SAN BERNARDINO COUNTY SHERIFF'S DEPARTMENT
JBCT PROGRAM CONTRACT

EXHIBIT II

California Department of State Hospitals

COMMUNITY FORENSIC PARTNERSHIPS DIVISION

Jail Based Competency Treatment Programs

Policies and Procedures Manual

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Jail Based Competency Treatment Programs

Department of State Hospitals (DSH) Policies and Procedures Manual

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JBCT PROGRAM OVERVIEW

Description

The Department of State Hospitals (DSH) is responsible for providing competency restoration treatment services to felony incompetent to stand trial (IST) patients. Inpatient-level DSH competency restoration treatment facilities include, but are not limited to, four State Hospitals (Napa, Atascadero, Metropolitan, and Patton), contracted community inpatient facilities, multiple Jail Based Competency Treatment (JBCT) programs, and the Admission Evaluation and Stabilization Center (AES).

Mission

The primary mission of the JBCT and AES programs, hereafter referred to as JBCT programs, is to efficiently and effectively restore patients to trial competency.

Philosophy

The JBCTs provide individual and milieu-based treatment services for the purpose of restoring competence to stand trial. The competency restoration treatment services are individually tailored to the patient based on the results of semi-structured assessments of trial competency. The competency restoration treatment services are delivered according to a treatment plan developed and approved by the patient's treatment team.

The full scope of competency restoration treatment services includes but is not limited to:

- The use of semi-structured and standardized measures of trial competency and feigning/malingering
- A multimodal and experiential educational experience in which materials are presented in multiple learning formats by multiple staff
- Consistent psychiatric services and medication management
- Group and individual competency education and psychosocial treatments
- Incentivized medication and program compliance

In all aspects of care, JBCTs aim to align with DSH's value of promoting diversity, equity, and inclusion, providing culturally informed and linguistically appropriate care.

Target Population

The target population consists of felony IST patients committed to DSH for inpatient competency restoration services.

Competency Restoration Treatment Standards

The JBCT programs have required treatment service standards which set expected treatment levels. Please see ***Appendix D Required Services*** for details.

JBCT Program Housing

JBCT patients are housed separately from General Population (GP) inmates. However, in the event that a Sheriff's Department is not able to maintain this separation, exceptions may be made with approval and agreement from DSH.

Types of JBCT Programs

There are 4 different models of JBCT programs and 1 AES Center:

- **Local JBCT Program** – a local JBCT program only serves IST patients from the local JBCT's county.

- **Regional JBCT Program** – a regional JBCT program serves IST patients from a pre-determined region. The selected counties in the region are negotiated and determined during contract negotiations between the Sheriff's Department and DSH. The selected counties are often within regional proximity to the hosting JBCT's county.

- **Statewide JBCT Program** – a statewide JBCT program serves IST patients from anywhere in the state of California.

- **Small County JBCT Program** – a small county JBCT program only serves IST patients from the local JBCT's county, but it differs from other JBCTs in size. Small county JBCT programs typically only serve 1 to 3 IST patients at any given time. Additionally, because of the smaller treatment population, most small county JBCT programs do not have a milieu space and competency restoration treatment is conducted individually.

- **Admission Evaluation and Stabilization Center (AES)** – An Admission, Evaluation, and Stabilization Center (AES) is similar to a statewide JBCT program. However, the AES also has medical staff devoted to the IST patients in the AES center and admits a wider range of patient profiles.

See map of current JBCT and AES programs as of publication of these policies in ***Appendix A***.

License and Certification

Clinical Staff Qualifications and Licensure

All staff serving in the role of program director in the JBCTs shall possess a current valid license for practice in California from the Board of Psychology, Board of Behavioral Sciences, Medical Board, or other body created by California to monitor and license mental health clinicians as appropriate. All staff serving in the role of psychologist in the JBCTs shall possess a current, valid license for practice in California by the Board of Psychology. In each case, licensure shall be in good standing and without conditions at all times.

JBCTs wishing to have a candidate acquiring supervised hours for licensure or who is in the process of transitioning licensure to California from another state, province, or country may submit a request for an unlicensed staff waiver detailing how all applicable laws will be complied with, supervision and oversight will be provided, and quality of patient care will be ensured to DSH. A waiver for these candidates to serve as program director or psychologist at the JBCT shall be subject to approval by DSH. Such a waiver will be for a maximum of two years for social workers or for one year with the possibility of a single one-year renewal for practitioners from other disciplines. These standards and requirements also apply to any clinician providing temporary coverage in either of these positions whose period of coverage is expected to reach or reaches 30 working days.

In addition to the clinicians serving in the program director and psychologist roles, the JBCT is responsible for ensuring that all professionals, paraprofessionals, or trainees operate only within their scope of licensure and their training and experience, commensurate with general community practice. Each JBCT will have a program policy and procedure to ensure that all relevant staff licenses and certifications remain active and in good standing, that all requirements for supervision, training, and registration of unlicensed staff or trainees is provided in accordance with law, and that all duties performed are consistent with the privileges and limitations established by their licensure status. This includes monitoring clinicians providing telehealth services who are practicing from a site outside of California to ensure that they comply with all relevant laws regarding licensure and service provision both in the originating state and in California.

DSH may periodically review the individual JBCTs' policies and procedures, and any accompanying required training plans and licensure tracking documents, to ensure compliance with these requirements and that all services are provided in accordance with the law.
In the spirit of culturally responsive treatment, the interdisciplinary staff should reflect the diversity and needs of the population that it serves.

Program staff function as an effective interdisciplinary team as demonstrated by productive treatment team meetings and targeted treatment plans.

JBCT Custody Staff Crisis Intervention Training

Prior to assignment to the JBCT program, JBCT designated custody staff shall receive Enhanced Mentally Ill Offender or Crisis Intervention Training (CIT) provided by the Sheriff's Department. Custody staff shall also participate in the JBCT treatment team meetings by providing custodial input (i.e., any notable behavioral problems, security issues, collateral data for assessment of feigning, etc.) regarding patients in the JBCT program.

STAFF COVERAGE DURING HOLIDAYS AND ABSENCES

The JBCT will ensure treatment continues during holiday periods and times of limited staff coverage, outside of the actual day of any state holidays. If staffing challenges emerge, the JBCT is required to seek consultation from their assigned DSH Consulting Psychologist.

Each JBCT will maintain a written policy and procedure for emergency and non-emergency psychiatric coverage that is maintained in its internal policies and procedures manual. The program will submit a copy for review and approval upon the request of DSH.

THE COMPETENCY STANDARD

The Dusky Standard

The California standard for competency in the criminal court was adopted from the 1960 U.S. Supreme Court case of *Dusky v. United States*. The Court held that the test is whether a defendant has "sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and whether he has a rational as well as a factual understanding of the proceedings against him." (*Dusky v. United States* (1960) 362 U.S. 402, 402 [80 S.Ct. 788, 788-789, 4 L.Ed.2d 824, 825].)

Standard for Competency Pen. Code, § 1367, subd. (a)

The California standard for competency to stand trial states that a criminal defendant cannot be tried or adjudged to punishment "if, as a result of a mental disorder or developmental disability, the defendant is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner." (Pen. Code, § 1367, subd. (a).)

Important Penal Codes

Below is a list of important Penal Codes related to mental competency:

- Penal Code section 1367
- Penal Code section 1368
- Penal Code section 1369
- Penal Code section 1370
- Penal Code section 1372

Incompetency Proceedings

If a defendant is found incompetent to stand trial, the criminal proceedings remain suspended and the trial court may, after consideration of outpatient alternatives, commit the individual to DSH (which includes a State Hospital, JBCT, AES, other locked psychiatric facility contracted with DSH, or other programs developed by DSH) until the defendant is competent to stand trial.

Maximum Term of Commitment

The maximum term of commitment for a felony IST defendant is 2 years from the date of the court's commitment order, or the maximum term of imprisonment for the most serious offense, whichever is shorter. If a defendant was previously committed as incompetent to stand trial and is recommitted for the same case, the prior period from the time the patient was found IST to the point when proceedings resumed will impact the maximum term of commitment. If there are questions about the maximum term of commitment, especially if is known that the defendant had a lengthy prior commitment on the same case, JBCT programs can request clarification through the DSH Patient Management Unit (PMU).

