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Jail Planning and Construction Division

Guide to Planning and Evaluating Inmate Medical/Mental Health Services

September 1989

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STATE OF CALIFORNIA

BOARD OF CORRECTIONS

GUIDE TO PLANNING AND EVALUATING INMATE MEDICAL/MENTAL HEALTH SERVICES

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INTRODUCTION

Emerging standards, fiscal pressures, population increases, public sentiment and litigation are all parts of the fast-changing environment of jail health services. In the face of all this rapid change and amid increasing pressure, one thing remains constant: the jail administrator is expected to take a lead in understanding what is and what must be maintained for the jail's medical and mental health care programs.

Medical and mental health services for jail populations have had a rather checkered past. While a great deal of litigation has focused on jail health care, no clear directive has emerged saying what the minimum levels of care must be. As a consequence, jail administrators, health care providers and funding agencies have often been at odds with one another about what a jail system should provide. Too frequently, funding has been insufficient for medical and mental health services and the result has been expensive litigation and costly judgments. In almost every jail system, there is a high level of frustration about not having a precise plan to maximize efficient use of available medical/mental health funds.

This manual is intended to assist detention managers/ administrators in assessing the current status of your facility's medical/mental health care services and to help you prepare to meet changing standards. It can also serve as a guide to planning medical and mental health care programs for new facilities.

This manual is not about "rules". There are no definitive ways to create or modify an existing health care system. There are--and what this document presents--ways to determine what works best given the size, configuration, philosophy, management style and financial resources of each jail. These are the factors that will determine what works best for your facility and for you.

While a jail administrator has the final responsibility for what occurs in the jail, that does not mean you are expected to be an expert in all aspects of jail operation. This manual assumes that medical and mental health services may not be areas in which you have special expertise and thus points you towards resources available to help you in planning and evaluating medical and mental health services. Look to the experts who work in county health departments, clinics and hospitals that interact with your facility. Bring in consultant specialists. Consider contacting the Board of Corrections for assistance and references to other facilities that have dealt with problems similar to yours.

Health care is a significant and essential custodial function. Every jail must have a comprehensive and updated strategy for delivery of service comparable to that of the community at large. How you develop that strategy and provide those services in the most cost efficient and effective manner is the question this document seeks to help you answer.

In terms of specifics, a process for planning and analyzing what inmate health services best meet your jail's needs and resources is outlined in Table I (preceding Section II, Planning Methodology). The intent is to emphasize that a process is necessary and to provide you with one which is familiar, although not the only one available.

Since jails are most often referred to by size, let us work from common terms and define jails by the average daily population (ADP) size as follows:

Small jail	=	0 - 200 ADP
Medium jail	=	200 - 600 ADP
Large jail	=	600 plus ADP

Because there are some separate and distinct issues and regulations relating to mental health services, that subject is dealt with in its own section of the manual. Nonetheless, the processes for planning analysis and cost analysis, facility design, location of services, etc. will generally apply, and thus should be considered applicable, to mental health care as well as to medical care.

It is sound public policy to meet existing health and corrections codes and regulations, to prepare for probable changes, to implement planning strategies and to reduce liability wherever possible. The goal of this document is to describe ways to do that while developing the most prudent and rational use of health care resources and maintaining the unique and complimentary identities of jail and health care administrations.

Ultimate responsibility for a jail's medical/mental health care service delivery lies with the jail administrator. This document is a tool to help the administrator feel more comfortable with that responsibility.

SECTION I: CRITICAL ISSUES

CHAPTER 1. RESPONSIBILITY

The question of responsibility for health care services in jails has at least two parts: one is statutory responsibility and the other relates to management or operational responsibility. You need to look at both as you review or begin your strategic planning process, and before you can do that you may have to establish a framework for the planning responsibility as well.

Strategic Planning

As you no doubt know, strategic planning is a process which involves a comprehensive approach to all elements of the system to which the planning relates. In order to do strategic planning for your health care services, you will have to evaluate those services in the context of your entire jail or local detention system. The integrity of your system requires you to take into consideration what effect changes in one part (i.e., the health services aspect) will have on other parts (security, for example) and vice versa. You will have to balance demands for particular kinds of health care services against factors relating to other aspects of your facility's operation. You will have to look at the immediate needs of the system and at long-term projections for future needs, and then develop a plan which takes as many of the variables as possible into account.

The planning might best be accomplished by a task group or committee comprised of 'duty experts' in a number of different subjects so that the widest possible range of expertise is brought to bear on the task. Keep in mind that you don't have to, nor should you try to, do it alone. Get help from the medical, dental and mental health communities as well as from other jail personnel. Take advantage of the resources available to you.

In order to set the stage for your strategic planning process, it is best to begin at the beginning. The questions are 'what are we responsible for providing?' and 'who is responsible for which parts of the total?'

Statutory Responsibility

The California Code of Regulations, Title 15, Article 10, Section 1200, places the responsibility for health care services in all local detention facilities with the sheriff or

other official charged by law with the administration of the local detention facility. As with all other elements of jail operation, the sheriff, or director of a local department of corrections, is ultimately responsible for the provision of adequate medical and mental health care services to the inmates of the facility or facilities under his/her charge.

The approach of the delivery system for health services is discretionary. There is no specific mandate telling the sheriff, director of corrections or jail administrator how to provide medical and mental health care. However, this does not mean the door is wide open to anything and everything.

Whatever approach is used must comply with the Board of Corrections' Minimum Standards for Local Detention Facilities (found in the California Code of Regulations, Title 15, as noted above) and must comply with requirements adopted by the local governing body--the city or county--if such local standards exceed and do not conflict with state requirements (see Title 15, Article 1, Section 1005). There are also a number of state regulations relating to health facilities, programs, staffing, medical records and informed consent practices which must be adhered to in the jail setting. (A compendium of relevant California health services regulations and codes is included in Appendix A of this manual.)

Furthermore, since recent court decisions relating to the adequacy of jail health services have held that jails must provide medical care comparable to that which would be provided under the same circumstances in the community, jails are being clearly told that they do not have the latitude to provide whatever health services they can. The message is that jails must develop a delivery system and services within that system which can be measured against the standard of care in the community at large. What exists in the way of medical and mental health services and access to those services in the community where your jail is situated is the guideline you must use in designing or modifying the services and access to services available to inmates in your jail.

Operational Responsibility

Jail administrators generally know a lot more about jails than about "standards of health care in the community". That in part explains why, although the responsibility for inmate medical/mental health services ultimately lies with the sheriff or other detention official, operational responsibility is frequently delegated or contracted to a city, county or private health services provider. Arranging for health care services delivery by medical and mental health professionals outside the sheriff's, police or corrections

department is a common practice and one which has proven effective in a number of jurisdictions.

Whether provided by outside agencies or by medical and mental health personnel employed directly by the jail, efficient, cost-effective inmate health services are and must be a cooperative effort between custody and medical administrations and staff. Since both custody and medical personnel have important roles to play in the operation of the jail, planning efforts must include ways to maximize communication and mutual assistance between them. Written memoranda of understanding with clearly defined lines of authority and communication, defined roles and responsibilities for medical and custody programs and personnel, and an orientation program for all new staff much address, among other things:

- the distinct yet mutually supportive roles of medical and custody staff,

- security policies and procedures; and

- special needs of the health services program (e.g., the need for confidentiality of medical information).

An attitude of mutual respect for each group's mission within the detention system will go a long way in avoiding or resolving some of the conflict and misunderstanding which have occasionally arisen between custody and medical personnel working in jails. (A sample memorandum of understanding can be found in Appendix B.)

It has often been the case that the health services program is plugged into a jail well after the jail has been designed and built. This always poses a hardship on both the custody and the health care programs and personnel. If your strategic plan includes construction of a new or renovation of your existing facility, by all means solicit the input of health services personnel at the earliest possible point. Take the time to include the health services provider's needs, ideas, suggestions and input into your planning process. Any initial inconvenience in doing so will be more than offset by the fact that you will not have to make costly architectural revisions or defend lawsuits involving failure to provide space for adequate health care services later.

Perhaps now we have the answers to the two original questions -- 'what are we responsible for providing?' and 'who is responsible for which part?' The jail is responsible for providing inmates access to health care which is comparable to that care they would get under similar medical circumstances in the community. The jail administrator is

responsible for seeing that happen. How the services are provided is discretionary with possibilities including provision by in-house personnel; by contract or agreement with city, county or private health care providers; by arrangements with other agencies and by combinations of the above. The strategic planning process will provide answers specific to your jail and your jurisdiction.

CHAPTER 2. LEGAL ISSUES

Inmates have a right to health care. The minimum level of care which must be afforded changes from case to case and even perhaps from location to location, because the "standards of care in the community" may change from one jurisdiction to the next. Nonetheless, basic among the rights which inmates have is their right to an adequate or reasonable level of health care services. The legal underpinnings of this right exist in statutes and in case law.

Statutes, Standards, and Regulations

Jail administrators should be aware of the statutes governing inmate health care, thus these are outlined in Appendix A of this manual. Also important are national standards such as those published by the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC) as well as state standards (Title 15 of the California Code of Regulations). For case law relating to inmate health care services as well as other jail issues, you may want to subscribe to the AELE Journal (Americans for Effective Law Enforcement, Inc., 5519 North Cumberland Avenue, #1008, Chicago, Illinois 60656-1471) and/or the Detention Reporter (P.O. Box 234, Kents Hill, Maine 04349). You will also want to be in touch with medical and mental health service providers because they can help you understand the vagaries of the laws and regulations.

Some of the standards and concepts, like "standards of care in the community" for example, may seem vague. Medical or mental health professionals and consultants know what the terms and concepts mean and can help a great deal. You are not risking your authority by trusting the health services professional to be the expert about medical matters. Working in collaboration with those people who understand the issues and can help you to develop your strategic plan is safe and wise on your part. As a matter of fact, the real risk would be in not calling on those who can make it easier for you.

Case Law

Statutory and standards language tend to be general while case law is more specific. Health care services delivery in jails is a relatively new area for litigation, so the "rules" flowing from case law are still evolving. One thing is clear, however. The courts are handing down definitive rulings about how programs are to be administered, operated and budgeted.

This is a significant point for correctional administrators. It means that if you are going to keep the flexibility and control you now have for health care programs in your jail(s), you are going to have to be responsible for providing the best services you can. The administrator who is proactive, who designs and implements an appropriate health services delivery system for his/her jail(s), is the administrator most likely to be able to independently manage his/her own operation. The administrator who has to operate under a consent decree, or in the throes of protracted litigation, has a good deal less to say about the levels and methods by which health care services are provided.

Rather than defining what is adequate health care for jails, the courts have almost uniformly said what is inadequate. The lead case regarding health services delivery is the United States Supreme Court case, Estelle v. Gamble in which the court concluded that:

> deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain," ... proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.
>
> (U.S.- 97 S. CT. at 291, 1976)

Another example is a federal appellate court case, Stokes v. Hurdle (393 F. Supp. 757ff, D. Md., 1975) in which the court addressed the question of whether a physician exercising ordinary skill and care would have concluded that the symptoms evidenced a serious injury, whether the potential for harm by reason of delay or denial of medical care was substantial and whether such harm did result (citations omitted). The finding was that deprivation of medical treatment which seriously endangers a prisoner's well-being would be actionable under the Civil Rights Act (U.S. Code, Section 1983).

Issues Arising from Case Law: What is Reasonable Care?

For care to be considered reasonable, it must be adequate given what the courts refer to as the "totality of circumstances". Some of the circumstances which courts would be likely to consider in their evaluation of adequacy are:

- whether appropriate health care providers are used in the facility. Are the health care staff competent to perform assigned functions?

Do they have the licensure or certification required by law? Are they performing functions which fall within their legal scope of practice as defined by their licensure or certification regulations?

- whether inmates are being used to provide health care services. State (T-15) and national standards (ACA, NCCHC) prohibit inmates from providing direct patient care services.

- whether there are adequate medical supplies and equipment for routine and emergency care.

- whether equipment is in good shape or not. Is it old, outdated, in poor condition? Does it work?

- whether there was a lack or denial of transportation resources to get the inmate to his/her required health care services.

- whether the medical record and other files document that necessary services were provided on a timely basis.

A growing concern in litigation is the lack of access to health care services. Facilities housing the best equipment and services available will continue to find that (without the provisions of access) courts will persist in finding programs deficient.

As the inmate's link to medical/mental health services, custodial staff plays an integral part in the overall delivery of these programs. Thus custodial staff are as answerable for the lack of access, either through denial or delay, as the medical staff of the facility.

This is also true with regard to following doctors' orders. Disregarding a physician's orders is one of the more frequently litigated issues. Both medical and custodial personnel must comply with the orders of the physician; in failing to do so, they risk liability for the entire health services program and thus for the jail itself.

Refusal of Care

Inmates have a right to refuse medical care unless that refusal poses a threat of serious bodily harm. This raises

the question of involuntary treatment vs. informed consent. Court findings suggest that the answers in a custody setting are similar to those in other environments. Courts have said that appropriate emergency medical responses may be initiated without inmate consent when a medical problem is considered by staff--and confirmed by a physician--to be life-threatening or limb-threatening. Similarly, involuntary psychiatric evaluation and treatment may be provided for a limited period of time for inmates who, as a result of mental disorder, are a danger to themselves or others or who are gravely disabled as determined by qualified mental health staff (see California Welfare and Institutions Code, Section 5150). Involuntary treatment in any other circumstances requires a court order.

Intake Screening

From a legal standpoint, the absence of adequate intake screening poses a great risk for jails. In addition to being sued for failure to provide adequate screening in compliance with national and state standards, jails are putting themselves at great risk if they fail, at the time of booking, to identify at a minimum those people injured prior to being brought to jail; those with chronic, acute, and communicable conditions; and people who are alcohol and/or drug dependent. Screening those people before they are housed can insure against unnecessary aggravation of their medical or mental health conditions, can dramatically reduce the spread of infection to the rest of the population and/or can provide protection against lawsuits claiming that inmates' health problems are the result of their incarceration.

Training

Training is another issue frequently addressed in court. Were staff--medical and correctional--appropriately trained for their assigned duties? Were those officers, for example, who solicit health care information at booking given any training about medical and mental health problem identification? Were they trained to make decisions regarding the need for further evaluation or special housing?

Policies and Procedures

One of the most crucial areas of jail management is the development, implementation and maintenance of policies and procedures. This is true of all areas of jail services, but is especially critical to the area of inmate health services. The courts have repeatedly found the absence of written policies and procedures for inmate health services to be

to be deliberate indifference. The adage, "if it isn't documented, it didn't happen", applies to policies and procedures in the eyes of the court. Policies and procedures provide documentation of the level of health services provided by a facility, direction for staff and consistency/continuity in service delivery. They serve as the facility's cornerstone in defense of lawsuits. California jails should have written policies and procedures which, at the very least, address all areas of health service delivery defined within Title 15, Minimum Standards for Local Detention Facilities.

Pharmacy Services

The matter of dispensing medication--who does it, under whose supervision, under what circumstances--is a complex issue often raised in litigation. Should security staff administer medication prepackaged in appropriate doses by medical personnel? Legally, who can prepare medication packets? Nurses? A physician's assistant? Must a pharmacist be available to provide this service? What, if anything, is a nonmedical, security staff person able to do in this regard?

These and other questions will arise in developing a legal medication system for jail. If you have a pharmacist, utilize that person in developing your pharmacy policies and procedures. If you do not have pharmacist at the jail, seek assistance through the State Board of Pharmacy, the local health department, the county or private hospital or a correctional health services consultant.

Accreditation

A successful strategy, which is becoming increasingly popular, for lessening a jail's potential for litigation involving inmate health services is accreditation of the jail's inmate health services program through the National Commission on Correctional Health Care (NCCHC), the California Medical Association (CMA) and/or the American Correctional Association (ACA). The accreditation process forces the facility to formalize and document the health services delivery system by requiring written agreements or memoranda of understanding with various service providers; policies and procedures; documented training programs; defined job descriptions; and complete medical records. This formalized approach to and documentation of inmate health service delivery places the jail in a position to defend claims of inadequate and/or inappropriate medical/mental health services. The process also includes a bi-annual inspection of the jail and its health services program by outside, "objective" correctional health services professionals. This external audit procedure tells the courts, public, media and others that the system is open to inspection and a good faith effort is being made to

meet nationally recognized standards. This goes a long way toward deterring frivolous lawsuits and improving the jail's image.

Summary

These are some of the many issues which have been litigated and which are still in the forefront of judicial and statutory considerations regarding jail health care services. Lawsuits involving inmate health services will continue. There is absolutely no way to insure that you will not be sued. What you can do is take the initiative by planning and instituting an adequate health care delivery system and thereby attempt to reduce your liability risk. The cost of undertaking the effort now is considerably less than the cost of complying with a consent decree in addition to paying court and legal fees later.

TABLE 1. PLANNING/EVALUATION PROCESS FOR INMATE HEALTH SERVICES

TASK	SUBTASKS	TASK RESPONSIBILITY	OUTCOME
1. **WHERE ARE WE NOW?** (Analysis of current system) (Chapter 3)	Determine: a. population served b. staffing (medical/security) c. space & equipment d. services delivered/method of delivery e. service provider f. cost g. utilization h. program strengths & deficiencies i. Review current and past lawsuits and/or court orders involving health services	Custody Administration* Jail Health Authority* Legal Counsel	Summary of program cost to include security, transportation, costs per category of service (mental health, inpatient, outpatient, etc.) and per inmate. Summary data of annual utilization. Summary of strengths and deficiencies
2. **WHAT IS THE SERVICE DELIVERY GOAL?** (Scope & level of services to be provided) (Chapter 4)	Review relevant state regulations and recent case law regarding inmate health services. Review requirements of state and national jail health services standards and voluntary accreditation. Review applicable state health facilities licensing requirements.	Custody Administration Jail Health Authority*	Mission statement/program objectives for inmate health services program. Statement of intent to meet state minimum standards; seek accreditation and/or licensure status (inpatient beds).

*Primary Responsibility

TABLE 1. PLANNING/EVALUATION PROCESS FOR INMATE HEALTH SERVICES (cont.)

TASK	SUBTASKS	TASK RESPONSIBILITY	OUTCOME
3. HOW TO DO IT? (Method/location of service) (Chapter 5)	Determine size, characteristics & location of population to be served. Determine security needs & limitations. Determine transportation limitations/requirements. Evaluate the availability of community services. Conduct COST/BENEFIT analysis of: a. onsite vs. offsite delivery b. centralized vs. decentralized delivery.	Custody Administration* Jail Health Authority* Financial Analyst	Summary statement defining method & location of all inmate health services.
4. THE PLAN (Develop Program Statement) (Chapter 6)	Incorporate the outcomes from TASKS 1-3.	Custody Administration Jail Health Authority*	Health Services Program Statement
5. THE PROVIDERS (Determine program provider(s)) (Chapter 7)	Determine provider options, capability and availability. Analyze costs, benefits & detriments of various provider options. Develop specifications for request for proposal, memoranda of understanding and/or contracts.	Custody Administration Jail Health Authority County CAO Financial Analyst Legal Counsel	Select Providers Draft memoranda of understanding and/or request for proposal or contract(s).

*Primary Responsibility

TABLE 1. PLANNING/EVALUATION PROCESS FOR INMATE HEALTH SERVICES (cont.)

TASK	SUBTASKS	TASK RESPONSIBILITY	OUTCOME
6. THE PLACE AND PARTS (Determine facility design, space & equipment requirements) (Chapter 8)	Determine space & equipment needs based on outcomes of TASKs 1-5. Review CA Code of Regulations Title 24, space & building requirements for jails. Review state & national jail health services standards for minimum observation/supervision requirements in special housing or treatment areas.	Custody Administration* Jail Health Authority* Mental Health Services Dental Consultant Pharmacy Consultant Nursing Consultant	Statement of facility design, space & equipment requirements for all onsite health services.
7. THE PEOPLE (Identify staffing requirements) (Chapter 9)	Determine staffing requirements based on outcomes of TASKS 1-7. Review relevant professional licensing scope of practice regulations.	Jail Health Authority* Mental Health Consultant Dental Consultant Pharmacy Consultant Nursing Consultant	Health Services FTE Staffing Requirements List Health Services Staffing Plan

*Primary Responsibility

SECTION II: PLANNING METHODOLGY

CHAPTER 3. WHERE ARE WE NOW?

Having looked generally at the issue of responsibility for medical and mental health services delivery and having a sense of the legal issues involved, your next step in the strategic planning process is to determine "what is"--where your system is right this minute. This is Task 1 in Table 1, the first order of business.

Decisions about future inmate medical/mental health programs must be based on a thorough analysis of the jail's present health services program. This analysis should include a study of the program's strengths and weaknesses (what is right with it and what is not working), how much the current approach costs, and how and by whom it is being used. In other words, you need to answer questions such as:

- What services are currently provided, how, where and by whom?

- What are the size and characteristics of the inmate population(s) served?

- What is the cost of the current program (including security and transportation services provided by sheriff's or police departments and services provided by other city or county agencies such as mental health, etc.)?

- What are the strongest elements of the current program (e.g., having it mainly in-house, having total control of costs, interaction with community agencies to provide services, etc.)?

- What are the deficiencies of the current program (e.g., inability to meet minimum standards or court mandates, inability to meet service demands of an increasing inmate population, excessive use of community hospital emergency departments, lack of around-the-clock nursing staff, etc.)?

These questions are the base of your planning process. As you answer them, the data you generate will provide you with a picture of what you need in relation to what you have. While you know that the planning process should be ongoing and the analysis of your current system should always be in process,

you also know that one has to start somewhere. In this instance, the place to begin is with a look at your prisoner population and its health service needs, the staff and space your jail has allocated to health services, the costs--both in capital and operating funds--and utilization data. In other words, you are looking at audits of the entire health services program.

You can accomplish the necessary audits internally or with the help of external organizations such as the county or state medical society or jail medical consultants. Regardless of whether they are done internally or externally, the audits should involve on-site jail health care professionals, including personnel of your department as well as those of all other providers of inmate health services such as the county health department, county mental health department, hospitals used for inpatient services and ambulance companies.

Population Served

Your information management system should yield data about your population, such as the demographics with which to begin assessing potential medical needs. Your medical record-keeping system should be able to tell you what services are used most often; what the most common medical, dental and mental health complaints are; and what resources are being used to address those complaints.

