTINUING IOL)

Alameda County Behavioral Health Care Services

CRIMINAL JUSTICE MENTAL HEALTH PROGRAM

Santa Rita Jail

[redacted]

Date: [redacted]

To: ACSO Classification. Attn: CLASS KEY

From: CJMH

Re: Classification & Housing Recommendation

Inmate Name: DOE, JOHN **PFN#:** ABC123 **HU Location:** 9

This inmate's mental health status was evaluated on [redacted] (date) (time). The recommendation is:

☒ **ACSO logs have been signed, initialed and dated.**

(circle all that apply)

☐ **Ad-Seg** ☐ **P./C**

IOL	Intensive Observation Log: Respond ASAP within 8 hours of initiation, then every seven days (or more often) for duration of IOL. When CJMH responds to an IOL, on the first contact, always circle "initiate" IOL.	Initiate	Continue	Discontinue	N/A
Safety Cell	Respond ASAP within 8 hours of initiation, then within 24 hours each day thereafter, not to exceed 72 hours. Consult supervisor/Watch Commander if need exceeds 72 hours.	Initiate	Continue	Discontinue	N/A
Mental Status		Initiate	Continue	Discontinue	N/A
R[illegible]nts	Restraints: Must respond ASAP within 8 hours, then within every 8 hours until restraints removed.	Evaluation of behavior-- Report results to Classification			

Housing (check one and explain in Comments)

- ☐ A. Cleared for Mainline
- ☒ B. House in Behavioral Health Housing Unit (HU9)
- ☐ C. House in **Ad Seg** (explain reason below)
- ☐ D. If female, house in HU24 (check one) ☐ ***Ad Seg*** **or** ☐ ***Mental Pod***

Justification (circle all that apply and provide rationale in Comments):

Stable *Assaultive* *Agitated* *Suicidal* *Hx. of assault*

Cooperative *Homicidal* *Threatening* *No longer suicidal* *Other:*

Comments: CLIENT REPORTED [redacted]

Signature: [signature] LMFT **Title:** Jonathan Oakes, LMFT Behavioral Health Clinician II Staff # 15380

Distribution:

1. Original to chart
2. Day shift, 7 days/week, fax to Main Classification [redacted] Faxed on (date) [redacted]
3. Evening/Night shift, 7 days/week, give a copy to ITR Classification deputy. Given to (name):
4. Clinic/HU generated class forms, fax a copy to ITR Screening Office [redacted]
5. Fax to Director [redacted]

Trade and Generic Names of Psychiatric Medications.

Compiled by, Ivan Goldberg, MD

Generic and Trade Names of Medications (Trade Names Are Capitalized)		Use of Medication
Abilify	aripiprazole	Antipsychotic
Adderall	amphetamine salts	Psychostimulant / ADD
Adapin	doxepin	Antidepressant
Akineton	biperiden	Side-effect control
alprazolam	Xanax	Antianxiety
Ambien	zolpidem	Hypnotic
amantadine	Symmetrel	Side-effect control
amitriptyline	Elavil, Typtanol, Saroten, Tryptizol	Antidepressant
Amobarbital	Amytal	Hypnotic
amphetamine salts	Adderall	Psychostimulant / ADD
Amytal	amobarbital	Hypnotic
Antabuse	disulfiram	Rx of alcoholism
Anafranil	clomipramine	Antidepressant
Aripiprazole	Abilify	Antipsychotic
Aropax	paroxetine	Antidepressant
Artane	trihexyphenidyl	Side-effect control
Atarax	hydroxyzine	Hypnotic, Antianxiety
atenolol	Tenormin	Side effect control
atomoxetine	Strattera	Anti-ADD
Ativan	Lorazepam	Antianxiety
Aurorix	moclobemide	Antidepressant
Aventyl	nortriptyline	Antidepressant
Benadryl	diphenhydramine	Hypnotic, Side-effect control
benztropine	Cogentin	Side-effect control
bethanechol	Urecholine	Side-effect control
biperiden	Akineton	Side effect control
bromazepam	Lexomyl, Lexotanil Lexotan	Antianxiety
buprenorphine	Subutex	Opioid addiction
bupropion	Wellbutrin, Odranal	Antidepressant
Buspar	buspirone	Antianxiety
buspirone	Buspar	Antianxiety
butabarbital	Butisol	Hypnotic
Butisol	butabarbital	Hypnotic
carbamazepine	Tegretol	Mood stabilizer
Catapres	clonidine	Anti-ADD, Antianxiety
Celexa	citalopram	Antidepressant
Centrax	prazepam	Antianxiety

chloral hydrate	Somnote	Hypnotic
chlorpromazine	Thorazine	Antipsychotic
chlordiazepoxide	Librium	Antianxiety
Cibalith-S	lithium citrate	Mood stabilizer
Cipram	citalopram	Antidepressant
Cipramil	citalopram	Antidepressant
citalopram	Celexa, Cipramil, Prisdal, Seropram Cipram, Citopam	Antidepressant
Citopam	citalopram	Antidepressant
clomipramine	Anafranil	Antidepressant/Anti-OCD
clonidine	Catapres	Anti-ADD, Antianxiety
clonazepam	Klonopin, Rivotril	Antianxiety
clorazepate	Tranxene	Antianxiety
clozapine	Clozaril	Antipsychotic
Cogentin	benztropine	Side-effect control
Concerta	methylphenidate	Psychostimulant / ADD
Cylert	Pemoline	Psychostimulant / ADD,
Potentiates		
Cymbalta	duloxetine	Antidepressants Antidepressant
cyproheptadine	Periactin	Side-effect control
Cytomel	liothyronine	Potentiates
antidepressants		
Dalmane	flurazepam	Hypnotic
Decadron	dexamethasone	Diagnostic test for
depression		
Depakene	valproic acid/valproate	Mood stabilizer
Depakote	divalproex, valproate	Mood Stabilizer
Deprax	fluoxetine	Antidepressant, Anti-
OCD, Antipanic		
deprenyl	see selegiline	Antidepressant
Deroxat	paroxetine	Antidepressant, Anti-
OCD, Antipanic		
desipramine	Norpramin, Pertofran	Antidepressant
Desoxyn	methamphetamine	Psychostimulant / ADD
Desyrel	trazodone	Antidepressant,
hypnotic		
dexamethasone	Decadron	Diagnostic test for
depression.		
Dexedrine	dextroamphetamine	Psychostimulant / ADD,
Potentiates		
dextroamphetamine	Dexedrine	antidepressants Psychostimulant / ADD,
Potentiates		
diazepam	Valium, Stesolid	antidepressants Antianxiety
diphenhydramine	Benadryl	Hypnotic, Side-effect
control		
disulfiram	Antabuse	Rx of alcoholism
divalproex	Depakote	Mood stabilizer
Dobupal	venlafaxine	Antidepressant
Doral	quazepam	Hypnotic
doxepin	Sinequan, Adapin	Antidepressant,
Antipanic		

duloxetine	Cymbalta	Antidepressant
Dutonin	nefazodone	Antidepressant
Edronax	reboxetine	Antidepressant
Elavil	amitriptyline	Antidepressant,
Antipanic		
Effexor	venlafaxine	Antidepressant, Anti-
OCD, Antipanic		
Equinil	meprobamate	Antianxiety
Escitalopram	Lexapro	Antidepressant
Eskalith	lithium carbonate	Mood stabilizer
estazolam	Prosom	Hypnotic
eszopiclone	Lunesta	Hypnotic
ethchlorvynol	Placidyl	Hypnotic
Eufor	fluoxetine	Antidepressant, Anti-
OCD, Antipanic		
Favarin	fluvoxamine	Antidepressant, Anti-
OCD, Anti-panic		
felbamate	Felbatol	Mood stabilizer
Felbatol	felbamate	Mood stabilizer
Fluanxol	flupenthixol	Antipsychotic,
antidepressant		
Fluctine	fluoxetine	Antidepressant, Anti-
OCD, Anti-panic		
Fluocim	fluoxetine	Antidepressant, Anti-
OCD, Anti-panic		
fluoxetine	Prozac, Veritina,	Antidepressant, Anti-
OCD, Anti-panic	Eufor, Deprax, Psiquial Fluctine, Fluocim	
flupenthixol	Fluanxol	Antipsychotic,
antidepressant		
fluphenazine	Prolixin	Antipsychotic
flurazepam	Dalmane	Hypnotic
fluvoxamine	Luvox, Faverin	Antidepressant, Anti-
OCD, Antipanic		
gabapentin	Neurontin	Mood stabilizer
Gabitril	tiagabine	Anticonvulsant, Mood
stabilizer		
Geodon	ziprasidone	Antipsychotic, Mood
stabilizer		
Galdem	sertraline	Antidepressant
Halcion	triazolam	Hypnotic
Haldol	haloperidol	Antipsychotic
haloperidol	Haldol	Antipsychotic
hydroxyzine	Atarax, Vistaril	Hypnotic, Antianxiety
imipramine	Tofranil	Antidepressant,
Antipanic		

Imovane	zopiclone	Hypnotic
Inderal	propranolol	Side-effect control,
Anger control		
isocarboxazid	Marplan	Antidepressant
Kemadrin	procyclidine	Side-effect control
Keppra	levetiracetam	Anticonvulsant, Mood
stabilizer		
Klonopin	clonazepam	Antianxiety, Mood
stabilizer		
Lamictal	lamotrigine	Anticonvulsant, Mood
stabilizer		
lamotrigine	Lamictal	Anticonvulsant, Mood
stabilizer		
levetiracetam	Keppra	Anticonvulsant, Mood
stabilizer		
levothyroxine	Synthroid	Potentiates
antidepressants,		
(Bipolar rapid cycling)		Mood stabilizer
Lexapro	escitalopram	Antidepressant
Lexomyl	bromazepam	Antianxiety
Lexotan	bromazepam	Antianxiety
Lexotanil	bromazepam	Antianxiety
Librium	chlordiazepoxide	Antianxiety
liothyronine	Cytomel	Potentiates
antidepressants, Mood stabilizer		
Litharex	lithium carbonate	Mood stabilizer,
Potentiates antidepressants		
lithium carbonate	Eskalith. Lithane,	Mood stabilizer,
	Lithonate, Lithotabs	Potentiates
antidepressants		
	Litharex	
lithium citrate	Cibalith-S	Mood stabilizer,
Potentiates antidepressants		
Lithonate	lithium carbonate	Mood stabilizer,
Potentiates antidepressants		
Lithotabs	lithium carbonate	Mood stabilizer,
Potentiates antidepressants		
lorazepam	Ativan, Temesta	Antianxiety
loxapine	Loxitane	Antipsychotic
Loxitane	loxapine	Antipsychotic
Ludiomil	maprotiline	Antidepressant
Lunesta	eszopiclone	Hypnotic
Lustral	sertraline	Antidepressant, Anti-
OCD, Antipanic		
Luvox	fluvoxamine	Antidepressant, Anti-
OCD, Antipanic		
Manerix	moclobemide	Antidepressant, Anti-
social phobia		
maprotiline	Ludiomil	Antidepressant

Marplan	isocarboxazid	Antidepressant, Antipanic
meprobamate	Miltown, Equinil	Antianxiety
Metadate	methylphenidate	Psychostimulant / ADD
mesoridazine	Serentil	Antipsychotic
methamphetamine	Desoxyn	Psychostimulant / ADD
methotrimeprazine	Nozinan	Antipsychotic
methylphenidate	Ritalin, Metadate, Methylin	Psychostimulant / ADD
Miltown	meprobamate	Antianxiety
Mirapex	pramipexol	Potentiates antidepressants
mirtazepine	Remeron	Antidepressant, Antipanic
Moban	molindone	Antipsychotic
moclobemide	Manerix, Aurorix	Antidepressant, Anti-social phobia
modafanil	Provigil, Modiodal	Narcolepsy, Potentiates antidepressants
Modiodal	modafanil	Narcolepsy, Potentiates antidepressants
molindone	Moban	Antipsychotic
Nalorex	naltrexone	Rx of alcoholism, Potentiates antidepressants
naltrexone	ReVia, Trexan, Phaltrexia, Nalorex	Rx of alcoholism, Potentiates antidepressants
Nardil	phenelzine	Antidepressant, Antipanic
Navane	thiothixene	Antipsychotic
Nefadar	nefazodone	Antidepressant
nefazodone	Serzone, Dutonin, Nefadar	Antidepressant
Nembutal	Pentobarbital	Hypnotic
Neurontin	gabapentin	Mood stabilizer
Norebox	reboxetine	Antidepressant
Norpramin	desipramine	Antidepressant
Nortrilen	nortriplyline	Antidepressant, Antipanic
nortriptyline	Aventyl, Pamelor	Antidepressant, Antipanic
Nozinan	Nortrilen methotrimeprazine	Antipsychotioc
Odranal	bupropion	Antidepressant
olanzapine	Zyprexa	Antipsychotic
Orap	pimozide	Antipsychotic
oxazepam	Serax, Seresta	Antianxiety
oxcarbazepine	Trileptal	Anticonvulsant, Mood stabilizer
Pamelor	nortriptyline	Antidepressant, Antipanic

Parnate	tranylcypromine	Antidepressant, Antipanic
paroxetine	Paxil, Aropax, Seroxat, Deroxat	Antidepressant, Anti-OCD, Antipanic
Paxil	paroxetine	Antidepressant, Anti-OCD, Antipanic
pemoline	Cylert	Psychostimulant / ADD, Potentiates antidepressants
pentobarbital	Nembutal	Hypnotic
Periactin	cyproheptadine	Side-effect control
perphenazine	Trilafon	Antipsychotic
Pertofran	desipramine	Antidepressant
Phaltrexia	naltrexone	Rx of alcoholism, Potentiates antidepressants
phenelzine	Nardil	Antidepressant, Antipanic
pimozide	Orap	Antipsychotic
pindolol	Visken	Potentiates antidepressants
Placidyl	ethchlorvynol	Hypnotic
pramipexole	Mirapex	Potentiates antidepressants
prazepam	Centrax, Reapam	Antianxiety
Prisdal	citalopram	Antidepressant, Anti-OCD, Antipanic
Procyclidine	Kemadrin	Side-effect control
Prolixin	fluphenazine	Antipsychotic
propranolol	Inderal	Side-effect control
Prosom	estazolam	Hypnotic
protriptyline	Vivactil	Antidepressant, Antipanic
Provigil	modafinil	Psychostimulant / ADD, potentiates antidepressants
Prozac	fluoxetine	Antidepressant, Anti-OCD, Antipanic
Psiquial	fluoxetine	Antidepressant, Anti-OCD, Antipanic
Quazepam	Doral	Hypnotic
quetiapine	Seroquel	Antipsychotic
reboxetine	Vestra, Edronax, Norebox	Antidepressant
Remeron	mirtazepine	Antidepressant, Antipanic
Restoril	temazepam	Hypnotic
ReVia	naltrexone	Rx of alcoholism, Potentiates antidepressants
Risperdal	risperidone	Antipsychotic
risperidone	Risperdal	Antipsychotic
Ritalin	methylphenidate	Psychostimulant / ADD, Potentiates antidepressants

		antidepressants
Saroten	amitriptyline	Antidepressant,
Antipanic		
Secobarbital	Seconal	Hypnotic
Seconal	secobarbital	Hypnotic
selegiline	Eldepryl	Antidepressant
Serax	oxazepam	Antianxiety
Sercerin	sertraline	Antidepressant, Anti-
OCD, Antipanic		
Serepax	oxazepam	Antianxiety
Seresta	oxazepam	Antianxiety
Serlect	sertindole	Antipsychotic
Seropram	citralopram	Antidepressant
Seroquel	quetiapine	Antipsychotic
Seroxat	paroxetine	Antidepressant, Anti-
OCD, Antipanic		
sertindole	Serlect	Antipsychotic
sertraline	Zoloft, Sercerin,	Antidepressant, Anti-
OCD, Antipanic		
	Tolrest, Lustral, Gladem	
Serzone	nefazodone	Antidepressant
Somnote	chloral hydrate	Hypnotic
Sonata	zaleplon	Hypnotic
Symmetrel	amantadine	Side-effect control
Stelazine	trifluoperazine	Antipsychotic
Stesolid	diazepam	Antianxiety
Strattera	atomoxetine	Anti-ADD
Suboxone	buprenorphine + naloxone	Opioid addiction
Subutex	buprenorphine	Opioid addiction
Surmontil	trimipramine	Antidepressant,
Antipanic		
Synthroid	levothyroxine	Potentiates
antidepressants,		
(Bipolar rapid cycling)		Mood stabilizer
Tegretol	carbamazepine	Mood stabilizer
temazepam	Restoril	Hypnotic
Tenormin	atenolol	Side-effect control
Thiothixene	Navane	Antipsychotic
Tiagabine	Gabitril	Anticonvulsant, Mood
stabilizer		
thioridazine	Mellaril	Antipsychotic
Timesta	lorazepam	Antianxiety
Thorazine	chlorpromazine	Antipsychotic
Tofranil	imipramine	Antidepressant,
Antipanic		
Tolrest	sertraline	Antidepressant, Anti-
OCD, Antipanic		
Topamax	topiramate	Anticonvulsant, Mood
stabilizer		

topiramate	Topamax	Anticonvulsant, Mood stabilizer
Tranxene	clorazepate	Antianxiety
tranylcypromine	Parnate	Antidepressant, Antipanic
trazodone	Desyrel	Antidepressant, Hypnotic
Trexan	naltrexone	Rx of alcoholism, Potentiates antidepressants
triazolam	Halcion	Hypnotic
trihexyphenidyl	Artane	Side-effect control
Trilafon	perphenazine	Antipsychotic
Trileptal	oxcarbazepine	Anticonvulsant, Mood stabilizer
trimipramine	Surmontil	Antidepressant, Antipanic
Typtanol	amitriptyline	Antidepressant, Antipanic
Typtizol	amitriptyline	Antidepressant, Antipanic
Urecholine	bethanechol	Side-effect control
Valium	diazepam	Antianxiety
valproic acid	Depakene	Mood stabilizer
Valproate	Depakote/Depakene	Mood stabilizer
venlafaxine	Effexor, Dobupal	Antidepressant, Anti-OCD, Antipanic
Verotina	fluoxetine	Antidepressant, Anti-OCD, Antipanic
Vestra	reboxetine	Antidepressant
Vistaril	hydroxyzine	Hypnotic, Antianxiety
Vivactil	protriptyline	Antidepressant, Antipanic
Wellbutrin	bupropion	Antidepressant
Xanax	alprazolam	Antianxiety
zaleplon	Sonata	Hypnotic
ziprasidone	Geodon	Antipsychotic, Mood stabilizer
Zoloft	sertraline	Antidepressant, Anti-OCD, Antipanic
zolpidem	Ambien	Hypnotic
Zonegran	zonisamide	Anticonvulsant, Mood stabilizer
zonisamide	Zonegran	Anticonvulsant, Mood stabilizer
zopiclone	Imovane	Hypnotic
Zyprexa	olanzapine	Antipsychotic

Alameda County Behavioral Health Care Services
CRIMINAL JUSTICE MENTAL HEALTH PROGRAM
Santa Rita Jail Clinic
5325 Broder Blvd.
Dublin, CA 94568

☒ ITR Screening Office [redacted]
ITR Fax: [redacted]

☐ Clinic Office [redacted]
Clinic Fax: [redacted]

CONSENT TO OBTAIN MEDICATION VERIFICATION

Client Name	Social Security #	Date of Birth
DOE, JOHN	123-45-6789	01/01/01

Date: 01/01/16

PFN# ABC 123

To: CVS

CDC# _____

Fax #: (510) 555-5555

The above-named client has requested treatment with our program. In order to provide continuity of care, please provide us with a copy of the most current psychotropic medications prescribed. Medication verification can be sent to the fax number checked above. Please return a copy of this form with the information requested.

I authorize the facility listed above to provide medication information to the Criminal Justice Mental Health Program.

*Client signature _____ Date: _____
* ☒ If person is in custody a signature not needed per HIPAA rules for continuity of care.

Witness: _____ Date/Time: _____

Faxed by: LMFT Jonathan Oakes, LMFT Behavioral Health Clinician II Staff # 15380 1/1/16 3:00pm

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edver rev12/26/08/Resburgjqcd

Location: _____

PSP # [redacted]

Client Name: DOE, JOHN

DOB: 01/01/01 PFN# ABC123

ICC

SPECIAL HANDLING

Scheduled for Immediate Care Clinic

on [redacted]

X Meds verified

___ paperwork

X see CG/Catalyst

___ CAP Referral – see note

X TBA appt. [redacted]

X MD appt. [redacted]

Green Sheet

APPLICATION FOR EMERGENCY PSYCHIATRIC DETENTION

NAME OF SUBJECT: DOE, JOHN ABC123	REPORT/CASE NUMBER
ADDRESS: SANTA RITA JAIL	PHONE: [redacted] SEX RACE DOB
Wit.-1 NAME: OAKES, J.	LOCATION OF INCIDENT: SANTA RITA JAIL
ADDRESS: CJMH AT SRJ	DATE/TIME OCCURRED: [redacted] DATE/TIME REPORTED
RES. PHONE and BUS. PHONE: [redacted]	CRIME (if applicable) / SECTION-SUBSECTION-CODE
Wit.-2 NAME	COMPLAINANT'S NAME (first name if business) / COMPLAINANT'S ADDRESS
ADDRESS	ADDITIONAL INFORMATION
RES. PHONE and BUS. PHONE	NATURE OF INCIDENT: **MENTAL ILLNESS (5150 W&I)**

W&I CODE SECTION 5157: requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

DETAINMENT ADVISEMENT: My name is *(state name)*. I am a *(peace officer, physician, etc.)* with *(department or medical facility)*. You are/are not under criminal arrest, but I am taking you for examination by mental health professionals at *(name of facility)*.
You will be told your rights by the mental health staff.
If taken into custody at his or her residence, the person shall also be told the following information in substantially the following form:
You may bring a few personal items with you which I will have to approve. You can make a phone call and/or leave a note to tell your family and/or friends where you have been taken.

CHECK ONE.

☐ Advisement Complete ☐ Advisement Incomplete Good cause for incomplete advisement:

Advisement completed by YOUR NAME, LICENSE # Position BEHAVIORAL HEALTH CLINICIAN II Date

BHCS-CJMH AT SANTA RITA JAIL COUNTY ID #

PLEASE USE SPECIFIC DETAILS, SIMILAR TO FILING YOUR OWN POLICE/MEDICAL STAFF REPORTS (Definitions on reverse side):

A. By whom and where was subject brought to the attention of police/medical staff:

WHAT YOU OBSERVED, WHAT WAS REPORTED TO YOU, PATTERN OF RECENT

B. What situation had developed prompting request for help from police/medical staff:

BEHAVIORS THAT LEAD TO CLIENT BEING 5150'D. EX= "CLIENT BANGED HIS HEAD."
ALSO WHAT THE CLIENT SAID.
*CLIENT SAID HE WOULD KILL HIMSELF IF WHEN GIVEN A CHANCE.

C. What situation developed after police/medical staff intervention prompting decision to request emergency psychiatric detention:

CHECK ALL THAT APPLY

The undersigned believes, based on probable cause that the above subject, as a result of ☐ MENTAL DISORDER, ☐ INEBRIATION, ☐ THE USE OF NARCOTICS, OR RESTRICTED DRUGS, is ☐ A DANGER TO HIM/HERSELF, ☐ A DANGER TO OTHERS, or ☐ GRAVELY DISABLED in accordance with W&I Code Sections 5150, 5170, and 5343.

Officer/Physician Signature YOUR NAME LICENSE # Badge No./Title BEHAVIORAL HEALTH CLINICIAN II COUNTY ID #

Police Department/Treatment Facility BHCS-CJMH AT SANTA RITA JAIL Telephone [redacted]

CERTIFICATION OF CRIMINAL CHARGES (W&I Code Sections 5152.1 & 5152.2):
If a person is not accepted for admission, or is detained for less than 72 hours, notification shall be made pursuant to 5152.1 W&I.

☐ Notification of _____, at phone number _____, is requested, as person has been referred under circumstances in which criminal charges might be filed.

Officer Signature _____

REPORTING OFFICER(S)	SUPERVISOR

*STEPS X

1. Write the Pharmacy note FIRST in CB.
2. Write out the Green sheet - clear and concise (JBP staff may only read the Green sheet.)
3. Then Prepare the Packet
   name, RFN, Date, 5150 to JBA w/sharpie
   Give it CP-1

IV. 5150 CRITERIA

DANGER TO SELF: Manifest or reliably reported recent attempt, expressed or inferred intent; or self destructive observed behavior, need not be lethal in quality, as long as significantly self-destructive in nature; need not be demonstrably result of mental illness, this is taken for granted.

DANGER TO OTHERS: Recent history reliably reported, observed behavior, or unexpressed or inferred intention; this must be suspected to be the result of mental illness, if not, then the situation is strictly a police matter with the possible final outcome as imprisonment not hospitalization.

GRAVELY DISABLED: No apparent means of providing food, clothing or shelter which includes lacking the organization to access shelters or soup kitchens because of mental illness, not because of lack of resources or physical condition.

NOTE: There must be evidence of two types of behavior, those that constitute grounds for 5150, and those which indicate presence of mental disorder (except for danger to self); both must be present on 5150. Because of the severe under-funding of the Community Mental Health system, the threshold for 5150 Criteria is much higher than just a few years ago.

1. Behaviors Which May Constitute Grounds for a 5150

a. Danger To Self:

* Actual recent suicide attempt
* Threat to commit suicide with available means
* Hearing voices instructing the person to injure
* Self-mutilation - burning or cutting self, banging head
* Refusing medical treatment for a life threatening medical problem
* Walking in front of cars
* Leaving gas on, setting fires

b. Danger To Others:

* Assaultive behavior
* Threatening behavior with immediate intent to harm

* Person admits to"hearing voices"instructing him to hurt someone
* Fire setting, leaving gas on
* Engaging in dangerous behavior without regard to the safety of others - throwing objects, reckless driving, brandishing a weapon, breaking windows

c. Gravely Disabled:

* Unable to provide food

  - Refuses to eat - "food is poisoned", person claims he/she must purify body, persons claims he/she "doesn't have to eat"
  - Too depressed to eat, no appetite
  - Too "busy" to eat, no interest in eating
  - Person is afraid to leave room to obtain food.
  - Precipitous weight loss

* Unable to Provide Clothing

  - Nude or semi-nude in a public area
  - Person has thrown all of his/her clothes away
  - Refuses to wear clothes because they are "contaminated"
  - Clothing is so dirty, tattered, etc. that they cannot be considered as "minimum clothing"
  - Clothing is inappropriate for the situation- no coat or barefoot in the cold, wearing a bathing suit

* Unable to Provide Shelter

  - Living on the streets or recently evicted because of lacking the minimal organization or where-with-all to maintain any type of shelter
  - Living conditions are uninhabitable or a fire or health hazard

2. Behaviors Which May Indicate The Presence of a Mental Disorder:

a. Appearance:

* Nude or semi-nude
* Bizarre dress
* Disheveled, dirty, unkempt
* Inappropriate to circumstance
* Intoxicated - 5170 hold for intoxication

Green Sheet

APPLICATION FOR EMERGENCY PSYCHIATRIC DETENTION

NAME OF SUBJECT: DOE, JOHN ABC123			REPORT/CASE NUMBER
ADDRESS: SANTA RITA JAIL	PHONE: 925-551-6905	SEX: M	RACE: W	DOB: 1/1/61
Wit.-1 NAME: OAKES, J.	LOCATION OF INCIDENT: SANTA RITA JAIL		
ADDRESS: CJMH AT SRJ	[redacted]		
RES. PHONE and BUS. PHONE: [redacted]			
Wit.-2 NAME	COMPLAINANT'S NAME (first name if business)	COMPLAINANT'S ADDRESS	
ADDRESS	ADDITIONAL INFORMATION		
RES. PHONE and BUS. PHONE	NATURE OF INCIDENT: **MENTAL ILLNESS (5150 W&I)**		

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You may bring a few personal items with you which I will have to approve. You can make a phone call and/or leave a note to tell your family and/or friends where you have been taken.

CHECK ONE.

☐ Advisement Complete ☐ Advisement Incomplete Good cause for incomplete advisement: _____

Advisement completed by YOUR NAME, LICENSE # Position BEHAVIORAL HEALTH CLINICIAN II Date _____

BHCS-CJMH AT SANTA RITA JAIL COUNTY ID #

PLEASE USE SPECIFIC DETAILS, SIMILAR TO FILING YOUR OWN POLICE/MEDICAL STAFF REPORTS (Definitions on reverse side):

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WHAT YOU OBSERVED, WHAT WAS REPORTED TO YOU, PATTERN OF RECENT

B. What situation had developed prompting request for help from police/medical staff:
BEHAVIORS THAT LEAD TO CLIENT BEING 5150'D. EX: "CLIENT BANGED HIS HEAD." ALSO WHAT THE CLIENT SAID. *CLIENT SAID HE WOULD KILL HIMSELF IF/ WHEN GIVEN A CHANCE.

C. What situation developed after police/medical staff intervention prompting decision to request emergency psychiatric detention:

CHECK ALL THAT APPLY

The undersigned believes, based on probable cause that the above subject, as a result of ☐ MENTAL DISORDER, ☐ INEBRIATION, ☐ THE USE OF NARCOTICS, OR RESTRICTED DRUGS, is ☐ A DANGER TO HIM/HERSELF, ☐ A DANGER TO OTHERS, or ☐ GRAVELY DISABLED in accordance with W&I Code Sections 5150, 5170, and 5843.

Officer/Physician Signature YOUR NAME, LICENSE, # Badge No./Title BEHAVIORAL HEALTH CLINICIAN II COUNTY ID #

Police Department/Treatment Facility BHCS-CJMH AT SANTA RITA JAIL Telephone [redacted]

CERTIFICATION OF CRIMINAL CHARGES (W&I Code Sections 5152.1 & 5152.2):
If a person is not accepted for admission, or is detained for less than 72 hours, notification shall be made pursuant to 5152.1 W&I.

☐ Notification of _____, at phone number _____, is requested, as person has been referred under circumstances in which criminal charges might be filed.

Officer Signature _____

REPORTING OFFICER(S)	SUPERVISOR

STEPS

1. Write the Phrases note first in CG.
2. Write out the Green sheet - clear and concise (JAP ~~staff~~ may only read the Green sheet)
3. Then Prepare the Packet
   name, PFN, Date, SIGS to JA w/sharpie
   Give it CP-1

IV. 5150 CRITERIA

DANGER TO SELF: Manifest or reliably reported recent attempt, expressed or inferred intent; or self destructive observed behavior, need not be lethal in quality, as long as significantly self-destructive in nature; need not be demonstrably result of mental illness, this is taken for granted.

DANGER TO OTHERS: Recent history reliably reported, observed behavior, or unexpressed or inferred intention; this must be suspected to be the result of mental illness, if not, then the situation is strictly a police matter with the possible final outcome as imprisonment not hospitalization.

GRAVELY DISABLED: No apparent means of providing food, clothing or shelter which includes lacking the organization to access shelters or soup kitchens because of mental illness, not because of lack of resources or physical condition.

NOTE: There must be evidence of two types of behavior, those that constitute grounds for 5150, and those which indicate presence of mental disorder (except for danger to self); both must be present on 5150. Because of the severe under-funding of the Community Mental Health system, the threshold for 5150 Criteria is much higher than just a few years ago.