PRE-ADMISSION

1370 Commitment Packet:

PMU will provide the JBCT the 1370 commitment packet from the committing court.

PMU will also send the JBCT available jail medical records, mental health records, and classification records if the county is unable to access these themselves (e.g. for a patient committed in another county).

Admission Criteria

To be admitted into the JBCT program, a patient must meet the following admission criteria:

1. At least 18 years of age
2. Court committed to DSH
3. Felony offense
4. Mentally incompetent as a result of a mental disorder
5. Must pass facility clearance (security and medical clearance)
6. The JBCT must be able to admit the patient by the date specified by PMU

Admission Screening, Acceptances, and Bypasses/Denials - JBCTs:

The JBCT will receive a referral from PMU with the 1370 commitment packet. Jail classification records and jail medical and mental health records will also be provided in instances in which the program would not already have access (e.g. for out of county placements referred to statewide or regional programs). The referral documents will be reviewed by the JBCT, as well as custody and medical staff if deemed necessary by the individual program and contract holder (e.g. for out of county referrals), in order to ensure suitability for admission. PMU may provide a date by which the patient needs to be admitted to the program. If the program cannot admit the patient by that date, the program will alert PMU via the currently approved communication process (currently via a denial in the JBCT Application).

If the patient is found to be suitable for admission after completion of the admission screening process, the patient will be admitted or placed on the JBCT's waitlist. If the patient is not suitable

for admission, the patient will be denied admission and PMU will place the patient on a waitlist for admission to another DSH facility.

In order to communicate an admission or denial decision to DSH, the JBCT must inform PMU via the current approved communication pathway. At the time of publication of this manual, that communication pathway is via the JBCT Application for the Enterprise Data Platform (EDP). When a patient is denied admission, the program will also provide a screening form explaining the reasoning for the denial.

Programs are required to review the patient and communicate a decision regarding whether the patient is accepted for admission within the following timeframes:

- Local Program 3 calendar days of receipt of the referral from PMU
- Small County Model 3 calendar days of receipt of the referral from PMU
- Regional and Statewide 5 calendar days of receipt of the referral from PMU

In some instances when patients have been approved for admission and are on a JBCT waitlist but can be admitted more rapidly to another DSH program, PMU may initiate a bypass. In these instances, the program will be informed via email and will notate the bypass in the JBCT Application.

Typical Reasons to Bypass - JBCTs:

Reasons for a bypass vary from program-to-program and reasons may include but are not limited to the ability of the facility to address the patient's comorbid medical conditions or house the patient safely. Below are examples of typical reasons a program may bypass a patient:

- Gang affiliation conflict between a patient pending admission and a patient currently in the program
- Serious medical issues that the jail is not equipped to treat
- Patient's jail classification would preclude participation in treatment, even after admission into the program
- The patient's psychiatric presentation is very complicated and the program is not confident that the patient could be psychiatrically stabilized and/or restored to competency in less than 4 months even after serious attempts to provide the most robust treatment.

Admission Screening, Acceptances, and Bypasses/Denials – AES:

An AES is staffed and resourced to accept all patients referred to them for care and if the AES is unable to treat a patient, a review process occurs with AES and DSH. The AES will receive a referral from PMU with the 1370 commitment packet. Jail classification records and jail medical and mental health records will also be provided in instances in which the program does not already have access (e.g. for out of county referrals). PMU may provide a date by which the patient needs to be admitted to the program. If the program cannot admit the patient by that date, the program will alert PMU via the currently approved communication process (currently via a denial in the JBCT Application).

For individuals who can be admitted within the timeframe that PMU provides, an AES may only deny admission to individuals with highly acute medical issues that the AES cannot safely manage on site or Americans with Disabilities Act (ADA) housing restrictions that cannot be clinically accommodated by the Contractor. Should the AES believe that a patient meets one of these criteria, or has a concern that assessment and treatment at the AES is contraindicated for another reason, the AES will contact the assigned Consulting Psychologist within three days of receipt of a complete referral packet with the concerns. If the Consulting Psychologist concurs with the AES, the patient may be denied admission. In a case in which a request to deny a patient is denied, the AES can choose to appeal to the Assistant Chief Psychologist for the JBCT program. The AES's review process, including any requests to bypass or appeals, is to occur within 5 calendar days of receipt of the referral packet from PMU.

If the patient is found to be suitable for admission, the patient will be admitted or placed on the AES's waitlist, which will inform PMU of the decision to admit via the currently approved communication pathway (via JBCT Application for the EDP at the time of writing). Similarly, if the AES and DSH agree that the patient meets the medical exclusion criteria or should not otherwise be admitted to the AES, or if the AES cannot admit the patient by the required date, the AES will notate this as a denial and provide a Screening Assessment – Denial form explaining the denial via the currently approved mode of communication (via the JBCT Application at the time of writing).

In some instances when patients have been approved for admission and are on the AES waitlist but can be admitted more rapidly to another DSH program, PMU may initiate a bypass. In these instances, the program will be informed via email and will notate the bypass in the JBCT Application.

ADMISSION PROCESS

Basic Admission Requirements:

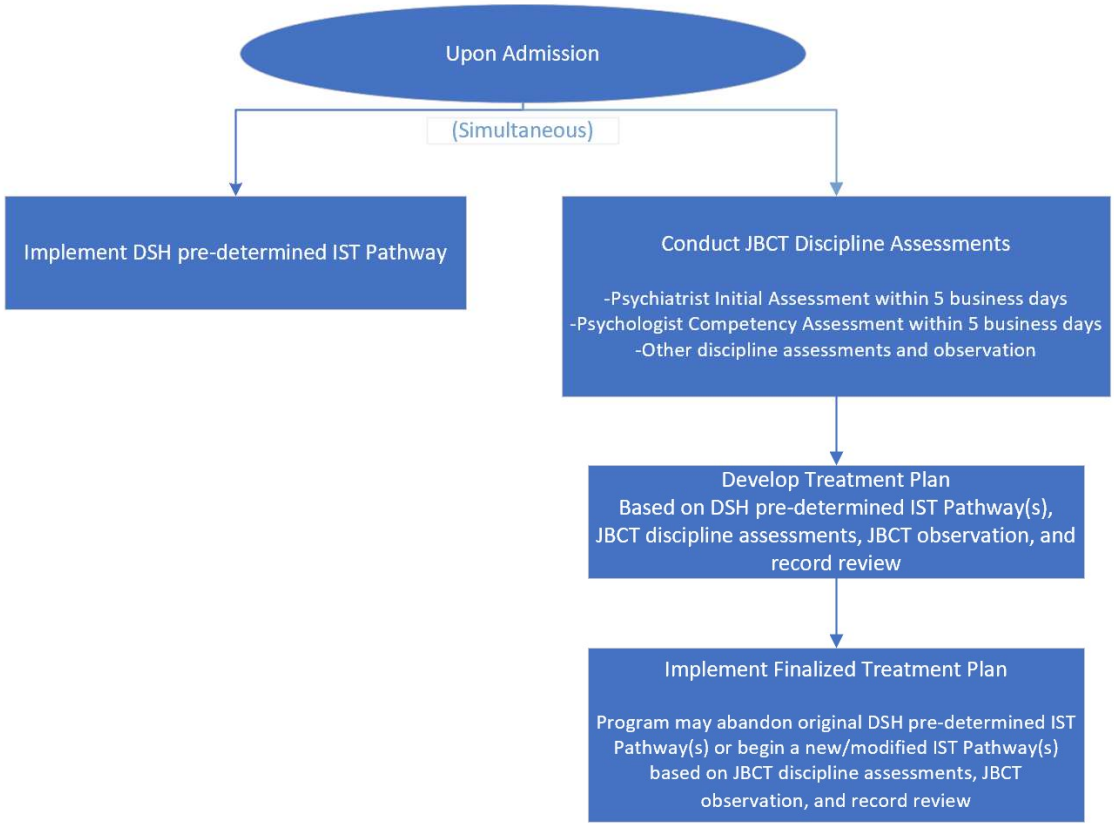
- Pursuant to California Code of Regulations, Title 9, Section 4700 all patients must be admitted in order of commitment date (oldest to newest). Any exceptions to allow admittance of patients out of order of commitment date due to extenuating circumstances must be approved by the Consulting Psychologist, who will communicate the extenuating circumstance to PMU.
- Admission letter – An admission letter must be filed with the court on the day the JBCT admits the patient (no sooner or later than the day of the admission).
- After the JBCT submits an admission letter to the court, the patient cannot be bypassed.
- The JBCT must also upload a copy of the admission letter via the current DSH approved secure method (at the time of publication via uploading to the PMU Workspaces folder).