Staffing

Your facility's staffing plan, plus a thorough review of how and by whom health services are provided, will give you a comprehensive picture of the staff currently involved in your health services program. Draw a chart; make a list; graphically and clearly delineate what personnel are used, at what level and employed by what agency. You need to know what staffing demands are being made on your department and how much of your program is being supported by ancillary or outside personnel in order to make decisions later about optimum models for service delivery.

Space

Consider and evaluate the areas of your facility which are used for health services. What do you have that you do not use and what do you need that you do not have in the way of examining rooms, infirmary space, acute care space, storage space, equipment storage, etc.?

Utilization

Your analyses of existing services will require cost and utilization data bases. If you do not have baseline data readily available, you will have to compile the necessary information from old and current records. It would be well worth your while, in addition, to create a mechanism for ongoing, systematic compilation of information so that you will have what you need, not just for this analysis, but also for future planning, budget purposes and quality control.

Utilization data consist of a statistical accounting of how frequently specific services are used. Jail health services utilization data can be divided into two categories--on-site services and off-site referrals--and information should be collected in each category monthly and summarized on an annual basis.

While any data category can be expanded to suit the jail's medical program, some of the service areas on which you will need to collect information are set out in Table 2.

TABLE 2. UTILIZATION DATA

On-site Services:	How Many
Clinical visits:	
Sick Call	
by a Physician's Assistant or Nurse Practitioner	
by a Registered Nurse	
by a Physician	
Health Screening/Physical Assessments	
Food Service Worker Screening	
Mental Health Interventions:	
by a Master, Social Work	
by a Psychological Social Worker	
by a Psychologist	
by a Psychiatrist	
by a Physician	
Lab Use	
Pharmacy Services:	
New Prescriptions	
Total Prescriptions	
Total Prescription Doses Administered	
Infectious Diseases:	
TB Skin Tests	
Positive TB Skin Tests	
VD	
Hepatitis	
Other Reportable Diseases	
Infirmary Daily Occupancy:	
Medical	
Psychiatric	
Total	

TABLE 2. UTILIZATION DATA (cont.)

Off-site Referrals	How Many
Hospital Emergency Department	
Special Clinics:	
Dermatology	
General Surgery	
ENT	
Internal Medicine	
Ophthalmology	
Optometry	
Orthopedic	
OB/GYN	
Outpatient Diagnostic/Special Services:	
Lab	
X-ray	
EKG	
EEG	
Other	
Inpatient Hospital Referrals:	
Hospital Admissions	
Diagnosis-	
Length of Stay-	
Total patient days	
Dental:	
Patients Treated	
Oral Surgery	
Diagnosis-	
Referrals	

Costs

The identification, classification, assembly and analysis of medical data for cost purposes are increasingly important parts of budgeting for jail operations. Further, the costs of medical portions of new, expanded or remodeled jails represent a significant element of total capital outlay.

While medical expenses represent a growing portion of the jail operating dollar, the actual dollar figure allotted to health services will vary from one facility to another depending on a number of variables. Some of these are:

- number of inmates;
- the extent to which clinical services are delivered on-site at the jail;
- the number and kinds of arrangements with clinical personnel such as physicians, nurses, etc., for jail medical services;
- the distance from and availability of hospital inpatient and outpatient services;
- the nature of the contractual arrangements for payment of outside hospital services (inpatient and outpatient);
- the availability of a jail infirmary;
- the existence and nature of court orders and/or mandates; and,
- fiscal support by county and city officials.

Your health services costs, like your utilization data, can be divided into the two broad categories of costs for on-site services and costs for off-site services. To develop a comprehensive picture of the total, you will want to break out expenditures for all the services and line items included in health services provision. Table 3 provides a generally inclusive listing; if there are additional cost items for your facility(ies), be sure to include them in your cost analysis.

TABLE 3. COST ITEMS

On-site Services	Dollar Amount
Personnel (Salaries/benefits)	
Linen supplies/laundry	
Office expenses/equip/supplies	
Supplies	
medical	
dental	
laboratory	
Medical Records	
Pharmaceutical	
Equipment and Equipment Maintenance	
Communications	
Insurance, including but not limited to Malpractice, Liability, etc.	
Space Utilization Costs; i.e., janitorial, heat, light, other	

Off-site Services	Dollar Amount
Hospital	
inpatient services	
outpatient services	
specialty clinics (such as kidney dialysis, etc.)	
Transportation	
by sheriff's or police department	
by ambulance	
Physician Specialists and/or Consultants	
Contract lab - X-ray services	

Since all California jails have been delivering medical care to inmates, there are data available which can help you arrive at an estimate of percentages of service costs. In addition to rounding out your picture of expenses, this information will give you the opportunity to assess the adequacy of your service provision. By looking at the last fiscal or calendar year's health services expenditures, you should be able to determine what elements of service absorb what percentage of the budget. Personnel costs will represent the single largest component of on-site medical expenditures (usually over 75%) and inpatient hospital costs will be the largest expenditure made for off-site service costs. It is possible that off-site emergency room visits could cost more than inpatient hospital services if a jail administrator elected to have limited medical staff on duty and send all inmates with potential health problems for screening at an off-site emergency room.

Table 4 presents a sample budget format which serves well as a monthly or quarterly report on jail health care expenditures. The utilization data discussed previously and the cost/expenditure information generated by this format will be most helpful to the facility administrator for ongoing management analysis, control, projection and comparison in addition to the strategic planning process at hand.

TABLE 4. SAMPLE BUDGET FORMAT

XYZ COUNTY JAIL MEDICAL SERVICES
Statement of Appropriations, Expenditures and Encumbrances
June 30, 1985

CST CTR	ACCT#	SUB-ACCT #	ACCOUNT NAME (1)	TOTAL APPROPRIATION(2)	CURRENT PD EXPENDITURES(3)	YEAR-TO-DATE EXPENDITURES(4)	OUTSTANDING ENCUMBRANCE(5)	UNENCUMBERED BALANCE(6)	PCT UNENC(7)
340	1011	0	Salaries & Wages	485,761.00	97,480.16	558,155.74	0.00	(72,394.74)	14.8
340	1015	0	Overtime	5,032.00	363.10	3,134.42	0.00	1,897.58	37.7
340	1211	0	Retirement Tier 1	64,152.00	5,115.09	32,707.47	0.00	31,444.53	49.0
340	1221	0	Retirement Tier 2	322.00	141.34	205.50	0.00	116.50	36.2
340	1311	0	FICA	28,985.00	2,964.14	17,277.09	0.00	11,707.91	40.4
340	1411	0	Health Insurance	18,659.00	6.98	21,604.61	0.00	(2,945.61)	15.7
340	1421	0	Dental Insurance	6,080.00	532.54	6,205.28	0.00	(125.28)	2.0
340	1511	0	Other Employee Benefits	1,675.00	46.52	374.11	0.00	1,300.89	77.7
340	1611	0	Compensation Insurance	1,184.00	434.64	2,363.41	0.00	(1,179.41)	19.5
340	1711	0	SDI	2,203.00	109.67	505.29	0.00	1,697.71	77.1
	TOTAL		**Salaries and Employee Benefits	614,053.00	107,194.18	642,532.92	0.00	(28,479.92)	4.5
340	3111	0	Office Expense	2,315.00	67.79	1,414.17	409.02	491.81	21.2
340	3112	0	Reprographics	418.00	0.00	170.47	0.00	247.53	59.2
340	3131	0	Med Dent Lab Supplies	8,600.00	276.61	9,013.59	403.23	(816.82)	9.4
340	3151	0	Pharmaceuticals	7,880.00	0.00	126.00	0.00	7,674.00	98.4
340	3231	0	Maintenance-Equipment	450.00	188.90	311.72	397.85	(259.57)	57.6
340	3291	0	Communications	2,677.00	940.98	4,612.74	0.00	(1,935.74)	72.2
340	3351	0	Transportation	880.00	260.13	758.15	0.00	41.85	5.2
340	3354	0	Motor Pool	1,353.00	0.00	0.00	0.00	1,353.80	100.8
340	3411	0	Outpatient Hospital Care	1,700.00	4,110.26	27,521.91	439.70	(26,261.61)	544.7
340	3412	0	Inpatient Hospital Care	227,000.00	32,868.88	150,695.01	3,671.20	72,632.99	32.0
340	3471	0	Prop & Public Liab Ins	0.00	0.00	0.00	0.00	0.00	0.0
340	3551	0	Rents/Leases-Equipment	500.00	0.00	122.48	0.00	377.52	75.5
340	3571	0	Rents/Leases-Land, Struc, Inps	0	0.00	0.00	0.00	0.00	0.0
	TOTAL		**Services and Supplies	253,613.00	38,712.84	194,747.04	5,321.00	53,544.96	21.1
			******** TOTAL DEBIT ACCOUNTS	867,666.00	145,907.02	837,279.96	5,321.00	25,065.04	2.9

TABLE 4 (cont). EXPLANATION OF BUDGET FORMAT TERMS

Column

1. Cost Center - the numerical indicator assigned by the city or county to a particular service or program. In this case, it is the example XYZ Jail Medical Service.

2. Account Number - The specific expenditure account; e.g. 1101-Personnel, 3111-Office Expense, etc.

3. Sub-Account Number - Available if more specific detail is desired for a particular expenditure. (For example, it may be desirable to further clarify hospital inpatient expenditures into medical, surgical, and obstetrical. In this case, 01 would be surgical, 02 medical and 03 obstetrical. Their sum total would represent the expenditure for account 3412-Inpatient Hospital Care).

4. Account Name

5. Total annual appropriation for the account

6. Current paid expenditures for the statement period

7. Year to date expenditures

8. Outstanding encumbrances - (These are costs for which funds have been committed during the statement period, such as supplies ordered with payment to be made on receipt of the order.)

9. Unencumbered balance - (This is how much money remains in a particular account for the remainder of the year.)

10. Percent unencumbered - (This relates to Column 9 and conveys the percentage of money in a particular account for the remainder of the year. By way of an example, in an account with a $120,000 annual appropriation, three months into the fiscal year there should be $90,000 or more dollars unencumbered for a 75% unencumbered balance.)

Accounts should be reviewed at least monthly and more frequently if it appears necessary. Account adjustments should be made at mid-year when it appears from utilization data that jail medical activity is significantly higher than projected, for instance because the population is larger or there has been an unusual occurrence such as an episode of contagious illness.

There is value in comparing gross expenditure amounts by Cost Center and Individual Accounts on an annual basis. This can give a foundation for budget projection as well as defining areas that require further analysis. You would want to pay attention, for example, to any large increase in hospital expenditures which may mean there have been changes in the jail population's medical needs or that physician personnel have changed their referral patterns.

You will also want to develop an index that can be used to compare your health services program costs with those of other jails. Obviously comparing gross expenditures is meaningless given the different sizes, locations and jurisdictions of jails. One indicator that can be used is the Medical Cost Analysis, which uses the cost per inmate day as the gauge. Table 5 illustrates how you can arrive at your per diem inmate health care costs.

TABLE 5. EXAMPLE: MEDICAL COST ANALYSIS

SAMPLE (XYZ COUNTY JAIL)
FISCAL YEAR 1984-85

HOW TO FIGURE DAILY INMATE MEDICAL COSTS - ON SITE, OFF SITE AND TOTAL .....

AVERAGE DAILY CENSUS (ADC)

FEMALES	77.3
HONOR FARM	92.4
MALES	281.5
1984-85 ADC	451.2
	x 365 days

(A) TOTAL INMATE DAYS	164,688
(B) TOTAL HEALTH CARE COSTS	$842,601.00
(C) ON SITE ...	$660,274.00
(D) OFF SITE ..	$182,327.00

TOTAL INMATE DAYS: Multiply average daily census by 365 days (451.2 x 365 = 164,688 (A)).

ON-SITE COSTS PER INMATE: Take total dollars expended for on-site services (C) and divide by total inmate days (A)
($660,274 divided by 164,688 = $4.00 per inmate daily for on-site health care services)

OFF-SITE COSTS PER INMATE: Take total dollars expended for off-site services (D) and divide by total inmate days (A)
($182,327 divided by 164,688 = $1.11 per inmate day for off-site health care -- hospital, etc.)

TOTAL COSTS PER INMATE HEALTH CARE: Add up all costs (B) and divide by number of inmate days (A)
($842,601 divided by 164,688 = $5.11 per inmate day)

The data in Table 5 enables you to compare your health services costs with those of similar jails and with statewide norms or averages. Significant variations above or below a multi-county average using like statistical collection, input and reporting should be thoughtfully examined. It is of equal concern when your operation seems to be spending too little money as when cost data comparisons indicate you are significantly exceeding the average.

In the former instance, when your costs appear significantly lower than other jails, you will want to make sure your health services are sufficient to meet the needs of the population given all relevant legal considerations and the standards of care in your community. Remember there are persons available to assist you in evaluating whether your health services program does meet community standards.

There are valid reasons for fluctuations in expenditures. Perhaps the jail population had a particularly high number of drug abusers which caused more referrals to the hospital than in previous years. Perhaps there was an especially virulent flu which infected the population. There are many factors which could affect the data, but the significant concern is that the jail administrator be aware of, and can satisfactorily account for, variations outside the specified norm. You must have a clear understanding of where your medical and mental health dollars are being spent to manage your service effectively.

Analysis of Strengths and Weaknesses

Analysis of the strengths and weaknesses (deficiencies) of your jail health delivery system should be an ongoing process. It should be a priority part of your planning process to build in those quality assurance activities such as internal audits, routine review of inmate health care grievances and writs, lawsuits and incident reports, as well as periodic evaluation of services in relation to state and national inmate health care standards. Make sure you are familiar with California's Minimum Standards for Local Detention Facilities, the National Commission on Correctional Health Care (formerly AMA's) Standards and the American Correctional Association Standards.

It is required to have periodic internal and external system audits performed by a third party such as local or state professional societies or associations. Medical, dental, mental health, nursing associations and/or professional jail health care consultants can provide objective evaluations of the jail's health care services within the broader community standard of care.

Audit findings should be looked at as part of the continuous planning process discussed previously. The data generated by an audit provides a method for measuring the effectiveness and quality of current activities, a basis for planning and documentation, and validation of fiscal and programmatic needs useful when dealing with county administrative officers, boards of supervisors and other funding sources.

California's Minimum Standards for Local Detention Facilities (Title 15, Article 10, Section 1202, California Code of Regulations) requires "the health authority to develop and implement a written plan for regularly scheduled, at least annual, internal and external service audits. The plan shall include a means for the correction of identified deficiencies of the medical and mental health and pharmaceutical services delivered."

This is one of the areas in which the utilization and cost data discussed earlier proves very useful. It will provide valuable information for identifying areas which warrant further investigation in the audit process. Inmate grievances, writs, lawsuits and incident reports involving health services delivery should also be routinely reviewed to identify deficiencies or trends which may signal potential problems. Routine audits to measure compliance with established clinical protocols is another method of identifying system strengths and weaknesses.

Once the topic of study, the subject of an audit, has been identified, the responsible physician or some other designated health services staff person should develop the audit plan, the criteria and the percentage levels for compliance. For example, a facility may wish to study its capability to respond to and evaluate suicidal behavior. The performance criteria could be that all inmates identified by facility or health services staff as expressing suicidal tendencies or demonstrating suicidal behavior will be evaluated by mental health staff within four hours. The acceptable percentage rate of compliance is 100 percent.

A random sampling of medical records of inmates evaluated or treated for suicidal behavior is completed. Each record is measured against the selected performance criteria. The findings of the chart review are tallied and measured against the established acceptable compliance percentage. If the study shows an unacceptable rate of compliance, the reasons are analyzed, a plan for corrective action is developed and implemented (e.g., a change in referral procedures, inservice training, additional mental health staff, etc.) and a re-audit is scheduled in six months.

In summary, an analysis of a system's cost, utilization and audit data assists the facility administrator and health authority in identifying program strengths and needs. The next step is to identify the most appropriate and cost effective methods to meet those needs.

CHAPTER 4. WHAT IS OUR SERVICE DELIVERY GOAL?

The first step in the planning methodology demonstrated in Table 1 was to analyze your present system. The second major task, and the one on which this chapter focuses, is determining the scope or level of health services to be provided. Program objectives need to be determined and, following this, what it will take to meet those objectives has to be identified.

The final decision, which should be reviewed by an appropriate health care committee or planning group, will ultimately have to be made by the sheriff, chief of police or director of corrections working in conjunction with the responsible health authority. The goal is to determine how and to what extent health care services will be delivered at the jail site and/or obtained in the community setting.

Whether you are planning for an existing facility or one which is in the design stage, there are a number of factors which must be considered in making the decision on the type and amount of service to be provided. Some of these are:

- identification of overall inmate health care requirements;
- the size and type of facility;
- ability to recruit quality professional staff;
- the effect of court orders;
- ability to meet special housing needs;
- security considerations that affect inmate movement;
- state and local statutes, standards, regulations;
- the average length of stay of prisoners (where inmates remain for extended periods of time more comprehensive, long-term health services must be planned for);
- inmate characteristics; e.g., gender (where female prisoners are held, appropriate OB/GYN services must be made available);
- current and historical cost and utilization data for jail medical services (see Chapter 3);
- initial and operating cost of providing in-house services;

- space limitations;

- the proximity of basic and specialty services in the community;

- the availability of portable services; and,

- the desire to exceed minimum standards in order to gain state or national voluntary jail health care accreditation status.

Levels of Care Explained

The information you generate about the factors affecting scope of service will be crucial in determining what your real needs and abilities are. Also important in making the decision is an understanding of the term "level of care".

"Level of care" defines the type of health services that are to be provided which in turn affects personnel, equipment and facility needs. How much care (what level?) is going to be provided onsite versus offsite? Definitions of the major levels of care and discussion of the relevance of each to the corrections setting might be useful at this point.

Outpatient Services

First Aid - Emergency aid or treatment given before regular medical services can be obtained.

Note: Care equivalent to that which a lay person would be capable of providing at home can be provided by either medical or trained custody staff in the jail setting. Cardiopulmonary resuscitation (CPR) is considered part of first aid. Jail personnel must have current training in first aid and CPR (see Minimum Standards for Local Detention Facilities, Section 1020, Training Requirement, and Section 1220, Availability of First Aid Kits in the Facility).

Emergency Services - Services equivalent to those provided in hospital emergency departments, including immediate availability of physician, life-support services, ambulance services and pre-hospital emergency personnel.

Ambulatory (Outpatient) Services - Services equivalent to those which an ambulatory patient would normally obtain in a physician's office or clinic. It is

essentially all care not requiring hospitalization. Ambulatory services can be provided on or offsite or through a combination of both methods.

Note: In the custody setting, ambulatory services must be planned for medical, mental health and dental services.

In-patient Services

Infirmary - A segregated unit of a school, licensed residential care home or similar institution which is established and operated to provide limited, short term medical and nursing services to employees, residents or enrollees. Such services consist of isolation, observation, first aid or treatment of minor illnesses. As defined above, an infirmary does not require a license (see California Code of Regulations, Title 22, Section 70005, Subsection C).

Note: The majority of California jails which provide inpatient services in-house fall in the category of infirmary as defined above. Several recent lawsuits have challenged this fact, alleging certain jails are providing a higher level of care and thus must seek licensure as 'skilled nursing facilities.' In light of the court's intervention, a bill was passed by the California Legislature in the 1987 session which created a "Correctional Treatment Center" licensure category and authorized the development of regulations. The category of "Correctional Treatment Center" encompasses what is now known outside of corrections as "infirmary", "skilled nursing" and "acute psychiatric" levels of care.

If you are planning in-house medical beds you may want to get in touch with the Department of Health Services Licensing and Certification Division at 916-445-3054 to find out what licensing requirements are likely to be enacted that would affect your plans.

Skilled Nursing Care - that care provided in a skilled nursing facility to patients who require care by a licensed nursing staff and supportive care on a long term basis. The skilled nursing facility is one which provides around the clock in-patient care including, at a minimum, physician, skilled nursing, dietary, and pharmaceutical services as well as an activity program (see California Code of Regulations, Title 22, Section 72103). This level of care requires a license under the jurisdiction of the State Health Services Department.

Note: Jails must provide access to skilled nursing level services. In most cases this means admitting the inmate to an acute care hospital because most community skilled nursing facilities are overcrowded and do not accept inmate-patients. Another option is providing skilled nursing care in the jail infirmary. At the time this manual was written, several California County jails are seeking licensure for a number of skilled nursing beds from the State Department of Health.

Acute General Hospital Care - that care provided in a hospital licensed by the State Department of Health Services. An acute general hospital has a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour in-patient care. Basic services include medical, nursing, surgical, anesthesia, laboratory, radiology, pharmaceutical and dietary.

Note: Jails must provide access to acute general hospital services, however, at this time no California jail provides this level of care on site.

Sheltered Living Unit - is special housing for individuals with particular medical or mental health needs. In corrections this is a relatively new term for an old concept. For example, a special housing area of the jail could fit this definition since it could be specially equipped if necessary, to provide for the needs of inmates who are not acutely ill, but whose medical or mental health conditions require either segregation from the general population or special housing conditions on an ongoing basis. Sheltered living units do not call for any type of health service licensure; in fact, in the jail they are considered an area of custody housing rather than health services.

As more attention is being paid to standards for correctional health services and as courts are comparing correctional health services to the standards of care in the community, level of care categories are increasingly being applied to jails. This does not mean every level of care must be provided by all facilities nor does it require that services have to be provided within the facility itself. What it does mean is that each jail must arrange for a full range of services to be available to inmates in a timely and satisfactory manner. Again, the issue is access and availability of appropriate health care services.

California jails must provide inmates with access to all the levels of care described above as well as to psychiatric

services which are discussed later in this manual. Apart from services such as first aid and receiving screening, the selection of the location where the care is actually provided becomes an administrative decision based on those factors listed previously in this chapter. Good planning, however, requires that you make your decisions early.

CHAPTER 5. HOW TO DO IT

Assuming you have been through steps one and two, you have answered some important questions for your system--questions about where your health services program stands right now and where optimally it is heading. You have made some determinations about scope of service. Now, you have to deal with considerations about how best to achieve the objectives you have set.

As you know, you can provide inmate medical services on site at the jail or off site by transporting inmates to health service providers in the community. With regard to on-site services, there is a further set of decisions to be made in terms of whether services will be centralized (inmates will be brought to the health care provider) or decentralized (health services will be taken to the inmates as much as possible). In order to move forward with the "How To Do It" part of your planning, you will have to examine and make some decisions about each of these options.