1. Behaviors Which May Constitute Grounds for a 5150

a. Danger To Self:

* Actual recent suicide attempt
* Threat to commit suicide with available means
* Hearing voices instructing the person to injure
* Self-mutilation - burning or cutting self, banging head
* Refusing medical treatment for a life threatening medical problem
* Walking in front of cars
* Leaving gas on, setting fires

b. Danger To Others:

* Assaultive behavior
* Threatening behavior with immediate intent to harm

* Person admits to"hearing voices"instructing him to hurt someone
* Fire setting, leaving gas on
* Engaging in dangerous behavior without regard to the safety of others - throwing objects, reckless driving, brandishing a weapon, breaking windows

c. Gravely Disabled:

* Unable to provide food

  - Refuses to eat - "food is poisoned", person claims he/she must purify body, persons claims he/she "doesn't have to eat"
  - Too depressed to eat, no appetite
  - Too "busy" to eat, no interest in eating
  - Person is afraid to leave room to obtain food.
  - Precipitous weight loss

* Unable to Provide Clothing

  - Nude or semi-nude in a public area
  - Person has thrown all of his/her clothes away
  - Refuses to wear clothes because they are "contaminated"
  - Clothing is so dirty, tattered, etc. that they cannot be considered as "minimum clothing"
  - Clothing is inappropriate for the situation- no coat or barefoot in the cold, wearing a bathing suit

* Unable to Provide Shelter

  - Living on the streets or recently evicted because of lacking the minimal organization or where-with-all to maintain any type of shelter
  - Living conditions are uninhabitable or a fire or health hazard

2. Behaviors Which May Indicate The Presence of a Mental Disorder:

a. Appearance:

* Nude or semi-nude
* Bizarre dress
* Disheveled, dirty, unkempt
* Inappropriate to circumstance
* Intoxicated - 5170 hold for intoxication

b. Speech:

* Mute, unresponsive
* Conversation is disjointed, or unintelligible - forceful language
* Slurred speech
* Speech is rapid, flighty or non-stop

c. Affect:

* Agitated, anxious
* Depressed, tearful
* Hyperactive, manic
* Frightened, fearful
* Hostile, angry
* Inappropriate laughter, smiling, giggling

d. Behavior:

* Erratic, bizarre
* Catatonic, unresponsive
* Talking to self
* Threatening, assaultive
* Impulsive
* Restless, pacing
* Peculiar mannerisms - tics, wringing of hands, picking at self, staring blankly, rocking

e. Thinking:

* Confused
* Disoriented - reports bizarre, grandiose or paranoid thoughts which cannot be possible
* Hallucination - reports hearing, seeing, feeling or smelling things which are not real
* Inability to concentrate or focus thoughts

NOTE: Be sure to prepare elaborate documentation in your charts of your actions and the rationale behind your actions.

Assembly Bill No. 1194

CHAPTER 570

..... shall consider available relevant information about the historical course of the person's mental disorder...

An act to amend Section 5150 of the Welfare and Institutions Code, relating to mental health.

[Approved by Governor October 07, 2015. Filed with Secretary of State October 07, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1194, Eggman. Mental health: involuntary commitment.

Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of persons with specified mental disorders for the protection of the persons so committed. Under the act, when a person, as a result of mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, he or she may, upon probable cause, be taken into custody by a peace officer, member of the attending staff of an evaluation facility, designated members of a mobile crisis team, or other designated professional person, and placed in a facility designated by the county and approved by the State Department of Social Services as a facility for 72-hour treatment and evaluation. Existing law requires, when determining if probable cause exists to take a person into custody, or cause a person to be taken into custody pursuant to the provisions described above, any person who is authorized to take or cause that person to be taken into custody to consider available relevant information about the historical course of the person's mental disorder, as specified, if the authorized person determines that information has a reasonable bearing on the determination described above.

This bill would provide that, when determining if a person should be taken into custody pursuant to the provisions described above, the individual making that determination shall consider available relevant information about the historical course of the person's mental disorder if the individual concludes that the information has a reasonable bearing on the determination, and that the individual shall not be limited to consideration of the danger of imminent harm.

Existing law requires the admitting facility to require an application in writing stating the circumstances under which the person's condition was called to the attention of those persons authorized to make the determination of probable cause, and stating that he or she has probable cause, as specified.

The bill would also require the application to record whether the historical course of a person's mental disorder was considered in the determination of probable cause.

By imposing additional duties on local officials, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

DIGEST KEY

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 5150 of the Welfare and Institutions Code is amended to read:

5150. (a) When a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services. At a minimum, assessment, as defined in Section 5150.4, and evaluation, as defined in subdivision (a) of Section 5008, shall be conducted and provided on an ongoing basis. Crisis intervention, as defined in subdivision (e) of Section 5008, may be provided concurrently with assessment, evaluation, or any other service.

(b) When determining if a person should be taken into custody pursuant to subdivision (a), the individual making that determination shall apply the provisions of Section 5150.05, and shall not be limited to consideration of the danger of imminent harm.

(c) The professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county shall assess the person to determine whether he or she can be properly served without being detained. If, in the judgment of the professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, the person can be

properly served without being detained, he or she shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis. Nothing in this subdivision shall be interpreted to prevent a peace officer from delivering individuals to a designated facility for assessment under this section. Furthermore, the assessment requirement of this subdivision shall not be interpreted to require peace officers to perform any additional duties other than those specified in Sections 5150.1 and 5150.2.

(d) Whenever a person is evaluated by a professional person in charge of a facility designated by the county for evaluation or treatment, member of the attending staff, or professional person designated by the county and is found to be in need of mental health services, but is not admitted to the facility, all available alternative services provided pursuant to subdivision (c) shall be offered as determined by the county mental health director.

(e) If, in the judgment of the professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or the professional person designated by the county, the person cannot be properly served without being detained, the admitting facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, and stating that the peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county has probable cause to believe that the person is, as a result of a mental health disorder, a danger to others, or to himself or herself, or gravely disabled. The application shall also record whether the historical course of the person's mental disorder was considered in the determination, pursuant to Section 5150.05. If the probable cause is based on the statement of a person other than the peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, the person shall be liable in a civil action for intentionally giving a statement that he or she knows to be false.

(f) At the time a person is taken into custody for evaluation, or within a reasonable time thereafter, unless a responsible relative or the guardian or conservator of the person is in possession of the person's personal property, the person taking him or her into custody shall take reasonable precautions to preserve and safeguard the personal property in the possession of or on the premises occupied by the person. The person taking him or her into custody shall then furnish to the court a report generally describing the person's property so preserved and safeguarded and its disposition, in substantially the form set forth in Section 5211, except that if a responsible relative or the guardian or conservator of the person is in possession of the person's property, the report shall include only the name of the relative or guardian or conservator and the location of the property, whereupon responsibility of the person taking him or her into custody for that property shall terminate. As used in this section, "responsible relative" includes the spouse, parent, adult child, domestic partner, grandparent, grandchild, or adult brother or sister of the person.

(g) (1) Each person, at the time he or she is first taken into custody under this section, shall be provided, by the person who takes him or her into custody, the following information orally in a language or modality accessible to the person. If the person cannot understand an oral advisement, the information shall be provided in writing. The information shall be in substantially the following form:

My name is _____.

I am a _____ (peace officer/mental health professional) _____.

with _____ (name of agency) _____.

You are not under criminal arrest, but I am taking you for an examination by mental health professionals at _____.

_____ (name of facility) _____.

You will be told your rights by the mental health staff.

(2) If taken into custody at his or her own residence, the person shall also be provided the following information:

You may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken.

(h) The designated facility shall keep, for each patient evaluated, a record of the advisement given pursuant to subdivision (g) which shall include all of the following:

(1) The name of the person detained for evaluation.

(2) The name and position of the peace officer or mental health professional taking the person into custody.

(3) The date the advisement was completed.

(4) Whether the advisement was completed.

(5) The language or modality used to give the advisement.

(6) If the advisement was not completed, a statement of good cause, as defined by regulations of the State Department of Health Care Services.

(i) (1) Each person admitted to a facility designated by the county for evaluation and treatment shall be given the following information by admission staff of the facility. The information shall be given orally

and in writing and in a language or modality accessible to the person. The written information shall be available to the person in English and in the language that is the person's primary means of communication. Accommodations for other disabilities that may affect communication shall also be provided. The information shall be in substantially the following form:

My name is .

My position here is .

You are being placed into this psychiatric facility because it is our professional opinion that, as a result of a mental health disorder, you are likely to (check applicable):

☐ Harm yourself.

☐ Harm someone else.

☐ Be unable to take care of your own food, clothing, and housing needs.

We believe this is true because

(list of the facts upon which the allegation of dangerous

or gravely disabled due to mental health disorder is based, including pertinent

facts arising from the admission interview).

You will be held for a period up to 72 hours. During the 72 hours you may also be transferred to another facility. You may request to be evaluated or treated at a facility of your choice. You may request to be evaluated or treated by a mental health professional of your choice. We cannot guarantee the facility or mental health professional you choose will be available, but we will honor your choice if we can.

During these 72 hours you will be evaluated by the facility staff, and you may be given treatment, including medications. It is possible for you to be released before the end of the 72 hours. But if the staff decides that you need continued treatment you can be held for a longer period of time. If you are held longer than 72 hours, you have the right to a lawyer and a qualified interpreter and a hearing before a judge. If you are unable to pay for the lawyer, then one will be provided to you free of charge.

If you have questions about your legal rights, you may contact the county Patients' Rights Advocate at _____ (phone number for the county Patients' Rights Advocacy office) _____ .

Your 72-hour period began _____ (date/time) _____ .

(2) If the notice is given in a county where weekends and holidays are excluded from the 72-hour period, the patient shall be informed of this fact.

(j) For each patient admitted for evaluation and treatment, the facility shall keep with the patient's medical record a record of the advisement given pursuant to subdivision (i), which shall include all of the following:

(1) The name of the person performing the advisement.

(2) The date of the advisement.

(3) Whether the advisement was completed.

(4) The language or modality used to communicate the advisement.

(5) If the advisement was not completed, a statement of good cause.

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SB 364 includes substantial amendments to Section 5150

SEC. 5. Section 5150 of the Welfare and Institutions Code is amended to read:

5150. (a) When a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services. At a minimum, assessment, as defined in Section 5150.4, and evaluation, as defined in subdivision (a) of Section 5008, shall be conducted and provided on an ongoing basis. Crisis intervention, as defined in subdivision (e) of Section 5008, may be provided concurrently with assessment, evaluation, or any other service.

(b) The professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county shall assess the person to determine whether he or she can be properly served without being detained. If in the judgment of the professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, the person can be properly served without being detained, he or she shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis. Nothing in this subdivision shall be interpreted to prevent a peace officer from delivering individuals to a designated facility for assessment under this section. Furthermore, the assessment requirement of this subdivision shall not be interpreted to require peace officers to perform any additional duties other than those specified in Sections 5150.1 and 5150.2.

(c) Whenever a person is evaluated by a professional person in charge of a facility designated by the county for evaluation or treatment, member of the attending staff, or professional person designated by the county and is found to be in need of mental health services, but is not admitted to the facility, all available alternative services provided pursuant to subdivision (b) shall be offered as determined by the county mental health director.

(d) If, in the judgment of the professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or the professional person designated by the county, the person cannot be properly served without being detained, the admitting facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, and stating that the peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county has probable cause to believe that the person is, as a result of a mental health 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 peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, the person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false.

(e) At the time a person is taken into custody for evaluation, or within a reasonable time thereafter, unless a responsible relative or the guardian or conservator of the person is in possession of the person's personal property, the person taking him or her into custody shall take reasonable precautions to preserve and safeguard the personal property in the possession of or on the premises occupied by the person. The person taking him or her into custody shall then furnish to the court a report generally describing the person's property so preserved and safeguarded and its disposition, in substantially the form set forth in Section 5211, except that if a responsible relative or the guardian or conservator of the person is in possession of the person's property, the report shall include only the name of the relative or guardian or conservator and the location of the property, whereupon responsibility of the person taking him or her into custody for that property shall terminate. As used in this section, "responsible relative" includes the spouse, parent, adult child, domestic partner, grandparent, grandchild, or adult brother or sister of the person.

(f) (1) Each person, at the time he or she is first taken into custody under this section, shall be provided, by the person who takes him or her into custody, the following information orally in a language or modality accessible to the person. If the person cannot understand an oral advisement, the information shall be provided in writing. The information shall be in substantially the following form:

My name is .

I am a _____ (peace officer/mental health professional) _____ .

with _____ (name of agency) _____ .

You are not under criminal arrest, but I am taking you for an examination by mental health professionals at .

_____ (name of facility) _____

You will be told your rights by the mental health staff.

(2) If taken into custody at his or her own residence, the person shall also be provided the following information:

You may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken.

(g) The designated facility shall keep, for each patient evaluated, a record of the advisement given pursuant to subdivision (f) which shall include all of the following:

(1) The name of the person detained for evaluation.

(2) The name and position of the peace officer or mental health professional taking the person into custody.

(3) The date the advisement was completed.

(4) Whether the advisement was completed.

(5) The language or modality used to give the advisement.

(6) If the advisement was not completed, a statement of good cause, as defined by regulations of the State Department of Health Care Services.

(h) (1) Each person admitted to a facility designated by the county for evaluation and treatment shall be given the following information by admission staff of the facility. The information shall be given orally and in writing and in a language or modality accessible to the person. The written information shall be available to the person in English and in the language that is the person's primary means of communication. Accommodations for other disabilities that may affect communication shall also be provided. The information shall be in substantially the following form:

My name is .

My position here is .

You are being placed into this psychiatric facility because it is our professional opinion that, as a result of a mental health disorder, you are likely to (check applicable):

☐ *Harm yourself.*

☐ *Harm someone else.*

☐ *Be unable to take care of your own food, clothing, and housing needs.*

We believe this is true because

(list of the facts upon which the allegation of dangerous

or gravely disabled due to mental health disorder is based, including pertinent

facts arising from the admission interview).

You will be held for a period up to 72 hours. During the 72 hours you may also be transferred to another facility. You may request to be evaluated or treated at a facility of your choice. You may request to be evaluated or treated by a mental health professional of your choice. We cannot guarantee the facility or mental health professional you choose will be available, but we will honor your choice if we can.

During these 72 hours you will be evaluated by the facility staff, and you may be given treatment, including medications. It is possible for you to be released before the end of the 72 hours. But if the staff decides that you need continued treatment you can be held for a longer period of time. If you are held longer than 72 hours, you have the right to a lawyer and a qualified interpreter and a hearing before a judge. If you are unable to pay for the lawyer, then one will be provided to you free of charge.

If you have questions about your legal rights, you may contact the county Patients' Rights Advocate at _____ (phone number for the county Patients' Rights Advocacy office) _____ .

Your 72-hour period began _____ (date/time) _____ .

(2) If the notice is given in a county where weekends and holidays are excluded from the 72-hour period, the patient shall be informed of this fact.

(i) For each patient admitted for evaluation and treatment, the facility shall keep with the patient's medical record a record of the advisement given pursuant to subdivision (h), which shall include all of the following:

(1) The name of the person performing the advisement.

(2) The date of the advisement.

(3) Whether the advisement was completed.

(4) The language or modality used to communicate the advisement.

(5) If the advisement was not completed, a statement of good cause.

SEC. 6. Section 5150.3 of the Welfare and Institutions Code is repealed.

SEC. 7. Section 5151 of the Welfare and Institutions Code is amended to read:

5151. If the facility designated by the county for evaluation and treatment admits the person, it may detain him or her for evaluation and treatment for a period not to exceed 72 hours. Saturdays, Sundays, and holidays may be excluded from the period if the State Department of Health Care Services certifies for each facility that evaluation and treatment services cannot reasonably be made available on those days. The certification by the department is subject to renewal every two years. The department shall adopt regulations defining criteria for determining whether a facility can reasonably be expected to make evaluation and treatment services available on Saturdays, Sundays, and holidays.

Prior to admitting a person to the facility for treatment and evaluation pursuant to Section 5150, the professional person in charge of the facility or his or her designee shall assess the individual in person to determine the appropriateness of the involuntary detention.

Involuntary Detention of Patients: An Understandable Overview of the Lanterman, Petris, Short Act

THE LANTERMAN, PETRIS, SHORT (LPS) ACT SPECIFIES THE CONDITIONS UNDER WHICH A PERSON MAY BE INVOLUNTARILY HOSPITALIZED AND THE RIGHTS AFFORDED A PERSON FOR WHOM INVOLUNTARY HOSPITALIZATION IS SOUGHT. PURSUANT TO THE LPS ACT, AN INDIVIDUAL MAY BE INVOLUNTARILY HOSPITALIZED FOR DEFINED PERIODS OF TIME IF THE INDIVIDUAL MEETS THE APPROPRIATE COMMITMENT CRITERIA. THE LEGAL CRITERIA FOR A PERSON TO BE INVOLUNTARILY DETAINED AND TREATED IS "PROBABLE CAUSE TO BELIEVE THE PERSON IS, DUE TO A MENTAL DISORDER, A DANGER TO HIM/HERSELF, A DANGER TO OTHER PEOPLE, OR GRAVELY DISABLED. "GRAVELY DISABLED," MEANS A CONDITION IN WHICH A PERSON, AS A RESULT OF A MENTAL DISORDER, IS UNABLE TO PROVIDE FOR HIS OR HER BASIC NEEDS FOR FOOD, CLOTHING OR SHELTER. THE DEFINED PERIODS OF TIME INCLUDE AN INITIAL SEVENTY-TWO HOUR HOLD FOR EVALUATION AND TREATMENT; A FOURTEEN DAY CERTIFICATION FOR INTENSIVE TREATMENT; AN ADDITIONAL FOURTEEN DAY CERTIFICATION FOR INTENSIVE TREATMENT FOR SUICIDAL PERSONS; AND A THIRTY DAY HOLD FOR ADDITIONAL INTENSIVE TREATMENT FOR GRAVELY DISABLED PERSONS. IN ADDITION, A PERSON WHO IS GRAVELY DISABLED MAY BE PLACED UNDER A CONSERVATORSHIP FOR UP TO ONE YEAR. THIS SECTION OUTLINES THE PROCESS BY WHICH AN INDIVIDUAL MAY BE INVOLUNTARILY HOSPITALIZED PURSUANT TO EACH OF THOSE TIME LINES. FURTHERMORE, SOME OF THESE COMMITMENT LAWS ALLOW FOR A PERSON TO BE TREATED IN THE COMMUNITY, OUTSIDE OF A LOCKED HOSPITAL SETTING.

(The following summary was a product of the Research Committee of the State Coalition that examined the need for change to the Lanterman, Petris, Short (LPS) Act. This project was jointly sponsored by the State Department of Mental Health, California Association of Local Mental Health Boards, Mental Health Planning Council, California Mental Health Director's Association, and the California Institute for Mental Health. This summary was printed in a position statement of the California Association of Social Rehabilitation Agencies (CASRA), 1999, and is being reprinted here because it is a useful resource for therapists to have a better understanding of how the state system functions with regard to the involuntary detention of patients. Our thanks to CASRA for allowing the reprinting of this helpful information.)

Seventy-Two Hour Hold

Involuntary hospitalization generally begins with a seventy-two hour hold for evaluation and treatment. The law allows a peace officer, a professional person designated by the county, a designated member of the attending staff of a designated LPS treatment and evaluation facility, or a designated member of a mobile crisis team to initiate a seventy-two hour hold. Each of these individuals is authorized to cause an individual to be taken to a designated evaluation and treatment facility when he/she has probable cause to believe that the individual meets the involuntary commitment criteria above. Probable cause may be based on the accounts of someone other than one of the authorized persons (e.g., a friend or family member), but that other person may be held civilly liable for giving an intentionally false statement. A written application completed by the authorized person must accompany the individual who is being taken to the designated evaluation and treatment facility which includes the circumstances under which the individual's condition was called to the attention of the authorized person; the specific criterion the individual is believed to meet as a result of a mental disorder; the facts, stated with sufficient detail, to warrant the belief that the individual meets this criteria; and the time and date the seventy-two hour hold was initiated. If the professional person evaluating the person determines that the individual could be properly served without being admitted to the hospital, the facility shall provide appropriate evaluation, crisis intervention, or other outpatient services to the individual on a voluntary basis. If the professional person determines that the individual requires hospitalization, the person being detained must be offered the option to receive that treatment voluntarily, prior to being involuntarily treated. At the expiration of the seventy-two hour hold, the individual must be either released, continue to be treated on a voluntary basis, or certified for fourteen days of intensive treatment.

Fourteen Day Certification for Intensive Treatment

An individual who has been held on a seventy-two hour detention may be held for an additional fourteen days of intensive treatment if the professional staff of the designated facility has found that, due to a mental disorder, the individual is a danger to him or herself, a danger to others, or gravely disabled and the person has been advised of the need for treatment, but has not been willing or able to accept it on a voluntary basis. Two individuals must sign the notice of certification. The first signatory may be the professional person in charge of the facility or a physician or licensed psychologist who has been designated by the professional person. The second signatory may be a physician or a licensed psychologist who has participated in the evaluation. If the first signatory is the physician or licensed psychologist who participated in the evaluation, the second signatory may be another physician or psychologist or, if one is not available, a licensed clinical social worker or registered nurse who participated in the evaluation. The individual being certified for fourteen days has a right to a certification review, a judicial hearing, and the assistance of a patients' rights advocate or an attorney. The individual may not be detained on an involuntary basis once he or she no longer meets the involuntary detention criteria. At the conclusion of the fourteen day period, a patient must be released; remain in the hospital voluntarily; be placed on an additional fourteen day detention for suicidal persons; placed on a one hundred eight day detention for demonstrably dangerous persons; or placed in an LPS conservatorship.

Additional Intensive Treatment of Suicidal Persons

At the expiration of the fourteen-day certification an individual may be detained for a maximum of fourteen additional calendar days only if the individual, as a result of a mental disorder, either threatened or attempted to commit suicide during the seventy-two hour or fourteen day certification period or was detained originally for that reason; the individual continues to present an imminent threat of suicide; and the person has been advised of, but has not accepted voluntary treatment. Two people must sign a notice of certification in the same manner the first notice of certification was signed. The individual does not have a right to a certification review hearing but can request a judicial hearing (a "writ of habeas corpus") at any time during the detention period.

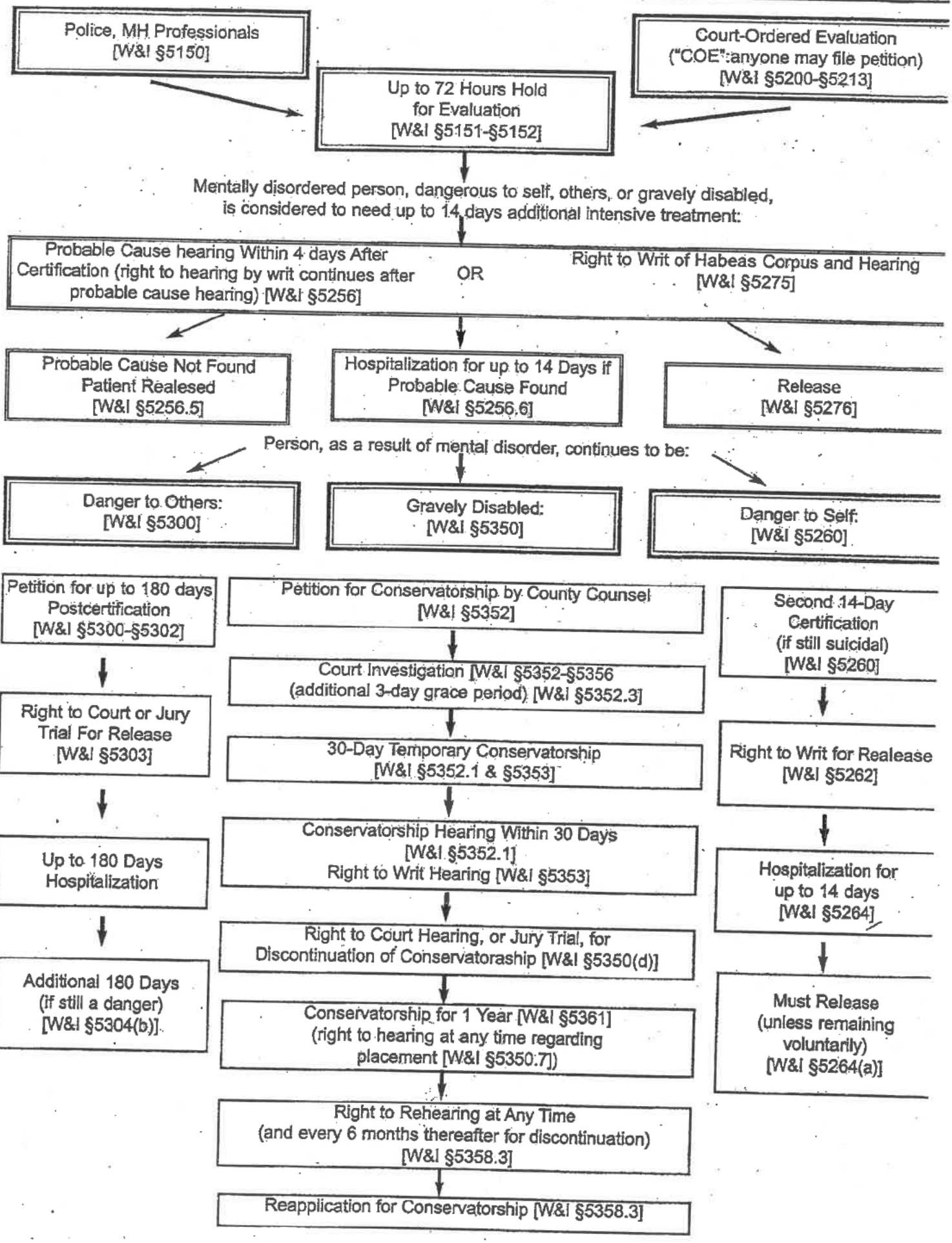
Additional Thirty Day Hold for Grave Disability

Upon the completion of a fourteen day certification for intensive treatment, an individual may be held for an additional thirty days if the mental health professional staff treating the person finds that the person remains gravely disabled and unwilling or unable to accept treatment voluntarily. A second notice of certification is required. The individual being certified has a right to a certification review hearing and to request a superior court judicial review (e.g., writ of habeas corpus). The person certified may be released before the end of thirty days if the psychiatrist directly responsible for the person's treatment believes the person no longer meets the criteria for the certification or is prepared to accept voluntary treatment in an outpatient or inpatient setting. The individual certified must be released at the end of thirty days unless the patient agrees to remain in the facility on a voluntary basis, is the subject of conservatorship petition, or is the subject of a petition for an one hundred eighty day post-certification for imminently dangerous persons.

Additional One Hundred Eighty Day Detention for Dangerous Persons

At the end of the fourteen day certification, an individual may be detained for up to one hundred eighty days of additional treatment if the person, because of a mental dis-

INVOLUNTARY DETENTION OF PATIENTS



order, presents a demonstrated danger or substantial physical harm to [illegible] and has:

- Attempted, inflicted or made a serious threat of harm to another after having been taken into custody for evaluation or treament; or

- Been taken into custody for evaluation or treatment; or

- Made a serious threat of substantial physical harm to another within seven days of being taken into custody.

A petition must be filed during the fourteen day certification for intensive treatment by the district attorney (or county counsel). The individual for whom post-certification is being sought must have a judicial hearing within four days and shall be represented by an attorney. Alternatively, the person detained can demand a jury trial. The individual shall continue t[illegible]treated in the intensive treatm[illegible]acility until released by court order, unless the petition for post-certification treatment is withdrawn. If no decision has been made within thirty days after the filing of the petition, not including extensions of time requested by the individual's attorney, the person shall be released.

A person who has been committed for up to one hundred eighty days may be treated on an outpatient basis if, in the opinion of the professional person in charge of the licensed facility, the person named in the petition will no longer be a danger to the health and safety of others while on outpatient status and will benefit from outpatient status. The county mental health director must advise the court that the individual will benefit from outpatient status and identify an appropriate program of supervision and treatment. The county mental health director, or d[illegible]ee, shall be the outpatient su[illegible]isor of persons placed on outpatient status. If at any time during the outpatient period, the outpatient treatment supervisor is of the opinion that the individual receiving treatment requires extended inpatient treatment or refuses to accept further outpatient treatment and supervision, the county mental health director shall notify the superior court by written request for revocation of outpatient status. The district attorney (or county counsel) may also submit a request to the superior court to revoke the individual's outpatient status if the individual is a danger to the health and safety of others while on outpatient status. The court shall hold a hearing within fifteen days to determine if the individual's outpatient status is to be revoked. The individual may be placed in a designated treatment facility pending the court's decision on revocation if the mental health director believes the individual presents a danger to self or others while on outpatient status and that delaying hospitalization would pose a demonstrated danger of harm to the person or others. The court shall approve or deny the request for revocation. If the court approves the request, the individual shall be admitted to a county designated or state hospital.

LPS Conservatorship
Petition for Temporary Conservatorship

In addition to being involuntarily hospitalized pursuant to the preceding criteria, an individual may also be placed under a conservatorship through the LPS Act. An individual may be placed on an LPS conservatorship if he or she is gravely disabled. An LPS conservatorship involves a protective relationship in which a person is appointed by the court to act in the best interest of a gravely disabled individual to ensure that the basic needs for food, clothing, and shelter are met, and that if required, the individual receives needed psychiatric care and treatment. The professional person in charge of an agency providing comprehensive evaluation or intensive treatment may recommend conservatorship if he or she determines that a person is gravely disabled due to a mental disorder and is unable or unwilling to accept treatment voluntarily. The court officer providing conservatorship investigation must file a petition with the superior court to establish a temporary conservatorship if the investigator agrees that the person meets the criteria for establishing a conservatorship. A temporary conservatorship usually lasts for thirty days unless a jury trial is requested. The court makes its determination based on the written reports alone, without a hearing. The officer providing conservatorship investigation acts as the temporary conservator and uses the thirty days to investigate the individual's condition, resources, and potential permanent conservator.

Permanent Conservatorship

A permanent conservatorship lasts one year and is renewable if the appropriate criteria are met and legal procedures followed. Before a permanent conservatorship may be established, a trial by judge or jury trial must be held to determine that the individual is in fact gravely disabled due to a mental disorder, and unwilling or unable to accept treatment on a voluntary basis. The specific powers granted to the conservator are set forth in the court order. The court may remove from the person on conservatorship the following rights:

To possess a driver's license;
To enter into contracts;
To vote;
To refuse or consent to mental health treatment;
To refuse or consent to medical treatment for an existing condition;
To possess firearms;
To make medical treatment decisions.

The court must determine the least restrictive and most appropriate placement for the person on conservatorship. The conservator authorizes the placement of the person in the appropriate setting in the community and can also consent to the hospitalization of the person for psychiatric treatment at any time. Persons subject to a conservatorship may petition the court at any time during the conservatorship

to contest certain rights denied to them or powers granted to the conservator. However, once the person has had this hearing, the person cannot have another such hearing for six months. When progress under the treatment plan reveals that the person is no longer gravely disabled, the conservator shall notify the court, which will then terminate the conservatorship.

This article is intended to provide guidelines for addressing difficult legal dilemmas. It is not intended to address every situation that could potentially arise, nor is it intended to be a substitute for independent legal advice or consultation. When using such information as a guide, be aware that laws, regulations and technical standards change over time, and thus one should verify and update any references or information contained herein.