DSH Pre-Determined IST Pathways

IST Pathways are competency restoration tracks based on a patient's psychiatric status and other relevant criteria determined pre-admission by DSH. DSH's model of IST Pathways operationalizes key decision points to ensure a systematic approach to the initiation of timely competency restoration treatment and psychiatric services. The IST Pathways model to competency restoration treatment is structured to guide an organized treatment approach that will improve timely access to treatment, allow early categorization of competency deficits, positively impact treatment outcomes, and help the patient more quickly achieve discharge.

IST Pathways are initiated by the DSH PMU. Therefore, upon receiving an IST patient referral from PMU, the patient will already have a DSH pre-determined IST Pathway(s). JBCT programs will be expected to simultaneously implement the DSH pre-determined IST Pathway but also to continue to assess the patient upon admission, determine a treatment plan, and maintain the DSH pre-determined IST Pathway or select a new IST Pathway based on JBCT discipline-specific assessments and observation. At the time of publication, the PMU identified pathway is included in the PMU clinical intake document, which may be received with or shortly after patient referral to the JBCT via the documents section of the JBCT Application.

IST Pathways Determination and Implementation



There are six IST Pathways, and each has a prescribed treatment plan for the commencement of competency restoration treatment services. A patient may fit in more than one IST Pathway. Of course, instances may occur when a patient does not fit one of the six IST Pathways and if such a case occurs the JBCT program will assess and determine an appropriate treatment plan for the patient. Treatment Teams shall document the IST Pathway(s) that a patient has entered by recording it in the weekly Treatment Team notes and on the treatment plan.

For a summary of IST Pathways and pathway implementation, please see ***Appendix E***

ADMISSION BY PSYCHIATRIC ACUITY

If a patient waiting for admission is severely decompensated, such that the patient's mental illness is causing complications which put the patient at risk of death or serious injury while awaiting admission into a DSH program, the committing county's clinician or designee may request an

acuity review so that DSH considers the patient for an expedited admission. Communication about acuity referrals goes directly through the DSH PMU.

If a patient who is currently in the JBCT is severely decompensated, such that the patient's mental illness is causing complications which put the patient at risk of death or serious injury and their needs cannot be adequately met in the JBCT, the JBCT can complete a redirect packet (see the Redirect to State Hospital section, to follow) and consult with the assigned Consulting Psychologist regarding an expedited redirect. The Consulting Psychologist will review the case and, if they agree that the case is appropriate, will send the case on to the PMU patient navigator as well as PMU leadership to request that the patient be transferred expeditiously to the state hospital.

COMPETENCY RESTORATION TREATMENT REQUIREMENTS

Below is an overview of the JBCT competency restoration treatment service requirements. For a summarized outline of these details, see ***Appendix D Required Services:***

Service	Frequency and Duration	Additional Requirements
Competency Education Workbook	N/A	All patients will be provided a competency education workbook that will include basic information about criminal court proceedings. At a minimum, the workbook should provide education about the following topics: 1. Charges 2. Severity of Charges 3. Sentencing 4. Pleas 5. Plea bargaining 6. Roles of the courtroom personnel 7. Adversarial nature of the trial process 8. Evaluating evidence 9. Working with an attorney Workbooks and handouts should be written at a level that is easy to read and understand. All workbooks and written handouts should roughly correspond to a reading level that is no higher than 5th grade. The program will maintain a copy in Spanish. JBCTs provide treatment material for patients in their language of preference whenever possible and clinically appropriate.
Group Treatment	Daily Group • Minimum of 4 hours of group treatment daily Monday through Friday • Group Duration: 30 minutes to 2 hours	At a minimum, group treatment must include 4 hours of group treatment daily, Monday through Friday, and 1 competency education group per day at least 4 days per week. Groups will have multiple learning formats, such as: • Simple didactic lecture • Instructional aids (e.g., handouts, white boards) • Group discussion • Vignette discussion

		• Watching and discussing a relevant video • Role-playing • Use of the expressive therapies (e.g. art, music) • Relevant games (e.g., crossword puzzles or Jeopardy with court/competency terms) For patients exhibiting cognitive impairments, group interventions will be modified to meet the patients' learning abilities, such as but not limited to: ensuring instruction is consistent with the patients' cognitive abilities and reading level, utilizing illustrations to describe the court process, using slow and simple language, repetition, and integration of strategies based on the results of cognitive screening assessments.

All group treatment contacts will be documented in each patient's chart. Adequate documentation includes information about the material presented and/or interventions utilized in group, the patient's participation during the session, and the patient's response to treatment and progress towards competency.

The JBCT is expected to incorporate the following 3 treatment domains into the weekly group schedule:

1. **Competency education** – including, at minimum, education in the following areas:
   a. Charges
   b. Severity of charge
   c. Sentencing
   d. Pleas
   e. Plea bargaining
   f. Roles of the courtroom personnel
   g. Adversarial nature of the trial process
   h. Evaluating evidence
   i. Working with one's attorney

2. **Understanding and management of mental illness** - including topics such as:
   a. Psychoeducation about mental illness
   b. Anxiety reduction strategies
   c. Coping skills
   d. The importance of medication adherence
   e. Substance use and relapse prevention

3. **Mental and social stimulation** - creating opportunities for patients to be engaged in mental and social stimulation, such as:
   a. Development of prosocial strategies for use of unstructured time

	b. Socialization with other patients and program staff c. Structured leisure and recreational activities	
Individual Clinical Contacts	Weekly Individual Sessions • Individual sessions can range from 10 minutes to 50 minutes depending on patient need and tolerance	An individual clinical contact is a one-to-one, face-to-face session between a patient and a clinical staff member. Weekly, individual sessions are used to conduct competency psychoeducation, including review of individual contextual factors relevant to the patient's case (e.g. review of the police report, other topics too sensitive for discussion in group, etc.), and/or to provide focused treatment of psychiatric symptoms impeding trial competency. Frequency and length of sessions will be based on the patient's current tolerance and clinical needs (e.g. increasing to twice a week to allow for both intensive work with a competency trainer and symptom management sessions with the clinician). Clinicians will maintain a forensic focus on competency restoration and general mental health management. The content of individual sessions is focused on the specific needs of the individual and provided within the limits of the provider's licensure and sphere of competence. Clinicians will not offer direct legal advice. For patients exhibiting cognitive impairments, individual treatment sessions will be modified to meet the patients' learning abilities, including but not limited to: increasing the frequency of individual competency education sessions, ensuring instruction meets the patient's cognitive abilities and reading level, utilizing illustrations to describe court processes, and using slow and simple language. Each individual competency education session will be documented in a progress note. All progress notes will indicate the competency education or mental health topic discussed during the session, the patient's current competency deficits, the patient's clinical presentation at the session, the patient's progress during the session, and a plan for the next individual session.

Daily Check-In	Daily check-ins are brief and typically range from 3-10 minutes	Daily check-ins are provided by clinicians or paraprofessionals and are intended to build rapport and ensure patients are not in crisis.
Treatment Planning	Initial Treatment Plan: Within 7 business days of admission Updated Treatment Plan: Every 30 days thereafter (plus or minus 5 days)	Treatment plans are individually tailored and focus on the patient's IST Pathway(s) and any barrier(s) to competency restoration.

A treatment plan is developed by the treatment team for all patients in the JBCT program. If a treatment plan was completed in EASS within 14 days of the date of admission to the JBCT and the plan remains relevant, the Program Director can document in the medical record that the team will be implementing that plan and that it will be reviewed and updated within 30 days of admission.