On-site vs. Off-site Services

As with all the other decisions discussed up to this point, this one requires consideration of a number of factors. In order to decide the best location for providing specific clinical services, you will want to look at the following:

- How often is the service needed?
- What is the cost of providing the service within the facility vs. obtaining it through an outside provider?
- What are your security needs and/or limitations (e.g., do you have high security inmates? Do you have officer staff available to escort and/or transport inmates?)
- What are the size, location and characteristics of the population to be served?
- What is your transportation capability?
- Are the services you need available in the community?
- Do you have or can you get the space, equipment and/or staff to provide the service in house?

Services that are required frequently and which call for a minimum of equipment, such as simple out-patient care; e.g., sick call, are generally done most efficiently and inexpensively at the jail, particularly if security and transportation are considered. Specialized and more expensive types of care may best be sought off site at local hospitals equipped to provide the needed services. For some large jails with a high volume of utilization of special services, such as X-ray for example, a cost benefit may be realized by providing such services on site.

Once your decisions are made to provide a certain level of care within the facility, it is essential from a liability standpoint that you actually abide by the limitations you define. Attempting to care for an inmate whose illness requires care beyond the in-house capabilities of your health services program is dangerous and fraught with potential liability.

If you do not already keep good statistics on the utilization of individual services provided both off site and on site, it is imperative that you do so. There is no way that you can compare the cost benefit of providing a service at the jail versus providing it off-site without accurate utilization and cost data.

Centralization vs. Decentralization

In contrast with most traditional jail construction, newer jail designs generally attempt to provide inmate services in the inmate living units, thus minimizing the need to move inmates from one place to another. While this has value in terms of custody staff time and facility operation, it poses some potential problems for health services planning.

It is difficult to perform medical exams and other functions in multi-purpose rooms, given the requirements for confidentiality and security. While ideal, providing a medical examination room in each module of a jail means you will need more space, you will undoubtedly have to hire more health care staff and you will need to duplicate equipment. (Appendix C describes the basic space requirements and items of equipment for a simple examination room.)

If it is feasible to have an examination room in each living module, the vast majority of routine out-patient care; e.g., sick call service, can be provided without moving the patient. This can enhance the efficiency of routine care, including screening health assessments required by

accreditation programs, without posing a burden for custody staff. Further, it reduces the down time health care providers spend waiting for inmates to be escorted to a central medical area.

For less frequently used services and for those requiring relatively large and/or expensive equipment, a centralized service location is preferable. Bringing inmates to those services will be less expensive in the long run than attempting to duplicate the necessary equipment in each housing area. Those services which lend themselves to a centralized, rather than decentralized, approach include but are not limited to:

- dental services
- minor surgery
- laboratory (although specimens may be collected in living units)
- special isolation rooms
- pharmacy (storage, preparation, packaging area)
- physical therapy, radiology, electrocardiogram and other special procedures.

Options to explore for delivering these services include portable equipment so the services can be provided in one or more areas of the jail, a fixed location in the jail with a permanent on-site provider or transportation to an outside provider.

If your health care services planning is for an existing facility, your decisions about centralized versus decentralized service delivery will be based on available space and the configuration of your jail. The jail design and philosophy will have a significant impact on the type of health services delivery system that will work best for you.

For the jail administrator looking at a facility still in the design phase, questions about the basic philosophy underlining your design will have to be asked with relation to health care services delivery as well as other aspects of your operation. Whether you will provide services on site or off site and whether services will be centralized or decentralized must be determined early in the design and construction cycle. The answers to those questions will affect the jail you build, not to mention the costs of running that jail for its 30 - 50 years of useful life.

CHAPTER 6. THE PLAN

Whether you are building a new jail, remodeling an existing one or simply redesigning your medical services delivery system within the confines of the physical plant you have, you need to have a **medical services program statement** (see Appendix C). Such a program statement will describe the objectives, the scope and the range of health care services you intend to provide for jail inmates. It expresses the design elements of the medical program and enables those involved in implementing the plan to start from a common understanding of goals and philosophy.

The program statement does not need to be lengthy; it just needs to be clear. It deals with both historical reference to the jail's past medical activity and projections of anticipated needs and requirements. It is a critical planning tool, required by common sense as well as by the minimum jail standards.

Prior to writing your program statement, you will want to become familiar with the following documents relating to jails and correctional health services:

- Title 15, Minimum Standards for Local Detention Facilities, Subchapter 4, Article 10, Medical Services.

- Title 4, California Penal Code, Part III, Chapter 1, County Jails. (The mandated provisions are Sections 4011, 4011.5-4011.9, 4012, 4020.7, 4021, 4023, 4023.5, 4023.6, 4028 and 4029.)

- Title 22, California Code of Regulations, Division 5, Licensing and Certification of Health Facilities; Chapter 3, Skilled Nursing Facilities and Chapter 7, Primary Care Clinics. (While these are not mandated for jail medical facilities, they will provide a valuable source of guidance and reference in planning such facilities.)

- Standards for Health Services in Jails, National Commission on Correctional Health Care.

- American Medical Association Guidelines for Correctional Facilities, Space and Basic Equipment.

In addition, local community hospitals, the county health officer and the county medical society can serve as resources in your medical services planning process. Also available are several well-qualified, professional jail health care consulting firms which can assist in developing your program statement. Visiting jails which have recently designed or redesigned their health services delivery system is also valuable.

CHAPTER 7. PROVIDERS

Moving through the planning process, you have considered what is and what needs to be with relation to your jail health services program. You have looked at where and how to accomplish what you established as your goals. In your plan or program statement, you have set out what will be done. Next, you need to determine who will be the provider(s) of your medical and mental health services.

The choices for providers of jail medical services are several, including but not limited to the following:

- personnel hired by the sheriff, chief or director of corrections; i.e., an in-house operation;

- other county or city departments such as the county health department, county hospital, county mental health department, county health care agency or any combination of the above;

- a combination of these first two options; e.g., the sheriff might hire the physician(s) and/or nurse(s) while the county mental health agency would provide the mental health services; and,

- contract service providers; i.e., a nongovernmental agency, individual or corporation. Private providers of jail health services offer a range of options, from providing only a physician or physicians to taking responsibility for all jail medical activities.

Combinations of any of the above arrangements are feasible and each sheriff or corrections administrator must determine which method is best suited to the particular circumstances of his/her jail or system. In making that determination, points to consider are the:

- cost of attaining the services;

- security issues; and

- the capability of the provider to meet the medical/mental health service demands of the jail.

You will need to consider, relative to each provider, scope of service, timeliness of service delivery, access to your population and continuity of service. Can the providers you are considering deliver? Will they be able to do the job you

need them to do? Will they be there for the "long run" when you need them? What track record, if any, do they have?

Additionally, it will prove useful to scrutinize the pros and cons of each provider option. Although by no means all-inclusive, the following outline highlights some of the positive and negative aspects to be considered:

Sheriff-Operated and Staffed Medical Programs
(Los Angeles County, San Bernardino County and San Diego County Sheriffs' jails are among those who use this option.)

Positive Aspects:

- There is a real or perceived sense of control over the medical program and staff. (This perception may be eroding as the courts, over the past few years, have mandated more autonomy for jail medical services/personnel and as there have been advances in professionalism and adherence to principles of medical ethics among correctional medical personnel.)

- Sheriff-operated medical programs and staff have one common goal: provide care to the inmates of the facility.

Negative Aspects:

- The management of jail health care services has become increasingly complex. Court mandates for improved services, increased incidence of civil litigation and larger inmate populations demanding more health care services and staff have all added to the complexity. Unless the system is large enough to justify a full-time professional health services administrator, it is difficult for a part-time doctor or a custody administrator to manage the day-to-day operation of health services.

- Many sheriff-operated health systems are isolated from the rest of the health care community and consequently have not developed linkages with other health care resources.

County/City Health Agency Operated Programs
(Adult Institutions -- Camps and Work Furlough Center--operated by the San Diego County Probation Department, Sacramento, Fresno, Contra Costa and Santa Cruz county

jails use their county health department to provide medical services.)

Positive Aspects:

- These agencies are managed by health care professionals oriented toward public health service delivery. They know county/city resources and have established linkage with other services in the community such as substance abuse programs, social services, nutritional services, etc.

- There are usually enough personnel within the system to provide for back-up staff coverage for illness and vacation and there is the availability of flexible staffing to the jail; i.e., part-time or full-time staff depending on what is needed.

Negative Aspects:

- These agencies have many constituencies which means the jail will not be the only or top priority in the competition for staff, programs and services.

- Often these agencies are the provider of last resort and, therefore, are unwilling or at least unenthusiastic about servicing the jail.

Contract Jail Health Care Services
(Butte, Shasta, Monterey, Stanislaus, Ventura and Alameda counties are examples of medical programs provided by a sole contract provider.)

Positive Aspects:

- The contractor assumes a good deal of the risk and liabilities.

- The contractor has an obligation and an incentive to provide monthly statistics and tangible results.

- A contract should provide for fixed costs for the length of the contract. There should be no unplanned cost increases confusing the budgeting.

- There is a single point of accountability and there is the ability to remove poor performers in a timely fashion.

- Contracting for services creates the flexibility to purchase only and exactly what you want.

Negative Aspects:

- Current employees often feel threatened by outside, contract employees and labor/employee organizations may offer considerable resistance.

- Contracting may bring with it a sense of loss of control and long-term insecurity because rising contract costs could mean having to find a new provider or having to return to providing the service yourself after being "out of the running" for the period of the contract.

Contracting

Let us look for a minute at this issue of contracting for inmate health care services. Should you or should you not? Is there something inherently right or wrong about doing so? Is there more to this question than immediately meets the eye? Probably not.

Contracting is an alternative to consider when there are continuing problems relating to the cost or administration of an inmate health care program and no solution appears to be forthcoming from within the system. Whether to contract or not is a question involving budgetary, operational, programmatic and political considerations. Each of those factors should be closely evaluated prior to a final decision.

Many jails throughout the country have contracted out their health care services and are satisfied with the results. At present, only one jail that had made the decision to go to contract services has returned to providing those services itself, although a few have changed from one contractor to another.

Any one or a number of factors have influenced local administrators to contract out inmate health care services. Among them are:

- the rising cost of inmate health care (especially in the areas of off-site in-patient care, emergency room use and specialty services);

- the jail's inability to apply private business principles to curbing costs, as evidenced by significant cost overrides in the medical services budget every year for the past several years;

- the desire to have an experienced company, specializing in correctional medical services, accept the legal and administrative responsibility for inmate health care;

- an interest in having a guaranteed fixed annual cost;

- a consent decree ordering improvements in health care;

- a concern for liability based on the jail's lack of adequate health care policies and procedures, lack of documentation of adequate services or concern about adequate and appropriately trained staff, among other things;

- the need for a change agent based on institutionalized staff, difficulty in implementing new procedures and difficulty in recruiting and retaining motivated health care personnel; and,

- the building of a new jail with increased staffing needs which appears to signal a good time to go to the contract service mode.

If a county or city has one or more of the problems that has led other jails to contract out their medical services, does that mean they should contract? No, not necessarily. It may be possible to clearly define the problems, to develop solutions which do not include contracting and to convince city or county officials to provide the funds to make the necessary changes. On the other hand, if the internal solution is far more costly than contracting would appear to be, then it may be appropriate to explore the option of contracting.

If contracting out medical services becomes the strategy of choice, be careful to proceed in a way which will give you the best possible service for dollars expended.

- Use the data you generated for your strategic planning to define what is being done now and what the deficiencies are.

- Plan the new program based on correcting deficiencies and instituting desired improvements.

- Decide whether accreditation by the National Commission on Correctional Health Care, the California Medical Association or the American Correctional Association is desired. There is nothing that mandates that a jail meet accreditation standards; however, it may be wise to include accreditation as a contract requirement since it is good protection against civil liability. In most instances, vendors' proposals are the same price with or without accreditation.

- Develop a request for proposal (RFP) or invitation to bid which clearly specifies in detail what the program is to include, how it is to be administered and monitored, what the terms of renewal will be and how costs are to be computed and controlled. Most agencies prefer a one-year contract with two one-year extensions allowed by agreement of both parties. It is wise to ask bidders for their second and third year price increases, if any, in the RFP so you will know from the start what to expect over the anticipated life of the contract. A termination requirement in the RFP notifies the bidders of the contractor's right to terminate the contract in a specified period of time (usually 30 or 60 days) if not satisfied.

- Once the proposals are received, have them reviewed by a team including representatives of the county or city administrative office, health department, jail commander, county/city hospital and others as desired. Call for vendor references.

- Select the vendor. Be cautious about using low bid as the primary selection criteria. Program quality should be the key factor, and only if all proposals are comparable in program is it appropriate to consider low bid. Remember, "you get what you pay for".

Once again, it is important to keep in mind the fact that the decision to contract out inmate health care takes a great deal of consideration. Before you make the decision or spend time writing a proposal or an RFP, make sure that political, economic and personnel constraints are thoroughly evaluated and that a contract can legally be initiated. If the decision is finally made to contract, minimize the potential for negative reaction and a poor program by explaining your action

so people don't have to guess if and why you are going private. Publicize your intention to protect current staff, to maintain stringent security regulations and to provide optimum services as cost effectively as possible.

Whatever provider option, or combination of options, is chosen, it is essential to develop a clearly defined, program statement, memorandum of understanding and/or contract to:

- define the level, scope, location and method of service delivery;

- identify authority and responsibilities;

- create a mechanism for daily interface between the jail administration and the provider;

- insure quality control and guarantee a means for resolving problems that may arise in the provision of health services at the jail. (A sample memorandum of understanding--MOU--is included in Appendix B of this document.)

This is true whether you are dealing with a single provider such as a physician or a dentist, with a contractor who will provide a host of services or with another agency of the city or county. Developing this kind of clarity of thought and specificity of agreement will serve you well regardless of the provider option on which you ultimately decide.

CHAPTER 8. THE PLACE AND THE PARTS: FACILITY DESIGN, SPACE AND EQUIPMENT REQUIREMENTS

The task before you now is to determine the space and design specifications needed to accommodate the program design and to provide options defined earlier in the planning process.

While there are currently no regulations specific to jail medical space, there are regulations and principles for health services facilities in the community which, when adapted and applied in the jail, provide a safe, cost-effective and efficient environment for inmate health services delivery. This chapter presents some key issues for consideration in determining medical services delivery space requirements in the jail. The final design and space plan will be dictated by your health services program design, your present and future population demands, and the fiscal and political atmosphere in you community.

It is important to remember that medical delivery space will have to meet the needs of the jail for its 30- to 50-year life cycle. Therefore, design and plan for your ultimate delivery goal to anticipate future program and population growth. Program, staff and space can be approached in incremental steps or phases, implemented only when the need and/or resources exist. Remodeling existing jail facilities to accommodate health services delivery needs is expensive and restrictive. It is prudent to plan ahead for anticipated space and utility needs during the initial planning and construction phase.

SPACE DESIGN AND EQUIPMENT CONSIDERATIONS

Health services delivery space can be categorized by the following functional areas:

Administration -
- offices
- clerical support space
- storage

Patient Care/Treatment-
- examination rooms
- treatment rooms
- patient rooms
- dental examination/treatment areas
- mental health interview rooms

Treatment Support-
- patient reception/waiting
- patient lavatories
- nurse's station

health records (maintenance and file storage)
pharmacy
lab
utility rooms (clean/soiled [clinic and infirmary])
equipment storage
supply storage

Staff Support-

work rooms
rest rooms
locker space
break room
conference/training rooms
medical reference library

Key tasks at this stage of planning are as follows:

- functional areas and the number of units in each area should be clearly identified;
- major equipment items should be described for particular functional area;
- functional adjacency needs have to be identified; and,
- special utility needs should be identified.

Appendices C (Program Statement/Space and Equipment Requirements), D (Space Requirements) and E (Equipment Request Summary) provide examples of functional space requirements and checklists for equipment and space designing.
These are examples only--they are provided as a tool by which you can define the space and equipment needs for your unique situation.

In addition to functional areas, other issues and concerns need to be recognized and addressed when planning jail health services delivery space.

Infirmary or Medical Units

Many jurisdictions are considering the provision of infirmary or special medical observation/treatment units in the jail. Appropriately designed, equipped and staffed, in-house infirmary units can reduce admissions to the general acute care hospital for less than acute level care. The length of stay in an acute care hospital for convalescence and post-treatment monitoring may also be reduced by providing a step-down level of care within the jail. This allows many inmates requiring less than acute hospital level services to be cared for in the jail thus reducing outside hospital, transportation and security costs.

Legislation has recently been passed to create a health facility licensure category of "Correctional Treatment Center" (CTC) and to authorize the development of regulations to guide facility managers and correctional health authorities in designing and managing in-patient jail health services. Until CTC regulations have been developed and approved, designers and planners of jail in-patient units should use the specifications set in Title 24 of the California Code of Regulations, Section 2-1013, b, 13:

> ...such (medical care) housing must provide sufficient lockable storage space for medical instruments and must be located within the security area of the facility accessible to both female and male inmates, but not in the living area of either. The unit may contain other than single occupancy cells. The medical care housing area is to be designed in consultation with the health authority.

Additionally, the space and facility specifications for hospitals outlined in Title 22, Article 8, Physical Plant; Part 2, Title 24; and the AMA guidelines for Correctional Facilities Space and Equipment (available through the National Commission on Correctional Health Care) are useful guidelines for defining space requirements for specific functional areas of in-patient units. The National Commission on Correctional Health Care and American Correctional Associations standards for infirmary care outline the minimal management and operational requirements. Designers and planners of such facilities should attempt to meet existing California health facility design and space requirements as much as the security parameters of the environment permits. Infirmary/medical units should be adjacent to, but distinctively separate from, the clinic area which provides out-patient services to inmates housed within the general population living units. This makes possible the use of common patient treatment support services; i.e., pharmacy, supply, X-ray, medical records, etc., while limiting inmate and staff traffic flow through the in-patient area.

Access and Observation Capability Versus Security Concerns

Health services staff must have the capability to observe and access inmate patients in units that have been designated as special medical care/treatment areas of the jail. For example, infirmary rooms which are designed in such a manner so that the only means of observation is a narrow slit window in the door severely limit the health services staff's ability to observe and care for patients and, thereby, limit the type

of inmate/patient who can be safely housed in that environment.

Quick access to inmate/patients in jail medical unit is essential. This means that health services staff have the ability to open doors to patient rooms or sufficient security staff are assigned to the area to provide immediate access into patient rooms. In situations where inmates are escape- or assault-prone and/or display uncontrollable behavior, medical housing units must be planned, staffed and equipped to balance access and security needs. Alarm systems, staff panic buttons and room arrangement which facilitate rapid staff access to doors are options which require thoughtful consideration. A system by which inmates may summon assistance from health services staff is also essential in units which are designated as special medical observation/treatment areas. A flat, wall mounted call button intercom system utilizing both light and buzzer alarms connecting all patient rooms and the nurse's station is recommended. (Cord call buttons as used in hospitals are not appropriate for the jail as they pose a security risk in terms of suicide or assault.)

Patient Rooms

Patient rooms that are to accommodate a hospital bed must be larger than the standard single jail cell. The California Code of Regulations, Title 22, Section 70811, recommends 110 square feet per room to allow for the presence of staff and equipment. Multi-patient rooms should allow for 80 square feet per bed and three feet between beds. Patient rooms should be no more than 90 linear feet from the nurse's station.

Door Size

Infirmary or other patient care/treatment rooms should have doors which are wide enough to allow passage of a hospital bed, gurney and/or wheelchair.

Corridors

Corridors must be designed to allow for the passage and turning of medical equipment such as wheel chairs, gurneys and hospital beds.

Elevators

Elevators must be large enough to accommodate a litter or gurney, medical emergency response personnel and resuscitation equipment.

Medical Isolation Rooms

The incidence of contagious disease in jail populations is increasing. Communicable diseases commonly result in a need for medical observation/treatment and segregation from the general population. It is advisable to have approximately one room suitable for infectious disease isolation available for every 100 inmates housed in the facility (more in areas where there is a high incidence of diseases such as tuberculosis or infectious hepatitis). With the advent of Acquired Immune Deficiency Syndrome (AIDS) comes a more frequent need for reverse isolation, in which the patient must be protected from exposure to common infectious agents. A room designed to provide containment of infectious disease will also be suitable for reverse isolation.

Medical isolation rooms require the following (also, see California Code of Regulations, Title 22, Section 70833, for more information):

- sinks with foot or knee-operated controls adjacent to or within the room for staff to use on entering and exiting;

- a designated area or vestibule at the room entrance for staff to don masks and gowns as needed and to discard contaminated materials in special containers (permanent or portable cabinets and bins are needed);

- separate room ventilation units to avoid cross-contamination of airborne infectious agents into other cells; and,

- separate toilet and bathing facilities (shower facilities may be shared, provided they are cleaned with disinfectant after use).

Examination and Treatment Rooms

Examination and treatment rooms must be designed to accommodate equipment and allow staff to move around equipment. Special ventilation needs must be identified, as in cast rooms where dust can become an issue, as well as in areas of high humidity. Sinks with foot or knee controls should be planned for all examination/treatment areas. Greater physician efficiency can result if more than one examining room is available and arranged so that they are adjacent and connect to the physician's office.

Office and interview space are among the most frequently overlooked space considerations relating to jail medical and mental health services. It is also one reason that jails have difficulty recruiting and retaining qualified medical/mental health professionals. At a minimum, office space needs to be provided for your responsible physician, psychiatrist, psychologist, visiting consultants and supervising nurse. Additionally, private interview space needs to be allocated for mental health staff in jails.

Utility Rooms

Any medical unit (outpatient and inpatient) must have separate, clean and soiled utility rooms located adjacent to examination and treatment areas. The clean utility room serves as a storage and preparation area for supplies and equipment as well as special linens, such as hospital gowns, which would not ordinarily be available through the facility laundry. The clean utility room requires counter workspace, a foot/knee-operated sink and storage space (shelves and cabinets). The soiled utility room serves as a clean up area for soiled, used equipment; disposal of contaminated waste; and, storage of contaminated instruments and linens until decontaminated and/or sterilized. This area requires counter top work space with a foot/knee-operated sink and soiled linen and waste receptacles. In addition, a "hopper" (a ceramic plumbing fixture with flushing device and foot/knee controls) is recommended for rinsing of grossly contaminated items, including bedpans.