UNIT 7
INVOLUNTARY HOSPITALIZATION STANDARDS

There are times when an inmate's behavior presents major concerns in the jail. You may be convinced that the inmate needs psychiatric hospitalization even if he or she does not want to be hospitalized. The law defines the conditions which must be met before a person can be hospitalized against his or her will. California's revised statute on involuntary treatment is the Welfare and Institutions Code Sections 5150 to 5350. In California, there are three conditions which must be present in order to involuntarily treat an individual:

1. *The person must be mentally ill.* In order to be considered mentally ill, a person must have a true psychiatric problem and not just seem odd or be acting out. A good example would be someone who is hearing voices, talking to God, and not sleeping. Persons who are merely drunk and babbling are not considered mentally ill. In some cases of alcohol, drug intoxication or withdrawal, a person may seem to be psychotic. (See Delirium Tremens in ALCOHOL EMERGENCIES)

2. *The person must be dangerous to self or others, or gravely disabled because of mental illness.* This means the person must be threatening homicide, making serious suicidal threats, or be unable to provide for his own food, shelter, or clothing. (In the jail environment, someone may be gravely disabled if seriously impaired in judgment and unable to fend for themselves). Merely appearing different or "mentally ill" will not be reason enough to commit someone. The person must be mentally ill and, because of that illness, be seen as clearly dangerous or gravely disabled.

3. *The person cannot be treated anywhere but in a hospital setting.* If it is possible to voluntarily medicate or counsel an inmate in the jail setting (as well as provide safe housing), and to treat him or her there, then the person should not be hospitalized. Hospitalization should be considered as a last resort.

Penal Code Section 4011.6 allows for the involuntary transfer of a jail inmate to a county-designated 72-hour treatment and evaluation facility upon the order of a judge or person in charge of the jail (watch commander, etc.) To make such an order, the county judge or person in charge of the jail must have probable cause to believe that the prisoner is a danger to himself or herself, to others, or is gravely disabled as a result of mental illness. The Jail Psychiatric Services clinicians provide services inside the jail which allow for the evaluation of the inmate prior to transfer to a psychiatric hospital.

CALIFORNIA WELFARE & INSTITUTIONS CODES

W&I 5003 Personal right to seek voluntary treatment.

W&I 5150 Provides for 72 hour evaluation and treatment when a person is a danger to self or others, or is gravely disabled.

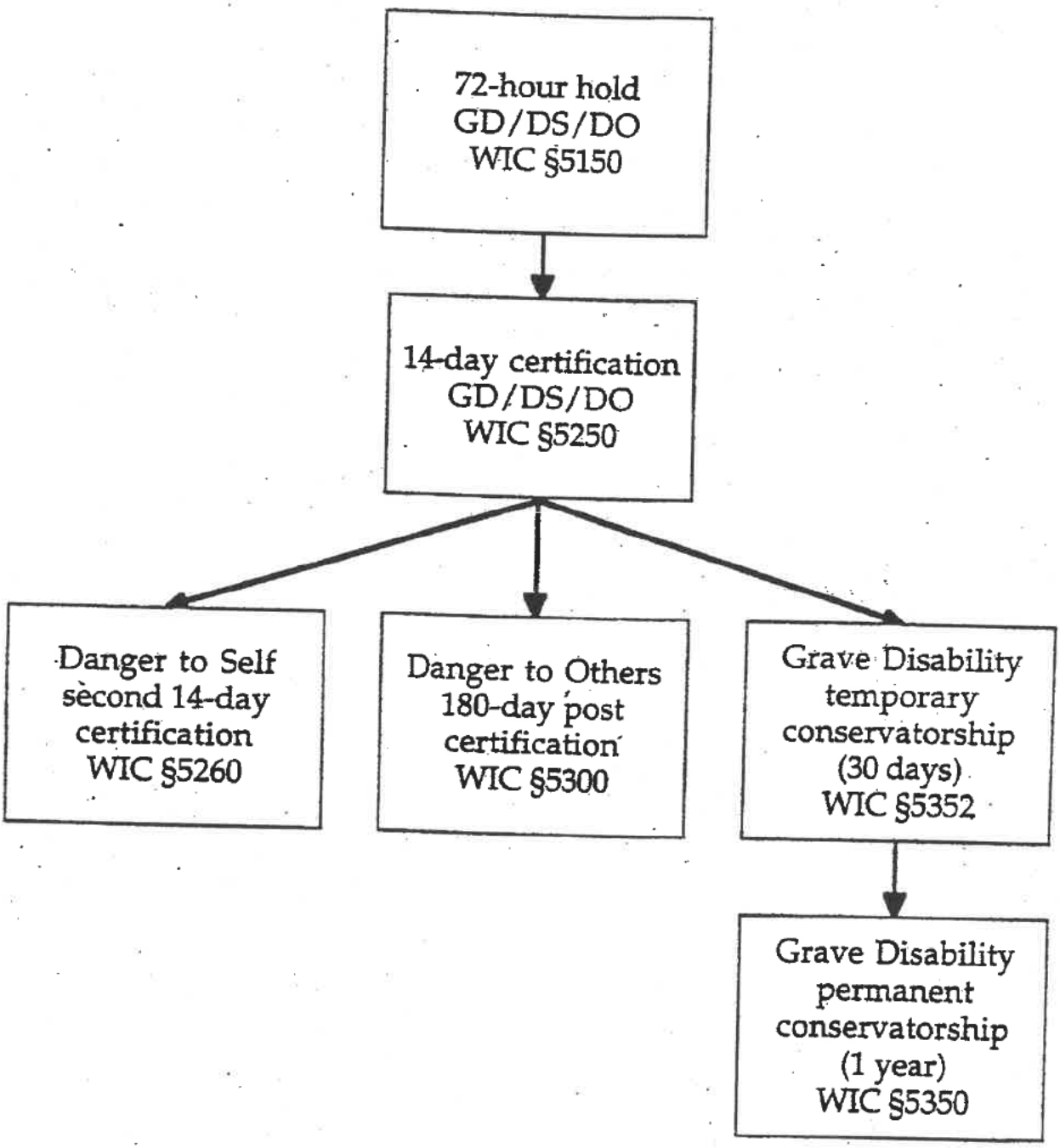
W&I 5152 Establishes basic procedures for patients being treated, including the right to be told of mental condition and effects of medication.

W&I 5250 14-day hold following 5150 hold.

W&I 5260 Suicidal persons can be extended to 14 days for intensive treatment.

W&I 5300 Imminently dangerous person can be held for 180 days.

CIVIL COMMITMENT
FLOW CHART



COMMON CHARGES

32 PC	FEL	HARBORING A FUGITIVE	
118	FEL	PERJURY	
146	MISD	IMPERSONATING POLICEMAN	
148	MISD	RESISTING ARREST	
182	FEL	CONSPIRACY	
187	FEL	MURDER	
192	FEL	MANSLAUGHTER	
203	FEL	MAYHEM	
207	FEL	KIDNAPPING	
211	FEL	ROBBERY	
217	FEL	ASSAULT/INTENT TO MURDER	
220	FEL	ASSAULT/INTENT TO RAPE, SODOMY, MAYHEM, ROBBERY	
240	MISD	ASSAULT	
242	MISD	BATTERY	
243	FEL	BATTERY AGAINST POLICEMAN	
245	FEL	AGGRAVATED ASSAULT-WEAPON	
245b	FEL	AGGRAVATED ASSAULT-POLICE	
246	FEL	FIRING AT A BUILDING	
261.1	FEL	STATUTORY RAPE	
261.3	FEL	FORCIBLE RAPE	
266	FEL	PIMPING	
270	MISD	CHILD NON-SUPPORT	
273.5	FEL	DOMESTIC VIOLENCE	
273.d	FEL	WIFE OR CHILD BEATING	
286	FEL	SODOMY	
288	FEL	LEWD ACT WITH A CHILD	
288a	FEL	ORAL COPULATION	
290	MISD	FAILURE TO REGIS. SEX OFFEND.	
311.6	MISD	OBSCENE LANGUAGE	
314.1	MISD	INDECENT EXPOSURE	
315	MISD	KEEPER OF BROTHEL	
316	MISD	KEEPER OF DISORDERLY HOUSE	
318	MISD	INVITING TO HOUSE OF PROST.	
330	MISD	GAMBLING	
337a	MISD	BOOKMAKING	
404.6	MISD	INCITING TO RIOT	
407	MISD	UNLAWFUL ASSEMBLY	
409	MISD	FAILURE TO DISPURSE	
415	MISD	DISTURBING THE PEACE	
417	MISD	POINTING A WEAPON	
447a	FEL	ARSON	
459	FEL	BURGLARY	
466	MISD	POSSESSION BURLARY TOOLS	
470	FEL	FORGERY	
475	FEL	POSSESSION FORGED CHECKS	
476a	FEL	CHECK FRAUD-OVER $100	
484a	FEL	USE OF STOLEN CREDIT CARD	
484e	MISD	CREDIT CARD THEFT	
484f	FEL	CREDIT CARD FORGERY	
487	FEL	GRAND THEFT	
488	MISD	PETTY THEFT	
496	FEL	RECEIVING STOLEN PROPERTY	
537	MISD	DEFRAUDING AN INNKEEPER	
594	MISD	MALICIOUS MISCHIEF	
602	MISD	TRESPASSING	
646.9		STALKING, THREATENING	
647a	MISD	SOLICITING LEWD ACT-CHILD	
647b	MISD	PROSTITUTION	
647f	MISD	DRUNK/UNDER THE INFLUENCE	
647g	MISD	PEEPING TOM	
650.5	MISD	IMPERSONATING OPPOSITE SEX	
653g	MISD	LOITERING AT SCHOOL	
659	MISD	AIDING IN MISDEMEANOR	
666	FEL	PETTY THEFT W/ A PRIOR	
12020	FEL	ILLEGAL POSSESSION WEAPON	
12021	FEL	EX-CON WITH A GUN	
12025	MISD	CONCEALED WEAPON	
12031	MISD	LOADED GUN	
1140 MPC	MISD	DEFRAUDING CAB DRIVER	
1291 MPC	MISD	CARRYING KNIFE	
11483 W&I	FEL	WELFARE FRAUD	
11054 W&I	MISD	WELFARE-FALSE APPLICATION	
4143a B&P	MISD	POSSESSION NEEDLE, HYPO	
4390 B&P	FEL	FORGERY OF PRESCRIPTION	

NARCOTICS: HEROIN, COCAINE, MORPHINE

11350	H&S	FEL	POSSESSION
11351	H&S	FEL	POSSESSION FOR SALE
11352	H&S	FEL	SALES
11353	H&S	FEL	ADULT-INFLUENCING MINOR
11354	H&S	FEL	MINOR-INFLUENCING MINOR
11355	H&S	FEL	SUBSTITUTION/FRAUD

MARIJUANA

11357	H&S	FEL	POSSESSION
11358	H&S	FEL	CULTIVATION
11359	H&S	FEL	POSSESSION FOR SALE
11360	H&S	FEL	SALES
11361	H&S	FEL	ADULT INFLUENCE OF MINOR

AMPHETAMINES, LSD

11350	H&S	FEL	POSSESSION
11351	H&S	FEL	POSSESSION FOR SALE
11352	H&S	FEL	SALES
11353	H&S	FEL	ADULT INFLUENCE OF MINOR
11355	H&S	FEL	FUBSTITUTION/FRAUD

BARBITURATES

11377	H&S	FEL	POSSESSION
11378	H&S	FEL	POSSESSION FOR SALE
11379	H&S	FEL	SALES
11380	H&S	FEL	ADULT INFLUENCE OF MINOR
11382	H&S	FEL	SUBSTITUTION/FRAUD

MISCELLANEOUS

11364	H&S	MISD	PARAPHERNALIA
11365	H&S	MISD	VISITING WHERE NARCOTICS USED
11366	H&S	FEL	LIVING WHERE NARCOTICS USED
11368	H&S	FEL	FORGERY OF PRESCRIPTION
11550	H&S	MISD	ADDICT UNDER THE INFLUENCE
4463	VC	MISD	FALSE REGISTRATION
10851	VC	FEL	AUTO THEFT
10852	VC	MISD	AUTO TAMPERING
12951	VC	MISD	DRIVING WITHOUT LICENSE
14601	VC	MISD	DRIVING WITH REVOKED LICENSE
20001	VC	FEL	HIT AND RUN W/INJURY
20002	VC	MISD	HIT AND RUN W/DAMAGE
23101	VC	FEL	DRUNK DRIVING W/ACCIDENT

Episode Opening

Client Number: (PSP#) RU: [redacted]

Street No.: Direction: Name: Type: Apt:
City: State: Zip Code: 00000+0000
Ph #: ( ) -

Opening Date: / / Referral From: [redacted] Legal: [redacted] Trauma: [redacted]

Initial Diagnostic Impression

Axis 1: [redacted] Axis 2: [redacted] Axis 3: [redacted] Axis 4: [redacted] Axis 5: [redacted] Past: [redacted]
Axis 1: Axis 2: Axis 3: Substance Abuse/Dependence
ICD10 Primary: Axis 3: Issue: [redacted] Diagnosis:

Clinician ID: (YOUR #) Living Situation: [redacted] Admission Hour: [redacted] Scheduled: N
Physician ID: Employment Status: Legal Consent: DNR: N
Source of Income: [redacted] Type of Employment: Research Item:

Patient Location: Effective: / /

Form Ok Y/N: Confidential Information USER:

Enter a client and reporting unit.

Alcohol Intoxication and Withdrawal

Jennifer Chaffin, MD
Criminal Justice Mental Health

Outline

- Review signs/sx of ETOH Intoxication
- Review signs/sx of ETOH Withdrawal and complications
- Case Example
  - Why do we bother asking about etoh?

Alcohol Intoxication

- 10% of US adults abuse ETOH
- Peak levels reached 30-90 min on empty stomach
- Legal intoxication= 80mg/dL (0.08)
- Blood levels are higher than breathalyzer

Alcohol Intoxication

- Sx:
  - Slurred speech
  - Nystagmus (bouncing eyes)
  - Disinhibtion
  - Unsteady gait
  - Memory impairment
  - Stupor or Coma
  - Hypotension and tachycardia
  - Metabolic derangements

Alcohol Intoxication

- BAC Levels:
  - 0.01 to 0.10: euphoria, mild ↓in coordination, attention and cognition
  - 0.10 to 0.20: ↓↓ coordination and psychomotor skills, decreased attention, ataxia, ↓judgment, slurred speech, mood variability
  - 0.20 to 0.30: incoherence; confusion, N/V
  - >0.30: stupor and LOC/coma, ↓respiration, possible death

Alcohol Intoxication

- May be antagonized or augmented by other substances (stimulants, sedatives)
- Can result in agitation, violence (including ↑ risk of suicide), and poor cooperation
- Treatment: usually supportive, but may require medical intervention and close monitoring

Alcohol Withdrawal

Alcohol Withdrawal

- ~50% of etoh-dependent pts have clinically significant sx of withdrawal
- Characterized by CNS hyperactivity upon decrease or cessation of ETOH use
  - Autonomic Hyperactivity (HR, BP)
  - Gastro-intestinal Hyperactivity
  - Cognitive and Perceptual changes

Alcohol Withdrawal

- Starts w/in 6-24 hours after last drink or significant decrease (may start while still intoxicated in heavy, long-term alcoholics)
- May be short-lived (<5 days) and require minimal or no medical intervention, or may be severe and require hospitalization, with severity increasing over the first 48-72 hours of abstinence
- Psychological sx can last for weeks to months: dysphoria, sleep disturbance, and anxiety

Alcohol Withdrawal

	Autonomic Hyperactivity	Gastrointestinal Features	Cognitive and Perceptual Changes
Uncomplicated Withdrawal	Sweating Tachycardia Hypertension Tremor Elevated Temp.	Anorexia Nausea Vomiting Dyspepsia Diarrhea	Poor Concentration Anxiety Psychomotor agitation Disturbed sleep, vivid dreams
Severe Withdrawal Complications	Dehydration and electrolyte disturbances		Seizures Hallucinations (visual, tactile, auditory) Delirium

Severe Withdrawal Complications

- Seizures (tonic-clonic):
  - Occur 6-48 hours after last drink, even if the BAC is high, in severely dependent drinkers
  - Occur in 2-9% of alcoholics
  - Increase chances of subsequent W/D seizures -13-24% within 6-12 hours if untreated

Severe Withdrawal Complications

- Delirium Tremens
  - Disturbance of consciousness (disorientation) and changes in cognition or perceptual disturbance (hallucinations)
  - Occurs in 5% of alcoholics who are un-medicated during withdrawal
  - Mortality rate 15% if untreated, 1% with aggressive treatment
  - Usually occurs 48-96 hours after the last drink, but may occur up to 7 days after
  - Usually lasts 2-3 days, but can last longer

Severe Withdrawal Complications

- Hallucinations
  - Can occur at any stage of etoh withdrawal
  - Usually w/in first 24 hours and last up to 3 days
  - Transient VH or TH (often bugs) occur in 3-10% of patients in severe withdrawal (no prognostic significance), AH may be accusatory
  - Some patients also experience paranoia, psychomotor disturbances, abnormal affect or other delusions
  - Differentiated from DTs by a clear sensorium and may not have autonomic instability

Predictors of Withdrawal Severity

- Current drinking pattern
  - Quantity, frequency, duration (>6yrs=15x risk)
- Past withdrawal experience
- Additional substance use
  - Benzos*, opiates, stimulants
- Medical conditions (seizures, heart issues)
- Psychiatric Conditions (psychotic disorders)

Case Example

- 49 yo male, arrested 11/15/13 for violation of a restraining order (M)
- Completed Corizon intake: alert, oriented, NAD, endorsed occasionally drinking beer-last 2 bottles, 2 days ago, denied drugs, HTN (on meds), hx of seizures (<1/mo, last 1-6mos ago), hx of hemoptysis/stomach ulcers, NO mental health history (self-reported or PSP), no referral made, no CIWA started
- Vitals @ 2024: T 97.8, HR 87, RR 18, BP 156/95

Case Example

- 11/16/13 @ 0145-
  - In holding cell, breathing fast, eyes "squeezed" closed, not responding to his name, gait unsteady, nose bleeding, "no nuerological issues noted", "Not cooperating with nurse (just holding down his head)"
  - Vitals: T 97.9, HR 94, RR 20, BP 120/84

Case Example

- 11/16/13 @ 0300- "Started Flipping Out" in Mainline, reclassed "Mental", not following directions, attempted to charge/run past deputies when cell door was opened, then tied clothes in knots and soaked them to make weapons; told deputy, "I'm already dead so it doesn't matter if I take some of you with me." Safety cell started-cell extraction necessary, attempting to fight deputies
- Vitals: T 98.9, HR 110, RR 18, BP 136/84

Case Example

- 11/16/13
  - @0430-not responding to name
  - @0815 (CJMH)-unkempt, hid in corner, uncoop
  - @1401- "I'm okay, Nurse." Aox3, refused vitals
  - @1530: "I'm okay, I'm in the church, I don't feel like hurting myself"; alert, not oriented to place or time, refused vitals, took meds (for HTN)
  - @2030-NAD, refused fluids and vitals

Case Example

- 11/17/13
  - @0330-not oriented; T 97, BP 110/60, HR 99
  - @830-Calm, refused vitals, no complaints
  - @1000 (CJMH): not oriented to time, place or situation, delusional re: deputies knowing him, "appears to have A/H, V/H and is extremely confused"; "Client has no PSP hx and made it through ITR without being flagged. Dep. Stated he decompensated. R/O dementia? Continue S/C-ITR assess 11/18/13"

Case Example

-11/17/13 @1530 and 2130-agitated, naked, non-stop talking and walking

--11/18/13@0300- "I hear voices", naked, refused vitals

-@0900-seen by CJMH, to be 5150'd

-@1224- "Inmate is disoriented," refused vitals-needs to go to HACH for clearance

Case Example

- 11/18/13 @0900-CJMH
  - "Clt is a 49y/o AA male, in custody since 11/15/2013 and has been psychotic and suicidal since incarceration. Clt has no prior mental health hx with ALCO. On 11/17/13 Clt was endorsing suicidal ideations and has a plan and means: i.e., tieing up clothes and using as a weapon. Clt has since decompensated more and is mumbling to self. Clt is psychotic and delusional and not oriented x 3. Clt unresponsive to writer. On 11/17/13, Clt attacked a Deputy; and ran out of cell needing containment. Clt internally preoccupied, has bizarre movements, psychotic and disoriented. Clt 'picking his buttocks' and smearing feces on walls and playing with feces. Writer recommending 5150 to JGP for stabilization."

Case Example

- 11/18/13-at HACH
  - "49 yo man w hx of etoh abuse, cad, pancreatitis, seizure dz with AMS x 1 day (but possibly w hallucinations for 2 weeks per patient but unreliable hx) +tremulousness (tongue, finger) w stable vss w unclear hx of last drink"
  - Labs: anemia, hypokalemia, hypernatremia, grossly elevated LFTs (AST>ALT), no BAC, CT head-negative
  - Tx: Banana bag, MVI, phenobarbital
  - Dx'd with Delirium (Tremens) and returned to OPHU

Case Example

- 11/18/13 @2200-Returned to OPHU, (housed there and detoxed until 11/20, when he was released from court), BP eventually normalized to 112/93 with HR of 74, sensorium cleared
- 11/19/13 @0900-seen by CJMH- "feeling much better", oriented x 3, denied AH/SI, denied outpt services, "reports that he has been addicted to ETOH for 15 years, a pint and one half per day."

Conclusions

- Patients aren't always honest or entirely forthcoming, so we have to be good detectives in order to help them
- ETOH can be deadly in both intoxication and withdrawal
- Severe ETOH withdrawal is a medical emergency!
- Hxof ETOH-use patterns and past withdrawal hx helps ID persons at risk for severe withdrawal, and ensures proper treatment, which may be lifesaving
- ALWAYS keep ETOH-withdrawal in your differential for acute psychosis-especially in someone with no psychiatric history
- Don't forget that inmates can still get ETOH in custody, so withdrawal can occur at anytime

use in your differential
ETOH of

ASSESSMENT OF MALINGERING
PART ONE
Clinical Evaluation of Malingered Psychosis

Charles L. Scott, MD

I. DEFINITIONS

A. The word malingering derives from the Latin word "*malum*" that means bad or harmful, in this context refers to the bad intent of the offender's actions.

B. DSMIV definition-the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as:

a. avoiding military duty
b. avoiding work;
c. obtaining financial compensation
d. evading criminal prosecution
e. obtaining drugs

C. "Types" of malingering:

1. Simulation-feigning positive symptoms that do not exist

2. Dissimulation-the concealment of minimization of existing symptoms.

D. **Non deliberate distortions**

1. **Omission**-the non deliberate leaving out of information

2. **Confabulation**-the unintentional filling in of information with what the person believes to have happened, when, in fact, it did not happen at all.

E. **Deliberate distortions**-deception-presentations provided by individuals for the purposes of convincing others of a false reality.

1. Secrecy-deliberate omission

2. Lying-verbal statement denying the truth or making up a story

F. Factitious disorder: the voluntary production of symptoms to assume the "patient role" and is not otherwise understandable in view of the individuals environmental circumstances.

G. **Ganser's syndrome:**

1. **Approximate answers** (examples: 2+2=5, an elephant has 5 legs, etc). Approximate answers is the symptom that has been classified as pathognomonic of Ganser's syndrome;
   a. Clouding of consciousness;
   b. Somatic conversion (particularly sensory symptoms);
   c. Hallucinations.

2 The symptoms often follow a severe psychological stress, are of brief duration with subsequent amnesia for the episode.

2. Ganser's Syndrome has often been viewed as an inmate's attempt to exhibit their own generic concept or interpretation of mental illness without accurately having knowledge of the symptoms that are associated with mental illness.

3. Debate has ranged from the classification of Ganser's Syndrome as a type of Malingering, Fictitious Disorder, or Dissociative Disorder. Classified in the DSM-IV as Atypical Dissociative Disorder.

II. PREVALENCE

A. In a study of malingered mental illness in a metropolitan emergency department, 13% of patients were suspected or considered to be malingering.

B. In a survey of forensic mental health experts, approximately 17% of the individuals evaluated in forensic settings were assessed as malingering.

C. In a study of individuals referred for evaluation of insanity, more than 20% of the defendants received diagnoses of suspected or definite malingering.

III. PURPOSES OF MALINGERING

A. Common reasons to malinger outside of a correctional environment include:

1. Avoid punishment by pretending to be incompetent to stand trial, insane at the time of the act, worthy of mitigation of penalty, or too ill (incompetent) to be executed.

2. Malingerers may seek to avoid conscription into the military to be relived from undesirable military assignments, or avoid combat.

3. Malingers may seek financial gain from social security disability, veterans' benefits, workers' compensation, or damages for alleged psychological injury.

4. Malingers may seek admission to a psychiatric hospital as a haven from the police, or to obtain free room and board.

B. Commons reasons to malinger inside a correctional environment:

1. Avoid punishment by pretending to be incompetent to stand trial, insane at the time of the act, worthy of mitigation of penalty, or too ill (incompetent) to be executed.

2. Obtain medications to help with sleep/insomnia.

   Anecdotal reports from clinicians and staff estimate that as many of 30% of inmates seen in psychiatric services at the Los Angeles County Jail report malingered psychotic symptoms (typically endorsing "hearing voices" or ill-defined "paranoia.") in order to obtain quetiapine. In addition to oral administration, the drug is also taken intranasally by snorting pulverized tablets. The drug has been observed to have street value and is sometimes referred to as "Quell." (Pierre et al, September 2004)

3. Obtain medications to continue pattern of drug abuse.
4. Obtain medication as item to barter and trade.
5. Seek relief from frightening situation, such as threatening cell mate or other inmate.
6. Method to receive psychological assistance/evaluation.

IV. GENERAL ISSUES IN THE DETECTION OF MALINGERING

A. The better you understand the phenomenology of the genuine disease, the easier it will be to detect faked symptoms.

B. In deciding if a specific symptom is faked, you must look beyond general credibility issues.

C. Look for inconsistency in symptoms that suggests malingering. Types if inconsistencies include:

1. Inconsistency in what the person reports. For example, a malingerer may intelligently and clearly discuss his difficulty speaking and thinking.

2. Inconsistency in what the person reports and observed symptoms.

   Example: a malinger may state that they cannot sit in a chair without looking under it many times to see if anything is there even thought they do not demonstrate this behavior during the interview.

7. The range of stay was from 7 to 52 days with the average being 19 days72 to 5

B: Powell (1991)-compared 40 mental health facility employees instructed to malinger schizophrenic symptoms with 40 schizophrenic inpatients.

1. The principal measure was the Mini Mental State (MMS), measure of basic cognitive functioning. Malingerers showed exaggerated cognitive deficits.
2. Malingerers were significantly more likely than schizophrenics to give approximate answers on the MMS.
3. Malingerers reported a higher incidence of visual hallucinations, dramatic exaggerated visual hallucinations, and atypical content (not ordinary human beings)
4. Malingerers more often called attention to their delusions.

VI. MALINGERED VS. TRUE HALLUCINATIONS

A. It is important when assessing potentially malingered hallucinations, to begin with very open ended questions in reference to what the person reports experiencing. Individuals with genuine hallucinations more commonly can describe various details of their auditory hallucinations. Details can include:

1. Content
2. Clarity
3. Loudness
4. Vividness
5. Duration
6. Frequency
7. Continuous or intermittent
8. Single or multiple voices
9. Male or female
10. Inside or outside of the head
11. Tone of voice of hallucinations
12. Voices speak in second or third person
13. Insight into unreality of voices
14. Belief that others could hear voices
15. Relationship to person speaking
16. Associated hallucinations of other senses
17. Patient alone or with others
18. Converse back with the voices
19. Ability to put the voices out of m mind
20. Mood during hallucinations
21. Relationship to delusions

22. Concomitant confusion
23. Patient's reaction to the voices
24. Direction to do things from voices
25. Consequences for failure to obey
26. Effort not to obey voices
27. Alternative rational motive for the acts
28. What makes the better or worse
29. The number of voices

B. Be careful not to educate the evaluee regarding what exact signs and symptoms you are expecting to make an accurate diagnosis. Over time, the person can anticipate answers to give based on prior questioning. Some have called this education "Clinician Assisted Deception." use open ended questions

C. Phenomenology of Hallucinations

1. Hallucinations occur in 7-25% of normal people (Coleman, 1984)

2. Hallucinations are generally associated with delusions (88%) (Lewinsohn, 1970), but only 35% of patients with delusions have hallucinations.

3. In schizophrenia (Mott, Small, and Andersen, 1965):

   a. Auditory hallucinations-66%

   b. Visual hallucinations-33% (In non organic mental illness, visual hallucinations almost always occur along with other hallucinations) In color, normal size Content goes along with delusions

4. In manias, hallucinations occur as follows:

   a. Auditory hallucination -47%
   b. Visual hallucinations 23%-Visual hallucinations alone occur in approximately 7% of affective disorders

D. Auditory hallucinations

1. Auditory hallucinations are usually perceived as words or sentences heard by the patient or as remarks or comments concerning him.

2. Command hallucinations: Drug hallucinations - unformed noises

   a. Command hallucination instructions (Hellerstein, Frosch and Koenigsberg, 1987).

1) Suicide	52%
2) Non violent acts	14%

3) Injury to self or others	12%
4) Homicide	5%
5) Unspecified	17%

3. Commands are less likely to be obeyed if they are dangerous.

4. Commands are more likely to be obeyed if (Junginger, 1990): ≈ 40% Compliance

   a. There is a hallucination-related delusion.
   b. The voice is familiar

5. In a study of 100 consecutive patients with hallucinations (61%) were schizophrenic, detailed phenomenology was studied (Nayani and David, 1996)

   a. Internal vs. external hallucinations:

      49% of the sample heard the voices through their ears as external stimuli.

      38% heard them in internal space.

      12% heard them in both variably.

   b. The most common encountered hallucinated utterances were simple terms of abuse (60%)

      Female subjects described words of abuse conventionally directed at women (e.g. slut).

      Male subjects described "male" insults such as those imputing homosexuality.

6. Strategies to decrease hallucinations-Ask what the person does to make the voices go away. In a study by Leudar, et al, 1997, 76% of patients were able to identify at least one activity, either cognitive or behavioral-which helped them in dealing with auditory hallucinations.

   Frequent coping strategies in actual schizophrenics are (Falloon and Talbot, 1981)

   a. Specific activities (working, watching TV)
   b. Changes in posture (lie down or walk)
   c. Seeking out interpersonal contact
   d. Taking medication

Activities that have been shown to make voices worse:

a. 80% of those with hallucinations stated that being alone worsened their hallucinations (Nayani and David, 1996)

b. The two things that made voices worse were listening to the radio or watching television (Leudar et al., 1997)

TV programs were particularly hallucinogenic. Voices sometimes comment about the program.

7. Malingered hallucinations are more likely to have a stilted quality in their language.

8. Summary of suspect auditory hallucinations

a. Continuous rather than intermittent
b. Vague or inaudible hallucinations
c. Not associated with delusions
d. Stilted language
e. No strategies to diminish voices
f. Claim that all instructions are obeyed

E. Visual hallucinations

1. Visual hallucinations (46% vs. 4%) were found more often with malingerers than genuinely psychotic individuals (Cornell and Hawk, 1989)

2. Visual hallucinations were usually of normal-sized people (Goodwin, Alderson, and Rosenthal, 1971), animals or other objects (Assaad, 1990) In color

3. Occasionally small (Lilliputian), especially in alcoholics, organic (Cohen et al., 1994), or toxic psychoses (Lewis, 1961), especially anticholinergic (Atropine) toxicity (Assaad, 1990).

Lilliputian hallucinations are rare in schizophrenia (Leroy, 1922).