All treatment plans will include:

1. The team's working diagnosis
2. Integration of information gleaned from the initial and ongoing assessments (psychiatry, psychology, etc.)
3. The patient's barrier(s) to competency
4. The patient's IST Pathway and prescribed treatment
    a. Please note, the IST Pathway prescribed treatment broadly captures the specified treatment approach, but the JBCT treatment team is expected to build upon the IST Pathway prescribed treatment with individualized, specific treatment interventions and approaches to resolving the patient's barrier(s) to competency to stand trial.
5. Treatment response over the last treatment interval
6. Changes in treatment and evaluations planned for the next month

All patients in the JBCT program will have a treatment plan that is accurate, uniquely designed to treat the patient's symptoms as they relate to competency deficits and safety, and consistently updated at the specified interval.

Documentation should be consistent in providing evidence of the discipline assessments (e.g., psychologist, psychiatrist, team observations) and treatment team discussions (e.g., treatment team notes) driving the treatment plan, and of the treatment plan driving the individual competency education sessions and other prescribed treatments.

Treatment Team Meetings	Weekly	Treatment team meetings will include all relevant clinical staff as well as custody staff. Treatment team weekly notes are maintained and accessible by all members of the team.

An interdisciplinary treatment team will convene weekly, at minimum, to discuss each patient's progress toward competence to stand trial, as well as:

1. The effectiveness of the treatment interventions and IST Pathway(s)
    a. This includes review of current medications and any medication changes over the last week, and updating the current medications in the JBCT EDP Application.
2. Whether additional treatment elements should be incorporated into the patient's treatment plans
3. Whether a patient is under consideration for discharge or redirect as well as support for this decision.
4. If biopsychosocial issues contraindicate effective jail treatment, the JBCT will contact their assigned DSH Consulting Psychologist to request a redirect review. Please see *JBCT Redirect Tool* in ***Appendix G.***

The JBCT is required to maintain weekly notes for each patient's treatment team meeting. Treatment team notes will document the Treatment Team's discussion, reasoning, and treatment decisions.

JBCT deputies are a part of the treatment milieu and their custody perspective regarding a patient's institutional behavior and general functioning will be solicited during the treatment team meetings.

Review of Charges and Police Report with Patient	As determined after stabilization but typically within 2-3 weeks of admission	It is required that a team member actively reviews these documents with the patient. There is no requirement that these documents must be given to the patient.

Psychiatric Services

Psychiatric services provided to the IST patients in the JBCT program will meet psychiatric best practice standards. The JBCT psychiatrist will:

- Complete a full initial assessment of all new JBCT patients within 5 business days of admission (documented in the chart within 10 business days), to include a formulation of how the proposed treatment plan will target the symptoms impeding the patient's trial competency. If the patient has recently had an initial psychiatric assessment in EASS within 14 days of admission to the JBCT, it can be reused for this purpose. However, initial assessments completed for patients in other programs unrelated to trial competency restoration are insufficient to meet this requirement.
- Meet all patients on their caseload weekly, although more frequent appointments will be available as needed.

- Document the rationale for their diagnostic formulation.
- Document the rationale for the prescribed psychotropic medications, including consideration of the degree to which treatable symptoms are currently impacting the patient's trial competency.
- Complete a progress note for each patient visit.
- Order and review necessary laboratory tests, including to ensure medication compliance.
- Obtain a patient's written or documented verbal consent to the medication when the patient retains the capacity and right to make decisions about their medication. In cases where the patient does not retain the right to consent to medication, prescribers will still attempt to provide information to patients in order to give them the opportunity to give their assent for the medication.
- Use long-acting injectable medication when clinically and medically appropriate.
- Document reasoning when determining that medications that could be provided involuntarily are not currently medically appropriate or necessary for patients who have an IMO.
- Use the DSH Psychopharmacology Consultation Network (DSH PRN Consult) or other consultation sources independently they deem appropriate and as requested by DSH.
- Attend and participate in case conferences and treatment team meetings.
- Provide opinions regarding patients' capacities to make decisions regarding accepting or declining antipsychotic medication for all court reports.
- Opine, certify, and testify to a patient's capacity to consent to antipsychotic medication and current dangerousness through the Administrative Law Judge (ALJ) process, as needed. See *Administrative Law Judge (ALJ)* section on Page 35 and ***Appendix H***.

Nursing Services (for JBCTs with allocated nursing services)	Initial Assessment: Within 5 business days of admission Re-Assessment: Every 30 calendar days (from the date of the initial assessment)	Additionally, nurses are available to administer medications involuntarily as deemed clinically appropriate and acceptable per doctor's order for patients with a court order for the administration of involuntary medications.
Initial Psychologist Competency Assessment	Initial Assessment: Within 5 business days of admission Report: Within 10 business days of admission	See *Competency Restoration Assessment Requirements* on page 22. If a competency assessment has been completed by EASS within 14 days of the admission to the JBCT program, this can be used as the initial assessment and subsequent assessments shall be monthly following the date of the EASS assessment. In these circumstances the treatment team will use the EASS assessment to develop the initial treatment plan, and the psychologist will document the review of the assessment and the date the next assessment is due in the medical record within 5 business days of the patient's admission.

30-Day Competency Re-Assessment	Every 30 calendar days (from the date of the initial assessment) at minimum	Re-evaluations should occur whenever there is evidence that the patient's competency status has changed, without waiting for the next scheduled evaluation. Interim competency assessments do not need to follow the court report template, though they should clearly indicate what instruments were used to structure the assessment of trial competency or related concepts (e.g. response style) and the reasoning to support the decision that a patient remains incompetent but likely to be restored (if they were competent or unlikely a court report would be completed instead). Additionally, they should be sufficiently titled and/or formatted to be *clear* at a glance that they are not court reports and have not been submitted to the court. If a patient declines to engage in formal interview, the scheduled assessment should still outline the relevant data supporting the opinion that the patient remains incompetent but restorable, as well as any plans to increase compliance.
Collateral Contacts	As appropriate and necessary to clarify the team's formulation, assessments, and treatment plans.	JBCT staff request the client's consent for release of information prior to making any collateral contacts. A current, valid legal authority to release information consistent with HIPAA and state law, whenever possible via a valid release of information signed by the patient, will be documented in the patient's chart prior to any collateral contacts. Best practices in competency assessment indicate that, as a part of the competency evaluation, evaluators should contact defense counsel (if the patient gives consent) to understand why the patient was deemed incompetent to stand trial and gather any other information relevant why doubt was raised and what the demands of the case are likely to be. JBCT staff shall seek collateral information from other sources (e.g. past treatment providers, family members, correctional facilities, military records, school records, etc.) when necessary (assuming the patient provides consent) to inform case and diagnostic formulation, assessment, and treatment planning.

		All collateral contacts and attempts at collateral contacts shall be documented in the patient's medical record.

COMPETENCY RESTORATION ASSESSMENT REQUIREMENTS

All patients will receive an initial assessment of trial competency within 5 business days of admission to ascertain patient progress toward competency and to inform treatment planning. Subsequent assessments of trial competency will be completed at least once every 30 days (from the date of the initial assessment), or sooner if it is believed that the patient may have restored to competency. If a competency assessment has been completed by EASS within 14 days of the admission to the JBCT program, this can be used as the initial assessment and subsequent assessments shall be monthly following the date of the EASS assessment.

Forensic Focus

Following best practices in forensic mental health assessment, the psychologist must maintain a focus on assessing the patient's competence to stand trial. That is, the psychologist must stay within the bounds of answering the question of whether the patient is "unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner." For this reason, the competency assessments and court reports should not include information unrelated to assessment of current trial competency, especially when that information may be related to other forensic issues, such as culpability, violence risk assessment, and/or criminal responsibility.

Assessment Focus

The JBCT psychologist will administer psychological assessments, semi-structured interviews, and/or standardized forensic assessment instruments for every newly admitted patient to gather information about the patient's background and ascertain the patient's current functioning, competency to stand trial, barriers to restoration, and likelihood of malingering.