Pharmacy

It is important to consider the space you will need for your pharmacy and/or the storage of pharmaceuticals. The health authority and the facility manager have a responsibility to "develop a written plan, establish procedures and provide space and accessories for the secure storage, controlled administration and disposal of all legally obtained drugs" (see California Code of Regulations, Title 15, Article 10, Section 1216). Your pharmacy must contain adequate space for lockable cabinets for drugs and pharmaceutical supplies, double locked cabinets for controlled substances (some levels of federally scheduled drugs; e.g., Methadone, require a safe--contact the Board of Pharmacy for more detail regarding storage of federally-controlled substances), counter work space, a refrigerator, sink, typewriter or computer terminal with printer, file storage and storage for medication delivery carts or baskets. The pharmacy space requirements

will be contingent on the scope of pharmacy functions which will be included within your facility, but as general rule of thumb the following minimums are recommended by the American Association Guidelines for Correctional Facilities Space and Equipment:

150-300 square feet of dispensing, compounding and storage;

120-150 square feet for dispensing and storage only; and

80-100 square feet for dispensing only (cart storage).

Jail pharmacy services are not currently required to be licensed or inspected by the California Board of Pharmacy; however, several jails have voluntarily elected to seek licensure of on-site pharmacies. The September 1988 revision of Title 15, Minimum Standards for Local Detention Facilities, added a provision for an annual review of jail pharmacy services by a licensed pharmacist to insure quality and appropriateness of pharmacy practice.

Health Records

Health records maintenance and storage areas are other frequently forgotten areas of jail planning resulting in makeshift file storage in hallways and patient treatment areas. Space must be planned for the storage of active and inactive medical records. Medical record confidentiality is governed by specific state regulations. Records must be stored in a manner that limits access to treating health services staff and the health authority. This requires either locking file cabinets or a separate room to which only authorized staff have access. Health records need to be readily retrievable and inactive records must be retained for a minimum of seven years (See Title 22, California Code of Regulations, Section 70751). Large facilities may wish to use microfilm storage or to consider computerized medical records. Either is a realistic possibility for compact storage of records. However, before you decide to computerize your medical records, you will need to plan for the risk of losing data through computer malfunction and the special problems posed by inappropriate access to data. In addition to file storage space, work space for medical records clerks and technicians as well as other jail health care providers needs to be planned to facilitate the maintenance of accurate and current records. Desks and/or writing tables, typewriter/word processing equipment, transcription equipment, computer terminal access to inmate locator data files and a copy machine are some of the basic equipment required for the medical records room.

Other Miscellaneous Considerations

Emergency Equipment and Evacuation

Space provisions should be planned for an emergency cart containing resuscitation equipment to be readily available in the clinic and medical housing areas. In addition, wheelchair, gurney or litter storage points need to be planned throughout the facility to insure their availability. The facility should have emergency evacuation routes planned to allow ready access to outside ambulance transport.

Oxygen

Portable oxygen units are generally practical and efficient for jails given the relatively low use of oxygen in the jail setting. However, if you wish to consider wall oxygen installation, procedures are required at the time of initial design planning.

Suction

Like oxygen, wall-mounted suction requires special construction. Portable suction units, while usually less effective, are generally adequate and less expensive.

Laboratory

If you are planning an in-jail laboratory, you will need a single gas line, particularly if microbiological work is to be done.

X-ray

Whenever X-ray equipment is to be used, construction plans need to include X-ray shielding for protection against scattered radiation (see California Code of Regulations, Title 17, reference in Appendix A).

Internal Communication System

The investment in an internal communication system in the medical clinic and medical housing unit to connect treatment and support areas can increase provider efficiency.

Suicide Prevention

All areas of the jail should be planned and constructed with suicide prevention in mind. Intake, detoxification and suicide watch areas, where the threat of suicide is

particularly acute, should be designed to permit direct, continuous staff observation. Plumbing fixtures, vents, sprinklers and furnishings throughout the facility should be the type which limit the weight they support or which do not allow noose-like objects to get a firm hold on them.

SUMMARY

It is essential that a health services representative be actively involved in new facility planning/construction as well as on the transition team. The delivery of health services impacts all aspects of jail services; the design and space allocation for health services has significant impact on the cost and efficiency of inmate health services delivery and staffing. It is important that needs and potential problems be identified early in the design/planning period to reduce costs and delays and increase the efficiency of the facility for its total service lifetime. A health services representative on the transition team will assist in reducing disruption by working with the rest of the team to develop policy and procedures for services, orienting and training staff and identifying problems well in advance of the move into the new facility.

CHAPTER 9. THE PEOPLE: STAFFING ISSUES

Custody has unique features which demand special attention in staffing all departments, including health care services. The successful operation of an inmate health care program calls for attitudes of mutual, professional respect and trust on the part of both health care and custody staff. It is clear that both must be able to work cooperatively for the total facility operation to run smoothly.

What may be less clear is how to achieve those levels of trust and cooperation between the custody elements of your facility's operation and the medical/mental health elements. You want to generate a 'team' approach which underscores the importance of all the contributors, but how, in what is often a skeptical environment, can you accomplish that?

Attitudes often generate from the top down, so administrators and managers--of both the jail and medical services--must be included in the planning and design of working arrangements. People support what they help to create, so you want to maximize the opportunities for your personnel to develop and therefore 'buy in' to strategies for cooperation.

Plan for orientation of all health care staff to security procedures. Make certain they know what is expected behavior for avoidance of or response to hostage situations as well as other potentially dangerous incidents. Health care personnel usually need specific education about the jail subculture, common manipulative ploys and the significance of contraband. They may need to be familiarized with pertinent sections of the Penal Code, such as Sections 825.5, 4007, 4001 et seq., 4012, 4023.5, and 2656 (see Appendix A for listing of Penal Code sections which address medical/mental health issues as well as Title 15, Minimum Standards for Local Detention Facilities).

Much tension among and between staff members can be avoided through adequate pre-service and in-service training which can prevent civilian staff from becoming liabilities in a security sense and can acquaint custodial staff with the responsibilities and limitations of health service providers. Joint staff meetings can go a long way toward opening lines of communication and airing problems before they escalate.

Medical and mental health <u>confidentiality issues</u> should be clarified with all staff members. All staff will have to know that, while it is essential for certain health care information to be shared, communications between health care personnel and inmate patients are privileged. Nonetheless, health care personnel have an obligation, if they learn that an individual or the facility is endangered, to relay that

information, and custody staff should be able to feel confident that they will do so.

Defining Health Services Staffing Requirements

Because there is a great deal of variation among California's jails in terms of physical design, programs, inmate populations and services, there is no way to establish a single staffing formula that works for everyone. In defining minimum staffing requirements for jail health care services, it is necessary to take a number of factors into consideration. Each and all of the following will have an impact on your staffing design:

- Size and characteristics of your inmate population

  You will need to consider the total number of inmates to be served, the number of males and females, the number needing mental health services, those needing drug/alcohol detoxification services, etc. This information should be readily available from daily census data and health services utilization statistics and should indicate if there is enough service demand to warrant providing on-site staff. For example, if the female population is significant and the utilization data show a demand, it may be cost effective to provide a part-time or full-time OB/GYN nurse practitioner on-site or to create a regularly scheduled, on-site OB/GYN physician specialist clinic.

- Physical design of the facility

  Is your jail designed for centralized or decentralized inmate services? Does it have single or multiple floors? Are there elevators? Is officer escort required for inmate movement? Where are the medical services areas and how are they accessed?

  You need to look at the design and construction of your jail(s) and to consider the process known as value engineering to determine the most effective staffing mode given your physical plant and total jail schedule. You will be trying to balance security staff costs, support staff costs, design costs and medical services costs to get at the best ratio for your facility or system.

  Jails which emphasize bringing services to inmates will generally require more health care staff than facilities in which inmates are brought to one central medical area. Similarly, multiple-floor facilities

with elevators increase the amount of time required for health services staff to make rounds. If officers are required to open doors or escort health services staff, this additional time factor will impact the number of health services staff (as well as custodial staff) needed to carry out mandated health services. In short, the jail's unique environment including the degree of freedom of movement for staff and inmates, the court, meal and visiting schedules and a host of other factors influence the efficiency and productivity of health service delivery and will affect staffing requirements.

- Scope of health care services to be provided

When does it become necessary to provide 24-hour, on-site nursing staff? This is dependent on the scope of services provided at the facility. If you have an infirmary or an in-patient psychiatric care unit, 24-hour nursing coverage is required.

If you are planning an infirmary for your facility, you should plan to staff it with licensed nursing staff around the clock. National correctional health standards require all inmate patients housed in an infirmary to be within sight or sound of a health care staff person at all times and that "sufficient and appropriate health care personnel be on duty 24-hours per day."

For facilities which do not include an infirmary or an in-patient psychiatric care unit, 24-hour licensed health provider staffing becomes a matter of cost and program efficiency. There is a point at which it becomes more cost effective to provide 24-hour nursing services at the jail than to transport inmates to outside providers for medical evaluation. The availability and cost of custody staff are often key factors. In many instances, it is less expensive to hire another nurse than to use sworn custody staff for after-hours health triage, referral and transfer of inmates.

An analysis of the utilization data and a review of costs of off-site emergency services will provide a base for making a decision about 24-hour, on-site nursing staff. Include the costs of deputy/corrections officer time involved in escorting and transporting inmates to off-site services when nursing/medical staff are not on site in your review. Another factor you might want to consider is that many sheriff's departments have opted for around the clock

health services staffing to remove custody staff from decision-making responsibility as to whether inmates require urgent or emergent medical evaluation, thereby reducing after-hours referrals to local hospital emergency departments.

An inmate population of 350 or more is an approximate rule of thumb for the point at which you should begin to look seriously at providing 24-hour, on-site medical staffing. Twenty-four hour nursing staffing will require five full-time equivalent employees (FTE) to provide one nurse on duty in the facility at all times. Jails considering 24-hour nurse staffing should plan on a registered nurse (versus a licensed vocational nurse) being on duty at all times due to the limited scope of practice of LVNs.

As a footnote, it is important to be aware of scope of practice regulations. Historically, jail health services personnel have been assigned functions without regard to their legal parameters of professional practice as defined by individual professional license provisions and common practice in the health care community. This is no longer acceptable as the courts are clearly moving in the direction of insisting on qualified, licensed, competent health care personnel working within their scope of practice in jail health care programs.

Appendix A provides a listing of relevant California codes addressing scope of practice and each specific profession's Practice Act. These acts define what each profession's license allows practitioners to do. Scope of practice capability and supervision requirements for each provider category should be a prime consideration when assigning health services function responsibility and identifying program staffing needs.

The cost savings of staffing the jail with the least expensive licensed provider may be tempting. However, given the jail population which is at high risk for medical emergencies and the increased incidence of civil litigation involving correctional health services, the value of that savings should be questioned. For health care professionals to practice beyond the scope of their licenses means they can be held personally liable, can risk the loss of their licenses and can leave you open to the very real hazard of being sued for their acts and omissions. It is extremely unlikely you will be able to win these lawsuits.

If you intend to have an on-site dental operatory, you will need to think about dental assistant services. Some contract dentists bring their own assistants; others will work alone or expect the jail to provide someone to assist. LVNs who have received on-the-job training fill this function in some facilities; however, the optimal staff is a trained dental assistant.

- Your interest in meeting national standards

Do you intend to meet national standards or seek medical services accreditation for your jail(s)? If so, know that this will have an affect on your staffing patterns. The National Commission on Correctional Health Care and the American Correctional Association standards require a health appraisal (history and physical examination) on all inmates within 14 days of confinement. This requirement is more than the minimum required by California's standards and does necessitate additional staffing.

The appraisal is optimally completed by the physician, nurse practitioner or physician's assistant. Registered nurses who have received additional training and certification in physical assessment may also conduct the health appraisal. Using mid-level practitioners; i.e., physician's assistants (PA) and nurse practitioners (NP), in the jail can be a cost-effective and practical way to provide physical examinations and definitive sick call services which are beyond the scope of registered nurse practice and reduce the number of on-site physician hours required.

The 14-day appraisal is a cursory examination requiring approximately 20 minutes to complete. Jail census data can provide an estimate of the number of inmates remaining in the facility longer than 14 days and, therefore, will enable you to project the number of examinations for staffing purposes.

- Availability of clerical support staff

If you will have clerical staff available for the health services program, you will be able to increase the productivity and efficiency of the professional health services personnel by freeing them from duties such as scheduling, maintaining medical records and health services statistics, ordering supplies, etc. This will affect the number of professional staff for whom you need to plan.

- Method and frequency of administering medications

You can generally assume that approximately 30 percent of the inmate population will be receiving prescription medications at any given time; a greater percentage will be receiving non-prescription or over-the-counter medications. Although it is permissible for custody staff to deliver medications to inmates, provided the medication is packaged in legal prescription form, it is advisable that licensed nursing staff administer all medications.

Prescription medications are generally administered once (qd), twice (bid), three times (tid) or four times (qid) per day if given on a single dose basis. Some jails give the inmate a 24-hour dose once a day; this is not recommended as there is no way to assure that the inmate actually takes the medication. This practice also promotes hoarding and exchange or sale of medications within the jail. Some facilities have experimented with a twice per day formulary for as many medications as possible, thereby reducing the number of times medications are administered and subsequently reducing the number of staff required to administer the medications.

If medications are to be administered on a single dose basis (recommended) three to four times per day, staffing planners should anticipate the need for one medication nurse per every 400 inmates. This position's duties would include set up of prescription medications from the jail stock supply, delivery to inmates in housing areas, giving over-the-counter medications and recording all medications. This is an approximation only; individual performance practices, the number of liquid medications given, the design of the jail and other factors will affect individual situations. The medication nurse position is appropriate for licensed vocational nurses in the jail.

Summarizing the findings related to all the above considerations and reviewing the requirements of Title 15 minimum jail standards, staffing planners should identify all health service functions necessary to meet the desired scope of services to be provided at the jail(s). Once the functions are identified, pinpoint the personnel responsible for each of the functions within the legal parameters of their professional practice and then consider the fiscal resources of your system. This should put you in a position to describe

your staffing needs in conjunction with all the other elements of your health services program planning to date.

Table 6 provides a checklist of routine jail health service functions and categories of staff appropriate for performing those functions. **Table 7** presents a listing of health service functions required within the jail, the categories of health service providers commonly utilized and their legal parameters of practice and responsibility relative to the functions listed. In other words, it is an interpretation of current regulations, showing the most appropriate level of staff to perform particular tasks.

For example, a frequent practice in jails is the packaging of medications for distribution to inmates in unit dose or multiple-dose packets from the jail's stock drug supply. This practice is commonly carried out by the facility's nursing staff. According to California's pharmacy regulations, this practice is a function for a licensed pharmacist or physician, or an agent thereof under their direct supervision. **Table 7** illustrates this by denoting the pharmacist as 'O'--the optimal professional to perform the function, the MD and psychiatrist as 'A'--acceptable--and RNs, as 'S'--requiring direct supervision to perform the function. (A standardized procedure is also required for RNs to perform this task in accordance with California Board of Registered Nursing requirements.)

As another example, the function of specimen collection for laboratory tests often requires the drawing of blood; the table indicates this function can be performed by RNs and LVNs, optimally by RNs as their training prepares them to perform venipuncture. LVNs can perform venipuncture only if they have attended classes and have been certified in this procedure.

While consideration of the scope of health services to be provided and the legal parameters of individual practice are essential to determining staffing of jail health service programs, another important aspect is <u>cost</u>. The goal of staffing planners should be to provide services and staffing commensurate with community standards of care and to keep whatever program is developed well within the fiscal resources available.

It is a given that salaries vary from jurisdiction to jurisdiction within the state, and the numbers presented here may not be generally applicable or current for very long. *

*The salary levels that follow were provided by Alameda County and were current in 1987.

Nonetheless, the following list of annual salaries for health service providers can serve as a representative overview for purposes of comparison. At the very least, the range and relative relationships may prove instructive.

General Practice Physician	$59,000 - 72,000
OB/GYN specialist	77,000 - 78,000
Dentist	55,000 - 65,000
Pharmacist	28,000 - 35,000
Physician Assistant	29,000 - 36,000
Nurse Practitioner	29,000 - 36,000
Registered Nurse	27,500 - 32,000
Licensed Vocational Nurse	18,000 - 21,000
Dental Assistant	15,000 - 18,000
Pharmacy Technician	16,000 - 20,000
Medical Records Technician	15,600 - 18,000
Clerk	15,000 - 17,000
Deputy	26,000 - 32,000

The final step in staffing planning is determining the hours of coverage desired for each health service function. This will allow you to determine the number of full time equivalent (FTE) staff required. Generally, a 7-day per week position, at 8 hours per day, requires 1.65 FTE and a 5-day per week position requires 1.2 FTE. These numbers include consideration of relief coverage for days off, sick time and vacation.

TABLE 6. JAIL MEDICAL SERVICES STAFFING CHECKLIST

FUNCTION	Responsibility												
	MD	NP/ PA	RN	LVN	PSYC MD	PSYC PhD	MSW/ PSW	DDS	DA	CLER	CUST	HR Cov	Remarks
Intake Screen													
Medications													
14-day hlth app													
Food Server cl.													
Inhouse Emergency resp.													
Infirmary													
Sick Call													
Lab													
Assist MD													
Assist DDS													
Schedule Appointments													
Transcribe Orders													
Medical Record Maintenance													
Reporting/ Statistics													
UR (Util. Review) Off-site serv.													
QA (Qual. Assur.)													
Maintenance Medical Supplies													
Clean/Maintenance Clinic													

Definition of Abbreviations for Tables 6 and 7

MD - physician
PSYCH MD - psychiatrist
PSYCH PhD - psychologist
MSW/PSW - Medical Social Worker/ Psychiatric Social Worker
NP/PA - Nurse Practitioner/ Physician's Assistant
RN - Registered Nurse
LVN - Licensed Vocational Nurse
DDS - Dentist
DA - Dental Assistant
PHARM - Licensed Pharmacist
X-RAY TECH - X-Ray Technician
MR TECH - Medical Records Technician
CLER - Clerk
CUST - Custody Staff

TABLE 7. JAIL HEALTH SERVICES STAFFING SCOPE OF PRACTICE CHECKLIST

FUNCTION	CATEGORY OF STAFF													
	MD	PSYCH MD	PSYCH PhD	MSW/ PSW	NP/PA	RN	LVN	DDS	PHARM	X-RAY TECH	DA	MR TECH	CLER	CUST
Receiving Screening						O	A							M*
Medications: Packaging	A	A				S			O					
Prescribing	R	R			S									
Administration					A	O	O							M*
Triage			O	O		O								
Sick Call Medical	R				O	A								
Psych		R	O	O										
Dental								R						
14-day hlth app	R				O	A*								
Food Server cl.	R				O	O								
Lab specimen coll.						O	A*							
perform tests					A	A*	M*							
X-Ray						M*	M*			O				
In-house emergency resp.: CPR	R	R	R	R	R	R	R	R			R			R
First aid						R	R							R
Emergency meds.	R				O	O								
Infirmary: medical	R					O	A							
Psych		R				O	A							
Assist MD						O	O							
Assist DDS							A*				O			
Schedule appt						A	A						O	
Transcribe ord						A	A						S	
Med Rec Maint					A	A	A					P		

M = minimal
A = acceptable
O = optimal
P = primary responsibility
S = with direct supervision
R = responsible
* = requires add. training/ certification

SECTION III. MENTAL HEALTH SERVICES

CHAPTER 10. PLANNING FOR A MENTAL HEALTH COMPONENT

There are an alarming number of mentally ill people in jails. A 1980 study indicated that between 20 and 60 percent of jail inmates across the country had mental health problems (see Comptroller General's Report to the Congress of the United States: Jail Inmates' Mental Health Care Neglected: State and Federal Attention Needed, GGD-81-5, Washington, D.C., General Accounting Office, November 1980). Indicators are that the numbers will continue to rise.

As you well know, mentally ill inmates disrupt the normal custodial routine of the jail and can, by their very presence if they are not handled appropriately, create legal, morale and management problems throughout your facility. Nonetheless, mentally ill inmates are more and more a "fact of life" for the jail administrator, thus strategic and comprehensive planning for the provision of mental health services to jail inmates is as important as planning for your medical health services.

What follows is an overview of requirements, options and considerations relative to mental health services for your jail. It is likely that you will have to take this material and incorporate it into the planning process outlined in the previous chapters in order to develop a comprehensive mental health system for your facility(s).

Mental health services should be provided to mentally ill inmates according to standards, policies and procedures established by the state and/or local departments of mental health. All inmates should receive and/or have access to written communications in English and other languages as necessary describing available jail mental health services, the confidentiality of those services and the procedures for gaining access to them.

As with other health services, jail mental health services can be administered in any one of a number of ways: by the county department of mental health, by the county sheriff's or city police department, by the county department of health services (health care agency) or through a contract with a private provider. Many of California's large jails use county mental health department-provided services while smaller jails contract for services with local private providers when mental health or other county agencies are unable to accept responsibility for the program.

All jails using county mental health services should develop written agreements (memoranda of understanding) between the

mental health department and the jail to clarify each party's obligation and responsibility for operation of mental health services in the jail. The jail administration should spell out its obligation and responsibility for providing supplemental support; i.e., space, security, telephones, etc., for operation of the mental health programs in the jail. It must be clear that the administrator of the jail has the final authority and responsibility for the safety of staff as well as patients in the mental health programs.

Funding support for jail mental health programs should come primarily from county Short-Doyle arrangements, with the State Department of Mental Health contributing 90 percent of the funds and the local government matching with the other 10 percent. Not all counties utilize their Short-Doyle funds to support jail mental health services and some do so only minimally. This is a decision made at the local level, so you need to determine what past practice has been in your county and what is likely to be the case in the future.

When Short-Doyle dollars are not provided, funding for mental health services in the jail must come from the county (general fund, county hospital, or sheriff's (jail) budget). There are some funding sources available at the federal level, but they are limited to special demonstration or pilot projects on a short-term basis only.

Components

There are a number of components to a comprehensive mental health services program which should be available to individuals detained in jails. The following several pages describe the major elements.

- Screening and Identification
  A procedure for screening and identifying mentally and emotionally disordered inmates in a timely fashion is essential regardless of the size of your jail. Ideally, all inmates should be screened by a mental health professional. However, if there is no mental health professional available, trained medical or correctional personnel can do the screening and make a recommendation regarding the need to refer an inmate to a mental health specialist. Of course, you will want to have well-defined, written procedures, training, and supervision when custody staff are given the responsibility for screening and referral.

  All inmates referred should be seen by a mental health professional as soon as possible, preferably within 24

hours. If the need is emergent, a process should be available to provide assistance at once.

The number of staff required for screening and identification depends on whether your program calls for mental health staff to screen every new inmate or only to provide follow up to referrals.