4. Visual hallucinations are usually consistent with auditory hallucinations and with delusional thinking (Asaad, 1990).

5. Psychotic hallucinations do not change if the eyes are open or closed.

6. Drug induced visual hallucinations are more readily seen with the eyes closed (Assad and Shapiro, 1986).

7. Dramatic, atypical visual hallucinations should arouse suspicions of malingering (Powell, 1991).

8. Summary of suspect visual hallucinations

   a. Visual alone in schizophrenia
   b. Black and white
   c. Dramatic, atypical
   d. Change with eyes closed
   e. Miniature or giant figures
   f. Visions unrelated to delusions or auditory hallucinations

VII. MALINGERED VS. TRUE DELUSIONS

A. Delusion-a false statement made in an inappropriate context with inappropriate justification. A fixed false belief.

B. Most delusions involve the following general themes (Spitzer, 1992)

1. Disease
2. Nihilism, poverty, sin and guilt
3. Grandiosity
4. Jealousy
5. Love (erotomania)
6. Persecution
7. Reference
8. Religion
9. Being poisoned
10. Being possessed (Cacodemonomania)
11. Being the descendant of royal family
12. Having insects under the skin (delusional parasitosis)
13. Significant others have been replaced by doubles (Capgras syndrome)

C. Clues to malingered delusions:

1. Abrupt onset or termination
2. Eagerness to call attention to delusions
3. Conduct not consistent with delusions
4. Bizarre content without disordered thoughts
5. Delusions with exaggerated cognitive deficit.

VIII. CLINICAL CLUES TO MALINGERED PSYCHOSIS

A. Malingerers may overact their part (Jones and Lllewellyn, 1917; Wachspress et al., 1953)

B. Malingerers are eager to call attention to their illnesses in contrast to schizophrenics, who are often reluctant to discuss their symptoms (Ritson and Forest, 1970)

C. It is more difficult for malingerers to successfully imitate the form, than the content of schizophrenic thinking (Sherman, Trief, and Sprafkin, 1975)

D. Malingerers symptoms may fit no known diagnostic entity.

E. Malingerers may claim the sudden onset of a delusion. In reality, systematized delusions usually take several weeks to develop (Spitzer, 1992).

F. A malingerers' behavior is unlikely to conform to his alleged delusions; acute schizophrenic behavior usually does. However, the "burned out" schizophrenic may no longer demonstrate agitation over his delusions. Common actions due to persecutory delusions are:

1. Changes of residence
2. Long trips to evade persecutors
3. Barricading their rooms
4. Carrying weapons for protection
5. Asking the police for protection

G. Malingerers are likely to have contradictions in their accounts of their illness.

H. Malingerers are more likely to try to take control of the interview and behave in an intimidating manner.

I. Malingerers are more likely to evasive, repeat questions or answer questions slowly, to give themselves more time to make up an answer (Powell, 1991)

J. Malingerers are likely to have non-psychotic alternative motives for their behavior, such as killing to settle a grievance.

K. It is rare for malingerers to show perseveration (Anderson, Trethwoan and Kenna, 1959)

L. Malingerers are unlikely to show negative symptoms and the subtle signs of residual schizophrenia, such as impaired relatedness, blunted affect, concreteness, or peculiar thinking.

M. Persons malingering psychosis often pretend cognitive deficit (Bash & Alpert, 1980; Powell, 1991; Jaffe and Sharma, 1998)

N. Malingerers are more likely to give approximate answers

O. Psychotic symptoms occur only when the person knows he is being observed or when being interviewed.

P. Persons who have true schizophrenia may also malinger auditory hallucinations or psychotic symptoms for other reasons, such as to escape criminal responsibility.

IX. PSYCHOLOGICAL TESTING AND ASSESSMENT OF MALINGERED PSYCHOSIS

A. Richard Rogers et al. (1990) designed this specifically for use with suspected malingerers. The SIRS is based on thirteen strategies that provide an excellent overview of the crucial areas of interest in the detection of deception. These thirteen strategies consider and assess:

1. The individual's degree of defensiveness about everyday problems, worries, and negative experiences;

2. How the individual has attempted to alleviate or solve his or her psychological problem;

3. How many of eight bona-fide but rare symptoms the individuals endorses;

4. Whether the individual will endorse any fantastic or absurd symptoms;

5. The symptom pairs that are likely to coexist in real clinical syndromes;

6. How precisely the individual describes the symptoms since, in reality, precision in unlikely;

7. How the individual's description of the onset of symptoms compares with actual symptoms onset;

8. Whether the individual has a stereotypical or "Hollywood" view of psychological problems;

9. The number of symptoms the individual reports that have an extreme or unbearable quality;

10. Whether the individual's endorsement of symptoms ahs a random quality;

11. How stable the individual's self-reports of symptoms are;

12. The level of honest and completeness in the individual's report;

13. The SIRS then asks the subject to report on behaviors that can be observed by the evaluator, and the report is then compared with the actual observations.

B. Miller Forensic Assessment of Symptoms Test (MFAST) (Miller, 2001)

1. Was developed to provide the evaluator with a brief reliable and valid screen for mental illness.

2. The M-FAST consists of 25 items that are presented in a structured interview format designed to screen for malingered psychopathology.

3. Each item is scored either 0 1.

4. The majority of items require that the examinee report true or false, always-sometimes-never, or yes or no.

5. The 25 items can be administered in approximately 5 minutes.

6. Research indicates that a total cut score of 6 was most effective for correct classification with a prison sample and forensic psychiatric patients no competent to stand trial.

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Current PSYCHIATRY

Faking it

How to detect malingered psychosis

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Reputed Cosa Nostra boss Vincent "The Chin" Gigante deceived "the most respected minds in forensic psychiatry" for years by malingering schizophrenia.[1] Ultimately, he admitted to maintaining his charade from 1990 to 1997 during evaluations of his competency to stand trial for racketeering.

A lesson from this case—said a psychiatrist who concluded Gigante was malingering—is, "When feigning is a consideration, we must be more critical and less accepting of our impressions when we conduct and interpret a psychiatric examination...than might be the case in a typical clinical situation."[2]

Even in typical clinical situations, however, psychiatrists may be reluctant to diagnose malingering[3] for fear of being sued, assaulted—or wrong. An inaccurate diagnosis of malingering may unjustly stigmatize a patient and deny him needed care.[4]

Because psychiatrists need a systematized approach to detect malingering,[5] we offer specific clinical factors and approaches to help you recognize malingered psychosis.

continued

Table 1

Common motives of malingerers

Motives	Examples
[illegible]	[illegible]
[illegible]	[illegible]

WHAT IS MALINGERING?

No other syndrome is as easy to define yet so difficult to diagnose as malingering. Reliably diagnosing malingered mental illness is complex, requiring the psychiatrist to consider collateral data beyond the patient interview.

Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.[6] In practice, malingering commonly must be differentiated from factitious disorder, which also involves intentional production of symptoms. In factitious disorders, the patient's motivation is to assume the sick role, which can be thought of as an internal or psychological incentive.

Three categories of malingering include:

- pure malingering (feigning a nonexistent disorder)
- partial malingering (consciously exaggerating real symptoms)
- false imputation (ascribing real symptoms to a cause the individual knows is unrelated to the symptoms).[7]

Motivations. Individuals usually malinger to avoid pain (such as difficult situations or punishment) or to seek pleasure (such as to obtain compensation or medications) *(Table 1)*. In correctional settings, for example, inmates may malinger mental illness to do "easier time" or to obtain drugs. On the other hand, malingering in prison also may be an adaptive response by a mentally ill inmate to relatively sparse and difficult-to-obtain mental health resources.[8]

INTERVIEW STYLE

When you suspect a patient is malingering, keep your suspicions to yourself and conduct an objective evaluation. Patients are likely to become defensive if you show annoyance or incredulity, and putting them on guard decreases your ability to uncover evidence of malingering.[9]

Begin by asking open-ended questions, which allow patients to report symptoms in their own words. To avoid hinting at correct responses, carefully phrase initial inquiries about symptoms. Later in the interview, you can proceed to more-detailed questions of specific symptoms, as discussed below.

If possible, review collateral data before the interview, when it is most helpful. Consider information that would support or refute the alleged symptoms, such as treatment and insurance records, police reports, and interviews of close friends or family.

The patient interview may be prolonged because fatigue may diminish a malingerer's ability to maintain fake symptoms. In very difficult cases, consider monitoring during inpatient assessment because feigned psychosis is extremely difficult to maintain 24 hours a day.

Watch for individuals who endorse rare or improbable symptoms. Rare symptoms—by definition—occur very infrequently, and even severely disturbed patients almost never report improbable symptoms.[10] Consider asking malingerers

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Table 2

Clues to identify malingering during patient evaluation

Internal inconsistencies	Example

External inconsistencies	Example

about improbable symptoms to see if they will endorse them. For example:

- "When people talk to you, do you see the words they speak spelled out?"[11]
- "Have you ever believed that automobiles are members of an organized religion?"[12]

Watch closely for internal or external inconsistency in the suspected malingerer's presentation *(Table 2)*.

MALINGERED PSYCHOTIC SYMPTOMS

Detecting malingered mental illness is considered an advanced psychiatric skill, partly because you must understand thoroughly how genuine psychotic symptoms manifest.

Hallucinations. If a patient alleges atypical hallucinations, ask about them in detail. Hallucinations are usually (88%) associated with delusions.[13] Genuine hallucinations are typically intermittent rather than continuous.

Auditory hallucinations are usually clear, not vague (7%) or inaudible. Both male and female voices are commonly heard (75%), and voices are usually perceived as originating outside the head (88%).[14] In schizophrenia, the major themes are persecutory or instructive.[15]

Command auditory hallucinations are easy to fabricate. Persons experiencing genuine command hallucinations:

- do not always obey the voices, especially if doing so would be dangerous[16]
- usually present with noncommand hallucinations (85%) and delusions (75%) as well[17]

Thus, view with suspicion someone who alleges an isolated command hallucination without other psychotic symptoms.

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Genuine schizophrenic hallucinations tend to diminish when patients are involved in activities. Thus, to deal with their hallucinations, persons with schizophrenia typically cope by:

- engaging in activities (working, listening to a radio, watching TV)
- changing posture (lying down, walking)
- seeking interpersonal contact
- taking medications.

If you suspect a person of malingered auditory hallucinations, ask what he or she does to make the voices go away or diminish in intensity. Patients with genuine schizophrenia often can stop their auditory hallucinations while in remission but not during acute illness.

Malingerers may report auditory hallucinations of stilted or implausible language. For example, we have evaluated:

- an individual charged with attempted rape who alleged that voices said, "Go commit a sex offense."
- a bank robber who alleged that voices kept screaming, "Stick up, stick up, stick up!"

Both examples contain language that is very questionable for genuine hallucinations, while providing the patient with "psychotic justification" for an illegal act that has a rational alternative motive.

Visual hallucinations are experienced by an estimated 24% to 30% of psychotic individuals but are reported much more often by malingerers (46%) than by persons with genuine psychosis (4%).[18]

Genuine visual hallucinations are usually of normal-sized people and are seen in color.[14] On rare occasions, genuine visual hallucinations of small people (Lilliputian hallucinations) may be associated with alcohol use, organic disease, or toxic psychosis (such as anticholinergic toxicity) but are rarely seen by persons with schizophrenia.

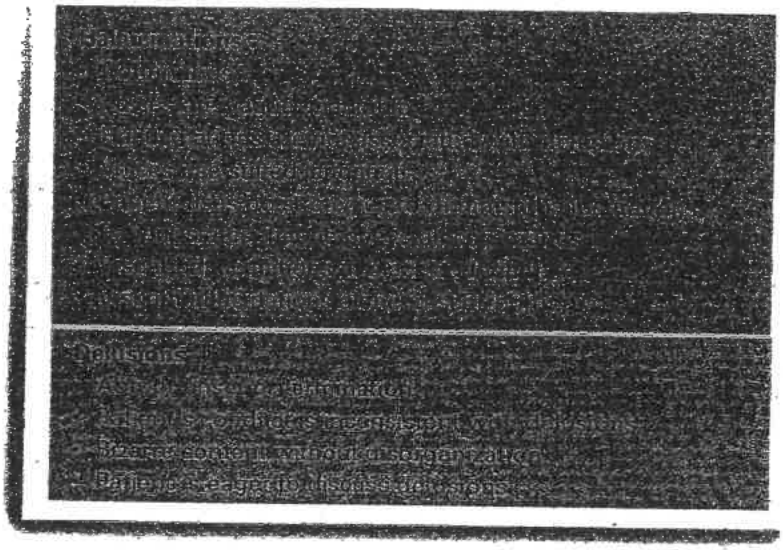
Psychotic visual hallucinations do not typically change if the eyes are closed or open, whereas drug-induced hallucinations are more readily seen with eyes closed or in the dark. Unformed hallucinations—such as flashes of light, shadows, or moving objects—are typically associated with neurologic disease and substance use.[19]

Malingerers report visual hallucinations more often than do persons with genuine psychosis

Suspect malingering if the patient reports dramatic or atypical visual hallucinations. For example, one defendant charged with bank robbery calmly reported seeing "a 30-foot tall, red giant smashing down the walls" of the interview room. When he was asked detailed questions, he frequently replied, "I don't know." He eventually admitted to malingering.

Table 3

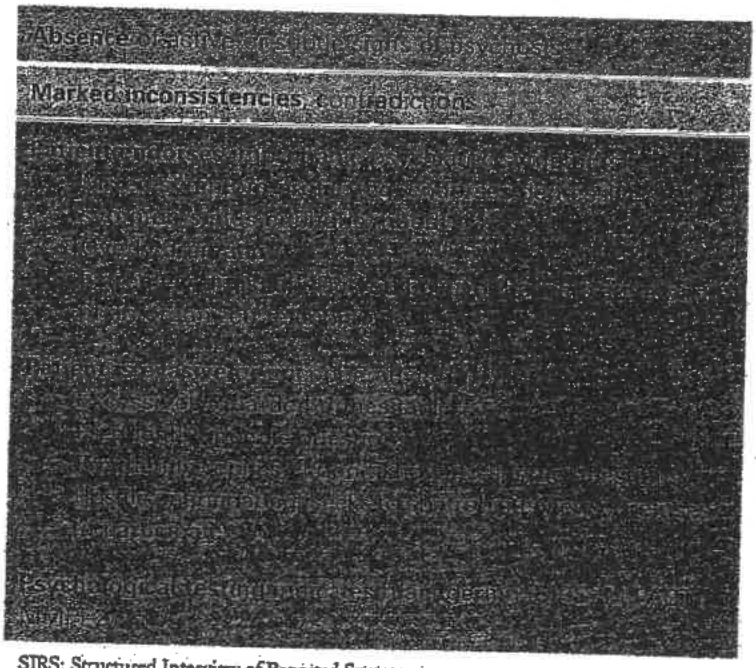
Uncommon psychosis presentations that suggest malingering



continued

Table 4

Clinical factors that suggest malingering



SIRS: Structured Interview of Reported Symptoms
M-FAST: Miller Forensic Assessment of Symptoms Test
MMPI-2: Minnesota Multiphasic Personality Inventory, Revised

Delusions. Genuine delusions vary in content, theme, degree of systemization, and relevance to the person's life. The complexity and sophistication of delusional systems usually reflect the individual's intelligence. Persecutory delusions are more likely to be acted upon than are other types of delusions.[20]

Malingerers may claim that a delusion began or disappeared suddenly. In reality, systematized delusions usually take weeks to develop and much longer to disappear. Typically, the delusion will become somewhat less relevant, and the individual will gradually relinquish its importance over time after adequate treatment. In general, the more bizarre the delusion's content, the more disorganized the individual's thinking is likely to be *(Table 3, page 19)*.

With genuine delusions, the individual's behavior usually conforms to the delusions' content. For example, Russell Weston—who suffered from schizophrenia—made a deadly assault on the U.S. Capitol in 1998 because he held a delusional belief that cannibalism was destroying Washington, DC. Before he shot and killed two U.S. Capitol security officers, he had gone to the Central Intelligence Agency several years before and voiced the same delusional concerns.

Suspect malingering if a patient alleges persecutory delusions without engaging in corresponding paranoid behaviors. One exception is the person with long-standing schizophrenia who has grown accustomed to the delusion and whose behavior is no longer consistent with it.

WHERE MALINGERERS TRIP UP

Malingerers may have inadequate or incomplete knowledge of the mental illness they are faking. Indeed, malingerers are like actors who can portray a role only as well as they understand it. They often overact their part or mistakenly believe the more bizarre their behavior, the more convincing they will be. Conversely, "successful" malingerers are more likely to endorse fewer symptoms and avoid endorsing overly bizarre or unusual symptoms.[21]

Numerous clinical factors suggest malingering *(Table 4)*. Malingerers are more likely to eagerly "thrust forward" their illness, whereas patients with genuine schizophrenia are often reluctant to discuss their symptoms.[22]

Malingerers may attempt to take control of the interview and behave in an intimidating or hostile manner. They may accuse the psychiatrist of inferring that they are faking. Such behavior is

rare in genuinely psychotic individuals. Although DSM-IV-TR states that antisocial personality disorder should arouse suspicions of malingering, some studies have failed to show a relationship. One study has associated psychopathic traits with malingering.[23]

Malingerers often believe that faking intellectual deficits, in addition to psychotic symptoms, will make them more believable. For example, a man who had completed several years of college alleged that he did not know the colors of the American flag.

> Malingerers often hedge, give vague answers, or say 'I don't know' when pressed for details

Malingerers are more likely to give vague or hedging answers to straightforward questions. For example, when asked whether an alleged voice was male or female, one malingerer replied, "It was probably a man's voice." Malingerers may also answer, "I don't know" to detailed questions about psychotic symptoms. Whereas a person with genuine psychotic symptoms could easily give an answer, the malingerer may have never experienced the symptoms and consequently "doesn't know" the correct answer.

Psychotic symptoms such as derailment, neologisms, loose associations, and word salad are rarely simulated. This is because it is much more difficult for a malingerer to successfully imitate psychotic thought processes than psychotic thought content. Similarly, it is unusual for a malingerer to fake schizophrenia's subtle signs, such as negative symptoms.

PSYCHOLOGICAL TESTING

Although many psychometric tests are available for detecting malingered psychosis, few have been validated. Among the more reliable are:

- Structured Interview of Reported Symptoms (SIRS)
- Minnesota Multiphasic Personality Inventory, Revised (MMPI-2)
- Miller Forensic Assessment of Symptoms Test (M-FAST).[11]

SIRS includes questions about rare symptoms, uncommon symptom pairing, atypical symptoms, and other indices involving excessive symptom reporting. It takes 30 to 60 minutes to administer. Tested in inpatient, forensic, and correctional populations, the SIRS has shown consistently high accuracy in detecting malingered psychiatric illness.[24]

Two MMPI-2 scales—F-scale and F-K Index—are the most frequently used test for evaluating suspected malingering. When using the MMPI-2 in this manner, consult the literature for appropriate cutoff scores (see *Related resources, page 25*). Although the MMPI-2 is the most validated psychometric method to detect malingering, a malingerer with high intelligence and previous knowledge of the test could evade detection.[25]

M-FAST was developed to provide a brief, reliable screen for malingered mental illness. This test takes 10 to 15 minutes to administer and measures rare symptom combinations, excessive reporting, and atypical symptoms.[11] It has shown good validity and high correlation with the SIRS and MMPI-2.[26,27]

> To conclude with confidence that an individual is malingering psychosis, the psychiatrist must understand genuine psychotic symptoms and consider data beyond the individual's self-report. Assemble clues from a thorough evaluation, clinical records, collateral information, and psychological testing.

Bottom Line

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CONFRONTING THE MALINGERER

If a thorough investigation indicates that a patient is malingering psychosis, you may decide to confront the evaluee. Avoid direct accusations of lying,[10] and give the suspected malingerer every opportunity to save face. For example, it is preferable to say, "You haven't told me the whole truth."

A thoughtful approach that asks the evaluee to clarify inconsistencies is more likely to be productive and safer for the examiner. When confronting individuals with a history of violence and aggression, have adequate security personnel with you.

Related resources

- Structured Interview of Reported Symptoms (SIRS). Available for purchase from Psychological Assessment Resources at www3.parinc.com (enter "SIRS" in search field).
- Graham JR. *MMPI-2: Assessing personality and psychopathology*. New York: Oxford Press; 2000. (Source of cutoff scores to use MMPI-2 scales [F-scale and F-K Index] to evaluate suspected malingering).
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CME

Prevention of Suicide in a Large Urban Jail

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We describe a successful suicide prevention program in a large urban jail. By doing so, we hope to offer clinicians, correctional administrators, and correctional health care advocates an opportunity to examine the specific efforts that have been made by a large urban correctional facility to reduce suicides. First, however, we review salient statistics on inmate suicide and briefly review the literature on jail suicide.

STATISTICS

The incidence of suicide, both attempted and completed, has always been high in jails and prisons. According to Bureau of Justice Statistics, during 1993 and 1994 more than 400 detainees took their lives annually.[1] In a national study of jail suicides published in 1989, it was calculated that there were 107 suicides per 100,000 detainees.[2] This rate was 9 times greater than the rate in the general nonincarcerated population during the same period. The New York State Commission of Corrections reported that suicide rates within jails in New York State averaged 42.2 per 100,000 admissions for 1988 through 1997.[3] This figure is considered improved; the rate in New York State was as high as 177 deaths per 100,000 detainees in 1984. Similar rates were noted for Texas county jails, which averaged 58 suicides per 100,000 detainees from 1986 through 1995.[4] Their rates had peaked at 151 per 100,000 detainees in 1984.

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LITERATURE REVIEW

Most of the literature on jail suicide implicates combinations of situational factors, detainee adjustment and coping factors, and conditions of confinement in suicidal behavior. These factors clearly differentiate the dynamics of suicidal behavior in jails from those of suicidal behavior in other settings. Although most authors indicate the presence of multiple precipitating factors, it is clear that they all agree that incarceration can be a uniquely overwhelming experience that has strong implications for suicidal behavior.[2,5-9]

Hayes[2] states that the precipitating factors for suicidal behavior in jails are well established. He cites the two primary causes of inmate suicide as the jail environment and the crisis situation that the inmate is facing. Environmental factors include fear of the unknown, distrust of an authoritarian environment, lack of control over the future, isolation from family and significant others, shame of incarceration, and dehumanizing aspects of incarceration. Factors in the crisis situation that predispose an inmate to suicide include recent excessive drinking, use of drugs, or both; recent loss of stabilizing resources; severe guilt or shame over the alleged offense; current mental illness; history of suicidal behavior; and approaching court date.

In a later publication, Hayes[5] distinguished characteristics of suicide situations in jails in large urban centers and jails in general. Detainees who complete suicide in large urban jails are more apt to be charged with violent crimes; recent intoxication is not a factor, and the suicide does not always occur immediately after incarceration. Hayes contrasts these factors with those associat-

TABLE 1

Components of the Cermak Mental Health Services–Cook County Department of Corrections Suicide Prevention Program

Mental health screening of all new detainees on intake
Inpatient care of detainees who are acutely ill and suicidal
Follow-up services for detainees who are suicidal
Referral and crisis intervention services for detainees housed in the general population of the jail
Community linkage of detainees who are suicidal
Training procedures for correctional officers

ed with suicide in smaller jails and lockups, where a typical suicide profile would include a nonviolent offense, recent intoxication, isolation from others, youthfulness, white ethnicity, and a completed suicide within 24 hours of incarceration.

Bonner[6] explained inmate suicide using a stress vulnerability model. His theory views suicide as a process by which an inmate is (or becomes) ill equipped to handle the common stresses of confinement. As the inmate reaches a breaking point, the result can be suicidal ideation, attempt, or completion. During initial confinement in a jail, these stressors can be limited to fear of the unknown or isolation from family, but over time may become exacerbated and include the loss of outside relationships, conflicts within the institution, victimization, further legal frustrations, physical and emotional breakdown, and problems coping within the jail environment.

Haycock[7] examined factors that are related to detainees' emotional functioning and family relationships. He differentiated non–life-threatening and life-threatening suicide attempts and discussed factors associated with life-threatening suicide attempts in jails and prisons. Inmate factors included the use of opiates, intoxication or withdrawal at the time of the attempt, recent family turmoil, and high scores on hostility, depression, and hopelessness measures.

Finally, Felthous[8] reviewed the literature on jail suicide and outlined factors that contribute to the risk of it. He implicated the state of mind of the suicidal detainee prior to incarceration and existing mental illness. Felthous stated, "(1) Jails can be extremely stressful places to be, and, combined with the inmate's dreadful legal situation, ominous possibilities of disruption of employment and family ties and other ensuing, destabilizing stressors can precipitate a situational crisis with a hopeless outlook; (2) Before apprehension and jailing, the individual may already have been experiencing an overwhelming crisis, which led to criminal acts and arrest; and (3) Mental illness alone can predispose inmates to take their lives, more or less independent of situational stressors." He supported his third assertion by pointing out that up to 11% of incarcerated individuals have serious mental illness.

PROGRAM DESCRIPTION

In the 10-year period from 1988 to 1998, the jail's receiving unit at Cook County Department of Corrections (CCDOC) averaged 80,000 new detainees annually. The intake at Cook County Jail surpassed 100,000 for the year in December 1998. Given the high volume of new detainees, the stressful conditions of arrest and confinement, and the multiproblem profile of the population entering the system at CCDOC, suicide rates could be expected to be high and certainly reflective of the rates historically seen in jails. However, the suicide rates at Cook County Jail have been reduced to a level of fewer than 2 suicides for every 100,000 admissions since 1990.

The comparatively low rate of completed suicides at Cook County Jail, the third largest jail jurisdiction in the United States based on total inmate population, can be directly attributed to a multifaceted program focused on suicide prevention and care of detainees who are at high risk because of their psychiatric status. Specifically, this low rate can be attributed to the set of program components outlined in Table 1.

Mental Health Screening of All New Detainees on Intake

The identification of detainees who are potentially suicidal begins at the CCDOC's "front door." Spread over 100 acres with 14 different divisions classified as minimum, medium, or maximum security that each house up to 1,500 detainees, CCDOC is a "correctional city" with an average daily census of 10,000 detainees. As buses arrive from local lockups across the county,

TABLE 2

Brief Primary Psychological Screening Tool Suicide Assessment Items of the Department of Psychiatry, Cermak Mental Health Services

Has the detainee ever been hospitalized for psychiatric treatment?
Does the detainee currently receive outpatient psychiatric treatment?
Does the detainee take medication?
Does the detainee use alcohol, drugs, or both?
Has the detainee ever attempted suicide? When? How?
Does the detainee feel suicidal now?
Is the detainee's behavior appropriate in the receiving room area?

TABLE 3

Secondary Psychological Screening Tool Items of the Department of Psychiatry, Cermak Mental Health Services

Is the detainee oriented to time, place, and person?
Is there a childhood history of physical, emotional, or sexual abuse?
What is the detainee's family psychiatric history?
What is the detainee's family substance abuse history?
What is the nature of the detainee's interpersonal relationships?
What was the detainee's living situation prior to incarceration?
What is the detainee's alcohol and drug use history (eg, substances, amount, frequency, and duration)?
Does the detainee have a history of head injuries?
What is the detainee's current charge and criminal history?
What is the diagnostic impression based on interview questions, receiving room observations, and past knowledge of the detainee (*DSM-IV*)?

as many as 300 new detainees daily are screened at the Receiving Classification and Diagnostic Center.

Detainees enter jail experiencing suicide-potentiating dysphoric states that include anxiety, guilt, shame, depression, hopelessness, sadness, anger, and psychomotor agitation. These mental and emotional states may be reactions to arrest and confinement, and may also reflect preexisting and chronic psychological conditions. In addition, these detainees may be predisposed to suicide when examinations of their backgrounds reveal histories of suicidal behavior, limited coping and social skills, dysfunctional families, educational and employment failures, substance abuse and addiction, and social alienation. These factors, along with high rates of major psychiatric disorders, make the proper screening of detainees before they join the general population of the jail a critical first step in suicide prevention.

It is the job of the mental health staff assigned to the receiving room to screen each new detainee as he or she enters the jail system and identify those who are in critical need of psychiatric assistance and potentially suicidal. During an afternoon and late-evening shift, 7 days a week, an average of 5 to 7 receiving room staff members use a combination of structured questionnaires, clinical observation, and experience from conducting thousands of screenings to accomplish their task. A licensed clinical psychologist supervises and trains them and coordinates their activities. The following vignette is an example of a typical screening that culminates in an admission to the acute care psychiatric unit.

Vignette 1. Mr. M, a 26-year-old African American man charged with first-degree murder, had been jailed three times previously on drug charges. During intake, he was interviewed by a mental health specialist with a bachelor's degree who administered a primary mental health screening instrument (Table 2). This questionnaire addresses various aspects of psychiatric history, drug and alcohol use, suicide history, and current risk of suicidal behavior, homicidal behavior, or both.

Mr. M reported no history of psychiatric treatment, but admitted to smoking upward of $150 of crack cocaine per day for the past 2 years. He also denied any history of suicide attempts and suicidal or homicidal ideation at intake. On closer questioning, the mental health specialist elicited that Mr. M was charged with murdering his mother. He spoke softly, appeared disheveled, and tears welled up in his eyes several times during the brief interview. Later he became mute and refused to answer further questions.

The mental health specialist conducted a secondary interview immediately (Table 3). The secondary interview determined whether Mr. M. should be referred for admission to the acute care psychiatric unit. A more in-depth assessment, the secondary interview includes

questions about mental status and background information designed to both elicit risk factors for suicide and detect mental instability.

Although Mr. M was unresponsive to secondary interview questions, he was referred for admission to the acute care psychiatric unit based on his despondent behavior and the fact that he was charged with murdering his mother. He also was considered high risk because of possible depression related to cocaine withdrawal. His disheveled appearance suggested possible underlying mental illness, an unstable living situation, and possible cognitive impairments related to substance withdrawal. These factors increase concerns about suicidal behavior.

The entire evaluation process takes less than 20 minutes. Brevity that does not undermine accuracy is important in screening when 300 other individuals are waiting for primary screenings. An irony of screening in a correctional setting is that often detainees who are most at risk do not readily or willingly reveal symptoms that indicate their need for assistance. Conversely, detainees who are malingering to avoid placement in the general population of the jail may quickly verbalize suicidal ideations, a plan, and a method of killing themselves. At CCDOC, the receiving room staff are taught to err on the side of caution whenever suicidal preoccupations are verbalized or indicated by a detainee's profile. The questionnaire items most relevant to detecting proneness to suicide and the presence of mental instability are listed in Tables 2 and 3.

Inpatient Care of Detainees Who Are Acutely Ill and Suicidal

The post-screening care of suicidal detainees initially takes place on a 58-bed inpatient psychiatric unit for men and a 24-bed unit for women located on the jail grounds that is part of Cermak Mental Health Services. After a medical assessment in the health services emergency department, any detainee who is considered to be at risk for suicide is immediately transported by correctional officers to the inpatient unit. Immediately on entering the acute care unit, suicidal detainees are assessed by a nurse and a mental health specialist. A psychiatrist evaluates the suicidal detainee during the first 8 hours that he or she is on the unit and continues to monitor the detainee while he or she remains in acute care treatment.

Psychological assessments conducted by psychologists are often used to rule out malingering and help develop treatment plans. Emergency procedures, including close observation, medical restraints, and therapeutic seclusion, may be initiated by clinical staff and followed with orders from physicians and psychiatrists for detainees who are highly agitated and suicidal. On-call psychiatrists are available for emergency medication orders during evening and midnight shifts.

Suicidal detainees who are treated on the inpatient unit of Cermak Mental Health Services present a variety of clinical challenges for psychiatrists. Adding to the complexity of patient care are factors such as the extremely high incidence of comorbid disorders, diagnostic uncertainty created by the absence or unreliability of background information provided by detainees, and endemic jail conditions (eg, overcrowding, dehumanization, and deprivation). Approaches to psychiatric treatment vary according to each suicidal detainee's clinical presentation. The appropriate and humane use of medical restraints is an important factor in the low suicide rate at CCDOC. The following case vignette illustrates the complexity of situational and clinical factors associated with the acute care treatment of a detainee who was extremely suicidal.