Assessment of Trial Competency

Competency assessments are completed by the JBCT psychologist. Registered psychological associates working under an unlicensed clinician waiver are permitted to administer assessments under a licensed psychologist's supervision. Registered psychological associates working under an unlicensed clinician waiver are also able to write court reports, but the court reports must be reviewed and co-signed by a licensed, supervising psychologist. The following are core aspects of all competency assessments:

- Clinical Interview
- Mental Status Examination
- Consideration of the validity of the data obtained (see below)
- Use or attempted use of structured or semi-structured assessments of trial competence, such as, but not limited to:
    - Evaluation of Competency to Stand Trial-Revised (ECST-R)
    - MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA)
    - Fitness Interview Test – Revised (FIT-R)
    - Revised – Competence Assessment Instrument (R-CAI)

Consideration of Malingering

Consideration of the forensic context and potential incentives to feign or exaggerate symptoms and deficits should be included in every assessment of trial competency. Assessment of response style and the validity of a patient's presentation begins at admission and continues throughout a patient's treatment. It is a best practice to utilize a formal screening instrument to assess for feigned or exaggerated symptoms, if suspected, during a patient's stay. At minimum, the JBCT psychologist reviews all relevant documentation, interview data, and collateral data (including reports from colleagues) and conducts an analysis of the likelihood of feigning at each encounter. If the evidence does not support a likelihood of feigning, the psychologist briefly documents their reasoning in their assessment. However, if there are clinical indications that suggest that there may be an increased likelihood of invalid responding (concerns about feigning from past evaluators, inconsistency of reported and observed symptoms, reported desire to move to a state hospital, concerns raised by other team members, extreme or uncommon symptoms, etc.) the psychologist will utilize or attempt to utilize one or more screening tools assessing response style and symptom validity, such as, but not limited to:

- The Miller Forensic Assessment of Symptoms Test (M-FAST)
- The Atypical Presentation Scales of the ECST-R
- Rey-15 Item Test
- Structured Inventory of Malingered Symptomatology (SIMS)
- b Test
- Dot Counting Test

When potential feigning or exaggeration is suggested by the results of formal screening measures (described above), patient history (e.g. a history of being diagnosed as malingering or if the presentation grossly deviates from the reported history), or staff observation, JBCT psychologists administer or attempt to administer formal assessment measures related to the symptoms and deficits claimed by the patient. These may include, but are not limited to:

- Structured Interview of Reported Symptoms-2 (SIRS-2)
- Inventory of Legal Knowledge (ILK)
- Test of Memory Malingering (TOMM)
- Test of Malingered Incompetence (TOMI)
- Validity Indicator Profile (VIP)

JBCTs are required to have, at minimum, the M-FAST, SIRS-2, ILK, and TOMM available for assessment of potential feigning. Additional observational data reported by various disciplines should also always be integrated into the assessment and final report and considered when determining whether a patient is feigning or exaggerating.

In cases of potential feigning in which the patient refuses to engage in treatment or the evaluation, a formal assessment of symptom validity will be difficult to complete. The psychologist and treatment team should gather observational data regarding the patient's symptom exaggeration or feigning to be used to as part of determining if a malingering diagnosis is supported and move forward with submitting this information in the court report. Team coordination and collaboration in evaluating symptoms and abilities of concern and intentional observation of the patient's opportunities to display or fail to display these symptoms and abilities are crucial in these instances. DSH Consulting Psychologists are available to provide consultation in these cases as well.

Assessment of Cognitive Functioning

If a potential cognitive impairment is presenting a barrier to restoration, cognitive screening/assessment will be administered, and the results will be used to inform and direct the treatment team's competency restoration approach. The JBCT will use cognitive screenings and/or assessments, such as, but not limited to:

- Montreal Cognitive Assessment (MoCA)
- Folstein Mini Mental Status Exam (MMSE)
- Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)
- Wechsler Abbreviated Scale of Intelligence – 2nd Edition (WASI-II)
- Reynolds Intellectual Assessment Scales – 2nd Edition (RIAS-2)
- Wechsler Adult Intelligence Scale – 4th Edition (WAIS-4)

It is not within the JBCT programs' expected scope of work to conduct full neuropsychological assessment batteries on patients, but programs are expected to conduct cognitive screenings and assessments for patients with cognitive impairments to inform treatment. In these cases, efforts should be made to obtain relevant collateral information to inform assessments of the causes, severity, consistency, stability, and remediability of presumed deficits (e.g. past testing results, hospital records, family reports of changes in presentation, etc.). When the working formulation is that cognitive deficits present a barrier to trial competency, the team's working diagnostic formulation should reflect and/or explain the deficits (e.g. a diagnosis of a primary neurocognitive disorder or a discussion of reported declines in functioning consistent with the long-term impact of schizophrenia on cognition).

Content and Quality of Court Reports

JBCT reports to the court are grounded in the assessments described above. All certifications and court reports will utilize templates provided by DSH. Only DSH approved, templated certifications and court reports may be used for court correspondence. The JBCT is not authorized to send correspondence to the court that is not a DSH approved court letter or report. If the JBCT determines that they need to provide information to the court that is not reflected in a DSH approved, templated certification or report, the JBCT will contact their assigned DSH Consulting Psychologist for assistance.

Court reports must be detailed, informative, and accurate. Furthermore, all court reports must:

- Contain an opinion that is well supported by evidence and grounded in data
- Include a qualifying diagnosis and defense of that diagnosis, including consideration and evaluation of potential feigning
- Provide the court substantive evidence for decision making about a patient's current competency status, including how symptoms of any diagnosis provided are or are not impairing the patient's relevant abilities
- Document all relevant attempts to conduct formal assessments and to seek collateral information when the patient declines to participate (e.g. attempts to obtain the patient's consent to speak to their family, attempts to administer a screening tool, incentive plan changes to achieve compliance, etc.)
- Include any relevant outcome data from assessments cited in the report (e.g. ECST-R scale results)
- Contain minimal jargon, spelling and grammatical errors
- Be based on multiple sources of information/data
- Be signed by a licensed psychologist. For registered psychological associates working under an unlicensed clinician waiver, court reports must be reviewed and co-signed by a supervising psychologist

COURT CORRESPONDENCE

After a patient is admitted into the JBCT, the program is responsible for keeping the court informed of the patient's progress in treatment through filing statutorily required reports to the court at specific timeframes until a final disposition is reached. The list below includes documents to be filed with the court as required by statute or DSH:

1. Admission Letter
2. 21-Day Extension Letter
3. Penal Code section 1370(b)(1) – Retain and Treat Letter and Report
4. Penal Code section 1372(a)(1) – Restored to Competency Letter and Report
5. Penal Code section 1370(b)(1)(A) – Unlikely to Restore Letter and Report
6. Penal Code section 1370(c)(1) – Maximum Commitment Letter and Report

Templates for these documents are provided by DSH. JBCT programs use the most current version of these templates, and no alterations are to be made in the templates without DSH's approval. No other official documentation should be submitted to the court without DSH approval. All correspondence to the court should be provided to DSH via the current approved process (via upload to the JBCT Application at the time of the publication of this document) at the time of submission to the court. Correspondence to the court is to be signed or co-signed by the JBCT Program Director or designee, consistent with the JBCT Court Report Templates.

If the JBCT receives any official communications directly from the court (e.g. a minute order) without it being provided through PMU, the JBCT will provide the document to PMU immediately upon receipt via the current approved communication method (at the time of writing via uploading to the Documents section of the JBCT Application with an email to the PMU Patient Navigator). The document will also be reviewed by the JBCT Program Director for determination of whether immediate action or escalation through the Consulting Psychologist is necessary. This includes any order for involuntary medication obtained via a non-DSH involved process (e.g. via the process outlined in PC 2603).