As a general rule, an ordinary screening and identification evaluation should include but not be limited to:

- psychiatric history
- previous psychiatric hospitalizations
- mental status
- current level of psychosocial functioning
- suicidal ideation and bizarre behavior
- presence of delusions or hallucinations
- psychotropic medications
- referral to proper level of mental health service.

The cost of initial or follow-up screening services, if performed by mental health staff, should run between $10 and $25 per screening, depending on the qualifications of the person doing the screening. If the number of screenings in your jail is less than 10 to 16 per day, it may be sufficient to hire a part-time mental health professional to deal with this task.

Inmates who have been identified as having mental or emotional disorders should be housed in a special module, separated from the general population and closely observed.

- Mental Health Outpatient Services
  Whoever has the responsibility for mental health services in the jail will be responsible for the development of non-emergent mental health out-patient services for inmates whose behavior suggests that they are suffering from mental or emotional disorders and are in need of evaluation, treatment and medication on a voluntary basis. The goals of out-patient mental health services are to eliminate suicide risk, reduce stress caused by incarceration, stabilize mental and

emotional disorders and alleviate psychological deterioration in the jail.

The Short-Doyle program requires that mental health professionals assigned to provide out-patient services to inmates shall develop a treatment plan to reflect the nature of the problem and the psychological needs of the inmate. The treatment plan must be reviewed and approved by a psychiatrist within one week.

A range of treatment modalities should be provided, including but not limited to:

- psychiatric diagnosis and evaluation,
- referral and aftercare services,
- individual therapy,
- group therapy,
- occupational therapy,
- recreational activities and
- medication.

Since mental health out-patient services are provided on a voluntary basis, informed consent for treatment must be obtained from the inmate to indicate that he or she is aware of the risks and benefits of the proposed treatment. However, in an emergency, if an inmate indicates clear and imminent danger of physical harm to self or others, that inmate may be examined, treated and medicated against his/her will for no longer than 72 hours (see Title 15, Section 1217, Minimum Standards for Local Detention Facilities). In the meantime, arrangements must be made to transfer the inmate to a facility designated for treatment of acute psychiatric episodes.

Special housing should be provided to inmates who are in need of close supervision due to their mental or emotional disorders or to those who are in the process of being evaluated for such illness or disorders. Custodial personnel working in special housing areas must be trained to monitor and identify inmates who are potentially suicidal or may pose other problems.

Inmates in special housing must be assigned to a mental health counselor and be interviewed and evaluated at least once a week. Where possible mental

health staff should be responsible for inmates' admission to and discharge from the special housing area.

As a separate matter, inmates who have been determined to be developmentally disabled should also have a special housing area available to them. They should be treated and supervised by staff from the Regional Centers for the Developmentally Disabled.

Agreements and arrangements should also be made with the department that deals with drug addiction and the disease of alcohol abuse so that treatment and services can be provided to inmates in these specialty areas as well.

Mental health out-patient services should be provided by trained mental health professionals. As a general rule, one full-time mental health staff person should be able to carry a minimum case load of 30. For those jails where mental health services are needed only sporadically or irregularly, perhaps out-patient services are best contracted for with the private sector.

- Mental Health Inpatient Services

For many if not most California jails, it is and will be a matter of insuring access to mental health in-patient services in the community rather than trying to create an in-patient facility in the jail. The services under discussion are those designed to provide acute psychiatric in-patient care for mentally ill individuals who, as a result of a mental disorder, are a danger to themselves or to others, are gravely disabled and are in need of involuntary psychiatric treatment per Section 5150 or voluntary treatment per Section 6000 of the Welfare and Institutions Code.

Sections 4011.6 and 4011.8 of the Penal Code allow a judge or person in charge of a jail to refer a mentally ill inmate to a mental health in-patient facility for evaluation and possible involuntary or voluntary treatment. Please note, those sections do not authorize the judge or jail official to require admission; the mental health staff at the in-patient facility can refuse to admit an inmate who, in their estimation, does not fit the criteria.

Assuming, however, that an inmate does fit the criteria and as a result of mental disorder is a danger to himself or others or is gravely disabled, he may be detained in an in-patient facility for up to 72

hours of involuntary treatment and evaluation (see Welfare and Institutions Code Section 5150). He may also be held for an additional 14 days of intensive treatment pursuant to Section 5250 of the Welfare and Institutions Code if he has not recovered by the end of the initial 72 hours. If he remains a danger at the end of the initial 14 days, he can be held for another 14 days of involuntary treatment pursuant to Welfare and Institutions Code Section 5260 (see Appendix F).

If the in-patient facility staff consider the inmate to be imminently dangerous to others, they can hold him for an additional 180 days after a specified court procedure under Section 5300, Welfare and Institutions Code. And finally, if he is unable to provide for his personal needs for food, clothing or shelter, he can be placed under Lanterman-Petris-Short (LPS) mental health "conservatorship" after a court hearing pursuant to Sections 5350 and 5353.

If you are going to consider developing a mental health in-patient service in your jail, there are two major issues to which you need to give serious thought. First, you will want to examine the fiscal issue. Is it more cost effective to establish in-patient services in the jail, use providers outside the jail or contract out entirely to the private sector? Can you afford to replicate within the jail what may already exist in your community? Secondly, you need to think about security. Some inmates, especially those thought to be extremely dangerous and those charged with very serious crimes, may have to be treated in a psychiatric in-patient facility inside the jail since there may be no community alternative for them. Can you safely place your highest risk inmates in facilities outside the jail? Can you afford the staffing costs which might be associated with doing so? How many of these individuals do you expect your jail would have at any given time?

If the demand for the services is sufficient, the cost of a jail in-patient facility is far less than the cost of an acute psychiatric hospital in the community. For example, the cost for one patient day in the Forensic In-patient Program in Los Angeles County's Central Men's Jail is approximately $124, whereas the cost for a contract bed in a private acute psychiatric hospital is between $300 and $350 per day.

There are two existing viable psychiatric in-patient licensure options for jails, acute psychiatric

hospital and psychiatric health facility in a non-hospital setting (both licensed by the Department of Health Services under Title 22. Readers should note, however, as of this writing, legislation is being proposed to move the authority for psychiatric health facility licensure to the Department of Mental Health under California Code of Regulations, Title 9). Another alternative for jail in-patient psychiatric services will be licensure under the "Correctional Treatment Center" category authorized in 1987 by SB 331 (regulations to be developed). Regardless of the in-patient licensure category chosen, a jail providing involuntary psychiatric treatment should also seek designation as a 72-hour psychiatric in-patient facility.

You should carefully examine the requirements for psychiatric health facilities in a non-hospital setting before you decide to create such a facility in your jail. They are delineated in the Title 22, Chapter 9 of the California Code of Regulations. The following are some of the basic requirements:

- The jail in-patient program should be established as an LPS-designated psychiatric in-patient facility approved by the County Department of Mental Health and the State Department of Mental Health and be in operation 24 hours per day, 7 days per week.

- The jail in-patient program shall meet all local fire, safety and other relevant ordinances and codes.

- The jail inpatient program should provide all the basic services that are required by the State Department of Mental Health and the State Board of Corrections. These services include diagnosis, evaluation and treatment, psychotherapy, medication and aftercare.

- The jail inpatient program should provide all the supplemental services required by the California Department of Health Services. These services include crisis intervention, family therapy, occupational therapy, recreational therapy, self-help skills, vocational rehabilitation, etc.

- The inpatient program shall have a clinical director who is present at the facility not less than 50 percent of the time during which active treatment programs are being provided. The

clinical director can be a psychiatrist, clinical psychologist, clinical social worker or registered nurse. If the clinical director is not a psychiatrist, medical responsibility for treatment plans shall be assumed by a psychiatrist. A physician shall be available at all times for medical services required by patients.

- The jail inpatient program should also meet the minimum staffing and staff requirements as imposed by the State Department of Health Services (Title 22, Chapter 9, Article 3, Section 77061).

- A registered nurse shall be employed 40 hours per week. There should be a registered nurse, a licensed vocational nurse or a licensed psychiatric technician on duty in the facility on all shifts.

- The jail inpatient program should ideally provide an average of 40 square feet of space per patient in addition to living space to conduct treatment and other activities. This would accommodate space for individual and group therapy, offices, occupational and recreational therapy.

- The facility should be clean, sanitary and in good repair at all times.

- The jail inpatient program should comply with Patients' Rights requirements and regulations as mandated by the State Department of Health Services with modifications necessary for custody needs.

- The jail inpatient program should also establish procedures and policies regarding its medical practices, nursing care, patients' records, restraints and seclusion, admissions and discharges, in-service training and treatment activities according to the requirements of the state and county departments of mental health.

- The facility should establish, maintain and implement quality assurance procedures such as medication monitoring, utilization review and peer review, subject to the approval of the county and in accordance with State Department of Health Services licensing regulations.

- Crisis Evaluation Services

  All jails should have the capability of providing crisis intervention evaluation and treatment services for inmates experiencing emotional crises or acute psychiatric episodes. This service can be provided on call by the jail's mental health outpatient staff or through the County Mental Health Department's community crisis centers and/or crisis intervention teams.

  Although no jails in California have established their own crisis evaluation units to date, provisions for such units are defined in California Code of Regulations, Title 9, Chapter 3, Community Mental Health Services. Crisis evaluation units can provide an alternative to acute psychiatric hospitalization. Such units should be designated as 72-hour evaluation facilities under the LPS regulations, should operate 24 hours a day and 7 days a week and should have a psychiatrist and nursing staff (RNs, LVNs and LPTs) present in the unit at all times. Other mental health professionals are also needed to provide a range of services such as crisis intervention, individual therapy, group therapy, recreational therapy and medication.

  Although the cost of a crisis evaluation unit should be much less than for an acute inpatient program (since the requirements for staffing and program activities are relatively fewer), nonetheless this option remains financially out of reach for all but the very large jail systems.

- Jail Day Treatment Services

  Day treatment in the jail setting is a relatively new concept. At present, Los Angeles has the only jail day treatment program in the state. Established in July 1984, the program involves two full-time mental health staff who provide day treatment for up to 24 patients who do not need inpatient treatment and yet require more intensive care than an outpatient service could provide. The day treatment service can be used as an alternative to, or diversion from, inpatient treatment. Due to the nature of the program, all treatment must be on a voluntary basis.

  Day treatment programs can be developed on either a full day (6 hours) or half day (3 hours) basis, depending on the needs of the jail. The Los Angeles program recommends a staff to patient ratio of 1 to 12. Program elements consist of mental status evaluation, individual and group therapy, exercise and

relaxation groups, occupational therapy and medication. The focus of the day treatment program is on maintaining the inmate's reality contact, increasing attention span, modifying dysfunctional behavior and peer interaction and helping the inmate take an active role in his/her own treatment.

Staffing

There are several levels of mental health professionals you can appropriately use to provide screening, follow up on referrals and to perform general mental health services in the jail environment. Whatever person or team you select should have their practice supervised by a psychiatrist who oversees the clinical aspects of the program.

While salaries differ by location throughout California, approximate annual salaries for mental health personnel are listed below to give you an opportunity to consider cost/benefits.*

Psychiatrist	$70,000 - 75,000
Clinical Psychologist	$45,000 - 50,000
Clinical Social Worker	$40,000 - 45,000
Psychiatric Nurse	$36,000 - 40,000
Psychiatric Technician	$30,000 - 32,000

In addition to salary information, patient to staff ratios may also prove instructive as you deliberate about what sort of mental health program you can design for your jail. Recommended ratios include:

- For Screening and Identification Services - each full-time staff person should be required to interview between 10 and 16 patients during an 8-hour work day.

- For Outpatient Services - each full-time mental health staff person should be able to carry a minimum of 30 active cases (patients).

- For Inpatient Services - if a mental health inpatient facility is to be established in the jail, each program would be required to meet the following staffing requirements in order to operate on a 24-hour and 7-day basis. (A minimum of 10 beds is recommended.)

*These salaries were current as of 1987.

Staffing Requirements:

Establishment of
Mental Health In-patient Facility
in Jail

NUMBER OF BEDS	1-10	11-20	21-30	31-40	41-50
LICENSED MENTAL HEALTH PROFESSIONALS	1	2	3	4	5
LICENSED NURSING STAFF	4	5	6	8	10
OTHER MENTAL HEALTH WORKERS	3	5	8	10	13

(Source: California Code of Regulations, Title 22, Chapter 9, Article 3, Section 77061(h))

For facilities in excess of 50 beds, staffing increments should be provided proportionally above the maximums noted. Correctional staff are required to provide the necessary security and safety measures for staff and inmate patients at a recommended ratio of 1 officer to 20 inmate patients.

Medications

Medications for the treatment of mental illness must not be used solely as a method of restraint or means of control, but rather as one facet of a treatment plan. Medication for mental and emotional disorders must be prescribed by a psychiatrist except in emergency situations.

Inmates receiving psychotropic medications must be given an explanation about the effects of the medication before it is administered to them, and they must give their consent for treatment. Inmates on psychotropic medications must be seen by a psychiatrist within 30 days for review of the effects of the medication, and female inmates who are prescribed psychotropic medication must be given the opportunity to be tested for pregnancy prior to the beginning of a drug regimen or at any time should a pregnancy be suspected. Only inmates who are detained and treated as patients under Welfare and Institutions Code Sections 5150, 5250, 5260, 5300, 5325 and 5350 can be given medication involuntarily in an in-patient facility.

Restraints and Seclusion

Restraints and seclusion, used in an in-patient psychiatric unit, are medical procedures. They must not be used as punishment nor for the convenience of staff nor as substitutes for treatment programs. They are to be used only upon the direct order of a psychiatrist, and that order has to include the reasons for taking such action. Physical restraints and seclusion are to be used only when absolutely necessary to protect and prevent inmates from injuring themselves or others.

Inmates in restraints have to be assessed and observed every 15 minutes, and those in seclusion rooms should be reviewed every 30 minutes by nursing or mental health staff to ensure their safety and security. A psychiatrist has to reevaluate an inmate in restraints or seclusion every 24 hours to determine whether continued restrictive measures are warranted.

Confidentiality

Of course, you know that all information and records obtained in the course of providing mental health services to inmates are confidential. Information and records cannot be released to any person or agency without consent of the inmate patient, unless there is a judge's order to the contrary. Mental health records have to be maintained separately from custody records and kept in a secure, locked file.

For safety and security reasons, certain mental health information may be released to custody staff when an inmate is identified as:

- suicidal,
- homicidal,
- posing a clear danger of injury to self or others,
- presenting a clear and immediate risk of escape or riot; and
- receiving psychotropic medication.

All mental health records must be retained for 7 years before they can be stored in archives. Smaller jails, with limited mental health on-site staff, may combine the psychiatric record with the medical record. Where this is done, strict confidentiality of medical and psychiatric information must be assured.

Patients' Rights

Inmates involuntarily detained or voluntarily admitted to a designated 72-hour jail inpatient psychiatric unit for psychiatric evaluation or treatment shall have certain patients' rights as defined in Section 5325 of the Welfare and Institutions Code, except those rights that are preempted as a result of their status as inmates in the jail system. Patients' rights regulations are intended to support, protect and ensure the fundamental human, civil, constitutional and statutory rights of mental health patients. If you are going to develop a jail inpatient facility, you will need to have a written policy and procedure describing the rights of patients and the means by which those rights are protected and exercised (see Appendix G for a sample of a statement of rights for mental health patients treated in the jail inpatient facility in Los Angeles County).

By way of conclusion it should be noted that jail mental health programs should be designed to provide a full range of mental health services to meet inmates' mental health needs. Screening and Identification Services attempt to identify the mentally ill inmate at the point of booking so appropriate housing and treatment can be afforded, and Outpatient Services are established to provide evaluation, psychotherapy and medication for chronically mentally ill inmates. The Inpatient Program handles involuntary treatment and crisis intervention for those inmates who are suffering from acute psychotic episodes or suicidal behavior. A Crisis Intervention or Day Treatment Program is used as an alternative for treating the chronically mentally ill inmate who no longer needs other levels of care. These components, together and singly, serve to accomplish what is required of all jails, regardless of size, to provide levels of care for inmates which are comparable to those available in the community at large.

CONCLUSION

The information provided in this document is not intended to be all encompassing but rather to provoke thought on the part of detention administrators and others to enable them to understand the need to carefully plan their facility's inmate health care program. There are large numbers of detention facilities which have legal actions against them relating to health care services. A little extra time spent in careful planning can go a long way toward preventing unnecessary medical-legal actions.

We hope this information will be of assistance.

APPENDIX A

Compendium of Statutes and Codes

Table of Contents

Compendium of Statutes and Codes

INTRODUCTION

The following outline addresses a number of statutes and regulations which may be beneficial in researching various aspects of health care. Space limitations do not allow for a fully inclusive listing of all available data. However, these citations can provide a starting point for research. A brief description of content has been included to provide a sense of the citation. These notes are not to be used in the place of a thorough review of the specific code or regulation.

In the sections dealing with the provision of Laboratory, Pharmacy and Radiological Services, Title 22 is used extensively. While jails are not required to comply with licensure regulations at this time, many of these sections provide excellent guidelines to assure a community standard of care is being met.

OVERVIEW OF RELEVANT CODES AND REGULATIONS

I. Medical Care

A. Emergency Treatment:

Title 15; Section 1200, Re: Facility administrators are responsible to ensure the provision of emergency and basic health care services.

Title 15; Section 1208, Re: Responsible physician/health authority in cooperation with facility administrator shall develop a plan for identifying and treating inmates.

Penal Code, Section 4011.5, Re: Immediate removal of inmate for emergency medical or psychiatric care.

Penal Code, Section 1208 (d), Re: Work furlough release for medical attention.

B. Hospitalization

Penal Code, Section 4011 (a), Re: Courts' right to remove inmate from jail and place in a county hospital.

Penal Code, Section 4007, Re: Use of California Department of Corrections or contiguous county jail medical facilities for high security risk. Note: must be with consent of directors.

C. Overall Responsibility for Health Care

Title 15, Section 1200, Re: Medical, dental and mental health matters are the sole province of licensed physicians, dentists, and psychiatrists or psychologists.

Penal Code, Section 4023, Re: A duly licensed and practicing physician shall be available for the care and treatment of inmates.

D. Reimbursement Policies

Penal Code, Section 4011, Re: Charges for care shall be charged against the county. The board of supervisors may set different rates. Additionally,

an inmate may decline county hospital treatment and provide other care at his own expense.

Penal Code, Section 4023, Re: Inmate paying for private physician care: costs to include custody staff and transportation.

Penal Code, Section 4011.1, Re: Billing private insurance plans for hospitalization. Note: The federal government has rescinded any payment for its portion of MediCal for institutionalized persons.

II. Health Care Staff Qualifications

Title 15, Section 1203, Re: State licensure or certification requirements equal to the community standard.

Penal Code, Section 4023, Re: Requires a duly licensed and practicing physician be available for the care and treatment of inmates.

Title 22, Section 70721, Re: Guidelines for personnel policies for health care staff.

Business and Professions Code, see attached list for specific "Practice Acts".

Business and Professions Code, Section 2732.05 requires RN licensure verification by employer.

III. Health Care Policies and Procedures

Title 15, Section 1204, Re: Medical care must be performed pursuant to written protocol or order of the responsible physician.

Title 15, Section 1206, Re: Written policies and procedures to ensure appropriate medical care.

Health and Safety Code, Section 1316.5, provides specific legal authorization for the administration of medications and therapeutic agents by RNs.

Business and Professions Code, Section 2725 (d) defines standardized procedures for RNs.

California Code of Regulations, Title 22, Section 70706.2 Provides framework for joint development of standardized procedures between RNs and MDs

Board of Medical Quality Assurances Regulations, Article 3, Subchapter 3, Chapter 13 of Title 16 of the California Code of Regulations. Provides guidelines for the development of standardized treatment procedures.

IV. Special Inmates

A. Females

Penal Code, Section 4023.5, Re: Birth control, family planning and personal hygiene materials.

Penal Code, Section 4023.6, Re: Pregnancy determination, right to choice and services of a licensed physician and surgeon.

B. Mentally Disordered

Title 15, Section 1052, Re: Immediate segregation if appears to be a danger to self or others.

Title 15, Section 1209, Re: Transfer to a treatment facility for diagnosis and treatment.

Penal Code, Section 4011.6, Re: Facility administrator's right to transfer an inmate to a facility for 72 hour treatment and evaluation pursuant Section 5150 of the Welfare and Institutions Code.

Penal Code, Section 4011.8, Re: Voluntary inpatient and/or outpatient mental health services.

Welfare and Institutions Code, Sections 5150 - 5157 set forth specific statutes for involuntary detention, evaluation and treatment of mentally disordered persons.

Welfare and Institutions Code, Section 5225, enumeration of patients rights.

Welfare and Institutions Code, Sections 5350 - 5364 conservatorship for gravely disabled persons.

Welfare and Institutions Code, Sections 6000 - 6008, voluntary admissions to mental hospitals and institutions, rights of voluntary patients.

Health and Safety Code, Chapter 1234, Regulations for Psychiatric Health Facilities.

Welfare and Institutions Code, Section 5008, provides definition of "mentally ill". Section 5008.1, specifically defines "judicially committed".

Penal Code, Section 1343, affords a county the right to charge the inmate or his family for transportation services to and from a state or private treatment facility.

Welfare and Institutions Code, Section 4654, mental examination of a criminal defendant to determine if a developmental disability is the cause of behavior.

California Code of Regulations, Title 9, Subchapter 3, Article 8 - Mental Health Personnel.

620.1. Acting Director of Local Mental Health Services. If a county is unable to secure the services of a person who meets the standards set forth in Section 620, the county may select an Acting Director of Local Mental Health Services with appointment limited to a 12-month period subject to the approval of the Director of Mental Health.

621. Medical Program Responsibility. If the local director does not meet the qualifications of Section 620(a), the local Mental Health Services shall provide a psychiatrist licensed to practice medicine in this state as defined in Section 623 who shall have the medical responsibility as defined in Section 522.

622. Requirements for Professional Personnel. Wherever in these regulations the employment of a particular professional person is required, the minimum qualifications for that person shall be as hereinafter specified in this article. Required experience shall mean full-time equivalent experience. It is intended that these minimum qualifications shall apply to the head or chief of a particular service or professional discipline but

not necessarily to subordinate employees of the same profession.

623. Psychiatrist. A psychiatrist shall have a license as a physician and surgeon in this state and show evidence of having completed three years graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association.