Vignette 2. Mr. J was a 30-year-old white man who had been incarcerated for 4 days after being charged with the stabbing death of his wife. Due to his unstable psychological state on admission, Mr. J was housed on the acute care psychiatric unit with the added emergency precaution of medical restraints. He was anxious, agitated, and depressed, and reported mood-related psychotic symptoms. He told clinical staff that he constantly heard the voice of his dead wife telling him to "join her."

Mr. J was experiencing withdrawal symptoms from 3 months of daily cocaine use. Cocaine withdrawal increased the acuity of his depressive symptoms. As his mind cleared, Mr. J became more despondent about the reality of his legal and personal situation. His personal background included physical abuse during childhood, abuse of multiple substances, several prior suicide attempts, numerous head traumas from violent encounters, and recent treatment with methylphenidate that suggested a history of impulsive behavior.

Several hours later, Mr. J was released from restraints after appearing less agitated, assuring mental health staff that he was feeling better, and stating that his mood-related command hallucinations had decreased. He continued to have difficulty sleeping because of intrusive thoughts about the death of his wife. Psychotropic medication was prescribed to help control his ruminations and impulsiveness.

On day 4 of his acute care stay, without warning Mr. J attempted suicide by hanging himself with a sheet. An alert correctional officer rescued him after other detainees called out when they witnessed the hanging attempt. After Mr. J received medical treatment for his injured neck, he continued to report intense suicidal ideations and uncertainty about his ability to control his suicidal impulses. Emergency procedures, including restraints, emergency medication, and close observation, continued for several days until he was stable enough to be discharged to a lower acuity psychiatric unit in the jail.

The strength of the inpatient care system of Cermak Mental Health Services of Cook County is that detainees are continually evaluated and monitored in a therapeutic environment. Psychiatrists, with input from several disciplines, make decisions regarding the detainee's stability for transfer to the jail's general population or whether care should be continued on a low acuity psychiatric care unit. This process also serves to screen out detainees who may be feigning symptoms of suicide and occupying limited space in the inpatient unit. Detainees often use unsophisticated and overly dramatic attempts to feign visual and auditory command hallucinations and deliberately self-inflict superficial injuries to appear suicidal.[9]

Follow-Up Services for Detainees Who Are Suicidal

Follow-up treatment of detainees who are at high risk and have been stabilized is accomplished by referring male detainees to a 286-bed residential treatment unit for intermediate and subacute care and female detainees to a comparable 60-bed unit. Symptoms are monitored daily in a low acuity therapeutic environment within the jail complex. Suicidal detainees whose active symptoms reemerge can be returned immediately to the acute care inpatient unit. In the residential treatment unit's dormitory-style settings for men and mental health tier for women, observations made by correctional officers, nurses, mental health specialists, psychologists, and psychology interns determine whether changes in a detainee's mental status necessitate a return to the inpatient unit for restabilization of suicidal symptoms.

Referral and Crisis Intervention Services for Detainees Housed in the General Population of the Jail

After stabilization and the remission of suicidal symptoms, some detainees may be appropriately housed in the general population of the jail. In this population, suicide prevention efforts are accomplished through 24-hour availability of a 2-person crisis team to respond to psychiatric emergencies. Flexible procedures have been established for medical, civilian, and correctional staff to refer to the crisis team detainees who appear to be in need of psychiatric evaluation.

The mental health crisis team stationed in the receiving area of the jail evaluates as many as 8 to 10 "backdoors" (ie, detainees who are referred from general population living units for mental health evaluations) daily. These detainees typically do not come to the attention of psychiatric services at the time of their primary screening on admission. This group may also include detainees who are receiving psychotropic medication in the jail's general population. If they have a psychiatric crisis, cannot adjust to the general population, or have serious problems with their medication before scheduled psychiatry clinic visits, they can be readmitted to an acute care unit. All emergency requests and referrals are responded to immediately.

Community Linkage of Detainees Who Are Suicidal

The court determines when a detainee is released from CCDOC. Detainees cannot be held beyond the point that their court cases are adjudicated unless the judge sentences them to serve time in the jail. When a detainee is determined to be suicidal at the point of release from the jail, special efforts have to be made to certify the individual and petition the court for civil commitment to a state hospital.

Training Procedures for Correctional Officers

A key component of suicide prevention in CCDOC is the training of correctional officers to increase their sensitivity to the mental health needs within a jail population. Officers are trained in identifying potentially suicidal detainees when they enter the Sheriff's 11-week training academy to become correctional officers, and those who are assigned to psychiatric units receive an additional 80 hours of mental health training. Within this additional 2-week training program, 8 hours are dedicated to suicide prevention. The training of officers is essential. Officers' attitudes or insensitivity can affect whether a detainee who is suicidal seeks assistance. Officers' observations can facilitate access to emergency services for a detainee who is potentially suicidal. Officers also assist with the medical restraint process for detainees who are highly agitated and suicidal.

CONCLUSION

The treatment of detainees who are suicidal and the prevention of suicide in jails have improved substantially during the past 20 years. Decreasing national suicide rates attest to this improvement. Generally, increased attention to the plight of incarcerated individuals with mental illness has created an atmosphere of positive change. Specifically, legal actions related to completed suicides,[10] greater sensitivity on the part of jail administrators to controlling factors that affect facility management, and greater attention to safety and security in physical plant designs have improved suicide rates.

Health care professionals who have published articles to increase understanding of jail suicide also have helped reduce suicide rates. It is an optimistic sign that although jail populations have increased, suicides in jail have decreased. Organizations such as the National Commission for Correctional Health Care, which sets standards for health care in jails, and the American Correctional Association, which sets standards for conditions of confinement in jails, have greatly contributed to national reductions in jail suicide rates.[11,12] It is hoped that the trend will continue with greater attention to quality mental health care and the creation of continuity of care among jail-based programs, state mental health facilities, and community programs.

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Legal Issues in Treating Suicidal Patients

By: Zachary Pelchat
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Introduction

Treating a suicidal patient can be incredibly challenging and frustrating for a therapist. Many clinical, legal, and ethic issues must be addressed and resolved to ensure the physical safety of the patient and the professional safety of t clinician. The three main legal issues involved are Confidentiality (and the applicable exceptions), the Standard of Care, and Record Keeping. The purpose of this article is to present a general discussion of legal options available t you. This article is not a substitute for actual clinical and/or legal consultation in your individual case.

Questions

With each client, you should be asking yourself some fundamental questions regarding suicidality. These questions assume you have the proper training, education, and experience to assess for suicidality and you have assessed th client for suicidality. Ask yourself these questions:

1. Do I have emergency contact information for this patient?
2. Is there a communication to make pursuant to Evidence Code 1024?
3. Am I seeking appropriate clinical and legal consultations?
4. Have I discussed increased therapy with this patient?
5. Have I made a referral for a medication evaluation?
6. Would a suicide contract be appropriate?
7. Have I discussed voluntary hospitalization with this patient?
8. Have I considered involuntary hospitalization?
9. Should I terminate and refer?
10. Am I documenting everything completely?

Answers

The answers to these questions are designed to assist you in assessing your options with a particular patient. First and foremost, if you do not feel that you are competent to assess for suicidality, immediately seek clinical consultatic and refer the patient to a physician for a medical evaluation. In addition, seek the training, education, and/or experience you need to be competent. Almost as important is consciously determining whether or not the patient is suicide risk. If you believe that he or she presents a risk for suicide, discuss it with your supervisor or consultant.

It is important to have emergency contact information for all of your clients, but especially for your clients who may pose a suicide risk. If one of these clients does not appear for his or her scheduled appointment on time, whom will you call? If you had to make a call to a friend or relative of the patient to get a gun out of the house, would you hav the number? The "emergency contact information" is intended to help you avoid an emergency, rather than merely providing a way to inform family and friends after one has occurred.

Confidentiality

Generally speaking, confidentiality would prohibit you from discussing the patient's suicidality outside of session. However, the California Evidence Code supplies an exception. Evidence Code Section 1024 is the legal authority for you to make communications necessary to protect the patient from himself. The code reads: "There is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger." For example, your client is depressed and says he contemplates suicide daily. Furthermore, he has several guns in his house. The law would allow you to call his wife and ask her to remove the guns from the house if that was necessary to prevent the threatened harm.

Tarasoff does not apply to suicidal patients. Analyze the situation under Evidence Code §1024, not as a Tarasoff warning. The reason that this distinction is important is the distinction between a mandated report and a permissive

report. Tarasoff is a mandated duty to warn. Evidence Code §1024 is permissive; it allows you to report but does not require you to report. Thus, it is incorrect to say that having a suicidal patient is a "mandated report." You have many options with suicidal patients, making a communication pursuant to Evidence Code §1024 is just one of them.

ndard of Care

The therapist must exercise "the average degree of skill, care, and diligence exercised by members of the same profession, practicing in the same or similar locality" in light of the present state of the science in treating the suicidal patient. Have you discussed a referral to a psychiatrist for medication with your client? What response did you get from your client? If you haven't discussed this option, why not? The same questions need to be answered for voluntary hospitalization. In some cases, it may be that you cannot help this client and a referral to someone else is the most appropriate course of action. Finally, you may need to consider involuntary hospitalization. If other interventions have failed, this may be your only option.

A discussion of the Standard of Care as a legal concept in treating suicidal patients is hampered by the fact that expert witnesses ultimately define the Standard of Care in court. One important way to show that you are meeting the Standard of Care is with appropriate clinical consultation. For a full discussion on the Standard of Care, see the May/June 2001 issue of The California Therapist or read the article online at www.camft.org in the "members only" section.

Record Keeping

The basis for your decisions, whatever they are, must be documented. Remember, both choosing to do something and choosing not to do something is a decision that should be documented. While the duty to keep records is very general, when you see danger signs you should consider keeping more detailed notes. An important part of that detail is explaining what you did, why you did it, what you chose not to do, and why you chose not to do it.

For example, you are treating an adult male for a gambling addiction. Your notes show that he sometimes becomes despondent when he has lost his paycheck at the local casino, but he denies any consideration of suicide. The next week, he gambles his car and house away and commits suicide. His estate is suing you for malpractice. If your notes scarce and only make fleeting references to "feels despondent after gambling," your records will not provide muc stance with your defense, and you are left relying on your recollection as your only defense. However, if your notes go into detail about your assessment for suicidality, his denials, and the appropriate response (continued weekly sessions), then your defense is present in the record.

Conclusion

The key legal issues for you to be familiar with in treating suicidal patients are Confidentiality (Evidence Code §1024), the Standard of Care, and Record Keeping.

Evidence Code §1024 allows you to make communications necessary to prevent the danger a patient may pose to him or herself. The Standard of Care covers the myriad of clinical options you have with your patients. Proper Record Keeping protects you should the tragedy of suicide and the filing of a lawsuit occur.

This article was published in the July/August 2001 issue of The California Therapist. The information contained in this article is intended to provide guidelines for addressing difficult legal dilemmas. It is not intended to address every situation that could potentially arise, nor is it intended to be a substitute for independent legal advice or consultation. When using such information as a guide, be aware that laws, regulations and technical standards change over time, and thus one should verify and update any references or information contained herein.

C0-OCCURRING DISORDERS

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OVERVIEW

- Definitions
- Prevalence
- Impact and Significance
- Common Substances of Abuse and Symptoms

CO-OCCURRING DISORDERS

- Definition:
  - Previously known as Dual Diagnosis, Co-Occurring Disorders (COD) refer to the existence of simultaneous mental illness and substance use disorders
  - Doesn't differentiate which came first, but rather notes that both issues need to be addressed

DEFINITIONS

- Mental Illness-refers to disorders generally characterized by dysregulation of mood, thought, and/or behavior, defined by the DSM
- Serious Mental Illness (SMI)- a diagnosable mental illness that substantially interferes with major life activities, such as work, education, relationships, etc.
- Substance Use Disorder (SUD)- when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home

PREVALENCE IN 2014

- Mental Illness
  - 18.1% of adults (43.6M) had any form of mental illness within the past year
  - 4.1% of adults (9.8M) had SMI
- Substance Use Disorders
  - 8.1% of adults (21.5M) had any SUD
    - 17M (79%) had Alcohol Use Disorder
    - 7.1M (33%) had illicit drug use disorder
    - 2.6M (12%) had both alcohol and illicit drug use disorder

PREVALENCE IN 2014

- Co-Occurring Disorder (COD)
  - 3.3% of all adults in 2014 had any mental illness and a substance use disorder in the past year
  - 1% had both a Serious Mental Illness (SMI) and a Substance Use Disorder (SUD)

PREVALENCE IN CUSTODY

- 2006 Bureau of Justice Statistics Report documented percentage of inmates who met criteria for a mental health disorder:
  - 74% of state prisoners
  - 63% of federal prisoners
  - 76% of jail inmates
    - 49% met criteria for both a mental health disorder and a substance use disorder

PREVALENCE IN CUSTODY

- SAMHSA statistics:
  - 14% of men and 24% of women in jails have a serious mental illness (SMI), such as Schizophrenia or Bipolar
    - Compared to less than 5% of the US population
  - Only 3-5% of violent acts are attributable to people with SMI, who are far more likely to be victimized than perpetrators of violence
    - No difference from general population when substances aren't involved

COMPARISON

COMMUNITY (2014)	CUSTODY (2006)
• Mental Illness: 18.1%	• Mental Illness: ≥ 76%
• SMI: 4.1%	• SMI: ≥ 14-24%
• SUD: 8.1%	• SUD: >68%
• COD: 3.3%	• COD: ≥ 49%

IMPACT

- SAMHSA's Treatment Episode Data, 2011:
  - The Criminal Justice system was the major source of referrals to substance use treatment
    - Mostly from probation and parole for ages 18-44
    - Most common substances: Alcohol, Cannabis and Methamphetamine

SIGNIFICANCE

- Persons with MI, SMI, SUD and COD are more concentrated in custodial settings than the community
- Their acute and chronic needs require coordination between medical, mental health, custody staff and the court system

SIGNIFICANCE

- Inmates with COD can present with acute intoxication, in acute or prolonged withdrawal, decompensated mentally (psychotic, manic) or any combination of these
  - All can lead to agitation and combativeness
  - It's important to address each need to reduce risk
  - Intoxication and withdrawal can mimic, as well as exacerbate mental health conditions

ALCOHOL

ALCOHOL

- Most commonly abused substance
  - 52.7% of adults used it in the past month
  - 23% of adults are binge drinkers
  - 6.2% of adults are "heavy" drinkers
    - 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days
    - Increased risk of serious withdrawal, which can be deadly

ALCOHOL INTOXICATION

- Can result in slurred speech, nystagmus (bouncing eyes), disinhibition, unsteady gait, memory impairment, Stupor or Coma, hypotension and tachycardia, Metabolic derangements
- Increases agitation, risk of violence (including ↑ risk of suicide), and poor cooperation
- Treatment: usually supportive, but may require medical intervention and close monitoring

ALCOHOL WITHDRAWAL

- ~50% of etoh-dependent pts have clinically significant sxs of withdrawal
- Characterized by CNS hyperactivity upon decrease or cessation of ETOH use
  - Autonomic Hyperactivity (↑HR, ↑BP)
  - Gastro-intestinal Hyperactivity
  - Cognitive and Perceptual changes

ALCOHOL WITHDRAWAL

- Starts w/in 6-24 hours after last drink or significant decrease (may start while still intoxicated in heavy, long-term alcoholics)
- May be short-lived (<5 days) and require minimal or no medical intervention, or may be severe and require hospitalization, with severity increasing over the first 48-72 hours of abstinence
- Psychological sxs can last for weeks to months: dysphoria, sleep disturbance, and anxiety

SEVERE ETOH WITHDRAWAL

- Seizures (tonic-clonic):
  - Occur 6-48 hours after last drink, even if the BAC is high, in severely dependent drinkers
  - Occur in 2-9% of alcoholics
  - Increase chances of subsequent W/D seizures
    -13-24% within 6-12 hours if untreated

SEVERE ETOH WITHDRAWAL

- Delirium Tremens
  - Disturbance of consciousness (disorientation) and changes in cognition or perceptual disturbance (hallucinations), resulting in severe agitation/aggression
  - Occurs in 5% of alcoholics who are un-medicated during withdrawal
  - Mortality rate 15% if untreated, 1% with aggressive treatment
  - Usually occurs 48-96 hours after the last drink, but may occur up to 7 days after
  - Usually lasts 2-3 days, but can last longer

PREDICTORS OF SEVERE WITHDRAWAL

- Current drinking pattern
  - Quantity, frequency, duration (>6yrs=15x risk)
- Past withdrawal experience
- Additional substance use
  - Benzos*, opiates, stimulants
- Medical conditions (seizures, heart issues)
- Psychiatric Conditions (psychotic disorders)

Severe alcohol withdrawal is a medical emergency!

METHAMPHETAMINE

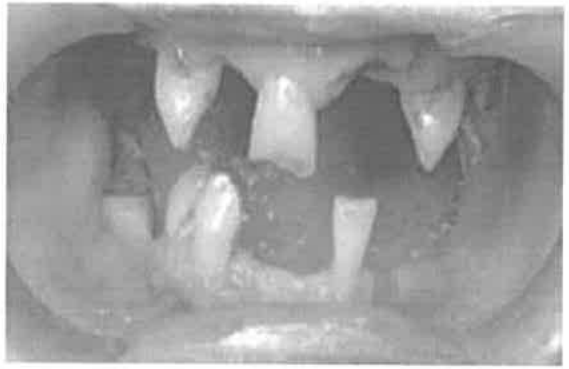
METHAMPHETAMINE

- Intoxication
  - Euphoria/grandiosity, ↑sex drive, agitation, irritability, anxiety, paranoia/delusions, delusional parasitosis (bugs), hallucinations, fast speech
- Withdrawal
  - "crash", ↑sleep, ↑appetite, anxiety, depression, psychosis can persist for months (especially if also used other stimulants)

METHAMPHETAMINE

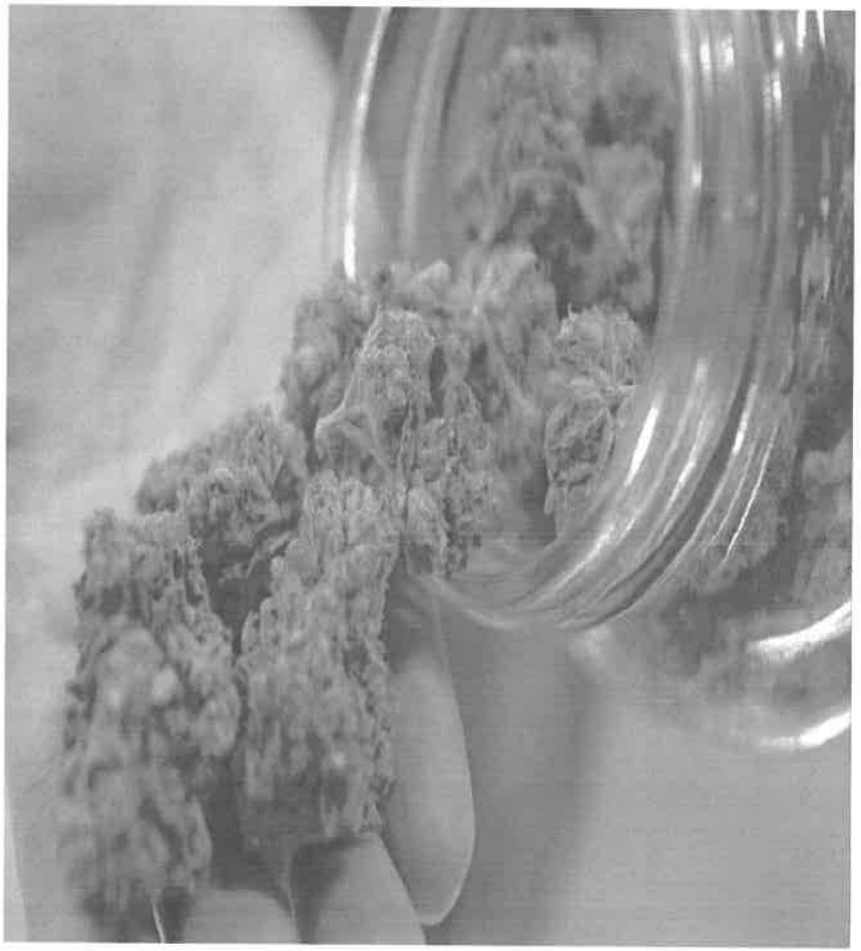
1 AGE: 29

2 AGE: 31 -20 lbs.

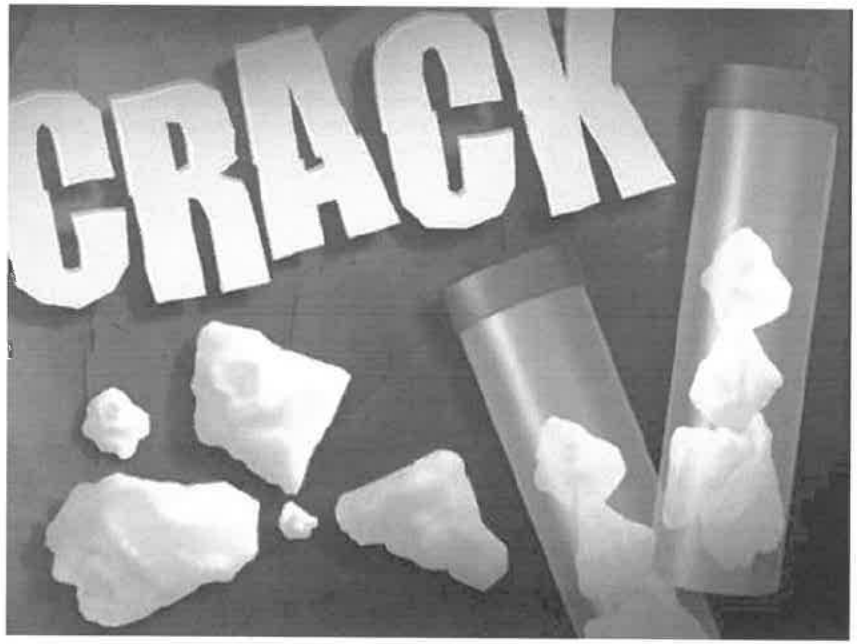


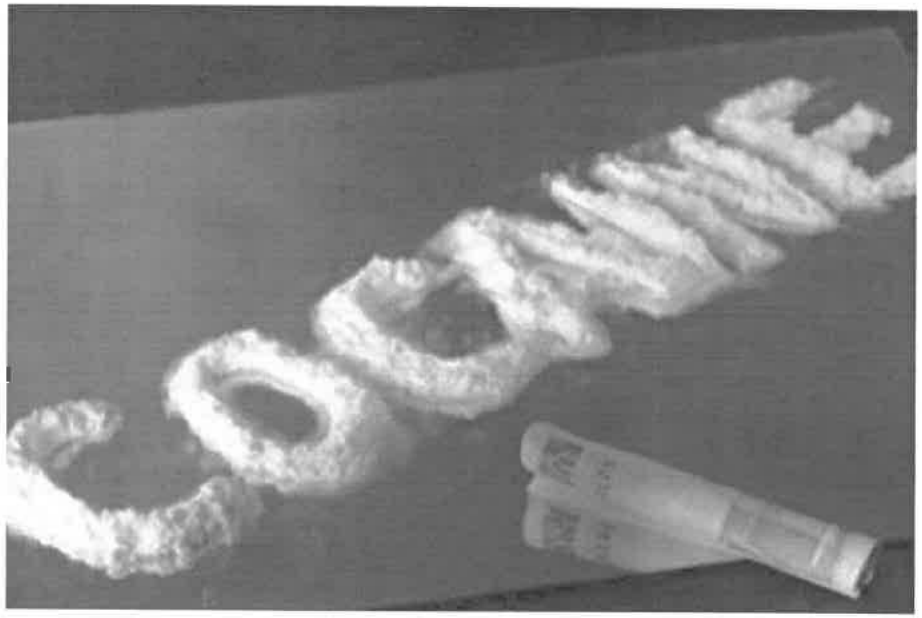
CANNABIS

- Intoxication
  - Euphoria, drowsiness, disinhibition, impaired cognition, ↑appetite, paranoia, hallucinations
- Withdrawal
  - Insomnia, depression, nightmares, vivid dreams, night sweats, anxiety, rapid mood swings, anger, irritability, ↓appetite



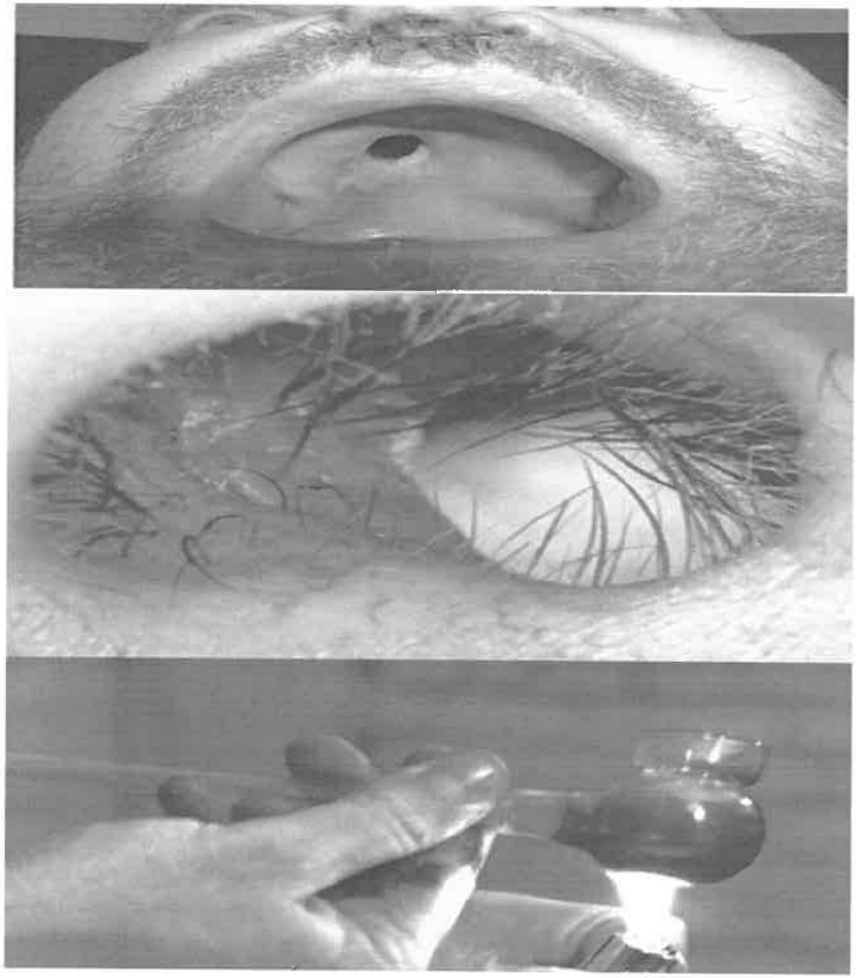
COCAINE





COCAINE

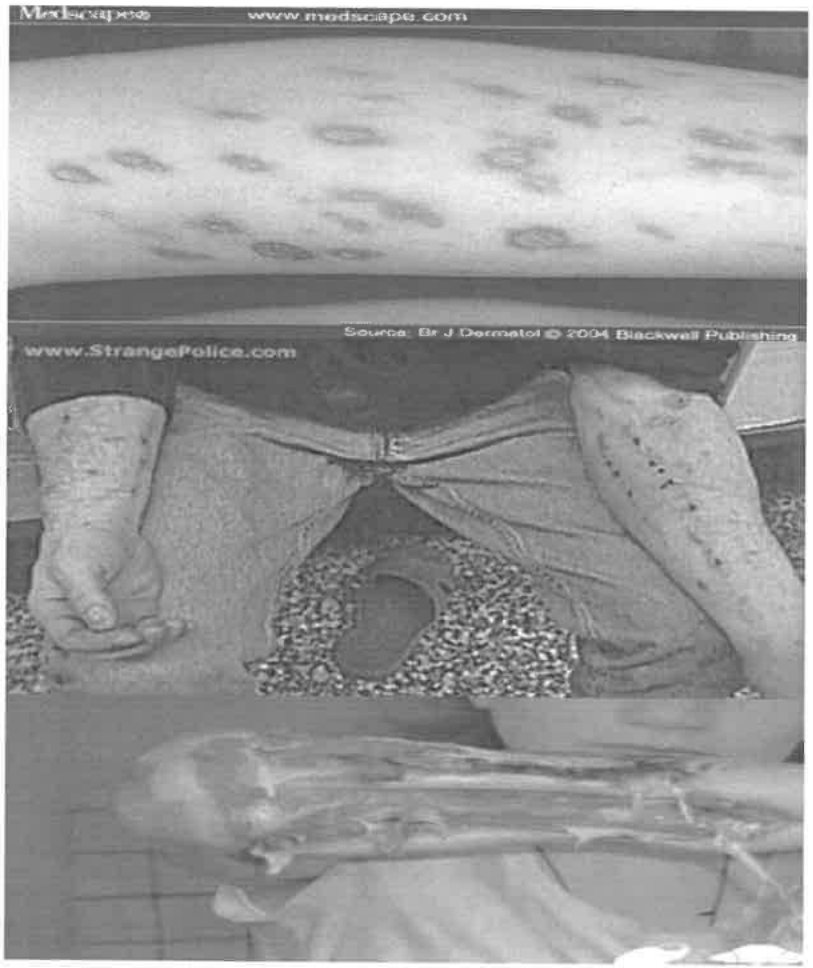
- Intoxication
  - euphoria, ↓inhibition, anxiety/restlessness, ↓appetite, insomnia, paranoia, rapid mood swings, hallucinations, ↑speech/energy, ↑violence
- Withdrawal
  - "crash", depression, ↓energy, panic, irritability



OPIATES

OPIATES

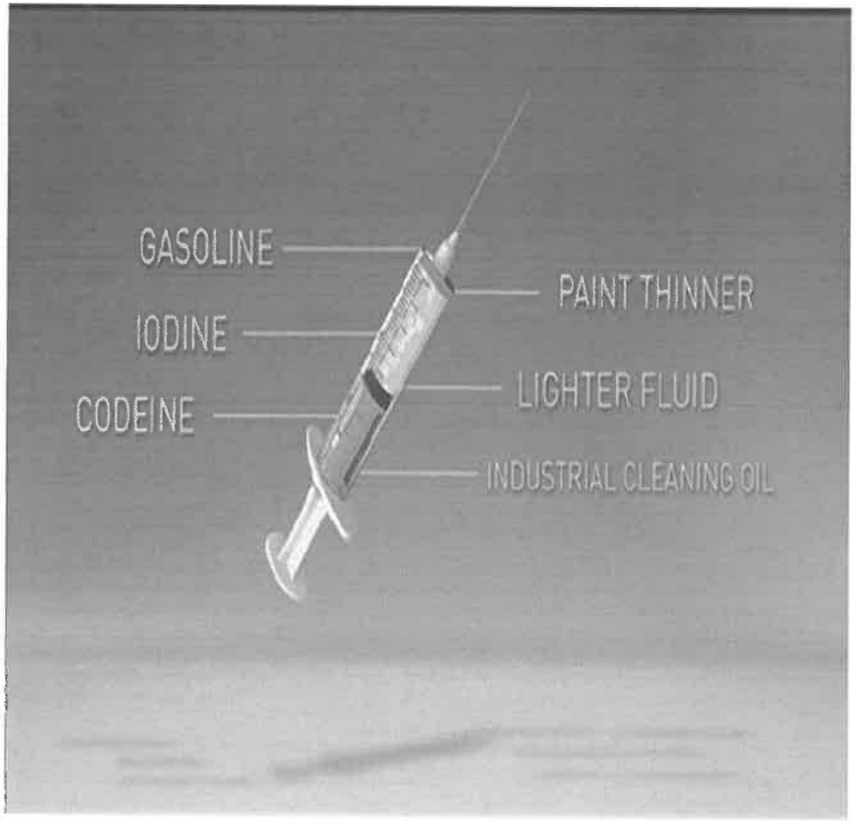
- Intoxication
  - Depression, ↓appetite, insomnia, mental cloudiness
- Withdrawal
  - Anxiety, agitation, restlessness, insomnia, tearfulness
  - Physical w/d and scars/infections are severe, often leading to psychological issues