Correspondence	Timeframe	Requirements
Admission Letter	On day of admission Never the day before admission	• The admission letter must be filed with the court on the day the JBCT admits the patient (no sooner or later than the day of the admission). • After the JBCT files an Admission Letter with the court, the patient cannot be removed or bypassed.
21-Day Extension Letter	Upon admission	If the patient is admitted into the JBCT program at or after the time the 90-Day Progress Report is due, a 21-Day Extension Letter is filed with the court upon admission to request additional time to complete the 90-Day Progress Report
1370 (b)(1) Retain and Treat Letter and Report	90 days from the commitment date or from the date of the first progress report (and at 6 month intervals thereafter)	Within 90 days of the date of *commitment*, the JBCT Program Director will submit to the court a letter certifying the patient's progress toward recovery of mental competence if the 90-day report has not yet been completed by another service (e.g. EASS, DSH Re-Evaluation) prior to the patient's admission to the JBCT. This certification will accompany a court report describing the patient's progress toward recovery of mental competence as well as the patient's capacity to consent to medication and need for an involuntary medication order. Subsequent Reports to the Court: • If the initial retain and treat report was authored prior to 90 days from the date of commitment, the next report is due to the court 6 months from the date of *the initial report.* • If the initial retain and treat report is completed on or after 90 days from the date of commitment, the next report is due to the court 6 months from *the date of commitment*.

1372 Restored Letter and Report	At any time during treatment	If a patient is opined to be restored to competence, the JBCT Program will file a 1372 Restored Letter and Report to the court no later than 7 business days after determining a patient is restored to competence.
1370(b)(1)(A) Unlikely to Restore Letter and Report	At any time during treatment	If the JBCT determines that there is no substantial likelihood that a patient will regain mental competence in the foreseeable future, the JBCT Program Director will submit an "Unlikely to Be Restored" Letter and PC 1370(b)(1) Report to the committing court within 7 days of this determination. A separate copy of the 1370(b)(1) Unlikely to Restore Letter must be provided to the committing county's Sheriff's Department to initiate transportation. The court report must also include a succinct summary of information about the patient's current level of dangerousness and ability to provide for their own food, clothing, and shelter. The intent is to share information already available to the team that would assist a conservatorship investigation and should follow the format in the current court report template.
1370(c)(1) Maximum Commitment Letter and Report	No later than 90 days prior to maximum commitment	The maximum term of commitment for a felony IST defendant is 2 years from the date of the court's commitment order (accounting for any previous periods in which the patient was found incompetent on the same charges), or the maximum term of imprisonment for the most serious offense, whichever is shorter. If the program is uncertain about the maximum commitment date, consult with PMU. 90 days prior to the expiration of a patient's term of commitment, if the patient has not been restored to competency, the JBCT Program Director or designee will submit a PC 1370(c)(1) – Maximum Commitment letter and report to the committing court. A separate copy of the 1370(c)(1) Maximum Commitment Letter must be provided to the committing county's Sheriff's Department to initiate transportation. The court report must also include a succinct summary of information about the patient's current level of dangerousness and ability to provide for their own food, clothing, and shelter. The intent is to share information already available to the team that would assist a conservatorship investigation and should follow the format in the current court report template.

DISCHARGE PROCESS

There are four common avenues by which a patient can be discharged from a JBCT program:

1. Penal Code section 1372(a)(1) – Restored to Competency
2. Penal Code section 1370(b)(1)(A) – Unlikely to Be Restored to Competency
3. Penal Code section 1370(c)(1) – Maximum Commitment
4. Redirect to State Hospital or other DSH facility

If a patient must be discharged from a JBCT program for any atypical reason, the JBCT Program Director must contact their assigned DSH Consulting Psychologist immediately and before the atypical discharge can occur.

Penal Code Section 1372(a)(1) – Restored to Competency

Pursuant to Penal Code section 1372, when the JBCT determines that a patient has regained mental competence, the Program Director will file a certificate of restoration with the committing court.

Pursuant to DSH JBCT Standards, a JBCT program will file a certificate of restoration with the committing court no later than 7 business days after determining a patient is restored to competency.

The procedure for filing a certificate of restoration with the committing court requires the JBCT to file with the court:

1. A certificate of restoration of mental competence letter, and
2. A Penal Code section 1372 court report documenting the patient's course of treatment and the opinion that the patient has been restored to trial competence.

The JBCT is required to maintain confirmation that all documents were sent and received by the court (e.g., fax cover sheet, certified mail confirmation, confidential electronic transmission, etc).

The JBCT will also upload a copy of the certificate of restoration of mental competence letter and PC 1372 report to DSH though the approved method (currently via the JBCT Application at the time of writing).

The committing county's Sheriff's Department will transport the patient back to court upon receiving a copy of the certificate of restoration of mental competence.

Pursuant to Penal Code section 1372, subdivision (c), requires that the patient be returned to the committing court no later than 10 days following the filing of the certificate of restoration, and the state will only pay for 10 treatment days for patients following the filing of the certificate of restoration of competence. This means that JBCT patients must be discharged from the JBCT, and returned to the county of commitment if different from the county in which they were treated, within this time frame.

If after 7 business days following the filing of the certificate of restoration of mental competence, a patient has not discharged from the program, the JBCT will contact the court by phone and/or email and document this communication and the action implemented by all parties to have the patient returned to court in a timely fashion.

Penal Code Section 1370(b)(1)(A) – Unlikely to be Restored

If the JBCT determines that there is no substantial likelihood that a patient will regain mental competence in the foreseeable future, the JBCT Program Director will certify this fact using the PC 1370(b)(1) Unlikely court letter and report and provide a copy of the letter and report to the court, with a separate notification (only the Unlikely to Restore letter) to the committing county's Sheriff's Department. The committing court must order the patient returned to the court for proceedings no later than 10 days following receipt of the certifying letter and report.

Requirement:	Submit to:
PC 1370(b)(1) Unlikely to Restore Letter and Report	Committing Court
PC 1370(b)(1) Unlikely to Restore Letter Only	Committing County's Sheriff's Department

Unlikely to Restore – Information Relevant to Conservatorship:

When opining that there is no substantial likelihood that a patient will be restored to trial competency, the JBCT will recommend that the court consider a conservatorship investigation. To support that investigation if ordered, the court report will include information of relevance to determining whether a patient presents a substantial risk of harm to others and whether the patient is able to provide for their own food, clothing, and shelter. It is the responsibility of the county to conduct the conservatorship investigation and it is not the responsibility of the JBCT to offer an opinion on whether the patient meets criteria for conservatorship, seek out additional information to support or refute that possibility, or to conduct a formal risk assessment. However, the JBCT should provide relevant information already known to its treatment team (e.g. violence while at the JBCT or in the previous six years, current known risk factors for violence, history of homelessness, current psychiatric symptoms likely to impact the ability to fulfill their basic needs, etc.).

Penal Code section 1370(c)(1) – Maximum Commitment

Ninety (90) days prior to the expiration of a patient's term of commitment, if the patient has not been restored to competency, the JBCT Program Director will submit a PC 1370(c)(1) – Maximum Commitment letter and report, following the steps outlined for an unlikely to restore report, above.

Redirect to State Hospital or Other DSH Facility

If the JBCT determines that the patient remains incompetent to stand trial and that there is a substantial likelihood that the patient will regain competency with further treatment within the DSH continuum of care, the JBCT program will:

1. Request that the patient be redirected to the State Hospital or another DSH facility by contacting the assigned DSH Consulting Psychologist to request a redirect review for consideration of redirect to the State Hospital.
2. Provide the Redirect Request Form, Transfer Checklist and all documents listed, and JBCT IMD Redirect Face Sheet to DSH via the currently approved method (at the time of writing via upload to Workspaces, later to be via the JBCT application).

The purpose of the redirect request form is to provide a succinct, detailed summary of the patient's course of treatment (including documentation of what pharmacological and psychosocial treatment trials were attempted and what assessments and consultations were completed to inform treatment), why further treatment at the JBCT is unlikely to lead to patient recovery in the near future, and why further treatment at a state hospital is likely to lead to the patient restoring to trial competency. It is meant to help programs ensure that they have engaged in all reasonable and expected approaches to restoration and a quick guide for the Consulting Psychologist to help speed packet review and approval.

The Consulting Psychologist will review the case and consult with the team regarding any further assessments or interventions that might allow for the patient's case to be resolved without a redirect to another facility or items that need to be addressed to ensure an effective transfer and to support continuity of care (see, also, Appendix G). If a patient is approved for a redirect to the State Hospital or another DSH facility, the patient will continue to receive all JBCT treatment services until the patient physically leaves the JBCT program for admission to the receiving facility.