624. Psychologist. A psychologist shall have obtained or have been declared eligible by the Psychology Examining Committee for a California license granted by the California State Board of Medical Examiners, and within one year shall have been granted a California license by the California State Board of Medical Examiners, and shall have two years of post doctoral experience in a mental health setting.

625. Social Worker. A social worker shall have a master's degree from an accredited school of social work and two years post master's experience in mental health; or shall have obtained or have been declared eligible for a California license as a clinical social worker granted by the California State Board of Behavioral Science Examiners.

626. Nurses. A nurse shall be licensed to practice as a registered nurse by the Board of Nursing Education and Nurse Registration in this state and possess a master's degree in psychiatric or public health nursing, and two years of nursing experience in mental health. Additional post baccalaureate nursing experience in a mental health setting may be substituted on a year-for-year basis for the educational requirement.

627. Licensed Vocational Nurse. A licensed vocational nurse shall have a license to practice vocational nursing by the Board of Vocational Nurse and Psychiatric Technician Examiners and possess six years of post license experience in a mental health setting. Up to four years of college or university education may be substituted for the required vocational nursing experience on a year-for-year basis.

628. Psychiatric Technician. A psychiatric technician shall have a current license to practice as a psychiatric technician by the Board of Vocational Nurses and Psychiatric Technician Examiners and six years of post license experience in mental health. Up to four years of college or university education may be substituted for the required psychiatric technician experience on a year-for-year basis.

629. Mental Health Rehabilitation Specialist. A mental health rehabilitation specialist shall be an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post social associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in mental health.

630. Administrative Support Responsibility.
(a) Any county local mental health service which serves a population in excess of 100,000 shall have at least one administrative person who does not have clinical program responsibility and who shall be responsible for the planning, development, direction, management, and supervision of all administrative and supportive services as defined by the Act, including but not limited to:

(1) All administrative functions such as personnel, accounting, budgeting, and patients' accounts.

(2) All life support functions such as food services, facility maintenance, and patient supplies.

(3) All other business and security functions.

(b) After March 1, 1976, new personnel employed into these positions shall have three years of experience with increasing responsibility performing health administration or staff administrative services such as accounting, auditing, budgeting, administrative analysis, or

personnel and have a minimum education equivalent to graduate with a baccalaureate degree from an accredited college or university. Additional qualifying experience may be substituted for the required education on a year-for-year basis.

631. Other Mental Health Personnel. The definition of professional, administrative and technical personnel listed above shall not be construed as limiting the establishment of positions in other categories. If, after persistent recruitment, persons with qualifications specified above cannot be obtained, the department may permit exceptions to the requirements upon receiving a written request describing the recruitment efforts. Such exceptions to the personnel requirements shall be limited to a 12-month period subject to annual renewal by the department.

C. Developmentally Disabled

Title 15, Section 1057, facility manager and the responsible physician shall develop written procedures for the segregation of developmentally disabled-individuals.

Title 15, Section 1207, receiving screening to include developmentally disabled screening.

Welfare And Institutions Code, Division 4.1, commencing with Section 4400, provides Statutes for the Powers and Duties of the Department of Developmentally Disabled. Division 4.5, Chapter 5, Article 2, specifically outlines "Regional Centers Responsibilities" to these individuals.

D. Physically Disabled

Penal Code, Section 2656, Re: orthopedic or prosthetic appliances; inmates' right to petition for their provision and a medical clearance may be requested.

V. Communicable Diseases

Title 15, Section 1051, calls for the determination, segregation and medical evaluation of possibly contagious inmates.

Penal Code, Section 4012, addresses a physician's responsibility during an epidemic.

Penal Code, Section 4007, provides for the removal of an inmate for safe treatment.

Health and Safety Code, commencing with Section 3000 et al. sets into statute the powers the county health officer has to control the spread of disease. Includes ability to arrest individuals for not following medical treatment; establishing quarantines and other such powers.

Title 17, California Code of Regulations, Section 2500, provides regulations for the reporting of communicable diseases to the local health officer.

Penal Code, Section 4020, a physician may order hair to be cut if it is "diseased".

Health and Safety Code, Section 3050, a health officer may quarantine and isolate an individual with active TB, in a jail to protect the public (see 30 Ops. Atty. General 229).

Business and Professions Code, Section 2727.3, allows RN to perform TB testing. Section 2860.7 allows LVNs to perform TB testing.

VI. Detoxification

Title 15, Section 1056, Re: Specific guidelines for the use of the detoxification cell.

Title 15, Section 1213, establishes that the responsible physician write medical policies regarding detoxification treatment to include specific guidelines of symptoms necessitating immediate transfer.

Penal Code, Section 1208, addresses counseling at work furlough programs.

Health and Safety Code, Division 10.5, Part 2, Chapters 1-10, outlines state alcohol and drug programs.

Welfare and Institutions Code, Section 5170, Re: public inebriation, civil protective custody by a peace officer for placement of 72 hours, in an approved designated facility for alcohol and drug abuse.

Welfare and Institutions Code, commencing with Section 5200 discusses court order evaluation of alcoholics.

Welfare and Institutions Code, Section 5002, mentally disordered persons and persons impaired by chronic alcoholism may no longer be judicially committed, except as specified under Penal Code Section 4011.6.

Title 22, California Code of Regulations, Chapter 11, addresses "Chemical Dependency Recovery Regulations." The following sections provide excellent definitions:

Section 79011 - "chemical dependency"
Section 79021 - "detoxification"
Section 79077 - "withdrawal syndrome"

Health and Safety Code, Section 11222, establishes procedures for the provision of Methadone to arrested persons.

Health and Safety Code, Section 11217, allows jails to conduct detoxification to individuals; exempts from licensure requirements.

VII. Medical/Mental Health Records

A. Medical Records

Title 15, Section 1205, sets forth specific contents of patients records; full confidentiality privileges; access controlled by health authority.

Penal Code, Section 4011.6, addresses confidentiality of mental health information

Welfare and Institutions Code, commencing with Section 4725, regarding developmentally disabled person access to medical records.

Title 22, California Code of Regulations, Section 70749, provides good guidelines on chart contents.

Title 22, California Code of Regulations, Section 70751 (c) addresses the rules for 7 year retention.

Welfare and Institutions Code, Section 5328, contains specific statutes re: confidential information and records; for developmentally and mentally disordered inmates.

B. Informed Consent

Title 15, Section 1214, all jails shall have established policies and procedures for "consent" and "refusal" of treatment which meet community standards.

Welfare and Institutions Code, Section 4655, regarding special circumstances for obtaining consent of a developmentally disabled individual.

Penal Code, Section 4011.6, may send inmates for evaluation without their consent.

Penal Code, Section 4011.8, provides for voluntary consent for mental health services.

Title 22, California Code of Regulations, Section 70707, sets out clear guidelines regarding consent and refusal for treatment and includes specific information which must be included on consent forms.

Welfare and Institutions Code, Section 5328.02, specifically addresses disclosure of mental health records to adult correctional agencies.

Penal Code, Section 1543, addresses the procedure to obtain disclosure of health care facility patient records.

Penal Code, Section 1524 (c), limits the provisions for a search warrant to be issued for medical and mental health records.

Health and Safety Code, Sections 11878 and 11879, address confidentiality of Methadone treatment records.

Health and Safety Code, Sections 11977 and 11978, address confidentiality of narcotic and drug abuse programs.

C. Treatment Plans and Audits

Title 15, Section 1210, Re: Sharing of information between custody and medical/mental health personnel for the well being of the inmate.

Title 22, California Code of Regulations, Section 70211, provides some guidelines for nursing objectives of a treatment plan.

Title 15, Section 1202, requires health providers to conduct audits of medical and mental health services.

VIII. Inspections

Health and Safety Code, Section 459, addresses inspection of health and sanitary conditions in jails by the county health officer. Such inspections shall occur at least annually. Report to be filed with the Board of Corrections, the sheriff, or other persons in charge of the facility, and the board of supervisors.

Penal Code, Section 6031, empowers the Board of Corrections to conduct biennial inspections. Reports to be filed with the facility manager, local governing body, grand jury, and presiding judge of the superior court.

Penal Code, Section 919, provides the grand jury the right for entry and inquiry into the conditions in the jail.

Penal Code, Section 4305, addresses an advisory committee's role for inspections and recommendations regarding a county jail.

IX. Pharmacy Regulations and Statutes

Title 15, Section 1216, provides specific regulations regarding the administration and storage of drugs within a detention setting.

Title 22, Section 70029, provides an excellent definition of "drug administering" and Section 70031 defines "drug dispensing".

Title 22, Section 70263, sets forth regulations for pharmacy services required of an acute hospital facility. Provides some good guidelines concerning storage and product labeling. Also establishes requirements for monthly inspections by pharmacy personnel of all medications stocked in the facility.

Title 22, Section 70265, gives a clear statement of what pharmaceutical staff should be responsible to oversee.

Title 22, Section 70267, discusses the general rules for the provision of safe and secure locked medication areas.

Business and Professions Code, Division 2, Chapter 9, Article 8, provides the basic laws pertaining to pharmacy practice act.

Health and Safety Code, Section 11000 et al., provides the laws regarding the provision of dangerous drugs.

Health and Safety Code, Section 729.70, discusses written orders and Nurse Practitioners/Physician Assistant.

Business and Profession Code, Section 4051, provides physician exemption for licensure of a pharmacy in his office, providing that the medication is only used for personal patients.

Health and Safety Code, Section 11222, calls for the provision of Methadone to pretrial inmates for maintenance.

Health and Safety Code, Section 11217, sets up parameters for the provision of detoxification to addicted inmates.

X. Laboratory Services

Business and Profession Code, Sections 1200-1322, contain statutes relating to clinical laboratory requirements for licensure.

Title 17, Sections 1030-1057, set forth specific regulations for licensure requirements.

Title 22, Section 70243, sets out good guidelines for general laboratory services.

Title 22, Section 70245, provides a good description of laboratory personnel requirements.

Title 22, Section 70247, provides direction regarding clinical laboratory service space.

Business and Professions Code, Section 1291, affords physicians an exception for licensure as clinical technician, providing the tests are performed on their personal patient. Section 1241.1 requires that physicians perform proficiency tests and hold a special certificate as a clinical pathologist.

Business and Professions Code, Section 1261, outlines the qualifications necessary to apply for a clinical laboratory technologist license.

Title 17, Sections 1030 et seq., set forth the specific regulations and rules regarding the examination requirements.

XI. Radiological Laws

Health and Safety Code, Sections 25660 et seq., set forth the laws regarding the inspection of radiological equipment.

Title 22, Section 70251, gives a good definition of what services a radiology department should be providing.

Title 22, Section 70253, provides the specific regulations that must be adhered to for the shielding and operation of radiology equipment.

Title 17, Chapter 5, Subchapter 5, sets forth the "California Radiation Control Regulations" for the use, storage and shielding of all radiation machines.

Title 17, Chapter 5, Subchapter 4.5, provides the regulations governing all persons operating X-ray machines.

Title 22, Section 70255, gives good direction regarding physician responsibility and attendance of a radiologic technologist.

Business and Professions Code, Section 2089, calls for the training of all physicians to include radiation safety.

Health and Safety Code, Sections 25660 et seq., discuss training for the certificate in radiologic technology.

Title 17, Sections 30460 et seq., set forth the regulations pertaining to the requirements for licensure of radiological technologist.

XII. Licensure Requirements: Health Care Providers

Physician Practice Act
Business and Professions Code, Division 2, Chapter 5, Sections 2000 et seq.

Vocational Nursing Practice Act
Business and Professions Code; Division 2, Chapter 6.5, Title 16, Chapter 25, Subchapter 1, California Code of Regulations (Rules and Regulations).

Nursing Practice Act
Business and Professions Code; Division 2, Chapter 6, Rules and Regulations
Title 16, California Code of Regulations, Sections 1400 et seq.

Nurse Practitioner
Rules and Regulations, Title 16; California Code of Regulations, Chapter 14, Article 8, Sections 1480 et al.
Business and Professions Code; Division 2, Chapter 6, Article 8, Sections 2834 et al.

Psychiatric Technicians Law
Business and Professions Code, Division 2, Chapter 10
Rules and Regulations, Title 16; California Code of Regulations, Chapter 25, Subchapter 2.

Marriage, Family and Child Counselors
Business and Professions Code, Division 2, Chapter 13.

Medical Practice Act
Business and Professions Code, Division 2, Chapter 5.

Psychology Licensing Law
Business and Professions Code, Division 2, Chapter 7.7.
Rules and Regulations, Title 16; California Code of Regulations, Sections 1399.500 et seq.

Pharmacy
Business and Professions Code, Division 2, Chapter 9.
Rules and Regulations, Title 16; California Code of Regulations, Sections 1700-1794; see H&S Div. 21-26000, H&S 11024 Uniformed Controlled Substance Act.
Exceptions for physician providing Rx to patients - Business and Professions, Division 2, Chapter 9, Article 3, Section 4051.

Dental Practice Act - Business and Professions Code, Division 2, Chapter 4. Dental Hygienists.
Business and Professions Code, Division 2, Chapter 4, Article 7, Sections 1740 et seq.

Physician Assistants
Business and Professions Code, Division 2, Chapter 5, Article 18, Sections 2510 et seq.

Social Worker Law
Business and Professions Code, Division 2, Chapter 14. (Added, 1985)

	Title 15	Penal Code	H&S Code	B&P Code	Title 22	W&I Code
Medical Care:						
Emergency trt	1200 & 1208	4011.5, 1208(d)				
Hospitalization Responsibility Reimbursement	1200	4011(a) 4007 4023 4011, 4023 4011.1				
Health Care Staff Qualifications	1203	4023	2732.05	See specific Practice Acts	70721	
Policies and Procedures	1204, 1206		1316.5	2725(d)	70706.2	
Special Inmates:						
Females		4023.5, 4028 4023.6				
Mentally Disordered	1052, 1209	4011.6, 1373				5150,5008 4654
Developmentally Disordered	1057, 1207					4400 et.al
Physically Disabled		2656				
Communicable Disease	1051	4012, 4007, 4020	3000et.al 3050	2727.3 2860.4		
Detoxification	1056, 1213	1208	Division 10.5, 11222, 11217		79011 79021 79079	5170 5200 et.al 5002
Medical Records	1205	4011.6, 1543 1524(c)	11879, 11979 25255 Divis. 20 Chap. 6,7		70749 70751(c)	4725 5328
Informed Consent	1214	4011.6, 4011.8			70704	4655 5320.02
Treatment Plans and Audits	1210,1202				70211	
Inspections		6031,919 4305	459			

Appendix B

SAMPLE MEMORANDUM OF UNDERSTANDING

MEMORANDUM OF UNDERSTANDING BETWEEN THE XYZ COUNTY SHERIFF'S DEPARTMENT AND XYZ COUNTY HEALTH DEPARTMENT REGARDING MEDICAL SERVICES FOR THE XYZ COUNTY JAIL

(Example only - Needs to be tailored to your system)

1. STATEMENT OF INTENT

This document is intended to define the respective responsibilities between XYZ County Sheriff's Department (SD) and the XYZ County Health Department (CHD) relative to providing medical, nursing, mental health and dental services at the XYZ County Jail. These services are to meet the requirements of California Code of Regulations, Title 15, Subchapter 4, Article 10, and to provide services consistent with AMA and ACA Standards. The services are to be designed to accommodate a (number) daily inmate population. Further, these services are to be cost effective through implementation of quality in performance; elimination of unnecessary hospitalization; transportation; and provision of maximum services on site, including specialty care and radiological tests as feasible and at a level consistent with community standards of medical practice.

2. DEPARTMENTAL ROLES

A. SD Objectives: The sheriff's department facility administrator for the XYZ County Jail shall have the responsibility to insure provision of emergency and basic health care services to all inmates of the XYZ County Jail.

B. CHD Objectives: CHD will provide such services to the SD. These services will be provided in accord with requirements of appropriate state agencies such as Board of Corrections, medical, and nursing boards as well as, other professional bodies and county board direction.

The CHD objectives shall be to provide a scope of services to include medical, nursing, pharmacy, mental health, dental and radiological testing with laboratory support.

from the XYZ County Hospital. The CHD is to operate under administrative, medical and nursing management with professional staff including physician, dentist, nurse practitioners, registered and vocational nurses and ancillary clerical staff. All nursing and medical personnel are to be licensed in California. Further, mental health service is provided through the XYZ County Mental Health Department for both on-site and referral services.

3. CHD MEDICAL SERVICES

Specifically, CHD will provide primary adult care on a 24-hour, 7-days-a-week, on-site basis. These services will be provided by qualified, licensed personnel as required. The services shall include, but not be limited to:

A. Intake Health Screening: New inmates at XYZ County Jail will be screened by CHD nursing staff. The screening procedure and form will conform to community standards and include an inventory and observation of medical and psychiatric conditions. Inmates in need of health care will be referred to sick call, infirmary or hospital as indicated by the nursing assessment. The objective of intake health screening is to identify inmates who need immediate or urgent health care, implement such treatment as may be required and to protect the population from communicable disease (see Attachment A). Further, the findings of the intake health screening will be recorded and maintained as a part of the inmate's permanent medical record.

B. Health Appraisal: The health appraisal consists of the health inventory, physical exam and referral for appropriate diagnostic tests and treatment (see Attachment B). The appraisal will be performed by CHD nursing staff within 14-days of incarceration and will include observation and examinations of any and all abnormalities related to physical and mental health. Referral to sick call (physician, mental health and specialty clinics) will be based on the assessment of needs. The objective of the health appraisal is to establish the data base for the health records and identify any conditions of an inmate that are in need of urgent or routine treatments. Further noted is that testing to detect communicable disease, including venereal diseases and tuberculosis, will be completed and examinations provided as appropriate.

Positive results of communicable diseases will be reported to the County Health Department as required.

C. Sick Call: Sick call will be provided daily at each housing unit. Sick Call shall entail an announcement made to the housing unit with the intent that each inmate desiring attention may come forward. Arrangements will also be made for those desiring attention but unable to come forward to submit sick call slips.

It is also recognized that due to the movement of inmates, i.e., those with external appointments, may miss the scheduled sick call. CHD will develop a means of attending to these inmates so that each inmate will have access to necessary medical attention each day.

As part of the above, inmates with identifiable health problems will be referred to the medical service as may be required.

Given the need to insure proper security, sick call will be scheduled so it will not conflict with other jail routines.

D. Physician Services: Physician coverage shall generally be by day shift, Monday through Saturday. However, hours are to be modified to meet peak demands for service as may be dictated by operational needs. On-call and phone contact consulting physician services are to be made available to reduce transportation, security and cost concerns.

E. Consulting Medical Specialties: Medical conditions which cannot be handled by on-site physician or medical staff and cannot wait for on-call medical staff will be referred for outside consultation. Every attempt will be made to provide these consultations at XYZ County Jail.

Referrals will take the following priority to minimize security and transportation costs:

i. The specialists will conduct regularly scheduled consultations, provided the volume warrants, at the jail.

ii. The inmate will be transported to the hospital for scheduled clinical appointments.

iii. For those specialists who are willing and paid for by the inmates, inmates will be transported to the specialist's office.

F. Emergency Services: The on-site CHD team will be the primary providers of emergency services. However, hospital emergency services will be available through XYZ County Hospital for health needs and emergencies that cannot be administered by the on-site CHD team. For example, minor suturing is to be considered an on-site service.

A physician will be available to provide evaluation, treatment, telephone consultation or referral to the hospital emergency room as necessary.

Nurses have the discretion to use a local ambulance service for emergency transportation to the hospital emergency room whenever necessary. However, such transportation is to be coordinated with the Watch Commander or designee to insure escort security.

It is recognized that there may be times when conditions occur in which a prisoner may come under 4011.5 of the Penal Code. In such a case, CHD staff shall initiate necessary action to insure the immediate removal of such person to the hospital is under guard.

In all emergency situations, the CHD staff shall go to the site prior to the movement of the injured or ill party at the discretion of Sheriff's personnel.

G. Infirmary: A (number) bed infirmary will be provided at the XYZ County Jail which is capable of housing male and female patients. It is to be staffed around the clock by nursing personnel. Patients are to be assigned by nursing and physician orders through an acuity level criteria defined in Attachment C. Pursuant to that, most patients above the acuity level two are to be transferred to the XYZ County Hospital. It is recognized that there are certain level three cases that can be handled at the XYZ Jail Infirmary.

The in-hospital stay will be monitored by the CHD physician to insure adequate care and timely release back to the jail. CHD will provide follow-up care upon return to the jail. If other hospital physician services are required, CHD will act as liaison between the attending

physician providing inpatient services to insure continuation of treatment.

H. Mental Health Services: These services are based on three major components: 1. Remission Unit; 2. The Hospital Unit; and 3. Mental Health Consultation.

1. Remission Unit: For their protection and to minimize their disruptive influence on the rest of the jail, identified mental patients who have either recovered to the point where they no longer need inpatient treatment or who have not deteriorated to that point, will be housed in a (number) bed designated area.

2. Hospital Unit: This is the portion of the XYZ County Hospital designated for inpatient, acute mental care. Inmates requiring such care will be transferred to that facility in accord with appropriate CALIFORNIA PENAL and WELFARE and INSTITUTIONS CODES.

3. Mental Health Consultation: XYZ County mental health professionals will provide this service at the jail site. This will include: (a) Screening; (b) Preliminary crisis intervention, diagnosis and counseling; (c) Consultation with CHD and SD regarding mental health-related matters, including suicide prevention, management of chronic substance abusers, sexual offenders, irrationally violent inmates who are not sick enough to warrant hospitalization, and malingerers. The mental health professionals will be assigned an office in the medical unit. They will have access to those areas in the jail where mentally ill inmates are housed.

I. Dental Services: On-site dental care is provided by a dentist based on the cases referred through the routine sick call. Referral to Oral Surgery will be made on dental orders or for dental emergencies as needed.