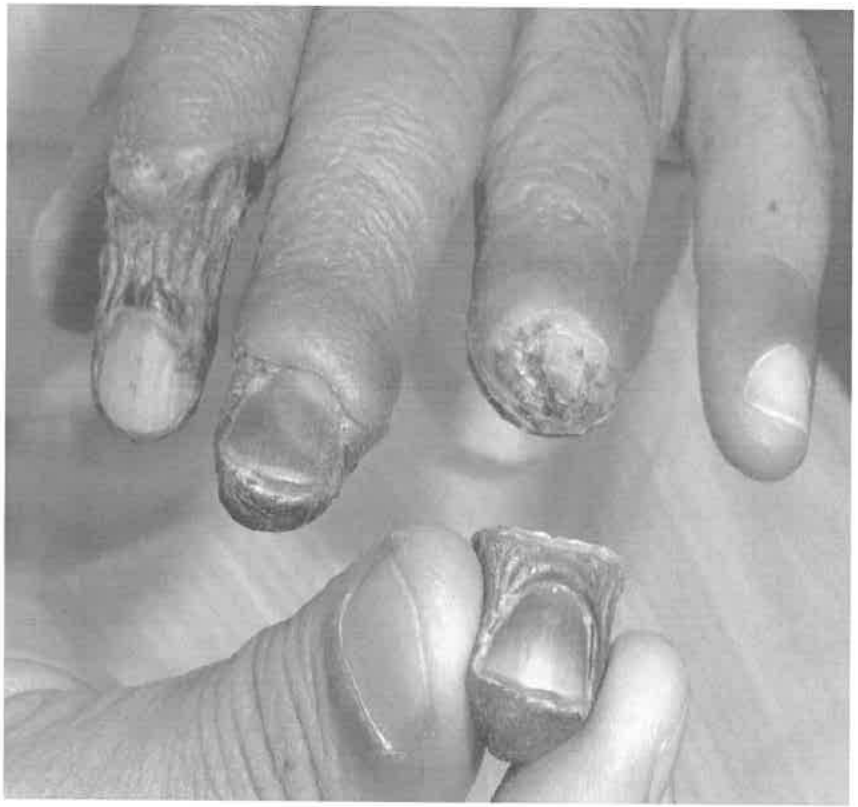


OPIATES-FENTANYL

- Synthetic opiate-easily made in "pill mills"
  - Multiple formulations/derivatives- pills, lollipops, patches-easily absorbed with rapid onset
  - Up to 100x more potent than morphine
  - Up to 50x more potent than heroin
  - Often mixed with poor quality heroin to increase the "high"- has led to drastic increase in OD and death

KROKODIL


GASOLINE
IODINE
CODEINE
PAINT THINNER
LIGHTER FLUID
INDUSTRIAL CLEANING OIL



HEROIN VS KROKODIL

ONE DOSE OF HEROIN

= A HIGH FOR 4-6 HOURS

IT TAKES WEEKS EVEN MONTHS
TO HARVEST, REFINE AND CONVERT
OPIUM INTO HEROIN

WITHDRAWS FOR HEROIN

CAN LAST A WEEK

HEROIN ON AVG COSTS

$100-$300/GRAM

ONE DOSE OF KROKODIL

= A HIGH FOR 1 HOUR

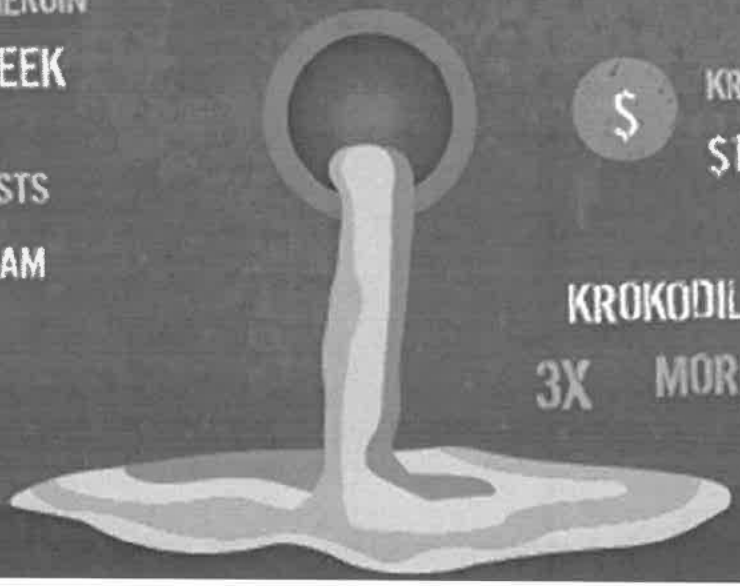
IT TAKES 1 HOUR
TO COOK KROKODIL

WITHDRAWS FOR KROKODIL

CAN LAST OVER A MONTH

KROKODIL ON AVG COSTS

$10-$30/GRAM

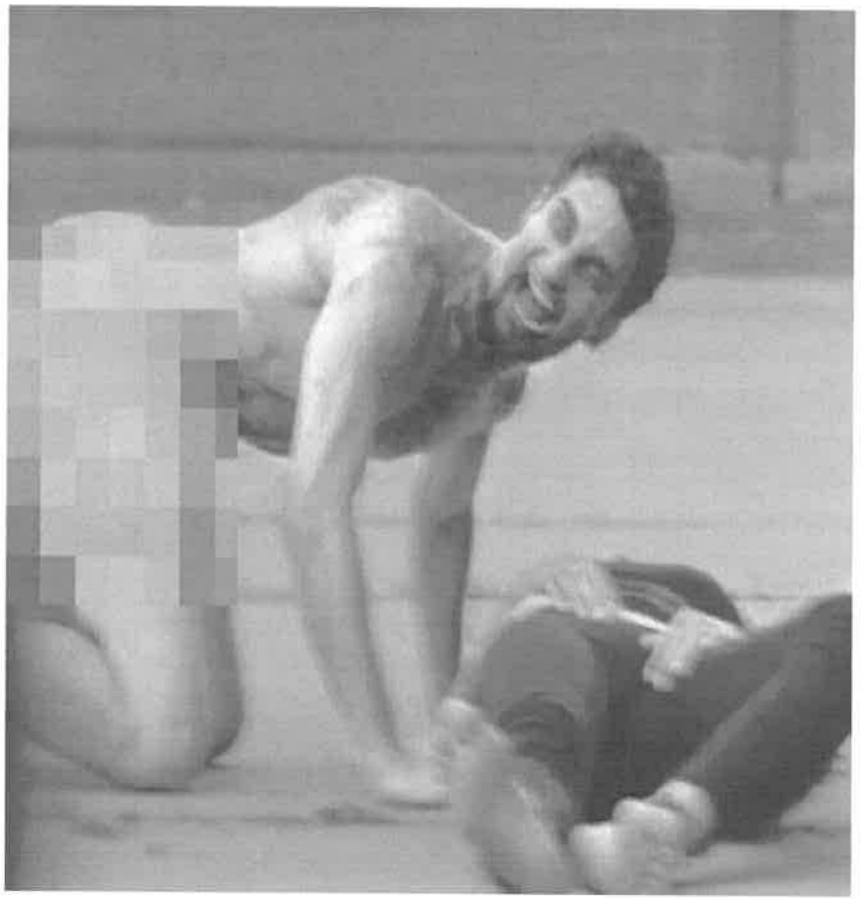


KROKODIL IS 10X STRONGER AND
3X MORE TOXIC THAN HEROIN

BATH SALTS

BATH SALTS

- Intoxication
  - Extreme aggression, psychosis and violent behavior, euphoria
- Withdrawal
  - Anxiety, depression, brain fog, ↑violence, delirium, hallucinations, bizarre behavior, suicidal behavior



SUMMARY

- Mental illness and substance use disorders often coexist, and are far more prevalent in incarcerated populations
- Substance use and withdrawal can mimic, and often worsen underlying mental health symptoms, resulting in increased agitation and risk of violence
- Both disorders need to be addressed in order to increase chance for success

LIAR LIAR

PANTS ON FIRE

THE ART AND SCIENCE OF DETECTING MALINGERING

Jennifer Chaffin, M.D.

MALINGERING

- Definition (DSM-V)
  - The intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives
    - Examples of 2° gain: avoiding military duty or work, financial compensation, evading criminal prosecution, obtaining drugs
    - Suspect if: medicolegal context, marked discrepancies (reported vs objective), lack of cooperation, presence of antisocial personality disorder

DIFFERENTIAL DX

- Factitious Disorder
- Conversion Disorder
- Confabulation

TYPES

- Exclusively feigning symptoms
- Exaggerating actual symptoms
- Feigning symptoms in addition to actual symptoms
- Feigning symptoms and exaggerating actual symptoms

SUBTYPES

- Psychotic Symptoms
- Mood Symptoms
- PTSD/Anxiety Symptoms
- Physical Symptoms
- "Kitchen Sink"

MOTIVATIONS

IMPLICATIONS

- "Do no harm"
- Financial
  - SSI/SSDI, lost productivity,misappropriation of limited resources and medical care
- Legal
  - Injustice
- Medical
  - Side effects

CLINICAL EVALUATION

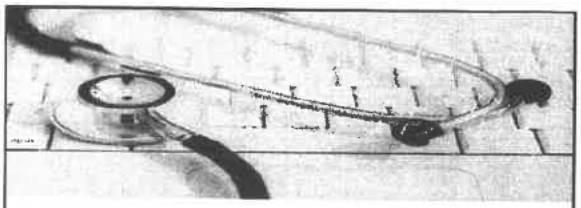
What's the best way to know if someone is feigning symptoms?

Know what the actual symptoms look like!

CLUES

TESTING

- MMSE
- MMPI-2 and PAI
- M-FAST
- SIMS
- TOMM
- SIRS



Clinical Documentation

Jennifer Chaffin, M.D.
Criminal Justice Mental Health

OUTLINE

- Who, what, when, where, why and how?
- Key Components
- Examples

4W's and an H

- Who?
- What?
- When?
- Where?
- How?

- YOU!!!!!
- Provide strong clinical documentation
- ASAP in relation to the service
- In the Chart
- Carefully, thoughtfully, thoroughly and CLINICALLY

Do the documentation daily - before you leave

current Psychiatry

CLINICALLY????

- Document Signs/Symptoms of Dx
- Mnemonics can be helpful
- Major Depressive Disorder:
  - SIGECAPS
- Bipolar Disorder:
  - DIG FAST
- Substance Use Disorders:
  - ADDICTeD
  - WILD
  - CAGE
- PTSD
  - TRAUMA

* The Psychiatric Interview *

WHY?

- Communication-Convey important information to self and others
- Decrease Risk and Liability
- Financial Reimbursement (in the non-CJMH world) or appropriation of resources (CJMH)

COMMUNICATION

- With Self
  - Track and monitor symptoms over the course of treatment
  - Avoid errors and bad outcomes, help
  - Refresh memory
  - Meet the "Standard of Care"

COMMUNICATION

- With Others
  - -Allow cross-coverage
  - -Continuity of Care
  - -Prevent errors
  - -Good outcomes
  - -Avoid bad outcomes
  - -Avoid litigation
  - -Audits/$$$$

PAINT A PICTURE

- Use your words (documentation) to paint a clinical picture of the patient

capture what the interaction was like.

PAINT A PICTURE

HOW?

- Start with a comprehensive interview
- ACBHCS Standards:
  - CC
  - HPI
  - ROS
  - PFSH

CHIEF COMPLAINT

- "The CC is a concise statement describing the symptoms, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words."
  - Examples: "I'm depressed and can't sleep." OR Referred by nursing due to bizarre behavior in booking.

HISTORY OF PRESENT ILLNESS

- "The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present." It includes:
  - Location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms

REVIEW OF SYMPTOMS

- "An ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms the patient may be experiencing or has experienced."
  - Constitutional (e.g. fever, sweats, weight change)
  - Eyes, ears, nose, mouth, throat
  - Cardiovascular, respiratory, GI, genitourinary
  - Musculoskeletal, skin, neurological, psychiatric, endocrine, hematological, immunological

EXAMPLE (CC+HPI+ROI)

- Mr. P. is a 29yo HM, presenting with c/o "panic attacks" for the past six months, since his arrest on PC 288 charges. He endorses SOB, chest tightness, heart palpitations, sweating, and feelings of claustrophobia. He also complains of muscle tension, leading to headaches and tingling in his hands. Episodes last from 5 minutes to 30 minutes, about 5x/week, and though he reports they can come at anytime, they appear more frequently clustered around his court dates, and have been increasing in frequency recently, as his trial is set to start next week.

EXAMPLE (CC+HPI+ROI)

- Mr. P:
  - He has tried walking/pacing and deep breathing, which minimally help. He does not endorse feelings of depression, difficulty sleeping, weight loss/gain, N/V/D, changes in skin/hair or problems with concentration/focus. He also does not endorse worsening of sxs when in crowds of people. He denies si/hi/ah/vh, and denies using illicit substances in custody, though endorses using cannabis daily in the community.

PAST, FAMILY AND SOCIAL HX

- "Past History- the patient's past experiences with illnesses, operations, injuries and treatments"
  - Past psych hx
  - Past medical hx

Past Psych:
- onset of illness/symptoms
- Current treatment/provider
- hospitalizations- why/when/where/duration
- past treatments/meds and outcomes
- diagnoses-when, where, who and symptoms at the time
- suicide attempts-when/what/extent of injury

PAST, FAMILY AND SOCIAL HX

- Past Medical Hx-
  - Current illnesss and tx (HTN, DM, SZ, Thyroid, HepC, Fibromyalgia, etc)
  - Past surgeries or injuries (GSWs, TBI, CVA, MI, etc)
  - Importance????
    - Any of these things, or their treatments, can cause mental health symptoms. The appropriate/effective treatment may be medical intervention, not psychiatric intervention!

PAST, FAMILY AND SOCIAL HX

- Family Hx- a review of medical and psychiatric events in the patient's family, including diseases which may be hereditary or place the patient at risk
  - HTN, DM, Bipolar, Depression, Schizophrenia, Anxiety, suicides, etc
  - Ex: Prevalence of Bipolar is ≤0.6%; risk increases 10-fold for adult relatives of someone with Bipolar I or II

2 hour block when in the housing unit

PAST, FAMILY AND SOCIAL HX

- Social Hx-
  - Housing/living situation and support system
  - Highest level of education
  - Current and past employment, income
  - Trauma history
  - Incarceration/legal history
  - Substance Use Hx- types, amounts, frequency, duration, history of w/d, hx of serious consequences (Ψ symptoms, DUI, arrests, etc), last use

EXAMPLE

- Mr. P:
  - Past psych- reports no prior hx of sxs, treatment, hospitalizations or suicide attempts
  - Medical hx- denies medical issues; NKDA
  - Family hx- reports mother has diabetes and takes Prozac for anxiety; reports father is an alcoholic
  - Social hx- reports he was living with wife and two children (alleged victims of PC 288 charges)-no recent contact with them; no prior arrests/incarcerations, has support from parents and priest; HS grad-no special ed; worked in a warehouse-forklift operator until arrest; denies etoh, daily cannabis prior to arrest-2 joints /day for past 10 years, denies other illicit drugs; endorses childhood sexual abuse by older brother from age 5-7 (never reported)

HOW DO I USE SOAP?

- SOAP
  - Subjective- what is told to you
    - CC, HPI ROS and PFSH
  - Objective- what you are clinically seeing
    - Mental Status Examination and test results
  - Assessment- diagnostic impression with reasoning/support (in the note!!!)
  - Plan- treatment plan, including goals, modalities, medications (MD), tests ordered, follow-up plan

MENTAL STATUS EXAMINATION

- General Appearance
- LOC/orientation
- Grooming/hygiene
- Speech/language
- Memory/IQ/reliability
- Psychomotor activity
- "Mood" and Affect
- Thought process
- Thought content
- Insight and Judgment

- **Mr. P: 29yo HM, appears stated age, alert, oriented, obese, well groomed, tattoo on right forearm, clear speech-normal rate, volume and tone, good historian, appears average IQ, no tremors or tics, "okay" mood, congruent but slightly anxious affect, logical & directed thought processes, denies ah/vh, no evidence of a thought disorder or delusions, insight and judgment are fair**

KEYS TO DOCUMENATION

- Each note should be able to "stand alone" and paint the clinical picture
  - Provide key history and interval history
- The Assessment and Plan should be supported by the Subjective and Objective
  - Diagnosis and treatment plan should be evident based on signs/symptoms in the note

EXAMPLE

- Mr. P:
  - Assessment: [29yo HM with no past psych hx or known medical issues, presenting with 6mo hx of panic attacks in context of incarceration/serious legal charges.] Diagnostic impression: Panic Disorder, without Agoraphobia vs Adjustment Disorder with Anxiety; Cannabis Use Disorder, Moderate, In Institutional Remission
  - Plan: Trial of Prozac 20mg qam to reduced anxiety/panic symptoms-risks/benefits/alternatives/common side effects discussed and consent obtained. Labs ordered to r/o medical causes/contributions. F/U Clinic/Chaffin on 11/18/15.

PITFALLS TO AVOID

- Don't confuse Subjective and Objective information
  - Always give attribution
  - Ex: "Patient reports he is hearing voices," not "Patient hears voices."
- Reconcile Subjective and Objective information in your MSE and Assessment
  - Ex: "Despite denial of ah/vh or mental illness, patient appears internally preoccupied with evidence of thought blocking and paranoid delusions that his food is being poisoned by the FBI. He also has 33 PSP episodes since 1999 for Schizophrenia and other psychotic diagnoses."

PITFALLS TO AVOID

- Cut and Paste
  - Especially from other author's notes!!!!.
  - If you do cut and paste—READ and UPDATE the material so that it is current, intelligible and ACCURATE

Think about encounter add or delete & edit each note.

PITFALLS TO AVOID

- Using excessive, unapproved or uncommon abbreviations and acronyms
  - Ex: CPS, SAD, BAD, BPD, NCD, JGP, PCN, etc
  - County approved abbreviations and acronyms are available on the website
- Assuming nobody reads your notes
- Assuming everyone knows your thoughts/reasoning
- Not reading/proofing your own notes
- Not tailoring the note to that individual (generic templates)

SUMMARY

- Quality documentation is essential for good patient care and outcomes
- Start with a comprehensive exam, followed by focused interval exams
- Document the clinical findings of the exams in a concise but comprehensive note with appropriate attribution
- Ensure the Assessment and Plan logically follow from the Subjective and Objective portions (and detail reasoning)
- Proofread your note to ensure accuracy

MENTAL STATUS EVALUATION: TERMS AND DEFINITIONS

1. ***"General Appearance and Behavior"***
Does the patient appear his/her stated age? Describe facial expression as well as condition, dress and grooming. Is the patient unkempt, or malnourished? Does he/she smell? Evidence for tattoos, scars, and lacerations should be recorded here. Does the patient use a wheelchair, a cane, glasses or a hearing aid? Describe the observed motor activity (overactive, underactive). Evidence for tardive dyskinetic movements and cogwheel rigidity are listed here. Is the patient cooperative, calm, or agitated? Does he/she regard the examiner during the interview, does he/she avert eye contact, or are his/her eyes fixated in space (on an apparent object that is not present)?

2. ***"Speech"*** This section is concerned only with the mechanics of talking.
What is the rate and volume? Is it monotone? What is the rhythm? Is there an increase in latency (normal time to respond is 3-5 secs)? Is the amount of speech increased or decreased (*e.g.* mute, poverty of speech)? Is it spontaneous or does the patient only talk when a question is asked? Is the speech stilted? What is the level of the vocabulary? Are there neologisms, word approximations, phonemic or semantic paraphasias?

3. ***"Flow of Thought" (FOT)*** This section describes how thoughts are connected to each other. When normal, thoughts are logical, sequential and goal directed (*i.e.* one can answer questions directly). This area of the MSE is difficult and requires constant work. It involves observations about verbal patterns, which one does not ordinarily make. This area of the MSE is the least precise but can be done well with the use of verbatim examples from the patient. Also describe the rate at which one thought follows the previous thought. Several patterns of thought flow have been noted to occur in patients and are described below.

- *Circumstantial speech* involves inclusion of too many trivial details. For the most part it is logical and sequential. Thus the connection between ideas is easily understood. In addition if the patient is given enough time he/she will also reach the goal (usually the answer to your question). Circumstantial speech is not necessarily pathological. It tends to be seen more commonly in the elderly (*e.g.* a patient starting back in 1914 and going through his/her whole life story to tell you why he/she looks both ways when crossing the street).

- *Tangential speech* is used to refer to the situation in which a patient's response to specific questions is oblique or irrelevant.

- *Derailment* is used to describe spontaneous speech in which ideas slip off the track and onto another one that is obliquely related. Thus, it is comparable to tangential speech, but tangential is used to describe the phenomenon when it occurs as the immediate response to a question. Loosening of Associations is an older term for derailment.

- *Flight of Ideas* describes derailment in which one idea is quickly followed by another (*e.g.* in the context of pressured speech). Use of this term, historically, is used to indicate the FOT in a manic and thus one should be careful in its use in non-manics, lest it be misinterpreted by others.

- *Incoherence* (a.k.a. word salad, jargon aphasia) denotes a pattern of speech that is more severely affected than derailment. In contrast to derailment, where the slippage occurs between ideas or sentences, the slippage in incoherence occurs between words or phrases. At times it can be difficult to differentiate incoherence from Wernicke's aphasia.

- *Clanging* (choice of words based on their sounds), rhyming, puns may be present.

- *Echolalia* (repeating what is said by others in an echoing fashion)

- *Perseveration* (repeating the same word, phrase, or idea over and over again)

4. ***"Content of Thought" (COT) or Thought Content (TC)***

This section describes predominant ideas and thoughts that the patient is discussing or is occupied by. One should not simply record patient complaints (*e.g.* "I am seeing things" or "I want to kill myself"). Such statements are subjective and are symptoms. Instead when evaluating a patient's COT one should be probing and examining several aspects of a belief, for example, in order to offer evidence for or against it being a delusion. COT can be subdivided into 4 components. Each should be commented on.

a) Suicidal and homicidal thoughts

Every patient must be evaluated for the presence of suicidal or homicidal ideas. Ideation should be delineated from intent and plan. Findings should be explicitly recorded in the note. It is not adequate or appropriate to just take at face value what a patient says (*e.g.* I'm suicidal") and list the patient as suicidal or homicidal. Not uncommonly, such statements by patients are attempts at inducing somebody to do something (*i.e.* manipulative). Suicidal or homicidal statements should be explored to determine the degree of intent. For example, is the patient planning for the future, is the statement conditional (*e.g.* "I will only kill myself if you discharge me"). Also include in this section any statements about the patient doing harm to him/herself or others that would not result in death (*i.e.* any form of violence to self or others).

b) Thoughts associated with psychosis

Delusions, ideas of reference, feelings of derealization and depersonalization are reported in this section of the mental status examination. Traditionally, hallucinations are also recorded here since they occur frequently with other psychotic phenomena like delusions. Hallucinations are false sensory perceptions. Sometimes an attempt is made to distinguish between illusions (the misinterpretation of real sensory stimuli) as opposed to hallucinations, which occur in the absence of real, external, sensory stimuli. For practical purposes, one cannot always distinguish between illusions and hallucinations. Often, patients with delirium experience illusions. Hallucinations can occur in any of the five sensory modalities.

Auditory hallucinations are the most common. *Visual hallucinations* can also occur, and are often associated with substance intoxication. *Tactile hallucinations* are sometimes called haptic hallucinations (not to be confused with hypnagogic hallucinations which occur in the state between wakefulness and sleep). *Olfactory and gustatory* hallucinations may sometimes occur, and are generally associated with organicity.

- A *delusion* is a fixed false belief outside of the norm of the patient's culture. When evaluating whether a particular false belief is delusional or not, one needs to determine whether the thought is fixed (*i.e.* in the face of evidence that the belief is false the patient persists in believing it.). Also determine whether the fixed false belief is a normal for the patient's culture (*e.g.* voodoo in somebody from Haiti). Such beliefs are not necessarily an indication of psychosis.

- *Persecutory delusions* are obviously those of persecution (note that they should NOT be referred to as paranoid. Paranoid means delusional). *Delusions of megalomania* are those of being a great person. One kind of delusion, which has its own name because it occurs so frequently, is the *delusion of passivity*. This is the belief that one's thoughts or one's motor behavior is under the control of an outside agent. The outside agent may be either animate or inanimate. It may be close at hand or at a distance. The patient may believe that his mind is being controlled, that thoughts are being put in his mind, taken out of his mind, being broadcasted, or somehow molded (thought insertion/withdrawal/broadcasting). He may believe that his body is being controlled, marionette-like. This experience of passivity is often accompanied by a complex array of other delusions and hallucinations so that it can be difficult to determine at what
point one pathological phenomenon ends and another begins.

- *'Delusion of reference'* This term is source of confusion because it covers such a variety of experiences. Normal people have *ideas* of reference in embarrassing social situations (feeling that somebody is talking about you). These beliefs are short-lived and are quickly recognized as lacking veracity. On the other hand, patients who are psychotic may experience *delusions* of reference in a bizarre and pronounced fashion. A delusion of reference is the unwarranted idea based upon a trivial occurrence (*e.g.* the person at the next table looked at the patient) that a person is talking about you, watching you, or noticing you. The belief continues in spite of no evidence supporting the belief. It also is used to describe the phenomenon where a patient reports that an event was meant as a special message to the patient (*e.g.* the death of the horse in The Godfather had a hidden message for the patient from God -- that horses should be killed because they are the messengers of Satan).

- *'Derealization'* is the feeling that the world has changed, usually in some alien way. The patient may or may not know that this feeling is abnormal. *'Depersonalization'* is a similar feeling, however it applies to the patient's own body. The patient feels that his/her body is somehow changed or that his/her identity has somehow changed or become lost. The patient may or may not believe the feeling is abnormal.

- *'Schneiderian First Rank Symptoms'* Kurt Schneider believed that several psychotic symptoms only occurred in patients with schizophrenia (*i.e.* are pathognomonic) and thus argued that their presence always indicated the presence of schizophrenia. Schneider called these symptoms, First Rank Symptoms (Second Rank Symptoms were symptoms that occur frequently in schizophrenia and in other illnesses). Subsequent work has shown that while First Rank Symptoms are seen frequently in schizophrenia they can occur in patients whose course of illness is not consistent with schizophrenia.

Thus, their presence suggests a high likelihood that a patient may have schizophrenia but this likelihood is not 100%. This fact accounts for why the presence of certain psychotic symptoms qualify outright for the A criterion of schizophrenia whereas other psychotic symptoms must occur in the presence of other symptoms in order for the A criterion of schizophrenia to be met. Psychotic patients should be evaluated for these specific symptoms. Schneiderian symptoms revolve around the concept that the patient has lost control of his body and is being controlled by others. First Rank Symptoms are:

- Hearing one's own thoughts out loud
- 3rd person voices commenting on the actions of the patient
- Voices arguing among themselves
- Thought insertion – insertion of a thought into ones mind by an outside agent
- Thought withdrawal – having one's thought withdrawn from one's mind
- Thought broadcasting – being able to broadcast one's thoughts
- Attributing one's feelings to others (delusion of passivity – feelings)
- One's drive is controlled from outside (delusion of passivity – impulses)
- Experiencing one's actions as controlled from outside (volitional passivity)
- Having bodily sensations imposed from outside (somatic passivity)
- Attributing special delusional significance to one's perceptions (delusional perceptions). Delusional perceptions combine a real perception with a delusional idea about its meaning. It, thus, is similar to a delusion of reference, *e.g.*, "when the doctor rubbed his nose, it meant I should leave the room."

c) *Non-psychotic thoughts*
Phobias and obsessions are included here if patient speaks of these phenomena as occurring at the present time. *A phobia* is an intense, unreasonable fear associated with some situation or object; *i.e.* fear of heights, closed places, etc.
An obsession is a recurrent or persistent idea or thought which is recognized as foreign or alien to the individual and which is accompanied by the desire to resist it.
A compulsion is a recurrent act recognized as foreign or alien to the individual and which is accompanied by the desire to resist it. As such compulsions should not be placed in "Content of Thought."

d) *Paucity/abundance of thoughts*
Finally one should be evaluating whether there is Poverty of Content. This is different than Poverty of Speech, which is recorded in the speech section. Poverty of Speech describes a decrease in the amount of words. A patient who only answers yes or no would be an example. Poverty of Content describes a decrease in the informational content. This sign is seen frequently in patients suffering from schizophrenia. A patient may have Poverty of Speech, Poverty of Content, both, or neither.

5. ***"Mood"*** As defined by DSM-IV mood is "a pervasive and sustained emotion that colors the perception of the world." This is usually accomplished by asking the patient how he/she is (or has been) feeling, the goal being to have the patient "average" his/her mood over a certain amount of time. Strictly speaking, since the patient is providing a subjective report of

his emotional state, mood is really a symptom and it should be recorded in the subjective section of the SOAP note. It is recorded here in order to allow comparison with the observed affect. Not uncommonly the patient's stated mood is given between quotation marks. (*e.g.* "angry," "sad," "depressed," "happy").

6. ***"Affect"*** As defined by DSM-IV affect is "a pattern of observable behaviors that is the expression of a subjectively experienced feeling state (emotion)." Affect, thus, is a sign ("observable") and describes a person's emotional state at the time of the exam. There are four basic qualities that should be detailed about a person's affect.

a) *Type of affect*
Is it depressed, normal or elevated/euphoric/happy? What is its range? Can it be evoked with prompting (*e.g.* laughs after a joke)? An appropriate description of a patient suffering from depression might be: "Affect is depressed and restricted to the lower range though the patient will laugh to jokes."

b) *Stability of affect*
Is the patient's affect labile? Does it remain stable, or does it change noticeably and quickly in response to small changes in the conversation?

c) *Appropriateness of affect*
Is the patient's affect appropriate to the conversation? Is it congruent to his stated mood? A patient's affect may be judged to be inappropriate for a number of reasons. Examples should be given.

d) *Amount of affect*
Blunted and flat affect is used to describe patients in whom the amount of affect is decreased (blunted) or non-existent (flat). This phenomenon is frequently seen in patients with schizophrenia. Usually patients with depression do have affect. It is just restricted to the negative emotions. In such instances a depressed patients should not be described as having a blunted or flat affect.

7. ***Sensorium and Intellect***
Intellectual functioning, factors such as the patient's educational level, ability to concentrate, anxiety, and willingness to cooperate should be considered.
a) *"Sensorium"*
- Orientation to person, place and time (day of month, month, year, day of week, season). If not oriented, give patient's answers and correct information.
b) *"Recent and Remote Memory"*
- Recent memory - date of admission, brought to hospital by whom.
- Remote memory - when and where born, date of marriage, names and ages of children.
c) *"Attention Span and Concentration"*
d) *"Language"*
- Naming objects, ability to repeat phrases and overall vocabulary are examples of language function.

e) *"Fundamentals of Knowledge"*
- Is patient aware of current events, past history and vocabulary?