If a progress report to the court is due by statute within 6 weeks of the date the redirect is submitted to the DSH Consulting Psychologist for review, or within 4 weeks of the approval of the redirect by the Consulting Psychologist, the JBCT is still responsible for submitting the report to the court in a timely manner.

In the event that a patient is acutely decompensating and the JBCT believes the patient's mental illness is causing complications that put the patient at risk of death or serious injury while awaiting admission to a DSH facility or otherwise can no longer be safely managed in the JBCT, the JBCT can request that a redirect be expedited. At the time of submission of the redirect packet, the JBCT will send an email requesting that the redirect be expedited with the reasoning for the elevated risk to the DSH Consulting Psychologist. If the DSH Consulting Psychologist concurs that an expedited redirect is necessary, they will work with PMU to achieve prompt admission. While DSH will endeavor to appropriately and expediently place the patient in an appropriate setting, timing may vary due to availability in specialized units, competing high risk priority patients, or other factors.

Discharge Continuity of Care

The JBCT is responsible for ensuring continuity of care when a patient is discharged from a JBCT program. This includes providing relevant documents (including, at minimum, psychiatric discharge summaries and relevant medical tests or documents related to major medical conditions) to receiving treatment providers, as well as responding to requests for contact from the receiving clinicians in the service of continuity of care and as allowed by HIPAA and other relevant privacy laws. This may include jail foundational mental health staff, DSH staff or contracted staff at other DSH facilities, or community service providers if known and if the patient is discharging directly to the community. If a patient is being discharged from DSH and directly to the local community, and the patient does not have or will not identify community providers, the JBCT will endeavor to provide contact information for relevant community support services (e.g. shelters, community clinics, etc.) as well as a supply of medications consistent with facility policy for released incarcerated persons. Additionally, if given sufficient notice of a patient's impending release the JBCT will assist the patient in applying for Medi-Cal if eligible and allowed by law and institution policy (e.g. by facilitating contact with the appropriate facility staff who assist in re-enrollment). Finally, JBCTs ensure the accuracy of discharge medications in the JBCT application prior to formally discharging the patient within the application.

REPORTING REQUIREMENTS

Special Incident Reports (SIR)

A Special Incident Report (SIR) is a formal notification to DSH whenever there is an occurrence that is potentially or actually physically and/or psychologically harmful to a patient and/or is inconsistent with the patient's expected behavior, conditions, treatment or care plan. SIRs are used for tracking patterns across patients and programs and for identifying areas in which DSH can support programs in process improvements or response to individual patient challenges in real time. A current list of incident categories requiring reporting is available in ***Appendix I***. However, the program can always utilize the "other" category to communicate any event they believe to be impactful to the patient or the program.

When an SIR occurs, the Program Director or designee is responsible for inputting the data via the currently approved method of communication to DSH. At the time of writing this method is via SIR logs sent directly to the DSH Consulting Psychologist monthly; in the future it will occur via the JBCT application and will communicate the information to DSH in real time. Thus, SIR entry should occur within 24 hours of the incident (or of the Program Director or designee becoming aware of the incident if that is delayed or occurs on a weekend or holiday). DSH Consulting Psychologists will regularly review the information and provide feedback if patterns or potential process improvements are identified. These may be provided informally or formally (e.g. via an action plan in a site visit report, via a directive memorandum, etc.).

Some categories of incident are designated as "major SIR incidents" and require further analysis. A list of categories of major SIR incidents is also available in ***Appendix I***, though the DSH

Consulting Psychologist may instruct a program to complete a 1725a and 1725b form, or a program may independently choose to do so, for other occurrences that were not anticipated in the SIR list and that are considered sufficiently significant to require further analysis. When a major SIR incident occurs, the Program Director will:

1. Notify their DSH Consulting Psychologist by email before the close of the business day of the major SIR incident
   AND
2. Complete and submit the DSH 1725a form ("Special Incident Report (SIR) Narrative") to their DSH Consulting Psychologist within 72 hours of the major SIR incident.
   AND
3. Complete and submit the DSH 1725b form ("Special Incident Report – Staff Analysis") to their DSH Consulting Psychologist within 15 business days of the date of the incident (unless otherwise indicated in ***Appendix I)***.

The purpose of the 1725a form is to provide a timely, detailed reporting of the incident to DSH and to document the immediate changes (primarily focused on the safety and treatment plans for the patients involved) that were made in response to the incident. The purpose of the 1725b form is for the program to document a program review based on the incident, analyzing what occurred before, during, and after the incident and what changes the program has made or will make based on what was learned. Examples may include treatment plan changes (e.g. changing a patient's medication to a liquid form, referring for an expedited redirect, assessing for likelihood of restoration for a patient who has a new, terminal diagnosis, etc.), process improvements (e.g. changing the form or frequency of suicide risk assessments, initiating use of drug diversion panels, improving communication processes between clinical and custody staff, etc.), physical plant changes or technological improvements (e.g. caulking gaps to reduce ligature risks, only providing golf size instead of full size pencils, use of a secured medication cart, etc.) or any other change made based on lessons learned. The JBCT program will keep a copy of any 1725a and 1725b documents in a designated area that is separate from patient charts.

Real Time Communication of Patient and Program Information

The JBCT program is responsible for providing information about patient admissions and discharges, patient variables (e.g. diagnosis, IMO status), program variables, and outlook (e.g. estimated dates of admission for waitlisted patients, bypass decisions, etc.) to DSH . Previously this was accomplished via daily censuses and weekly patient workbooks. Presently, this information is provided within the JBCT Application for the Enterprise Data Platform. Information is to be updated in as close to real time as possible, and within the business day that decisions are made or information is acquired, with the exception of medication changes which can be inputted on a weekly basis. Periodically, DSH may provide additional avenues of information for real time reporting or additional instruction on timelines and requirements.

Estimated Dates of Admission (EDAs)

Patients who are pending admission to a JBCT program are placed on a waitlist according to the date that the court committed them to DSH for competency restoration treatment. This is known as the "Commitment Date." The JBCT program is required to provide DSH estimated dates of admission for patients who are on the JBCT waitlist pending admission.

EDAs are estimates. Therefore, occasionally, estimated dates of admission provided by the JBCT program change due to unforeseen circumstances. Regardless, the JBCT program must strive to provide DSH the most reasonable estimate. Estimated dates of admission should be based on the average wait until admission in addition to the JBCT program considering other factors such as awareness of patients discharging from the program as restored or redirected to the State Hospital. Current reported EDAs are to be reviewed and updated as needed daily within the JBCT Application.

Additionally, the JBCT is required to provide DSH estimated dates of admission upon request and no later than 2 hours after the request is communicated (if it is communicated during business hours and is not reflected in the JBCT Application).

Additional Documents

In addition to the above, the JBCT programs will provide the following to DSH through the currently approved process (via uploading in the JBCT Application at the time of writing):

- All correspondence to or from the court
- All JBCT screening denial forms
- All redirect documents

DOCUMENTATION

File Storage

Patient records are stored in accordance with state law and Health Insurance Portability and Accountability Act (HIPAA) requirements, and in accordance with the Confidentiality and Information Security Provisions set forth in Exhibit E of the JBCT Agreement between DSH and the County.

Raw psychological test data are stored in a separate, secure file and are not stored in the patient's central health record. If a program decides to digitize paper documents for records retention (including but not limited to raw test data), they remain separate from the primary patient record but also must be in a storage program that meets all HIPAA and other legal requirements.

JBCTs retain all patient records for a minimum of 10 years after the last time the patient discharges from the JBCT.

Patient Record

A formal patient record/chart exists for each active patient.

PMU will provide the JBCT program the 1370 commitment packet from the committing court. All relevant components of the 1370 commitment packet, including at minimum the commitment order, must be received by the JBCT program for all patients prior to admission.

PMU will also provide the following documents upon request if a JBCT program is *unable* to access these records themselves (e.g. out of county placements at a regional or statewide JBCT):

1. Jail medical and mental health records for the current incarceration
2. Jail classification records, including such items as: ADA information relevant to medically recommended bed assignment, history of institutional behavior, discipline, safety concern/custody issues, gang involvement and association, and Prison Rape Elimination Act (PREA) concerns.