J. Ancillary Services: CHD will be responsible for all on-site health care ancillary services and supplies, including but not limited to:

i. Pharmacy services.

ii. Laboratory services.

iii. Radiology services.

iv. Detoxification services to provide an on-site drug and alcohol detoxification program, supervised by the Administrator. The treatment plan will be initiated, documented and supervised by CHD, and will be coordinated with the mental health program.

v. Non-inmate services will provide appropriate advice to staff and/or citizens who are on-site at the time of illness or injury. Any illness or injury to staff or visitors will be transferred to outside medical sources by ambulance if appropriate.

vi. OB-GYN and family planning services.

vii. Preventive medicine services to include, as a part of the intake health screening, the potential for contagious disease and/or contagious conditions will be evaluated and appropriate intervention initiated plus the planning for the containment of such diseases within the facility.

viii. A health education program for inmates to provide a medical preventive maintenance health education program. Topics will include venereal and other communicable diseases, drug abuse and dental hygiene. California Penal Code Section 4023.5, regarding female services will be followed.

ix. Vermin control services to provide for the prophylaxis, control and treatment of vermin-infested inmates.

x. Emergency response to the Court upon request.

xi. Court-ordered sampling of body fluids.

xii. Arrest agency-requested samples of body fluids at fee for outside agencies.

xiii. Providing staff to perform body cavity searches.

xiv. Special equipment to include collapsible wheelchairs, gurneys designed to meet the needs of elevators and other portable equipment necessary to provide services.

xv. Inmate court appearances generally have precedence over routine clinical services except in such cases wherein the health of the inmate is in a clear and present danger. The CHD assumes responsibility for medical cancellation of court appearance upon recommendation of the physician.

K. Administrative Services: Administrative direction will be on-site during normal business hours, but may be modified as deemed reasonably necessary to meet operational needs. When not on-site, 24 hours on-call direction will be available. Additional identified services shall include, but not be limited to:

i. Shift supervision.

ii. Special functions to include recruitment and hiring, scheduling, performance evaluation, personnel dispute resolution, interdepartmental coordination and program planning and development.

iii. Evaluation and monitoring of services will be done through a quality assurance program including a peer review procedure using CHD guidelines.

iv. Medical dental records. Each inmate's medical and dental records will be maintained on site. These records will be maintained separately from confinement records and will be kept locked and secure from routine traffic. Only medical staff will be permitted access to these records. Under no circumstances will inmates be allowed access to medical/dental records.

v. Appointment scheduling for hospital and other services as required.

vi. Staff health care education program providing in-service training. CHD personnel will participate in an in-service orientation and training program appropriate to their specific working requirements. Conducted monthly, the in-service program will include the use of an in-service training system and outside consultants for special topics. The training will be oriented primarily toward the health care staff, but will also include programs which involve the correctional staff. A health care training

program shall be provided for the correctional staff, and shall include first aid, CPR, emergencies, signs and symptoms of mental illness, and procedures for transferring patients to medical facilities. An in-service training program will be developed specifically for the facility to help in training of new correctional and nursing staff.

4. MAINTENANCE AND REPAIR

All equipment and fixtures under the control of CHD shall be the responsibility of CHD. The SD shall have responsibility for building problems.

5. SECURITY CLEARANCE

The Sheriff's Department will conduct a background investigation of CHD employees to be assigned duties within the jail. SD will establish criteria to be used in the selection of such employees. The Sheriff's Department will inform CHD as to the criteria so that any specific requirement peculiar to the jail can be considered in the selection of new employees. If a current CHD employee is refused clearance for assignment to the jail, CHD is to be informed of the reason for such refusal.

6. QUALIFICATIONS

Only individuals who possess the established minimum qualifications for the class to which they are assigned will be scheduled to work in the jail.

7. PERMANENT ASSIGNMENT

The CHD employee positions include full-time and part-time personnel to complete full time coverage for a 24-hour operation. The policy is to maintain full staffing in all areas of the program at all times including administrative, medical, nursing and clerical positions.

8. EMPLOYEE ABSENCES

CHD retains responsibility for hiring, monitoring and disciplinary actions of personnel. Vacancies will be filled on a priority basis in accordance with County requirements and Personnel procedures in order to maintain the level of mandated services. The right is reserved to assign personnel within the unit to cover priority needs.

9. HIRING AND MANAGEMENT OF EMPLOYEES

CHD has the responsibility to maintain the recruitment, hiring, evaluation and disciplinary action of its employees. The CHD employees must conform to standards of behavior (professional and security) as established by joint agreement between CHD and SD. The standards include appropriate regard for security requirements and professional conduct as established by CHD/SD management. Recognizing the unique operational requirements of a correctional institution, CHD will closely coordinate with SD command regarding timely and appropriate monitoring of CHD employees. The CHD has responsibility for disciplinary action of its employees and may invoke a procedure of reassignment and/or removal of an employee from the security setting.

Should such areas develop into disputes, the following dispute resolution mechanism shall be utilized:

A. The dispute shall be brought to the attention of respective supervisors. The final decision shall rest with the Sheriff's Watch Commander, and be carried out until resolved as per Item B.

B. Should the decision be considered unsatisfactory by any party, written reports are to be prepared and sent via appropriate channels to the CHD Supervisor and the Facilities Manager. These persons are to meet within seven (7) days to seek resolution.

C. Should no resolution be reached, the relative written positions are to be submitted to the Sheriff and Director, Health Department for resolution.

D. Should no resolution be reached, the written positions shall be submitted to a panel consisting of a representative from SD, CHD and a third party selected by them. The decision of the panel will be final.

10. MANAGEMENT INFORMATION AND MEETINGS

County Health Department management is to meet monthly, or as designated, with the facility administrator to review the health care program. A good working relationship between the health care and correctional staff is the basis for mutual resolution of each other's problems.

In conjunction with the above, monthly, semi-annual and annual statistical reports on services provided are to be prepared and submitted to the Facility Administrator or designee. The contents of these reports shall include, but not be limited to, those included in Attachment D. The format of the report shall be at the discretion of CHD with the consent of the Facility Manager.

11. EMERGENCY PLANNING

In the event of natural disaster, earthquake, fire, etc., sufficient personnel will be made available by the Sheriff's Department and CHD to provide for the care and evacuation of patients as may be required.

Training and drills shall be required semi-annually by mutual consent and planning. CHD and SD will provide copies of their respective Emergency/Disaster plans to be on file by July 1, 198 and subsequently updated by mutual agreement as needed.

Signed and entered into this _____ day of _____,

_____.

_____ _____

Director
County Health Department

Sheriff

_____ _____

APPENDIX C

SAMPLE PROGRAM STATEMENT/ SPACE AND EQUIPMENT REQUIREMENTS

PROGRAM FUNCTION AND POLICY

The XYZ County Jail Medical/Mental Health Services program will provide services which meet California Code of Regulations, Title 15, Minimum Standards for Local Detention Facilities; California Medical Association; and National Commission on Correctional Health Care accreditation criteria and the community standard of health care delivery to all female and male inmates within the sheriff's jurisdiction. It is the objective of this program to minimize the movement of inmates both within the facility and off-site for purposes of medical/mental health services delivery, thereby reducing costly deputy escort and transport services as well as reducing security risks inherent to inmate movement.

Five service delivery sites will be utilized within the jail complex: intake; housing units; central medical clinic; infirmary; and, residential care unit. Off-site delivery sites to be utilized are XYZ General Hospital (acute inpatient services and specialized outpatient services requiring equipment not available within the jail) and the involuntary Psychiatric Health Facility (psychiatric evaluation and treatment and special circumstances).

ON-SITE DELIVERY

INTAKE

The intake area will include a medical examination room to allow nursing and nurse practitioner/physician's assistant staff to interview and examine inmates who have been referred for follow-up examination by the booking officers completing intake medical screening. A toilet will be located adjacent to the medical examination room. The medical examination room will include:

- examination table
- counter space with foot/knee-operated sink
- lockable storage cabinets
- desk
- 2 chairs
- telephone
- free standing scale
- wall mounted otoscope/ophthalmoscope
- wall mounted sphygmomanometer

MENTAL HEALTH INTERVIEW ROOM

An enclosed, private mental health interview room with a large glass observation window will be located in the intake area to be used to interview and screen inmates who have been referred for mental health screening by booking officers.

HOUSING PODS

FUNCTION AND POLICY

Daily triage of inmates' health complaints/requests, nurse practitioner/physician's assistant and physician sick call, mental health evaluation and counseling, medication administration, routine laboratory specimen collection, minor treatments, and food service worker clearance examinations will be provided in the housing pods.

DESCRIPTION OF SPACES/EQUIPMENT

A medical examination/treatment room with adjacent, separate lavatory and office/charting room and mental health interview/counseling room shall be located between 2 pods (64 beds each) to serve 128 beds.

The Medical Examination/Treatment Room includes:

- multi-positional examination table with stirrups approachable from 2 sides
- desk
- 2 chairs
- free standing scale
- wall mounted otoscope/ophthalmoscope
- wall mounted sphygmomanometer
- 16 linear feet of counter space
- lockable storage area for small medication cart and/or medication trays
- small under counter refrigerator
- centrifuge
- foot/knee-operated sink

The Office/Chart Room includes:

- desk
- 2 chairs
- counter top work space
- telephone

The Mental Health Interview Room includes:

- desk
- 2 chairs
- telephone

CENTRAL MEDICAL CLINIC

FUNCTION AND POLICY

The co-educational central medical clinic will serve as the hub of scheduling and distribution of medical/mental health service delivery for the entire jail complex. All support services; i.e., pharmacy, lab, medical supply, X-ray and medical records will be centralized and located in the clinic. Inmates requiring specialized evaluation/treatment such as dental care, specialty medical consultation (e.g. orthopedics, obstetrics/gynecology), examination areas, such as sitz baths, will be escorted to the central medical clinic. The clinic will serve as "home base" for 24 hours per day, seven days per week to provide routine, scheduled clinic services from 8:00 a.m. to 5:00 p.m., Monday through Friday, and 24-hour emergency response and intake screening backup to custody staff seven days per week, Security staffing will be assigned to the clinic from 8:00 a.m. to 5:00 p.m., Monday through Friday. The clinic will be adjacent, but distinctly separate from the infirmary.

The object is to provide easy access from the infirmary to pharmacy, lab, X-ray and central medical supply and eliminate the flow of outpatients and staff in the inpatient area. The clinic will also be adjacent to intake and intake housing to facilitate rapid response to these areas by medical/mental health staff.

DESCRIPTION OF SPACES/EQUIPMENT

PATIENT RECEPTION AND TREATMENT

WAITING ROOM

The inmate waiting area will consist of two separate areas to accommodate minimum security inmates (from the honor farm) and inmates from the general housing compounds of the jail. Two inmate lavatories will be located adjacent to the inmate waiting areas.

OFFICER STATION

The officer work station will be located adjacent to the inmate waiting area and centrally within the clinic treatment areas to allow for constant supervision capability. The work station will be equipped with a desk, telephone and computer terminal for inmate location. From this station, the clinic officer will coordinate clinic appointments and inmate movement with the housing and escort officers, coordinate off-site transportation for medical/mental health services, and provide general security supervision for the clinic.

RECEPTION

The clinic reception area will be centrally located within the patient waiting and treatment areas and adjacent to medical records. The function of this area is to receive all incoming patients, schedule and coordinate on- and off-site appointments, insure the availability and maintenance of medical records for all clinic appointments, and to serve as a 24-hour medical/mental health emergency response command post for the jail complex. The reception area will accommodate three staff members and include:

- desk top work area with lockable storage capacity below
- telephones
- intercom capability to examination/treatment rooms, offices, lab, X-ray, pharmacy, dental
- computer terminal for inmate location data

EXAMINATION ROOMS

Three examination rooms will be located in the clinic to service medical specialty clinics (orthopedic, obstetrics/gynecology, surgery, podiatry, tuberculosis). These examination rooms will include:

- multi-positional examination table with stirrups
- desk/writing table
- 2 chairs
- free standing scale (one for the clinic is sufficient)
- wall-mounted otoscope/ophthalmoscope
- wall-mounted sphygmomanometer
- counter top work space
- lockable storage cabinets
- foot/knee-operated sink
- portable lighting
- X-ray view box

TREATMENT/CAST ROOM:

The treatment/cast room will serve as an area to provide treatment which cannot be conducted in the housing pod examination rooms; treatment of minor emergencies; minor surgery under local anesthesia such as debridement, suturing, incision and drainage of abscesses; etc.; electrocardiograms, and casting of uncomplicated, simple extremity fractures. Any life-threatening medical emergency will be transferred immediately from the housing area to XYZ General Hospital via paramedics and ambulance. This facility will not be equipped or staffed to provide advanced life support treatment, such as cardiac monitoring and defibrillation.

The treatment/cast room will include:

- multi-positional examination table (emergency room type) approachable from four sides
- overhead surgical lighting as well as portable lighting
- counter work space
- lockable storage capability for instruments and supplies
- EKG
- emergency crash cart
- suction machine
- oxygen tank
- spirometer
- knee/foot-operated sink
- large sink with plaster trap for casting
- X-ray view box (2)
- adjacent toilet and sitz bath room

EXAMINATION/TREATMENT OFFICE SPACE

A small office will be located between each of the two examination rooms and an examination room and the treatment/cast room to include:

- desk/writing table
- chair
- telephone
- dictating equipment

The function of this space is to increase provider and exam room productivity and efficiency by providing a separate, quiet area for the medical provider to complete documentation of the exam/treatment of one patient, make follow-up telephone consultation, etc., while the exam room is being cleaned and the next patient is being prepared for the provider.

DENTAL SUITE

A two-chair dental suite (with the capacity for expansion to four chairs if needed for final phase jail capacity) will provide medically necessary dental care for the relief of pain and preservation of viable teeth to male and female inmates within the jail complex. Dental prosthetics will be provided when, in the judgement of the attending dentist, the general health of the inmate would be adversely affected during his/her incarceration without such prosthetics. It is anticipated that the dental clinic would operate from 8:00 a.m. to 5:00 p.m., five days per week; however, with appropriate staffing (dentist, dental assistant and security staff), extended evening dental clinic hours would be feasible to accommodate demand above that which can be managed by a five-day per week, eight-hour clinic.

The dental suite will include:

- 2 chairs/operatories (with capability to expand to 4, if needed)
- X-ray
- counter space with foot/knee-operated sink
- stools (4)
- X-ray view box
- storage space for instruments and supplies
- dentist office
- file storage space
- clerical work space for dental assistant
- lab/workroom

PATIENT TREATMENT SUPPORT SERVICE

MEDICAL RECORDS:

The medical records room will serve as the central health records file storage area for all active (currently in custody) and inactive/archives (medical records must be kept for seven years past the health encounter in accordance with California regulations) for the jail complex. Records of inmates housed in the infirmary will be kept in the infirmary. Records of inmates scheduled for sick call in the housing areas or appointments in clinic will be pulled daily and distributed to the appropriate treatment area. The medical and psychiatric record will be one combined record.

The medical records room will be located adjacent to the clinic reception area and will include:

- free standing open file racks or electronic file system
- work areas to accommodate 2 medical records technicians
- word processing equipment
- inmate locator computer terminal
- transcription equipment
- telephones (2)
- copying machines
- chair level writing counter to accommodate 2 people
- storage area for supplies

PHARMACY

The central pharmacy will serve as the procurement, storage, unit dose preparation and distribution site for the entire jail complex. Medications will be prepared in unit dose by a licensed pharmacist assisted by a pharmacy technician for administration in the housing pods by licensed nursing staff.

The pharmacy will include:

- free standing open storage shelves for bulk storage
- 3 unit dose preparation areas
- wall mounted bins for unit dose preparation
- counter space
- sink
- secure storage space for controlled substances
- refrigerator
- free standing storage racks for medication trays (one per pod)

LAB

The central lab will serve as a collection and temporary storage site for all specimens collected in the housing pod exam/treatment areas prior to being sent to the hospital reference lab for testing. It will also serve as the primary specimen collection point for patients seen in the clinic. Specimen collection and limited on-site treatment will be conducted by nursing and medical staff.

The lab will include:

- foot/knee-operated sink
- counter work space
- lockable storage space
- centrifuge
- incubator
- microscope
- small refrigerator
- phlebotomy chair

INMATE LAVATORY

A small inmate lavatory will be located between the X-ray department and the lab. This will have a pass-through window for passing urine and stool specimens into the lab.

RADIOLOGY SUITE

A radiology suite, to include an integral stationary X-ray unit, will be located within the central clinic. This will allow the jail to hold orthopedic clinics on site and do follow up chest X-rays for tuberculosis screening. X-ray is currently the most frequently utilized of all services provided to inmates at the county hospital. The addition of an on-site radiology unit will reduce the number of inmates requiring transportation of off-site services. A part-time X-ray technician will be scheduled to coincide with scheduled orthopedic and chest clinics and will serve on an on call basis. X-rays will be "wet read" by the attending physician and sent to the county hospital radiology for final reading and report by a radiologist.

The radiology suite will include:

- an integral stationary X-ray machine
- darkroom
- leaded corner alcove for operator
- dressing cubicle
- office, file storage area, viewing room

CENTRAL MEDICAL SUPPLY

The central medical supply area will serve as inventory and storage area for all medical supplies and equipment for all health service delivery sites within the jail complex.

CLEAN UTILITY ROOM

The clean utility room is located adjacent to examination and treatment areas in the clinic and serves as a central storage and preparation area for supplies needed for treatments.

The clean utility room will include:

- counter work space
- foot/knee-operated sink
- storage space (cabinets)

SOILED UTILITY ROOM

The soiled utility room is located adjacent to examination and treatment areas of the clinic and serves as a cleanup areas for soiled, used equipment, disposal of contaminated waste; and storage of contaminated instruments and linens until decontaminated and/or sterilized.

The soiled utility room will include:

- counter space with foot/knee-operated sink
- flush sink (hopper)
- soiled linen and waste receptacles

JANITOR'S CLOSET

A janitor's closet for storage of cleaning supplies will be located within the clinic, to include:

- slop sink
- mop rack
- shelving
- garbage receptacle

SUPPORT STAFF AREAS

NURSES WORK ROOM

A large open-style office with partitioned cubicles will serve as a home base work area for 8-10 nursing and nurse practitioner staff providing health services in the housing pods for charting, report writing, telephone follow up and preparing medical records for return to central medical records room. This work area will be located out of the flow of clinic traffic to provide a quiet, uninterrupted work environment.

MENTAL HEALTH WORK ROOM

A large open-style office to accommodate 5-6 desks for mental health staff providing outpatient services in the housing pods. This will serve as the home base for these providers for charting, report writing, case conferences and telephone tasks. As above, this area will be located away from the flow of clinic traffic to provide a quiet, uninterrupted work environment.

STAFF LOCKER/LOUNGE/LAVATORY ROOM

A combination break room and locker room equipped with small, 12"x12", day type lockers to accommodate staff valuables during their duty shift (not meant as a clothing locker).

HEALTH SERVICES ADMINISTRATION

The health services administration suite will be located adjacent to the central medical clinic. The suite will be an open landscaped plan accommodating offices for the health care administrator, medical director, mental health coordinator, supervising nurse, psychiatrist, secretarial support and three conference rooms. One conference room will also serve as the medical reference library.

INFIRMARY

FUNCTION AND POLICY

The first phase of construction will include a 32-bed integrated medical/mental health infirmary unit. The co-educational unit will provide non-acute medical services (i.e., skilled nursing and intermediate care, and voluntary mental health services) in a therapeutic environment which allow for observation and ready accessiblilty to male and female inmate/patients by licensed health services personnel. The infirmary will be staffed on a 24-hour basis with licensed nursing staff and psychiatric technicians who will have 24-hour on call physician and psychiatrist back up availability. The unit will consist of several step down levels of beds to be utilized in accordance with the inmate/patient's level of need or care acuity. The intent is to move inmate/patients from the highest acuity level bed to lower level acuity beds within the infirmary setting as the individuals progress in their course of recovery thereby freeing up the higher level of beds for the more acutely ill, newly admitted patients. Inmate patients who have progressed through the infirmary, but still may not be ready for general population, will be moved to the adjacent, 32-bed, residential care or sheltered living area. The residential care unit will not be staffed by licensed nursing and mental health staff; however, health services staff will make rounds in this unit several times per shift. The infirmary will provide the services to inmates who require the following categories of patient care:

CATEGORY I:

MEDICAL - Patient may require short-term, moderate assistance with ambulation, feeding and elimination; requires around-the-clock observation; frequent vital sign monitoring; frequent treatments; may need noncontinuous intravenous therapy; patients requiring a hospital-type bed; and those individuals requiring respiratory, wound, and/or reverse isolation. Examples of the types

of patients requiring Category I care include newly booked alcoholics and/or individuals under the influence of other chemical substances who are at risk for withdrawal symptoms; inmates suspected of having sustained a head injury; individuals returning from the county hospital recuperating from surgery or other major treatment; sub-acute exacerbative episodes of chronic disease (e.g., diabetes, chronic obstructive lung disease [asthma, emphysema], seizure disorders, etc,) individuals with a suspected or confirmed contagious disease such as tuberculosis, chicken pox, rubella, etc.

MENTAL HEALTH

Voluntary patients who require acute level psychiatric care including around-the-clock observation and monitoring, medication, restraint, and seclusion. Involuntary patients who have been identified as a danger to self or others and/or gravely disabled prior to transfer to the ward. Examples of the types of patients requiring Category I infirmary care include suicidal individuals; inmates displaying symptoms of acute depression, psychosis, lack of impulse control, severe manipulative behavior; individuals under the influence of PCP; etc.

CATEGORY II

MEDICAL - Patients whose conditions have stabilized beyond Category I requiring less intense observation and monitoring, may require assistance with ambulation, can feed self, treatments required frequently, vital sign monitoring required three times daily, medication regulation and monitoring, teaching and support. Examples of the type of patients who require Category II infirmary care include patients with newly casted extremity fractures; post-operative patients who have been moved from Category I care; patients requiring treatments 3-4 times daily; newly diagnosed diabetics; and, stabilized, wired fractured jaws.

MENTAL HEALTH

Voluntary patients requiring post acute level of observation and supervision, medication regulation, and controlled environment. Examples of patients requiring Category II infirmary care include non- or post-acute stages of suicidal behavior, depression, psychosis, anxiety reactions, etc.

CATEGORY III

MEDICAL - Patients are fully ambulatory, require minimal assistance with activities of daily living; may require intermittent nursing care/observation on a 24-hour basis. Examples of the types of patients who require Category III infirmary care include patients requiring fasting blood specimens, 24-hour urine collection specimens, preparation for special radiologic diagnostic tests, dietary monitoring and control, diabetics requiring blood sugar monitoring 1-3 times daily, etc.

MENTAL HEALTH

Voluntary patients requiring intermittent observation and supervision and environment control on an intermittent 24-hour basis.

CATEGORY IV - RESIDENTIAL CARE OR SHELTERED LIVING AREA

MEDICAL - Patients whose medical condition and/or limited mobility requires separate toilet facilities within their cell (e.g., Hepatitis A; post-stroke patient with mobility limitations); patients who due to their medical condition, advanced age, and/or disability and/or the presence of a medical prosthesis pose a risk to the individual, or a security risk if housed in the general population. Patients who require frequent use of treatment and/or examination equipment located in the clinic or infirmary (e.g., sitz baths).