8. ***"Insight and Judgment"***

Insight and judgment are important components to determine not only in patients with psychiatric disorders but also in patients with "medical" illnesses. Studies have shown that good insight and judgment correlates with improved long-term outcome.

- *Insight* signifies that the patient realizes that he/she is ill and understands something of the nature of his/her illness. In addition it also refers to a patient's ability to recognize his/her symptoms. It does not refer to etiology or psychodynamic aspects of the illness. In describing their insight one should be specific about the object of their insight.
For example, a patient might have good insight into the fact that he/she has a major depressive disorder and is having problems with sleep and appetite but has little to no insight into the fact that his/her thoughts about guilt are also symptoms of the illness.

- *Judgment* may be assessed by evaluating the patient's ability to understand social context. This can be based on observation, *e.g.* you observe patient punching a security guard, and on responses to the following questions: What would you like to do next? What do you plan to do when you leave? Why were you brought here? Again as with insight one must specify precisely the object or symptoms on which one is evaluating the judgment. Clinicians may be particularly interested in the patient's judgment about treatment – does the patient actively participate in discussions of treatment and assist in a helpful way with treatment choices? social situations.

MENTAL STATUS GLOSSSARY:

- *Appearance* - overall impression, posture, clothes, grooming, health, apparent age, angry/afraid
- *General Behavior* - mannerisms, gestures, combative, rigid, twitching, psychomotor retardation
- *Attitude toward examiner* - cooperative, hostile, defensive, seductive, evasive, ingratiating
- *State of consciousness* - lethargic, alert, hyper alert
- *Attention* - concentration, ability to attend
- *Orientation* - person, place, time, situation
- *Psychomotor Activity* - increased, reduced, agitated, abnormal movements
- *Mood* - overall emotional state (sad, happy, depressed, elated, anxious, irritable)
- *Affect* - current emotional state (full, labile, restricted, flat, inappropriate, suicidal/homicidal)
- *Speech* - rate (increased, pressured, slow), tone (soft, angry) volume, articulation, language (aphasia)
- *Form of thought* - circumstantial, flight ideas, evasiveness, loosening associations, perseverance, blocking
- *Content of thought* - preoccupations, obsessions, phobias, rituals, delusions, depersonalization
- *Perceptions* - misperceptions, illusions, hallucinations,
- *Judgment* -
- *Memory* - immediate (digit span), recent (three objects at 5 minutes), remote (days to years)
- *Insight* - do they realize they are ill
- *Intellectual Functioning*- fund of knowledge, calculations, abstraction (proverbs, similarities)

ALAMEDA COUNTY Behavioral Health Care Services

Assessment (CJ)

Provider:	81142 CRIMINAL JUSTICE MHS SNTA RITA	Service Number:	[redacted]
Procedure:	323 90791 Psychiatric Diag Eval	Service Date:	
Client:	PSP #, NAME	Dup Reason Code:	
Emergency:	No Pregnant: No	Location:	Correctional Facility
Primary Clinician:	15380 Oakes, Jonathan, MFT	Number in Group:	1
		Med Compliant?	N/A Side Effects? N/A
		Staff Time:	0 hr(s). 50 min(s).
		Record Stamp:	[redacted]

Interactive Complexity: Not Present

Instructions and Pre-Existing Diagnoses

Respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

PFN # [redacted] SRMR#

BOOKING NAME: NAME

Primary FF Time | Time Of Day Housed In | Date Of Birth

[redacted]

Services were provided in English by ☐ interpreter or ☐ clinician

Episode Diagnosis Information

	Axis I	Axis II	Axis III	Axis IV	Axis V
DSM-IV	[redacted]				
ICD-10:					
DSM-IV					
ICD-10:					

Allergies

○ Yes ○ No ○ Unknown

● No new allergies reported

Assessment

CRIMINAL JUSTICE MENTAL HEALTH PROGRAM ASSESSMENT (331)

Race: Other Sex: Female

CDC:

✔ County (82) ☐ CDC (61) ☐ Fed (44) ☐ State Hospital

Location seen: ☐ ITR ☐ Clinic ✔ HU ☐ Other

SECTION A

Incarcerated before? ○ No ● Yes Where? (check all that apply) ☐ SRJ ✔ Other jail ☐ Prison (name):

Current Psych Tx? ● No ○ Yes Psych meds in last 30 days? ● No ○ Yes **VETERAN?** ● No ○ Yes

Name of medication	Dose	Last dose	Prescribed by (clinic/MD):
			Name/location of Pharmacy:

Recent inpatient ● No ○ Yes When/Where

Recent State Hospital ● No ○ Yes When/Where/Why

Current Outpatient ● No ○ Yes Last seen: Where: Case manager:

● No ○ Yes **Females BIRTH within last year?** (see clinical guidelines)

● No ○ Yes **Developmental Disability?** If yes ☐ suspected ☐ confirmed (see clinical guidelines)

[redacted]

[redacted] No [redacted] Yes **History of head trauma?**

[redacted] No [redacted] Yes **Substance use within last 30 days?**

[redacted] No [redacted] Yes **History of victimization?** ☐ sexual ☐ emotional ☐ physical

[redacted] No [redacted] Yes **History of Violence/Predatory behavior?** Describe: [redacted]

SECTION B	Arrest Date: [redacted]	Release Date:	Charges:

1. Reason for Referral/Referral Source:
Client had been housed in HU24, so this writer saw client to do a welfare check and to see if she had Mental Health needs.

2. Emotional Response to Incarceration:

3. History of Psychiatric Treatment (incl. prior psychotropic meds, dates, reason discontinued; psychiatric hospitalizations, CJMH):
Client's RSP HX [redacted] Client said that [redacted]

4. Substance Use/Abuse History (type of substance, frequency, duration, treatment history, last use):
Client reported that [redacted]

5. Medical History (include current and past medical conditions; medications; head injuries, seizures, allergies):
Client reported that [redacted]

6. SUICIDE ASSESSMENT

SUICIDE IDEATION ○ Yes ● No If yes, describe:

PLAN? ○ Yes ● No If yes, describe:

HISTORY OF ATTEMPTS? ○ Yes ● No # OF ATTEMPTS? IN-CUSTODY ATTEMPTS? ○ Yes ○ No

DATES OF ATTEMPTS & DESCRIPTIONS:

RISK FACTORS (see Clinical Guidelines and note each factor):

SECTION C	MENTAL STATUS EXAM

Observations (Orientation, Intellect, appearance, motor activity, speech, mood, affect, thought content, thought process, perceptions, insight, judgement, impulse control)
[redacted]

Other: race, sex, religion, culture, language, classification issues, etc.)

SECTION D	COMMENTS/IMPRESSION (include description of hallucinations, symptoms of depression/anxiety, etc.)

Clinical Diagnosis/Impressions
[redacted]

Plan: (Goals and Objectives)
[redacted]

Criteria for Treatment (check all that apply):

☐ 1. Medical Necessity/Diagnosis ☐ 2. Medical Necessity/Functional Impairment ☐ 3. Psychiatric History
✔ 4. Substance Abuse History ☐ 5. Dangerous to Self or Others ☐ 6. Continuity of Care

DIAGNOSES		DSM IV CODES			
Axis I	Polysubstance Dep	[redacted]			Indicate primary and secondary diagnoses (1, 2)
	Adjustment D/O w Anxiety				
Axis II	Deferred				

Axis III: Physical Disorders	Axis IV	Axis V	
High Blood Pressure, Diabetes, High Cholesterol, thyroid issues	H	55	

Outcome: ○ No return appt. ● Reappointment Date: 09/02/2016 to see Banks in ☐ Clinic ✔ HU # 24

Date: to see in ☐ Clinic ☐ HU #

Electronically Signed By
15380 - Oakes, Jonathan, MFT 8/12/2016 Marriage/Family Counselor

[redacted]

ALAMEDA COUNTY Behavioral Health Care Services

Clinician's SOAP Note (CJ)

Provider:	81142 CRIMINAL JUSTICE MHS SNTA RITA	Service Number:	[redacted]
Procedure:	441 90832 Psychotherapy 30 min	Service Date:	
Client:	PSP #, NAME	Dup Reason Code:	
Emergency:	No Pregnant: No	Location:	Correctional Facility
Primary Clinician:	15380 Oakes, Jonathan, MFT,	Number in Group:	1
		Med Compliant?	N/A Side Effects? N/A
		Staff Time:	0 hr(s). 40 min(s).
		Record Stamp:	[redacted]

E/M Plus Psychotherapy or Additional Crisis: None 2nd FF Time: 2nd Tot Time:
Interactive Complexity: Not Present

Instructions and Pre-Existing Diagnoses

Respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

PFN # #1 SRMR# BOOKING NAME: NAME

Primary FF Time | Time Of Day | Housed In | Date Of Birth

[redacted]

Services were provided in English by ☐ interpreter or ☐ clinician

Episode Diagnosis Information

	Axis I	Axis II	Axis III	Axis IV	Axis V
DSM-IV:	[redacted]				
ICD-10:					
DSM-IV:					
ICD-10:					

Allergies

○ Yes ○ No ○ Unknown

● No new allergies reported

[redacted]

Reason

Reason for Assessment (check one): ● Progress Note ○ ICC ○ Admission to Inpatient ○ Discharge from Inpatient ○ Safety Cell ○ Other

☐ Complete PHQ-9 Questionnaire?

Subjective (Client self-reported information):

[redacted]

Objective (M.S.E., Symptoms)

[redacted]

Assessment (Dx)

[redacted]

Plan:Interventions (Tx and Rationale): Meds (psych/other), Labs, Referrals

[redacted]

Outcome

Outcome: ○ Admit to Inpatient Unit ○ No return appt. ● Reappointment

Date: 08/23/2016 to see Banks in ☐ Clinic ✔ HU # 24

Date: to see in ☐ Clinic ☐ HU #

Electronically Signed By

[redacted]

HAND WRITTEN PROGRESS NOTE

Alameda County
Department of Behavioral Health Care Services
-Mental Health Division

Progress Notes
Mental Health Services

Client Name:
Birthdate:
Chart No.:
PSP Client ID No.:
Admit Date:
Reporting Unit:

DOE, JOHN (NAME)
[redacted] (DOB)
ABC 123 (PSN)

Respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress. Each month the clinician will complete a client stability ranking with justification. Use the stability rating criteria procedure and assign a numeric ranking. Identify the ranking and enclose the number in the box (e.g. Stability Rating [5]). Please sign each narrative with signature and title. Each progress note must include the following headings:

Date	Amt. of Time	Loc.	Srvc. Type	Prob. No.	
					BODY OF NOTE =
					CODE
					DATE
					LENGTH
					OF TIME
					THIS WRITER SPOKE WITH CLT'S SOCIAL WORKER ABOUT
					F/U APPOINTMENT
01/01/15	20 MINS				HUB TBA 1/6/15

SIGNATURE
LMFT

DATE / TIME,
01/01/15
12:00 pm

Jonathan Oakes, LMFT
Behavioral Health Clinician II
Staff # 15380

Date: Stability Rating [ ]

Amt. of Time: In hours and minutes **Location:** Office = 1, Field = 2, Telephone = 3, Home = 4, School Satellite = 5, Satellite = 6:
Service Type:

300	No Show	331	Assessment	361	Medication Support	391	Group Rehabilitation
311	Collateral	341	Individual Therapy	371	Crisis Intervention	571	Brokerage Services
321	Evaluation	351	Group Therapy	381	Individual Rehabilitation	581	Plan Development

For AB3632 services the ending digit for each code is a (2) except for No Show

313-MA11 (1/96)

Countertransference in the Jail

BY
JO ROBINSON, MFCC
&
KATHERYN HOLMES, RN

INTRODUCTION TO COUNTERTRANSFERENCE IN JAIL

Stereo-typical notions of a jail often include images of "bad" people, structural confinement and danger. In these, the sources of stress are obvious. Many times the stressors encountered within the jail system are subtle and easily overlooked by the mental health professional (Freud, 1921).

For our discussion here, we shall use the definition as put forward by Forensic Psychiatry; "so is the term countertransference often used in a general sense (both within psychoanalysis and outside it) to describe the whole of the therapist's feelings and attitudes towards his patient, and even to describe facets of ordinary non-therapeutic relationships." (Forensic Psychiatry, 1978).

The forensic setting houses many individuals who have severe personality disorders. These individuals can be highly manipulative, demanding, and have learned to freely express their sense of entitlement and anger. Quite the opposite is true for many of the mental health professionals who have chosen the field of forensic psychiatry. Some clinicians attracted to this setting are those who have a difficult time expressing their own aggression and have a tendency to internalize anger (Lion, 1981).

This difference, combined with the structural confinements and innate dangers of a jail, lead to a situation ripe for stress and subsequent countertransference issues.

This section attempts to bring forward in discussion the overt as well as the covert stressors and countertransference issues stimulated by the forensic setting.

Specifically, the discussion will focus on:

- Environmental impact;
- Interpersonal dynamics;
- Intra-personal dynamics, and
- Ways to manage these concerns.

RATIONALE

Unattended countertransference has been well documented and noted to frequently lead to increased feelings of confusion, helplessness and the sense of being overwhelmed.

Imagine the feelings of the humanistically trained clinician attempting to understand and work with the dynamics of an inmate whose drug use was monitored by and shared with his father. This clinician might feel outrage, incredulity and disgust. Without the ability to reconcile these feelings, the therapeutic hour might be compromised and perhaps used as a forum for the resolution of the therapist's problems.

By attending to issues of countertransference, it is possible to decrease these negative feelings and behaviors. Additionally, the identification and talking over of emotional reaction can reduce stress, facilitate the therapeutic process, and enhance professional self-esteem (Gibb, 1971).

ENVIRONMENTAL IMPACT

Initial exposure to the jail is most commonly described as overwhelming. The senses are bombarded with sights, sounds, and smells too numerous to sort out.

Increased anxiety results from:

Visual Encounters

-Witnessing forms of violence, bars or other barriers, uniforms.
-Debris.
-Crowded conditions.
-Exposure to nudity, toileting, bathing, and sexual activity.

Auditory Stimuli

-Clanging of gates and keys.
-Television or radio sounds.
-Plumbing sounds.
-Coarse and lewd language.
-"Wolfing".
-Constant bids for one's attention.

Olfactory Sensations

Sweat	Vomit
Excrement	Stale alcohol
Urine	Cigarette smoke
Food	Burning debris

Psychical Experience

-Confinement.
-Stepping over debris.
-Avoiding thrown objects.
-Oppression.
-Steam during shower time.
-Lack of privacy.
-Physical encroachments.

This kind of environment tends to elevate anxiety and the need for self-protection via "flight or fight". As one is committed to work, neither of these responses are appropriate, and ways to cope with the stimulation via personal defenses come into play. Along with desensitization (which does imply a concomitant reduction in stressors), one can

utilize mechanisms such as denial, by unconsciously ignoring the situation at hand; minimizing, by recognizing yet denying the impact of stressors and conflict; isolating, by intellectualizing the responses while suppressing the emotional impact; displacing, by venting the combined intellectual and emotional response onto an unrelated object (Freud, 1946).

While these mechanism allow one to cope on a day-to-day basis, they tend to foster the accumulation of unexpressed emotions.

Without an effective outlet, the perspective becomes distorted and contaminates the therapist's interaction with others, both professionally and personally, consequently the forensic professional can become rigid, non-productive and depressed.

INTERPERSONAL DYNAMICS

Within the contained community of the jail, the therapist is exposed to a spectrum of personality and psychiatric impairments. It is essential that the clinician be adequately prepared and able to adjust to the needs and demands of both patients and other professionals associated with the criminal justice system (Forensic Psychiatry, 1978) all the while continuing to maintain a personal equilibrium.

Most often perceived as the official mental health expert by inmate and staff, the therapist is constantly challenged to maintain a professional demeanor (Forensic Psychiatry, 1978). Requests for advice, decisions, and information are continuous and may become overwhelming (Kernberg, 1978). Once again, the previously cited individual defense mechanisms are evoked and called into play. Uniquely tied to the jail setting, certain situations commonly reoccur.

Threat to Confidentiality

Witnessing unusual and aggressive behaviors may stimulate uncomfortable feelings in people. Commonly, there follows an attempt to either avoid those feelings or release them via ventilation to another (Menzies, 1961). This is true in the jail, as well; custody, medical, and other personnel may seek out mental health staff for conversation. Along with this attempt to talk, those individuals may request information about a patient as a means to reducing their own anxiety. If the therapist gives that information, confidentiality is breached. If it is ethically refused, the therapist is viewed as not helpful and with-holding. Once again conflict manifests itself.

Informal Counseling

Being highly visible and readily accessible, the therapist is often approached by jail personnel for advice and solutions to matters which may be unrelated to the jail

community. After all, it is seemingly free and convenient! No conscious decision for therapy has been made when one can casually mention one's problems to a fellow jail worker. The working relationship subsequently becomes tainted. In addition, this informal approach to seeking counseling may include genuine complaints about other staff or inmates, concerns for welfare of others, and direct requests for psychiatric intervention. This not only adds to the workload by covertly increasing the stress of the therapist's day, it also visits a hidden cost upon the working relationships: an ensuing distance is created by the feeling that the therapist may know too much about the worker.

With the daily encountering of primitive personalities in the incarcerated population, jail personnel are constantly struggling with the pressure of their own feelings of aggression, including sadism and rage. At times, the clinician is utilized by others as a vehicle for validating and understanding those powerful and distressing affects in a non-judgmental way (Forensic Psychiatric, 1978). It is useful to remember that while the therapist is being called upon to respond in this role, she/he is likely to be struggling with the very same affects of aggression (Guggenbuhl-Craig, 1971). This is another situation which promotes the utilization of the therapist's defenses; however, it may get worse. If jail personnel do not externalize conflict via verbalization and validation, there is the risk of these feelings being displaced onto the mental health professional. The nature of the interaction between the clinician and jail personnel can become one of blame: i.e., "If **you** were competent, **you** would fix those problems; it's **your** fault; **you** are responsible for making me feel this way."

It becomes problematical for the clinician who feels that they must intervene and assume responsibility. They may become overwhelmed and not cope effectively. Here again, we see the emergence of the defense mechanisms. Basic loyalties to clients and fellow workers come into question, conflicts are exaggerated, and again the continued use of those mechanisms of denial, minimization, over-identification, isolation, and displacement occurs.

Additionally, prolonged and unremitting conflict may promote therapists to include those mechanisms of **idealization**, by promoting and protecting an objects' positive qualities while ignoring the negative; **devaluation** (self and others), by interjecting and recognizing only one's negative character traits; **projection**, by externalizing the unacceptable and conflicted aspects of one's personality onto objects. (Freud, 1946).

In a traditional clinical setting, it is an ongoing struggle for the therapist to maintain optimum empathy and objectivity; within the jail community it seems nearly impossible. The forensic therapist experiences a troubling internal battle stimulated by the environment and interactions with others. As the clinician enters the consultation room, they may bring along a highly conflicted and defended self.

INTERPERSONAL DYNAMICS

In the forensic setting the mental health professional is vulnerable to countertransference responses. As we have seen, multiple factors have conspired to invoke the human need to be psychologically defended. The basic issue becomes the challenge to the therapist of taking appropriate care of oneself while providing a reasonable amount of assistance, empathy and objectivity for clients. It seems obvious that an increased awareness is the solution. Given this, the therapeutic interaction with incarcerated clients presents a unique set of dynamics for the therapist to unravel.

PATHOLOGIES

Behind bars, the clinician encounters the entire range of pathologies in treatment: psychotics, borderlines and narcissists, mood disorders, and neurotics, as well as a large percentage of substance abusing clients. As if this were not enough to burden the therapist with clinical challenges, they can also plan on regular encounters with the anti-social personality.

The vicissitudes of treating the usual pathologies are well documented elsewhere; however, when one is faced with exposure to the "con" man or woman, new factors are introduced which bring about changes in the therapist's behavior. After being successfully "conned" a few times, one will see an increased skepticism. Conversely, the mental health professional begins to doubt the veracity of his/her other patients and becomes more guarded.

Although some mistrust is a healthy and unavoidable response, problems may develop in the area of countertransference if it is neither recognized nor expressed. Diminished trust on the therapist's behalf may be unconsciously projected and then acted out by the client: they don't trust you. (A certain amount of client distrust is innate in a forensic setting. The clinician is commonly identified as part of the criminal justice system with the result being a with-holding of thoughts and feelings.) A therapist's projecting of mistrust may retard the development of the therapeutic relationship.

INFLUENCE OF CRIMINAL CHARGES AND THE LEGAL SYSTEM

A major factor which mitigates the clinician's relationship with incarcerated clients comes into the area of legal charges; i.e.,, why the client was arrested and what responses are elicited in the therapist by the nature of the crime itself. Certain crimes carry emotional weight for everyone including therapists, yet objectivity is expected and necessary. One conflict arises between separating the clinician's feelings from the treatment needs of the client. The mental health professional comes to question their own sincerity, motivation, and integrity. (Lion, 1981). Fundamental issues arise concerning identification with (and affection for) the client. Questions may be asked of oneself; such as, "How can I like someone like that?", "Is it wrong to dislike a patient like this?" Other reactions may take the form of stimulating the clinician's unconscious aggressive

and erotic drives or cause an over-identification with the client's dilemma. This will be doubly distressing since the client will project their sense of hopelessness and despair onto the therapist, thus reducing both the real and fantasized expectations for treatment. The clinician's mood may then become one of frustration and depression (Lion, 1981), making the patient's problems appear insurmountable.

TERMINATION OF TREATMENT

Included in the origins of countertransference should be a recognition that treatment may be without prior agreement or knowledge. The mechanism of the criminal justice system will initiate sudden transfers or releases; there may be no opportunity to adequately complete treatment goals or the termination process. The forensic clinician must be able to tolerate a sense of relationships interrupted and work not completed.

Directly relating to a commonly perceived experience of diminished professional effectiveness and self-esteem arising from lack of control over termination is the clinician's employment of the mechanisms of defense. Any of those, if unattended, will lead to a withdrawal from therapeutic exchange. Passive-Aggressive behavior is also not an unusual response to those situations in which a sense of impotency or lack of control vis-à-vis external events is evoked. The clinician may act out by such means as ignoring clues to life-threatening situations, prematurely discharging the patient from treatment, or missing scheduled appointments.

EFFECTS CONTINUING AFTER BUSINESS HOURS

It would be naive of the clinician to assume that the influences of forensic work remain behind the bars at day's end; one's personal life may also be profoundly affected. One may displace aggression onto significant others or attempt to circumvent that process by an increasingly avoidant lifestyle. Depression, which is thought to be the largest countertransference problem (Lion, 1981), carries over into the clinician's personal life. Additionally, the clinician may find the need to defend their work setting and clientele to others socially and professionally encountered. In other words, countertransference may be pervasive.

The thoughts, feelings, and behaviors of the mental health professional need to be recognized and addressed. Ventilation and validation are essential to the continued well-being of the forensic clinician, as well as to their continued usefulness to the client. Avenues for the reduction of countertransference issues may be found in case supervision, study and process groups, personal therapy, and conversations with co-workers (Yalom, 1975). The jail is an overbearing environment, the individuals encountered on both sides of the bars demanding and difficult at times, and the clients frequently presenting complex and insurmountable dynamics; yet, in spite of everything, forensic work is exciting, useful to others, and rewarding.

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DEFENSE MECHANIMS

Acting Out
Emotional conflicts, internal or external stressors are dealt with by actions. These compulsive actions are in order to avoid painful feelings and are done without regard or reflection of consequences. Analytically it is defined as the direct expression of an unconscious wish or impulse in action to avoid being conscious of the accompanying affect, *an immature defense.*

Altruism
Meets the needs of other in order to avoid conflict (both internal and external), *a mature defense..*

Avoidance
The avoidance of anxiety-provoking situations, which results in limiting of one's life in order to avoid dealing with sources of distress, *a neurotic defense.*

Autistic Fantasy
Emotional conflicts or internal or external stressors are dealt with by excessive daydreaming, thus interfering with relationships and active problem solving.

Blocking
An inhibition of affect, thought, and action, *an immature defense.*

Controlling
Extreme attempt to regulate people and situations in an effort to minimize anxiety, *a neurotic defense.*

Denial
Emotional conflict is dealt with by refusing to acknowledge reality, *a narcissistic defense.*

Devaluation
Exaggerates negative qualities of self and others.

Displacement
The release of feelings on an object which is perceived as less threatening *a neurotic defense.*

Dissociation
A splitting off of mental awareness from the main body of consciousness to avoid emotional pain, *a neurotic defense.*

Distortion
Reshaping external reality to suit inner needs, *a narcissistic defense.*

Externalization
Attributes causes to external objects, *a neurotic defense.*

Humor
Conflict and stressors are dealt with by emphasizing the amusing; a mature defense, *a mature defense.*

Idealization
The exaggeration of positive qualities to deal with emotional conflict, *a narcissistic defense.*

Intellectualization
Affect is controlled by thinking instead of experiencing feelings, *a neurotic defense.*

Introjection
Unconsciously identifying another's characteristics as one own, *an immature defense.*

Isolation
The splitting of affect from content, *a neurotic defense.*

Passive-Aggression
The avoidance of anxiety associated with the expression of angry feelings by expressing the angry feelings in a covert manner, *an immature defense.*

Projection
Attributing one's own unacknowledged and unacceptable feelings to others, *an immature defense.*

Projective Identification
The induction of the projected feelings to others, *an immature defense.*

Rationalization
The justification of attitudes, beliefs, and behaviors that are unacceptable by incorrect application of justifying reasons, *a neurotic defense.*

Reaction Formation
The management of unacceptable thoughts or behaviors by substituting behaviors, thoughts, or feelings that are diametrically opposed to his or her own, a neurotic defense and usually as aspect of obsessional character, *a neurotic defense.*

Regression
The retreating to an earlier pattern of behavior and feeling as a means of avoiding overwhelming anxiety and distress, *a neurotic defense.*

Repression
The banishing to the unconscious of painful, anxiety-provoking material, *a neurotic defense.*

Splitting
Emotional conflict is dealt with by compartmentalizing positive and negative qualities of self and others, *a borderline defense.*

Somatization
The expressing of emotions through the body as a means of avoiding painful affect, *a neurotic defense.*

Sublimation
The channeling of maladaptive feelings or impulses into socially acceptable behavior, *a mature defense.*

Suppression
The conscious or semiconscious decision to postpone attention to a disturbing problem, wish, feeling or experience, *a mature defense.*

PRISON MADNESS

Terry Kupers, M.D. 1999

2

Why So Many Prisoners Develop Mental Disorders

More offenders with a history of mental illness are being sent to correctional facilities. In addition, harsh prison conditions cause even more prisoners to suffer breakdowns or commit suicide, and inadequate diagnosis and treatment of mental illness behind bars lead to more severe and chronic cases. Predisposing factors for mental illness include massive early childhood trauma, and prisoners as a group report an inordinate amount of severe trauma in their pasts. A significant number of prisoners display the classic signs and symptoms of posttraumatic stress disorder, while another large group of prisoners react to trauma by developing other kinds of psychiatric disturbance. Prison overcrowding increases the violence and makes life inside miserable for everyone, but especially for prisoners with traumatic pasts who are suffering from (or prone to) posttraumatic stress disorder (PTSD) and other serious mental illnesses.

From all the tours and interviews I have conducted, a composite picture stands out of a mentally disordered prisoner. He or she suffered massive and repeated traumas early in life, had great difficulty coping with the stress of harsh prison conditions, and then acted out and was sent to a punitive segregation unit where the isolation and idleness aggravated the mental disorder. This composite reflects the plight of a large number of prisoners who find themselves caught in a downward spiral into madness and despair.

Traumatic Lives

We are learning that the lives of low-income, inner-city children are filled with trauma. We know that early trauma plays a part in the etiology of all kinds of mental disorders, including posttraumatic stress disorder, psychosis, and severe depression. Since an overwhelming majority of prisoners hail from the inner cities, we should not be surprised to find that their backgrounds include many traumatic occurrences. Unfortunately, their prison careers are full of massive trauma as well. In fact, the daily traumas of prison life can serve, psychologically speaking, as reenactments of the earlier traumas, and the combination of old and new traumas can have a devastating effect on prisoners' mental health.

Posttraumatic stress disorder is usually underdiagnosed in prison. Correctional staff are too little concerned about the part that early trauma plays in the etiology of all forms of serious mental disorders, and they are almost oblivious to the danger, in terms of prisoners' eventual prognoses and potential for postrelease adjustment, of the reenactment of trauma in prison.

Childhood Trauma

Inner-city children experience or witness an extraordinary amount of trauma. By the time they reach high school, 35 percent of inner city, African-American children have witnessed a stabbing, 39 percent have personally viewed a shooting, almost 25 percent have seen someone murdered, and 46 percent have been the victim of at least one violent crime. Low-income children of all races experience a shocking amount of domestic violence as the victims of physical and emotional abuse or as witnesses to spousal abuse. We are also learning about a significant amount of sexual abuse among children living in poverty. Poverty itself is traumatic, if not violent.

Whether as victims or witnesses, boys who experience violence and other traumas connected with life in the inner city tend to react in one of two ways: They withdraw into isolation or they become

Criminal Courts 101*
Susannah MacKaye, LCSW

*Caveat emptor: I am a social worker, not a lawyer. I make no claims as to the accuracy of the information and intend it only as a guide for the interested clinician.

TYPES OF CRIMES:

Infraction, misdemeanor, felony

TYPES OF PLEAS:

Guilty, nolo contendere (no contest), not guilty, not guilty by reason of insanity, guilty but insane

STAGES OF A CRIMINAL CASE:

Arrest
Police stop person on suspicion of a crime, check for evidence of the alleged crime, check for outstanding warrants, check for probation or parole. If any one of the above is found the person is arrested, and if the charges are misdemeanor or felony they are taken to a police station holding cell. If the individual is on probation or parole, has an outstanding warrant, or is there is sufficient evidence to support a misdemeanor or a felony complaint, he/she is brought to to CJ9 from the police station and booked in. During this period the evidence is being evaluated and decisions are being made by the Assistant District Attorney as to what the actual charge will be. Some individuals may be "cited out" from CJ9, i.e. given a citation instructing them to come to court on a particular date. Others may be released on their own recognizance (O.R.), on bail, to Supervised Pretrial Release (S.P.R.) or the Homeless Release Project, or to the O.R. Project. The rest are "dressed in" and housed in the jail.

Arraignment
In California people have a right to arraignment within 48 hours (which actually translates two court days. Arraignment is when the individual is advised of the charges against him/her and asked to enter a plea (almost always "not guilty") and a new court date is set. At arraignment the public defender is appointed, and the judge considers motions to reduce or raise bail; in the case of a misdemeanor where a guilty plea is entered, sentencing could occur at an arraignment hearing. At this hearing the defense attorney will be trying to get the court to release the defendant OR, or to SPR, or to reduce the bail. Sometimes the case is discharged (due to lack of evidence) by the District Attorney at the arraignment hearing – reserving the right to the right to refile the charges within one year. If the person pleads not guilty on misdemeanor charges, trial date is set (in 30 days if in custody – 45 days out of custody). If felony charges, preliminary hearing date is set.