MENTAL HEALTH

Individuals who due to their psychiatric condition are not able to be housed in the general population.

DESCRIPTION OF SPACES/EQUIPMENT

PATIENT CARE/TREATMENT AREAS

INFIRMARY

30 shared medical/mental health bed capacity with the following special bed needs:

- Ten 120 sq. ft. patient care rooms which can accommodate hospital beds, have large window observation capability, are located on the ground floor of the unit to allow for wheelchair and gurney access, located close to clean and soiled utility rooms and are within direct visual observation of the nurse's station. No patient room opening will be more than 90 linear feet from the nurse's station.

  Four of the above described rooms will be medical isolation rooms with a decontamination vestibule (one shared vestibule per two rooms).

  All ten rooms have been planned to serve multipurposes; that is, medical isolation, hospital bed, psychiatric seclusion and restraint, and handicap accessible rooms.

- In addition, two four-bed wards (320 sq. ft. each) will be available to be utilized for mental health observation and treatment (Category II care).

- Two single suicide watch rooms (100 sq. ft. each) with large glass observation windows to be located within direct visual observation of the nurse's station.

  The remaining ten rooms (80 sq. ft. each) in the infirmary will be single cells, with half window doors, toilet and sink, and regular cell-type bunks.

  All infirmary rooms will have toilets and sinks. All infirmary rooms will be equipped with light and bell nurse call systems (flat, wall mounted call buttons versus the cord-type call light systems). All floor and wall coverings shall be of smooth, nonporous materials.

DINING/DAYROOM:

Inmates will have access to open, shared dining/dayroom space (420 sq. ft.).

NURSE'S STATION:

The nurse's station will be centrally located within the infirmary wing for direct visual observation capability to all patient rooms. The station should be an open desk area with work space to accommodate three people (105 sq. ft.) and will include:

- desk space
- chairs
- locked under desk storage for administrative supplies and chart storage
- telephones
- typewriter/word processor
- inmate locator computer terminal

OFFICER'S STATION

A separate work station (60 sq. ft.) for the officer assigned will be located centrally to assure direct supervision of the infirmary and residential care areas.

PATIENT SUPPORT AREAS

TUB/SITZ BATH ROOM

A combination tub/sitz bath room will be located within the medical housing unit to serve inmates housed in the infirmary and residential care areas (130 sq. ft.).

SOILED UTILITY ROOM

The soiled utility room (90 sq. ft.) is used as a cleanup area for used equipment and instruments as well as the area for bagging of contaminated linens prior to transport to laundry facilities and disposal of contaminated waste. It also has the facilities to empty and clean bedpans and urinals. The soiled utility room should be located in close proximity to the isolation and hospital bedrooms and medical examination room where most contaminated waste and linen will be generated. The

soiled utility room will include:

- countertop work space with foot/knee-operated sink
- locked storage cabinets
- flush sink (hopper)
- waste and linen receptacles

CLEAN UTILITY ROOM

The clean utility room is used to store treatment supplies, medical equipment and linen and as a preparation area for treatment (100 sq. ft.). It will be located in close proximity to the infirmary hospital bed rooms and will include:

- counter work space with foot/knee-operated sink
- locked cabinet storage space
- open shelf storage space for linens
- storage space for wheelchairs

MEDICATION STORAGE/PREPARATION ROOM

A small medication storage and preparation room will be located in close proximity to the nurse's station to accommodate storage of the unit dose medication trays prepared by the central pharmacy on a 12-hour basis or a ward stock supply of medications, and counter workspace with a foot/knee-controlled sink for preparation of medications for infirmary patients (60 sq. ft.).

DIET KITCHEN

A small diet kitchen (80 sq. ft.) will be located in the infirmary to store and prepare special medical/dental dietary supplements. This area will include:

- counterspace
- cabinets
- small refrigerator
- microwave
- free standing wheeled rack for soiled dishes

MENTAL HEALTH INTERVIEW ROOM/OFFICE

A mental health interview room/office will be located within the medical housing area to accommodate private interviewing and counseling activities with inmates housed in the infirmary or in residential care housing (100 sq. ft.). This will also serve as office space for the psychiatrist for charting, report writing,

telephone consultations and patient care conferences with infirmary staff. The office/interview room will include:

- desk
- 2 chairs
- telephone
- dictation equipment

MENTAL HEALTH GROUP SPACE

A 200 sq. ft. room for group therapy sessions will be located within the medical/mental health unit.

MEDICAL EXAMINATION/TREATMENT ROOM/OFFICE

A combined medical examination/treatment room and office will be located in the medical housing area (120 sq. ft.). The function of this room is to allow for private examination and treatment space available to the facility physician, consulting physicians and nursing staff for inmates housed in the infirmary and the residential care unit. The room will also serve as office space for providers requiring space to complete medical records, reports, telephone consultation and patient care conferences with infirmary staff. This area will include:

- multi-positional examination table
- counter space with foot/knee-operated sink
- locked storage space
- wall mounted otoscope/ophthalmoscope
- wall mounted sphygmomanometer
- desk
- 2 chairs
- telephone
- dictation equipment
- free standing scale
- adjacent toilet

JANITOR'S CLOSET

A janitor's closet (30 sq. ft.) for storage of cleaning supplies will be located within the medical housing pod, to include:

- slop sink
- mop rack
- shelving
- trash receptacle

STAFF SUPPORT AREA

STAFF LAVATORY/LOCKER/LOUNGE

A staff lavatory/day locker/lounge area (600 sq. ft.) will be located within the medical/mental health unit. This area will be accessible to all jail medical and psychiatric services staff as well as security staff assigned to the medical unit.

Total square footage of Infirmary = 4,295

RESIDENTIAL CARE/SHELTERED LIVING UNIT

This 30-bed co-educational unit will be comprised of a combination of 4-bed dorms (3 @ 320 sq. ft. each), double cells (6 @ 120 sq. ft. each) and single cells (6 @ 100 sq. ft. each). All single cells and one of the dorms shall be wheelchair accessible. All rooms will have toilet and sinks. A common dayroom and dining area (30 x 50 sq. ft. = 1500) will be accessible to all rooms. Shower facilities (3 @ 20 = 60 sq. ft.) will be located in the unit (individuals requiring a tub for bathing will utilize the facilities of the adjacent infirmary).

Total square footage of Residential Care Unit = 3840

INFIRMARY STAFFING

The medical/mental health unit will require 24-hour per day, 7-day per week staffing. A registered nurse shall be on duty at all times. Exact staffing; i.e., number and level of professionals utilized to staff the unit, will depend on the treatment philosophy of the medical/psychiatric health authorities. Psychiatric staffing may be a mix of psychiatric registered nurses, counselors, psychologist and psychiatric technicians. Medical staffing should be a mix of registered nurses and licensed vocational nurses. Staffing for this unit needs to be flexible in order to adjust for changing census and acuity levels as well as the mix of psychiatric to medical patients. Minimum base staffing for a 30-bed infirmary unit providing the levels of care as described in the preceding Categories of Care I through III should be as follows (these minimums are based on the assumption that all infirmary staff will assist each other as needed):

SHIFT	MEDICAL	PSYCHIATRIC
DAY	RN 1.65 FTE	3.00 FTE
	LVN 3.00 FTE	
PM	RN 1.65 FTE	3.00 FTE
	LVN 1.65 FTE	3.00 FTE
NIGHT	RN 1.65 FTE	1.65 FTE

APPENDIX D

SAMPLE - JAIL MEDICAL CLINIC SPACE REQUIREMENTS

(1) Designator	(2) Space Description	(3) Size	(4) Qty.	(5) Net	(6) Remarks
ADMINISTRATIVE AREA					
6.1	Admin. Office	120	1	120	
6.2	Clerical/Records	1,000	1	1,000	Open area
6.3	MD Offices	100	2	200	
6.4	RN Office	100	1	100	Supervising nurs
6.5	RN Work Rm.	300	1	300	W/ lockers
6.6	Conference/Library	500	1	500	
6.7	Staff Rest Room	60	1	60	
EXAM/TREATMENT AREA					
6.8	Inmate Wait	500	1	500	Seats 40
6.9	Inmate Rest Rm.	60	1	60	
6.10	Drug Counseling	140	1	140	Incls. records
6.11	Psych. Exam	120	2	240	Diagnoses/ treatment
6.12	Exam/Treatment Rms.	120	6	720	
6.13	Inmate Rest Rooms	35	3	105	Btwn exam rooms
6.14	Trauma Room	200	1	200	
6.15	Gurney Alcove	60	1	60	
6.16	Dental Operatories	30	2	480	Open area
6.17	Lab Facilities	200	1	200	
6.18	X-Ray Suite	900	1	900	Developer
6.19	Cast Room	120	1	120	Orthopedic treatment
6.20	Supply/Equip. Stg.	900	1	900	Shared by infirmary
6.21	Janitorial	100	1	100	Chemical/ equip stg.
	Total Square Footage			6,445 sq.ft.	

APPENDIX E

SAMPLE - EQUIPMENT REQUEST SUMMARY
Fiscal Year _____

Budget Unit Title & No.: XYZ County Jail Medical Clinic (340)

1. Item No.	2. Quantity	3. Description	4. Unit Cost	5. Estimated Total	6. Inventory No.	7. Approved Quant	7. Approved Amount
1N	2	Bookcase, 41" h x 12" d x 36" w, open	100	200			
2N	2	Bookcase, 60" h x 12" d x 36" w, open	110	220			
3N	1	Cabinet, key, 80 capacity	100	100			
4N	10	Cabinet, Storage, 40" h x 19" dx24" w 2 sliding doors with lock; 1 shelf, plastic laminate top	275	2750			
5N	3	Cabinet, storage 78"h x 18" d x 36"w, 2 hinged doors with lock, 4 shelves	175	525			
6N	12	Chairs, side arm, metal frame, fabric covered, upholstered seat and back	85	1020			
7N	3	Chairs, stenographer	75	225			
8N	15	Chairs, desk with arms, swivel, adjusting	125	1875			
9N	5	Desk, 45" x 30", single pedestal	215	1075			
10N	3	Desk, 60" x 30", double pedestal	300	900			
11N	9	File, 4 drawer, letter size with lock	175	1575			
12N	24	File, 4 drawer, letter size with lock	200	4800			
13N	3	Lamp, desk mounted	100	300			
14N	2	Light, under counter for nursing unit	100	200			
15N	2	Lockers, sectional 6' by 12"d x 24"w	175	350			
16N	1	Safe, Narcotic security for pharmacy Class V	3500	3500			
17N	21	Shelving, metal, 8'H x 12" d 21 linear feet @ $35/ft.					
18N	1	Sofa, 6' Damask, modern California Correctional Industries	400	400			
19N	2	Stools, foot (step ladder)	75	150			
20N	1	Table, Conference, 42" x 96", metal with plastic laminated wood grain top	500	500			
21N	2	Typewriter, Electric, Correcting	1100	2200			
		SUB TOTAL THIS PAGE		23,600			

Budget Unit Title & No.: XYZ County Jail Medical Clinic (340)

1. Item No.	2. Quantity	3. Description	4. Unit Cost	5. Estimated Total	6. Inventory No.	7. Approved Quant	7. Approved Amount
22N	1	Typewriter, Standard for Rx labels	550	550			
23N	26	Medication tray, unit dosage	25	650			
24N	8	Exam Table	800	6400			
25N	6	Otoscope/Ophthalmoscope, wall mounted	400	2400			
26N	1	Otoscope/Ophthalmoscope, portable	225	225			
27N	7	Blood pressure unit, mobile	200	1400			
28N	1	X-Ray viewing screen	125	125			
29N	12	Stool, medical, adjustable, metal	125	1500			
30N	2	Examination lamp, medical	150	300			
31N	1	Utility cart	100	100			
32N	1	Air/Suction compressor	625	625			
33N	9	Intravenous Stand, Stainless steel	150	1350			
34N	1	EKG Machine	3000	3000			
35N	7	Mayo Stand, Stainless steel	225	1575			
36N	1	Dressing Cart, Stainless Steel	275	275			
37N	7	Wheel Stretcher Carts with pad	800	5600			
38N	1	Linen basket, stainless steel	150	150			
39N	1	Patient Scale, Floor model	225	225			
40N	1	Scale, bathroom model	150	150			
41N	18	Hospital beds, manual, hi/low with gatch spring	625	11250			
42N	12	Bedside stands	150	1800			
43N	1	Patient Dental Chair	4495	4495			
44N	1	Dental unit Mobile cart system	2030	2030			
45N	1	Operating stool	520	520			
		SUB TOTAL THIS PAGE		47,695			

Fiscal Year _____

Budget Unit Title & No.: XYZ County Jail Medical Clinic (340) Page 3 of 4

1. Item No.	2. Quantity	3. Description	4. Unit Cost	5. Estimated Total	6. Inventory No.	7. Approved Quant	7. Approved Amount
46N	1	Operating stool - Dental Assistant	560	560			
47N	1	Compressor	1210	1210			
48N	1	Cental Vacuum, Dental	1680	1680			
49N	1	X-Ray Unit, Single head	5500	5500			
50N	1	X-Ray Developing Tank, Mixing Valve Dark Room Light and Ventilation Fan	360	360			
51N	1	Hand Piece, high speed	480	480			
52N	1	Hand Piece, low speed	695	695			
53N	1	Dental operating light	1115	1115			
54N	1	Steam sterilizer	850	850			
55N	1	Binocular Microscope	2915	2915			
56N	1	Centrifuge, Microhematicrit with reader	810	810			
57N	1	Centrifuge, Clinical	630	630			
58N	1	HB-Meter Set	220	220			
59N	1	Refrigerator, 1/2 size, under counter	550	550			
60N	1	Autoclave, Table model, 21x18x14 1/2"	2405	2405			
61N	1	T.S. Meter	660	660			
62N	1	Instrument Sterilizer, 16 x 8 x 8"	2215	2215			
63N	1	Chair, Patient Blood Collecting	460	460			
64N	1	Incubator, 15 x 15 x 20"	735	735			
65N	1	Pharmacy Refrigerator, Full Size	600	600			
		SUBTOTAL THIS PAGE		24,650			

COUNTY OF XYZ - EQUIPMENT REQUEST SUMMARY
Fiscal Year _____

Appendix E

Budget Unit Title & No.: XYZ County Jail Medical Clinic (340) Page 4 of 4

1. Item No.	2. Quantity	3. Description	4. Unit Cost	5. Estimated Total	6. Inventory No.	7. Approved Quant	7. Approved Amount
66N	1	X-Ray Generator Three Phase 600 MA with 125 KV, Solid State Timer,	-				
	1	Integrated Table, Tubestand and Collimator	-				
	1	X-Ray Tube	-				
	1	H.T. Cables	-				
	1	Wall Mounted Cassette holder	-				
		(Note: All of the above are part of a system.)	27,600	27,600			
67N	1	processor	10,285	10,285			
68N	1	Stand for processor	370	370			
69N	1	Chemistry Mixer	1000	1000			
70N	1	Film Loading Bin	225	225			
71N	1	Cassette Transfer Cabinet	560	560			
		SUB TOTAL FOR PAGE 4		40,040			
		ESTIMATED INSTALLATION CHARGES FOR X-RAY, LABORATORY, PHARMACY, AND DENTAL EQUIPMENT		24,015			
		GRAND TOTAL FOR ALL PAGES		160,000			

APPENDIX F

CALIFORNIA MENTAL HEALTH ACT OF 1967 (Effective July 1, 1969)
(Lanterman-Petris-Short Act)
Involuntary Care Provisions

	72-HOUR TREATMENT AND EVALUATION		14-DAY INTENSIVE TREATMENT BY MEDICAL CERTIFICATION	180-DAY POST-CERTIFICATION TREATMENT FOR IMMINENTLY DANGEROUS PERSONS BY COURT ORDER	CONSERVATORSHIP FOR GRAVELY DISABLED
	WITHOUT COURT ORDER	ON COURT ORDER			
Patient Description	Any person who "is, as a result of mental disorder, a danger to others, or to himself, or gravely disabled."	Any person alleged, as a result of a mental disorder, to be a danger to others, or to himself, or to be gravely disabled, or a chronically alcoholic criminal defendant similarly qualified in counties with appropriate facilities.	If patient has been detained for 72 hours under any of the 72-hour procedures and has received evaluation, he may be certified for intensive treatment if professional staff of agency or facility providing evaluation services has analyzed person's condition and has found person is, as a result of mental disorder or impairment by chronic alcoholism, a danger to others, or to himself, or gravely disabled, and person has been advised of, but has not requested voluntary treatment.	At the end of 14-day intensive treatment period, a person who has threatened, attempted, or actually inflicted physical harm upon the person of another and who, as a result of mental disorder or impairment by chronic alcoholism, presents an imminent threat of substantial harm to others.	Any person who is gravely disabled as a result of mental disorder or impairment by chronic alcoholism.
Initiated by:	A peace officer or other professional person who takes patient into custody and places him in treatment facility. Written application is then made to facility by peace officer or professional person.	Any person. Application is made to person or agency designated by county to provide "pre-petition screening" determines whether there is probable cause to believe allegations. Screening shall also determine whether patient will agree voluntarily to	Notice of certification signed by professional in charge of agency or facility providing evaluation services (under 72-hour detention) and a physician, if possible a board certified psychiatrist who participated in the evaluation. If professional	Professional person in charge of 14-day intensive treatment for facility, or his designee, by a petition to Superior Court. Petition may be filed with the Superior Court at any time after first week of 14-day intensive treatment period.	Recommendation of professional person in charge of agency providing 72-hour evaluation or 14-day treatment. If court designated officer recommends conservatorship, petition is filed with Superior Court.

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Initiated by (cont.)		receive professional counseling or evaluation. In cases of chronic alcoholism, initiated by Municipal Court judge.	person in charge is physician who performed medical evaluation, the second person to sign may be another physician, unless one is not available, in which case a psychologist, social worker, or registered nurse who participated in evaluation should sign certification. No		
Location of Treatment	County designated and State approved facility. Evaluation and treatment can be performed without detention depending on professional judgment.	If court order is refused, peace officer or court approved official may take into custody and place in designated facility for evaluation and treatment.	County-designated facility equipped and staffed to provide intensive treatment.	If court finds person to be in need of 90-day-treatment, it shall remand him to the Department of Mental Hygiene or court designated facility for that purpose.	Patient may be placed by conservator in a medical, psychiatric, nursing or other state-licensed facility, or a state hospital, county hospital, hospital operated by Regents of the University of California, or United States Government hospital; or in addition to any of the foregoing, in cases of chronic alcoholism, to a county alcoholic center.
Term of Petition or Treatment	Not to exceed 72 hours, exclusive of Saturdays, Sundays and holidays.	Not to exceed 72 hours, exclusive of Saturdays, Sundays and holidays.	Not to exceed 14 days (may be shorter); 14-day period may be renewed once if patient is suicidal.	Not to exceed 90 days (may be shorter).	Conservators may be appointed by court for successive periods of one year. Petition to court for renewal of conservatorship must include opinion of two physicians that

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Term of Petition or Treatment (cont.)					conservatee is still gravely disabled. At any time, but not to exceed more than once each six months, conservatee may petition Superior Court for a rehearing as to his status.
Disposition	(a) Release (b) Referral for further care and treatment on voluntary basis (c) Certification for intensive treatment under 14-day procedure (d) Recommendation for conservatorship.	(a) Release (b) Referral for further care and treatment on voluntary basis (c) Certification for intensive treatment under 14-day procedure (d) Recommendation for conservatorship.	(a) Release (b) Further treatment on voluntary basis (c) 90-day treatment for imminently dangerous. (d) Conservatorship. (e) Right to judicial review by writ of habeas corpus in superior court.	(a) Release at end of 90 days, or before. (b) If superintendent or professional person in charge of hospital in which patient is confined files with superior court a new petition on grounds that he has threatened, attempted, or actually inflicted physical harm to another during his 90-day detention and treatment and that he is a person who, by reason of mental disorder or impairment by chronic alcoholism, presents an imminent threat of substantial harm to others, court procedure would	Discharge from conservatorship or continuation on yearly basis by court.

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Disposition (cont.)				start over again and if court so orders at end of court hearing, patient would be detained for additional 90-day period. If superintendent or professional person in charge of hospital providing 90-day treatment releases patient before end of 90-day period, he must notify court which remanded patient for treatment.	

Appendix G

SAMPLE
PATIENT'S RIGHTS

FORENSIC INPATIENT PROGRAM
CENTRAL MEN'S JAIL
IF YOU ARE OR WERE A PSYCHIATRIC PATIENT - ADMITTED VOLUNTARILY TO THE FORENSIC INPATIENT PROGRAM, YOU HAVE THE FOLLOWING RIGHTS:

- To keep nondangerous personal possessions such as toilet articles, books and magazines.
- To have reasonable access to telephones, both to make and receive confidential calls or have such calls made for you when necessary.
- To receive visitors.
- To have ready access to letter writing materials including stamps.
- To receive and mail correspondence that has not been examined by the Forensic Inpatient staff.
- To be able to keep and be allowed to spend a reasonable sum of money for small purchases from the store.
- To refuse shock treatment or any form of convulsive therapy and you have the absolute right to refuse psychosurgery.
- To confidentiality and to have all information collected in the course of your treatment protected.
- To treatment services which promote your potential to function independently.
- To prompt medical care and treatment.
- To religious freedom.
- To be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse or neglect. Restraint/seclusion should be used only when your behavior is physically harmful to you or to someone else.
- To refuse medication for you mental condition if you are a voluntary patient.
- To be informed of the reasons why you are being held involuntarily, and how long you are being detained. You have the right to a lawyer and a hearing before a judge if you are held longer than seventy-two hours against your will.
- To be free from dangerous procedures and to refuse participation in any experimental treatment or research project.
- To physical exercise and recreational opportunities.
- Lastly, you have the same legal rights and responsibilities guaranteed al other persons by Federal Constitution and Laws, and the Constitution and Laws of the State of California unless specifically limited by State law.

<u>IF YOU THINK YOU HAVE BEEN DEINIED ANY OF THE ABOVE RIGHTS WITHOUT GOOD REASONS CONTACT:</u>

PATIENT'S RIGHTS OFFICE
LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
2415 WEST SIXTH STREET
LOS ANGELES, CA 90057
(213) 738-4888

(Our hours are 8:30-5:00 pm Monday thru Friday, but if your problem cannot wait, you can call anytime and someone will be in touch with you as soon as possible.