Preliminary Hearing or Probable Cause Hearing/Indictment
The next court date is the preliminary hearing, must occur within 10 days - this is the "trial before the trial" when the judge decides (using the probable cause standard, a

fairly low burden of proof) whether there is sufficient evidence that a crime has been committed and that the defendant should be brought to trial. At this hearing the DA files "an information" and presents evidence as to why the individual should be "held to answer" on the charges. Testimony is heard and the defense attorney has the opportunity to cross-examine the prosecution witnesses. If there is not sufficent evidence the charges are dropped and defendant is released. If there is, defendant is "held to answer" and a last date for trial is set. Usually, if the individual is out of custody the defense attorney will recommend that he/she waive the right to a speedy trial ("waive time"); if in custody they are less likely to initially waive time unless the charges are serious. In a very small number of cases, the district attorney calls for a grand jury indictment rather than a preliminary hearing to determine the probable cause. In these cases a jury, rather than a judge, decides if there is probable cause. Often a plea bargain agreement is made at a preliminary hearing and the individual pleads no contest and is sentenced or released depending on the terms of the agreement.

Superior Court Arraignment
A second, formal, arraignment takes place if a person is held to answer on felony charges and the trial date is set.

Pre-trial conferences/motions
In between the preliminary hearing/indictment and trial there are any number of pretrial conferences in which motions are filed and plea bargains are considered. The various motions are things like motions to exclude evidence or information, motions to dismiss, etc.

Plea Bargains
Most cases are resolved through plea bargaining, rather than by going to trial. In a plea bargain the defendant agrees to plead guilty or no contest, usually to a lesser charge than the original, in exchange for a more lenient sentence and/or dismissal of other charges. Often at the early stages of a case the "offers" from the district attorney are less desirable, but as the case progresses and time passes they may be willing to consider less punitive agreements. Frequently the outcome of a plea bargain on a lesser felony is "credit for time served and 3 years felony probation".

Trial
Those cases which do go trial have 5 phases: Jury Selection, Opening Statements, Witness Testimony and Cross-Examination, Closing Arguments, Jury Instruction and Verdict. Usually a case in trial has daily court dates.

Sentencing
Sentencing occurs after a guilty or no contest plea at arraignment or as the result of a plea bargain, or after a guilty verdict by a jury. In misdemeanors the judge will usually sentence the person at the same hearing as the guilty plea was entered, but in felonies a separate date is set for sentencing. Sometimes people are release "CTS" (credit for time served) at their sentencing hearing.

OTHER RELEVANT INFORMATION:

Probation:
Probation is a type of sentence in which the defendant is offered the opportunity to be released from jail and supervised by a probation officer. A typical misdemeanor probation is one year, and felony probation is 3 years. A very common felony sentence would be one year county jail time plus 3 years probation, in lieu of a 3 year prison sentence. When people are placed on probation they typically give up their civil rights prohibiting search and seizure without cause – police can search them or detain them for no reason other than that they are on probation. If they have police contact (even if they are not found guilty of any crime) or if they fail to stay in contact with their probation officer (P.O.) or fail to comply with other terms of probation (urine tests, eg or stay-away orders) their P.O. can "violate" them and they are remanded into custody. If they are remanded then a hearing is held to consider whether their probation should be revoked (in which case they would be sent to prison or do a jail term) or modified (extended). Sometimes the probation officer will recommend that the person is held for a short sentence (eg 3 months) "on a violation" and then released. There is a low burden of proof for violations or probation revocations – not nearly as high as the "beyond a reasonable doubt" standard of a trial. Inmates call probation "having paper" or "being on paper". The charge on the housing card for probation violation is 1203.1(a). A common probation violation is failure to complete a required treatment program – in such a cases a warrant is issued and if the individual comes into contact with police he/she is arrested.

Parole
People who are sentenced to prison usually serve a certain number of years in prison and are then eligible for parole hearings in which defense attorneys argue that they should be released to finish their sentence on parole. Parole is similar to probation except they check in with a parole agent and usually are prohibited from leaving the county where they are on parole. Parole agents may issue a warrant for a parolee if he/she doesn't check in, has a "dirty" urine test, fails to provide change of address or contact information in a timely fashion, is found to be consorting with known criminals, etc. Once a warrant is issued police will look for the parolee and remand him/her to custody. The charge on a housing card for parole violation is 3056. In most cases a person who violates parole is sent back to prison to "do a violation".

Prison Sentence vs Paper commitment
Inmates who are sentenced to prison are usually sent there within two weeks of their sentencing date. Individuals who have been convicted of a serious felony after a very drawn out legal case and have been incarcerated in the county jail throughout the case may be given what is called a "paper commitment". This means that although the person is sentenced to prison, they are permitted to serve all the time in the county jail. This is achieved by waiving their right to be sentenced until they have been in the county jail a period of time equal to what their prison sentence would have been. They are then sentenced, given credit for time served, and released on the same day.

"Good time" or SAGE credits

People sentenced to jail or prison are standardly given "good time", and serve on 2/3 of the actual sentence. Thus a one year jail sentence is actually 8 months and three year prison sentence is actually two years. If they get rule violations or lock-ups during their sentence their good time can be taken away from them and they must serve a longer sentence. This is at the discretion of the Sheriffs Dept or the prison warden.

Public defenders, "Conflicts" attorneys, private attorneys

Anybody charged with a crime has a right to counsel. If he/she cannot afford to hire a private attorney and is charged with a misdemeanor or a felony, the judge will appoint the public defender. In San Francisco there are public defenders assigned to particular courtrooms, sometimes the deputy public defender will follow the client as the case moves from one courtroom to another (eg goes from arraignment to trial) but in other cases the person gets a deputy public defender. "Conflicts" attorneys are private attorneys who are appointed by courts to defend those individuals who cannot pay but who cannot be defended by the Public Defender due to conflict of interest or overload of cases. A common scenario in which a conflicts attorney is assigned is when there is a co-defendant in the case who is already being represented by the Public Defender. It has been my observation that although deputy public defenders have huge caseloads and very little time to consult with their clients or prepare cases, it is not always the case that a paid private attorney does a better job. Often private attorneys are not as familiar with the judges and the assistant D.A.s or with various options for diversion, such as Jail Aftercare Services.

Drug Court, Domestic Violence Court, Behavioral Health Court

These are all courtrooms where defendants have the opportunity for diversion sentences. Diversion means that the defendant agrees to enter some form of treatment and/or community service or restitution and if he/she successfully completes the requirements the charges are expunged, so there is no record even of the arrest. This is better than a dismissal because in the case of a dismissal, the individual would still have to answer "yes" to the question "Have you ever been arrested?" but can answer "no" if the matter has the disposition "diversion deemed". Usually diversion involves much longer involvement with the court and more frequent court hearings once the person is placed in treatment for the purpose of progress reports. Diversion dispositions can be arranged in regular criminal courtrooms as well, but are less standard there. Some inmates don't like these courts because they often have to wait a long time in custody for available spots in the treatment programs and they see other inmates getting released more quickly (because they accept plea bargains with CTS sentences).

Immigration Hold

Non-citizens can have a "hold for INS" put on their housing card. If someone has such a hold, the Sheriffs Dept does not release them when they reach their TX date (release date) or if their charges are dismissed. Instead the person is held for pick-up by federal immigration officials. Usually SFCJ will hold the inmate for five days and if INS doesn't pick them up by then they release them. If the inmate is picked up by INS they are typically taken from SFCJ to the Santa Rita Jail in Oakland, which contracts with the Feds to house people suspected of immigration violations. From there their case is considered and they are either released (eg have a valid green card or visa and can prove it and their previous arrest did not damage their right to stay in the US), released

on bond (low flight risk, still have immigration charges to answer to), transferred to a federal prison (typically in Colorado or Arizona) (more serious charges, high flight risk), or are directly deported. Mexicans here illegally are usually deported very promptly, sent by bus from Santa Rita Jail to Tijuana.

Holds from other states or counties

Usually because person has a warrant. As in INS hold, inmate is not released when the SF Court says he/she can be released. Instead other county/state is notified and the inmate is held for their pick-up. SFCJ holds inmates for five days for other counties, and two weeks for other states. Sometimes the other state or county doesn't consider the case important enough to spend the money collecting the defendant, so they end up being released after the hold period ends. This can be problematic for discharge planning as we don't know if the person will be released or picked up until the last minute.

Incompetent to Stand Trial

Defendants have a legal right to only be tried if they understand what they are charged with and are able to assist their attorney to prepare a rational defense. If a doubt is raised (by any party in the court – judge, defense attorney, prosecutor) as to the mental competence of the defendant, either due to developmental disability or mental disorder, the case must be stopped and the defendant evaluated for trial competency. The Penal Code that is invoked in these cases is PC 1368. Time tolling toward the trial date is suspended and the judge orders an evaluation by a member of the "alienists' panel", a panel of forensic psychologists and psychiatrists who contract with the courts to do risk assessments and competency evaluations. The alienist will interview the defendant and try to determine whether he or she has a mental disorder (or developmental disorder) which impairs his/her ability to understand legal proceedings and/or assist counsel in preparing a rational defense. This is done using diagnostic assessment tools as well as a competency assessment test. Often the judge will ask two separate alienists to submit reports. If the recommendation of the alienist(s) is "incompetent to stand trial", the judge will make that finding and mandates the defendant to treatment for the restoration of competence. Both the defense and the prosecution have the right to either submit to the finding, or to object and call for a competency trial, in which case a jury listens to evidence from expert witnesses and decides whether the person is competent to stand trial. In the case of a felony charge (PC 1370) the treatment takes place at the state hospital; in the case of a misdemeanor (PC 1370.01), treatment takes place in county mental health. If the person is developmentally disabled treatment (1370.1) treatment takes place in a Regional Center. Once the treatment facility feels the person is restored to competence the defendant is returned to court (1372) and the case resumes with the trial calendar picking up wherever they left off. There are limits to the mandated treatment. Accused felons have a maximum commitment of three years Misdemeanants have a maximum commitment of one year or less depending on the charge. A recent Supreme Court ruling just put limits on the use of forced medications for IST treatment (Sells vs United States).

Professional Role Problems

The process of evaluating and treating mentally disordered offenders is almost always influenced by shortages of professional staff. When adequate staff is not available, evaluations tend to be brief and unreliable and treatment is less effective. The roles that various professions assume in the diagnostic and treatment process also change. In most public or private hospital settings, psychiatrists assume major responsibility for managing patients, prescribing drugs, and psychotherapy. In correctional or forensic settings, psychiatrists must spend a good deal of time preparing for courtroom testimony. Their evaluations may be directed more toward legal than therapeutic issues, and they may have little involvement in the therapeutic process. Much of the day-to-day administration and provision of counseling or psychotherapy in institutions that treat mentally disordered offenders is conducted by psychologists and social workers, who are somewhat easier to recruit into the correctional setting than psychiatrists. The relatively expensive time of psychiatrists tends to be reserved for tasks at which they are especially skilled or for which the law requires a licensed physician. Psychiatrists, therefore, may have little involvement in the process of treatment other than the management of pharmacotherapy.

While this distribution of labor may be efficient, it creates certain problems for all involved. The best trained psychiatrists will quickly become discontent when their diagnostic work is not integrated with treatment and they cannot use psychotherapeutic intervention or manage patients. While psychologists and social workers may welcome the opportunity to be administrators and therapists, they will usually come to resent a situation in which they do the most critical work but are paid half as much as the physician. It can be argued that a similar problem of discontent with professional roles exists in most public mental health centers. The situation in corrections, however, has more serious consequences. Recruiting any professional to work in the grim and frightening correctional setting is especially difficult. If professionals become discontent in the correctional or forensic setting, they will quickly depart to take better jobs. The turnover of certain professionals, particularly psychiatrists, tends to be high, and those who can be recruited are not likely to be the most skilled.

Problems in Providing Psychotherapy

Certain problems are inherent in providing effective psychotherapy of any type in the correctional or forensic setting. I have already noted that offenders may be less motivated to change their behavior than other clients and will be unlikely to present their problems honestly in situations where their therapists can influence the privileges they receive or their release date. However, several other problems peculiar to prisons and security hospitals complicate the task of therapy. Five such dilemmas are discussed here.

1. *Clinicians cannot be assured that clients will appear at a scheduled therapy session.* Prisons and forensic hospitals are administered by individuals whose first concern must be security. Inmates who are being punished or who are felt to be at risk of being disruptive may not be allowed to attend therapy sessions. Also, other institutional needs must occasionally take precedence over therapy. The hours during which inmates can work, play, eat, sleep, and have visitors are strictly regulated, so it may be very difficult to schedule or reschedule a therapy session. If the institutional routine is for any reason disrupted, the therapy hour may be the first event canceled.

2. *Confidentiality is a special problem in treating mentally disordered offenders.* In the free world, confidentiality is an essential aspect of successful psychotherapy. Confidential material is not usually shared with third parties unless patients request it or unusual circumstances arise. In working with mentally disordered offenders, therapists are often encouraged to share their patients' disclosures with other members of the prison or hospital staff. At times, however, such sharing can become a formidable impediment to developing an honest therapeutic relationship. Nevertheless, some information revealed in therapy must be shared with other members of the prison or hospital staff. Anything the inmate might reveal that threatens the integrity of the institution cannot be viewed as privileged information. Also, confidentiality is impossible when inmates announce plans to escape or to harm others. The

situation is more equivocal when patients tell therapists about the potential antisocial behavior of other inmates. In these situations, therapists must consider the possibility that their clients' perceptions are inaccurate. The advantages of sharing their clients' communications must be weighed against the problems that disclosure might create for the inmate, the institution, or the therapeutic relationship.

3. *The correctional or forensic setting presents a paucity of experiences to complement and validate the learning that goes on in psychotherapy.* Offenders cannot generalize their learning in psychotherapy to real-life situations. (This problem of lack of generalization occurs with behavior therapy as well as with psychotherapy.) For example, individuals may learn to be assertive in therapy but have no opportunity to experiment with assertiveness within the institution. Inmates may develop powerful insights into the roots of problems, such as sexual deviation, but have no opportunity to experiment with alternative behaviors. Nor can inmates test out how they would respond to the stresses they will encounter in the free world. Prisons are stressful, but they do not necessarily impose the same kind of stresses that may have elicited the offender's antisocial behavior. Although offenders may seem to be "cured" in a custodial setting, neither they nor their therapists can be assured that treatment has really worked. The artificiality of psychotherapy in a rigidly controlled institutional setting may have a great deal to do with its limited value as a rehabilitative technique.

4. *Therapists who work with offenders have little power to make recommendations that lead to changes in environmental situations conducive to their patients' mental health.* Changes in working or sleeping arrangements, or in the availability of recreational activities, may make an important difference in the patient's adjustment. A simple example of this would be the recommendation commonly made in mental health practice that an anxious patient take up an exercise program, such as jogging on a regular basis. Such a recommendation might be very difficult to implement in an institutional setting, however. Issues such as institutional needs and the policies of trying to treat all inmates exactly the same make it difficult to tailor any type of milieu program to the needs of a particular client.

5. *The nature of what is sometimes called transference and countertransference is distorted in institutional settings.* Many of the attitudes and responses offenders develop toward therapists are deleterious to the therapeutic process. Some of these attitudes and responses may not be related to the offender's past learning but rather are determined by the institutional setting. Qualities such as dependency and passive aggressiveness toward authority figures are quickly learned in prison and security hospitals. Thus, if offenders relate to therapists in these ways, it is extremely difficult to determine how much of their response should be interpreted as transference, based on distorted past learning experiences, and how much accepted as realistic and adaptive.

Therapists have a different set of problems. Mentally disordered offenders are often highly disturbed people who are likely to bring a great deal of aggressive and sexual material into the therapy hour. This material might be difficult for some therapists to deal with in any setting. In a custodial setting where tensions are high, where impulses are strong, and where the possible responses to deviation are so punitive, therapists may experience dealing with such material as highly stressful. This is more than what is usually called countertransference. It is extremely hard to avoid developing deep feelings toward those who are undergoing the ordeal of involuntary confinement, and empathic therapists will invariably experience some of the pain that afflicts their clients.

What to do if taken hostage

As a staff member on a locked unit, you are available if a patient decides to take a hostage. If this occurs, the following are some directions to increase your ability to survive a hostage situation;

a) Be a good listener. Use all listening skills by demonstrating and conveying interest and concern.

b) Let the hostage taker tell his/her story. This gives the hostage taker a chance to vent.

c) Maintain eye contact, but don't stare.

d) Follow orders to the best of your ability.

e) Rest if possible. It is important that you relax and rest to keep up strength for the rescue/recovery phase.

A hostage should NEVER do any of the following;

a) Never be hostile. This is not the time to complain, be sarcastic, or berate the hostage taker.

b) Don't moralize or threaten the hostage taker.

c) Don't be obnoxious. In some circumstances the hostage taker may choose the most obnoxious member of a group to harm.

d) Don't stare at the hostage taker.

e) Don't be a hero. The hostage should not try to be the rescuer of negotiator.

f) Don't be a go-fer. Even though you should comply with orders as much as possible, don't act like you are joining the hostage taker.

g) Don't make suggestions, plant ideas, or worry out loud. If your suggestions or ideas do not work, the hostage taker may take revenge on you.

The best advice that anyone can give is to remain calm and prepare to wait.

WHILE WORKING IN A JAIL…

"I will us treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them." – excerpt form Hippocratic Oath

All of us have chosen a career path that involves working in a challenging environment with special individuals; we work in jail with prisoners, and those who have recently been released from jail; including those who are both the victims and perpetrators of violence. It takes special people, and teams, to do this work, people who can see the individual through the crime and the difficult behaviors. ***"Working in an environment where freedom is restrained is challenging. Working with a system that is sometimes inflexible and with inmates who seem angry at the whole world (including you) is frustrating. But, it can also be rewarding"*** (Bayse, 1995, p. 2).

If you are new to this field, this paper will help to educate you as to how to work more effectively with this special needs population and maintain a healthy outlook on your selected profession. If you have been in this field for awhile, it will serve to provide you with additional tools to assist you in your continued efforts to be effective in your career and as a team member.

Working in a jail does require teamwork. The team is, in the truest since of the word, multi-disciplinary consisting of deputy sheriffs, program staff, health care professionals, chaplains, volunteers, mental health professionals, support staff, administrators, and, yes, inmates; all have a vitally important role. Together, this team can make positive changes in the criminal justice system and the people that it incarcerates. To do this, **WHILE WORKING IN A JAIL,** you must:

MAINTAIN PROFESSIONALISM

Just as in the community, correctional care providers are bound by the ethics of their particular professions. There are times when providing counseling or health care is fundamentally at odds with the correctional model. *For example, "The purpose of medicine is to diagnose, comfort and cure: the purpose of prisons, although sometimes rehabilitative, is to punish through confinement. These often mutually incompatible purposes provide the background for the interaction of correctional and health professionals and help explain why ethical dilemmas, even in well-managed correctional settings, are inevitable... Medicine generally is practiced in an office, clinic or hospital where the goals of patient care define, or should define, the administration, organization and process of care. Correctional medicine is practiced in alien space where the custody philosophy is predominant and the practice of medicine is viewed, at best, as a necessary support for good administration..."*(Dubler).

The jail milieu provides unique challenge for the caregiver. *"By definition, the inmate is a person of lesser status and lessened moral value and with fewer rights and privileges than administrators, officers and health providers. The essence of the relationship between the inmates and correctional employees is hierarchical, which is the converse of*

equal. To act within the ethic of their profession, health care providers must act counter to the prevailing ethic of the location. Between provider and patient, mutual trust and respect must exist in order for the relationship to work, i.e., to provide the support for diagnosis, care and treatment (Dubler). It is our task to insure that inmates get respectful, quality care, and that every effort is made to make the provider-inmate relationship as close to a community provider-client relationship as possible.

BE AWARE OF THE POWER OF YOUR PROFESSION

In *Power in the Helping Professions,* Adolf Guggenbuhl-Craig asserts that there are certain parallels between medieval inquisition and today's social work. *"An attempt is made to combat unhealthy family situations, to correct unsatisfactory social structures, to adjust the maladjusted unsatisfactory social structures, – in brief, we try to enforce that which we consider 'right' for people. And we often do this even when our help is rejected by those concerned. In our own way we frequently force a certain view of life upon others whether they agree to it or not. We do not choose to acknowledge a right to sickness, neurosis, unhealthy familial relations, social degeneracy and eccentricity"* (Guggenbuhln-Craig, 1982, p. 7). Simply stated we, as caregivers, in the name of the "greater good," often endeavor to change people's lives even when the change is neither invited nor welcomed. We should not force our values, ideals or goals on inmates. The autonomy of the individual needs to be respected.

BE FAMILIAR WITH STAFF INSTITUATIONALIZATION

It is human nature to adopt group roles. A shocking experiment conducted in 1971 by Philip Zimbardo demonstrates the power of roles and institutions. In this study, 21 young men (chosen for their maturity and emotional stability) were selected for this experiment. Eleven were randomly designated to be guards, the rest prisoners. The "guards" were told only to maintain law and order. The study had to be discontinued after only six days because of the harshness of the "guards" and the questionable emotional state of the "prisoners" (Zimbardo, 1971).

This study brought to light some unpleasant realities of human nature – we readily adopt assigned roles, including the role of institutions. In criminal justice, the care provider must maintain constant vigilance, self-awareness, and ongoing reexamination to avoid being co-opted by and developing identification with correctional staff (Dubler, p. 53). Caregivers in a jail setting must identify with their colleagues in the community.

KNOW THE DIFFFERENT POWER STANCES OF CORRECTIONAL MENTAL HEALTH PROFESSIONALS AND CHOOSE WISELY

1. The "Tough" Stance
   Mental health professionals in this setting have input into classification and housing decisions; therefore many inmates attempt to manipulate mental health professionals. Because of this correctional mental professional may

learn not to trust his or her clients and to adopt a "tough" stance of "No inmate is going to get over on me."

2. The "Soft" Stance
In this approach the mental health worker is likely to be an advocate for the inmate. This will likely cause corrections staff to be more distrustful of the mental health professional. It could also cause the therapist go break jail rules by doing "favors" for the inmate.

3. The Professional, "Neutral" Stance
In this approach the mental health professional does not identify with either the jail administration or the inmate. They develop a realistic view of the inmates, their manipulations, thinking errors, and treatment needs. To do this you must be fair, upfront, and consistent with the inmate. Give them choices and assist them in developing better problem solving skills. Remember it is important to have clear boundaries and be able to say "no" to inmate requests when appropriate. This approach earns you respect from both inmates ant correctional staff. (Schwartz, Gould, 2003)

WHAT GRADUATE SCHOOL DIDN'T TEACH YOU

Differences Between Mental Health Training and the Demands of Correctional Psychology

Traditional Mental Health Treatment	Correctional Psychology
Sees patient as suffering from illness, not responsible for behavior	Sees inmate as responsible for Behavior
Supports person's strengths	Confronts maladaptive behavior
Trusts patient	Does not trust inmate
Believes patient	Expects inmate to lie, minimize and justify (use Thinking Errors)
Allows patient to set agenda	Therapist sets agenda
Follows patient's values	Therapist teaches prosocial values
Goal is to remove negative feelings from behavior	Goal is to induce negative feelings a round behavior
Patient welfare is first concern	Public safety is first concern
Works to alleviate guilt	Works to induce guilt
Concern about how the patient feels	Concerns about how the inmate acts
Patient is accountable to self	Inmate is accountable to society
Complete confidentiality	Limited confidentially
Clinical judgment	Team decisions or administrative orders

Adapted from B. K. Schwartz, 1999

(Schwartz, 2003)

Webster's Dictionary defines culture as, "the concepts, habits, skills, arts, instruments, institutions, etc. of a given people in a given period; civilization." Often, without an understanding of an inmate's cultural dynamics, problems (whether physical, spiritual, or psychiatric) cannot be appropriately addressed. Answers must be sought for questions like:

1. What does the inmate define as a problem?
2. What does the inmate see as a solution to their problems?
3. Who does the inmate usually turn to for help?
4. How has the inmate responded to immigration?
5. How do they handle life cycle transitions?
6. What may be the difficulties for a caregiver of the same background or for a caregiver of a different background? (McGoldrick, 1982, p. xv)

Recent studies indicate that caregivers of different backgrounds can be just as effective in helping individual as caregivers with similar cultural backgrounds. This happens when the caregiver possesses cultural sensitivity and competence, and when these two qualities are manifested in the interaction. Additionally, the individual must have the perception that the caregivers are credible (being effective and trustworthy) and giving (the belief that the caregiver has provided something of value) (Paniagua, 1994, pp. 7-8).

Guiding principles recently established by the IAPSRS Multicultural Diversity Committee defines multiculturalism in human services as, *"Multicultural professionals are students of their own ethnicities and cultures: They have learned to understand and accept their heritage both personally and as objectively as possible. Professionals, have also studied other cultures and developed an appreciation and understanding of them. Professionals have developed the ability to change perspectives and view situations through the lens of a specific ethnic/cultural group in order to refine and modify interventions to increase compatibility with the cultural/ethnic group's values and expectations. Professionals are aware of their own and other's biases stereotypes and prejudices. This awareness can reduce, eliminate or set aside attitudes interfering with the development of a positive (therapeutic) working relationship with clients."* (IAPSRS, 1996, p. 3).

Becoming a multicultural professional involves ongoing development of:

1. cultural knowledge.
2. an awareness, respect, and acceptance of differences.
3. an understanding of one's own cultural values and the realization that it is not the only way.
4. an understanding of the dynamic of the differences between the cultures.
5. adoption of cultural knowledge into services.

As individuals, a commitment must be made towards providing culturally competent services for the diverse population that we serve. The knowledge that we strive to

acquire needs to include not only the many races and ethnic groups, but also the culture of the jail.

HAVE KNOWLEDGE ABOUT INMATE CULTURE

Not only does the care provider need to understand the personality traits common to many inmates and the different ethnic cultures in a jail, they also need to understand the culture that come with incarceration. The Kansas Department of Corrections recites six principles of the inmate's social code as:

1. ***Be loyal.*** *There seems to be an unwritten rule throughout prisons that says inmates must be loyal to each other. This includes maintaining a "code of silence" about criminal activities done by other inmates. Inmates are expected to lie, if necessary, to protect other inmates who they know have violated the rules. This loyalty is demanded regardless of the personal cost to the individual inmate. Inmates are never to take a problem to prison staff. Doing so would be considered a breach of loyalty.*
2. ***Be cool.*** *Inmates are always to be in control. They are to refrain from quarrels or arguments with fellow inmates. They are to remain cool regardless of how much pressure they receive from correctional staff. Their slogan seems to be: "just do your time and do not make waves."*
3. ***Be straight (with your fellow inmates).*** *Do not take advantage of another inmate. Do not lie. Do not break your word. Do not steal. Pay your debt. Inmates should share with one another by exchanging goods for gifts or favors. Unfortunately, many inmates break this rule, causing friction among inmates. Being straight with a staff member is telling enough half-truths to get off or doing what is necessary to get one's way.*
4. ***Be tough.*** *Do not weaken, do not whine, and do not cry "guilty." The inmate should be able to "take it" without quivering. Although the inmate code discourages inmates from starting a fight, running from a fight that someone else starts is considered disgraceful.*
5. ***Be sharp.*** *Do not be a sucker. Correctional officers are to be treated with suspicion and distrust. Whenever there is a conflict between an officer and an inmate, always assume that the correctional officer is wrong.*
6. ***Be right.*** *This is a combination of the other five. An inmate is "right" when he or she is loyal to fellow inmates. Inmates can depend on him or her. The right inmate never interferes with another inmate's schemes to break prison rules. He or she does not back down if someone picks a fight. "Right" inmates know their rights and use them to get their way. They can take whatever the prison system dishes out and never flinch* (Bayse, 1995, pp. 39-40).

It is important to note that knowing and understanding the inmate's code does not mean that you agree with it. However, having an awareness of "the code" can help to prevent some futile conflicts.

In jail, religion can be very important to inmates. While some inmates will "use" religion to meet their own selfish needs, other genuinely benefit and begin to apply religious

principles in their daily life. Incarceration can be a cold and lonely existence; spirituality can provide a core comfort. A 1990 study found that inmates who participate in religious instruction while incarcerated have a lower rate of recidivism (Bayse, 1995, pp.41-42).

BE SENSITIVE TO YOUR PATIENT'S TRAUMA'S – BOTH HISTORICAL AND CURRENT

Historical:
Many of the people we see come from impoverished or dysfunctional families. Many come from abusive backgrounds. Many have parents who abused drugs and alcohol. Most have abused substances. Many have grown up in neighborhoods ridden with violence. Many carry the diagnosis of Post-Traumatic Stress Disorder having experienced or witnessed a traumatic, life-threatening event (APA, 1994, pp. 424-429). Many have other forms of mental illness. Many have learning disabilities or other organic cognitive problems. Many are poorly educated. Many are homeless. Showing respect to inmates includes understanding the background that helped place them inside the jails.

Current:
Everything hurts more in jail. Connections with the outside world are restricted. Activities are limited. As the person's focus turns inward, pains and discomfort become magnified (Dubler). Then there is the question of the unknown, "What's going to happen to my case/my life?" Living with a high degree of uncertainty about the future causes stress. Stress causes a whole host of problems (irritability, sleeplessness, depression, and physical aliments). There is the worry about their family and the family's reaction to the incarceration. As staff members, we get to leave when our shift is over. However, we still have some awareness of what it would be like to "live" in the jail. There is no privacy, it's noisy, it smells bad, food is marginal at best, and it can be a frightening, dangerous place. No matter what mask they put on, it is important to remember, inmates are vulnerable and in crisis.

KNOW THE SIGNS OF STAFF BURNOUT

Working in a jail can be very interesting and rewarding; however it is an extremely stressful job and, at times, maddening. It is essential for all who work in this environment to be aware and attentive to signs of burnout and have an active plan for dealing with the stress of the job. Burnout happens because of good intentions; people try to reach unrealistic goals, deplete themselves of energy and lose touch with themselves, family and friends.

Some signs of burnout are:

- No longer laughing or having fun at work.
- Being irritable with clients or coworkers.
- Always seeing work as a chore.
- Feeling tired and empty in your work.

If you are regularly experiencing these symptoms make sure to set aside some time each day for relaxation exercises and pleasurable time with friends and family. Learn to laugh at yourself and at situations. Talk to others about what's going on and to your supervisor in order to develop realistic expectations.

SUMMARY

As care providers in a jail, how do we nurture that relationship to make it one of mutual trust and respect? To begin with, there must be an ever present awareness of:

- how use of certain terms directed at inmates can cause distance by being dehumanizing. If it could cause you to lose your professional sensitivity, then don't use the term.
- the inmate's traumas both historical and current.
- your own body language and facial expressions.
- what type of person you find most difficult.
- the "power" in the helping professions (Guggenbuhl-Craig, 1992).
- how you would like to be treated in a similar situation.
- the personality traits typical to many of the inmates.
- your own cultural issues and how they effect your work.
- your vulnerability to staff institutionalization (Zimbardo).

In addition to awareness, there are some "always." Always:

- practice professional ethics.
- practice good communication skills.
- be respectful.
- be empathic.
- be patient.
- be trustworthy.
- respect cultural differences and continually expand your knowledge of other's cultures.

In addition, caregivers in the jail must remember to care for themselves! If you are stressed it will be difficult for you to give appropriate, compassionate care.

This paper has only begun to touch upon the many challenges of maintaining professionalism while working in a jail. Without a doubt, this work does require special people. People who are committed to the individuals they have chosen to serve and to the team of professionals working along side them in the jail, together, providing services to the inmates and the community. As forensic caregivers you must, in an ongoing way, educate yourself about the population you serve. Without faltering, you must provide services that are ethical, respectful, empathic, and, of course, professional. Each person who chooses this as his/her profession must repeatedly remind himself or herself of the reasons why he or she chose to work with this disenfranchised group of people; to do this

will allow the caregiver to realize the rewards of this challenging and essential profession. **WHILE WORKING IN A JAIL.**

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