The primary patient records include documentation of:

1. Initial competency evaluation by the JBCT Psychologist (e.g. a note indicating that the evaluation was conducted and the report is filed elsewhere and/or is to follow)
2. Follow-up forensic assessment(s)/psychological evaluation(s) of competency to stand trial (notes reflecting at minimum their completion, and may include substantive findings to inform treatment).
3. Initial psychiatric evaluation
4. Weekly follow-up psychiatrist progress notes
5. Nursing assessments and re-assessments (if applicable)
6. At minimum, weekly individual clinical contact/competency education progress notes
7. Group progress notes (with documentation when a patient refuses/declines to attend) indicating the group topic, the patient's presentation, and the patient's progress toward competency
8. Initial treatment plan
9. Updated treatment plans (at minimum every 30 days)
10. Medication consent forms
11. Court reports (e.g. a note indicating that a report was submitted to the Court)
12. Documentation of collateral contacts or attempts (e.g., attempts to get a patient to sign a release for a family member, use of a signed release to obtain collateral information from defense counsel, etc.)

All service provisions are recorded in the patient record. This documentation should indicate the nature of the service, as well as the patient's response/interaction.

Notes which document suicide risk, a significant suicide attempt, or self-harm incident shall be documented in the patient's record by the end of the business day and will include documentation of the risk mitigation and patient protection strategies implemented based on the patient's presentation. Refer to the Special Incident Report (SIR) and Suicide Prevention sections for further procedural expectations.

INVOLUNTARY MEDICATION PROCEDURES

Administration of Involuntary Medications

Pursuant to Penal Code section 1370, the court may issue an order authorizing the involuntary administration of antipsychotic medication to a patient. Typically, nursing/psychiatric technician staff are responsible for administering all involuntary court-ordered psychiatric medications. The JBCT program is expected to have available a procedure for the administration of involuntary court-ordered medications, which is to include procedures for monitoring the patient after medication administration via injection for a medically appropriate period of time. If the JBCT program or Sheriff's Department have questions about how to manage involuntary medication procedures, DSH is available to provide consultation and assistance.

The following general principles are followed by all JBCT programs when involuntary medication is administered via injection:

- All patients with a court order authorizing the involuntary administration of antipsychotic medication must first be given the opportunity to take the prescribed medication voluntarily before being involuntarily medicated via injection. Staff will make a reasonable effort to obtain the patient's cooperation with their prescribed medication regimen. Intermittent compliance with oral medications or accepting medications without ingesting them does not constitute voluntary compliance.
- Incentivized voluntary medication compliance is encouraged, and it is expected that the JBCT program has a policy and procedure for maintaining a contingency management program for voluntary medication compliance.
- Medication options will be explained to the patient in clear, straightforward language reasonably expected to allow the patient to understand what is occurring and exercise choice where and how choice is available (e.g. which arm to receive the shot in).
- After each instance of involuntary medication administration via injection, there is a reasonable period of time in which staff visually observe the patient, the patient's mental status, and vital signs.
- A follow-up evaluation by clinical staff is done the next business day if force is necessary to implement the injection.
- Clinical concerns must be immediately raised and addressed with a physician (treating psychiatrist, covering psychiatrist or physician, or emergency psychiatrist or physician).
- Thorough, accurate, and timely documentation of the involuntary administration of antipsychotic medication must be entered in the patient's chart.

Documentation of Involuntary Medication Decisions

The JBCT will enact policies and procedures to ensure that when a patient is admitted to the JBCT and the court has authorized administration of involuntary medication, within 14 days of admission either:

a. The treating medical professional prescribes psychotropic medications to be administered over the patient's objection if the patient does not voluntarily comply with administration. Custody and JBCT policies and procedures will ensure that involuntary medication is administered over the patient's objection, if necessary, beginning with the date of the medical professional's prescription and in a manner consistent with the principles above.

Or

b. The treating medical professional determines that medications that could be provided involuntarily are not currently medically appropriate or necessary for the patient and documents their reasoning in the medical record.

The JBCT will enact policies to ensure that when a patient is admitted to the JBCT without an order for involuntary medication and the JBCT subsequently petitions the court and an order is granted, within four business days of the date of the court's order either:

a. The treating medical professional prescribes medications to be administered over the patient's objection if the patient does not voluntarily comply with administration. Custody and JBCT policies and procedures will ensure that involuntary medication is administered over the patient's objection, if necessary, beginning with the date of the medical professional's prescription and in a manner consistent with the principles above.

Or

b. The treating medical professional determines that medications that could be provided involuntarily are not currently medically appropriate or necessary for the patient and documents their reasoning in the medical record.

Administrative Law Judge Process (ALJ) Penal Code section 1370(a)(2)(B)(i-iii)

When a patient is admitted into the JBCT program without an involuntary medication order, but the JBCT psychiatrist believes the involuntary administration of antipsychotic medication is medically appropriate, the psychiatrist with the support of the team will evaluate the patient's current capacity to consent to medication and dangerousness secondary to their mental illness

pursuant to PC 1370(a)(2)(B)(i). If the psychiatrist finds the patient meets the criteria the psychiatrist will certify this fact in a petition to the court to request an involuntary medication order for the patient through the ALJ Process. *Please read Penal Code section 1370(a)(2)(B)(i-iii) and section 1370(a)(2)(D)(i)*.

The current step-by-step DSH process for seeking an involuntary medication order is listed in ***Appendix H***. If the ALJ concurs with the psychiatrist's certification, the medication can continue to be administered involuntarily (if the patient refuses) for up to 21 days from the date of the initial filing. Within that time frame (or longer if the case is continued by the court), the patient's committing Superior Court will hear the issue and either continue the involuntary medication order for up to one year or vacate the order. If the ALJ does not concur with the psychiatrist's certification, the involuntary medication administration must be discontinued. In cases where the ALJ does not concur that the patient meets criteria for involuntary medication, DSH will consult with the JBCT to determine if the program will decide to petition the Superior Court on the same grounds (capacity and/or dangerousness) and/or under the criteria outlined in *Sell* based on the seriousness of the charge and the state's interest in prosecuting.

The DSH Consulting Psychologist and DSH Legal Division are able to provide support, consultation, and assistance through the entire ALJ process.

If an IMO is obtained through processes other than via the ALJ process, the JBCT will send a copy of the order to PMU through the process outlined above, and include it in in any redirect packets.

ADDITIONAL REQUIRED SERVICES AND PROCEDURES

Interpretation Services

The JBCT will accept non-English speaking patients and have the ability to access interpretive services through an in-person or call-in interpretation service. The JBCT will have access to translation services for essential forms and patient workbooks, and/or interpreter services for completion and use of those materials, in order to serve patients in their language of preference as required by law, regulation, and clinical judgment.

Subpoena Procedure

If a JBCT receives a subpoena duces tecum (a subpoena for records held by the JBCT), within one business day the JBCT Program Director (or designee) is responsible for sending the following via email to BOTH their Consulting Psychologist and to DSHSacSDT@dsh.ca.gov:

1. A copy of the subpoena
2. How the subpoena was received
3. Any relevant context known by the JBCT (if any)
4. Confirmation of what records the JBCT holds as listed in the subpoena
5. Any specific legal concerns or questions related to this subpoena

DSH will provide guidance about how any records should be provided before they are released.

If a JBCT staff member receives a subpoena for testimony, whether as a fact or expert witness, the staff member is responsible for responding to the subpoena and appearing as directed. If the subpoena is for a criminal case (most commonly for a hearing about a patient's current trial competence), DSH JBCT staff are available for consultation and support if requested. However, if the subpoena is for any other type of testimony (e.g. civil litigation, order to show cause, etc.) the JBCT shall inform the assigned DSH Consulting Psychologist of the subpoena within one business day of receipt.

Incentive Program

All JBCTs will develop and implement an incentive program for patients. At a minimum, the incentive program will be used to promote and incentivize voluntary medication compliance and engagement in treatment. JBCT programs may decide what types of incentives or rewards to provide to patients and will provide incentives on a scheduled basis to ensure proper contingency management and positive reinforcement. The JBCT will maintain a policy and procedure for contingency management.

Consultation Services

Consultation on cases in which patients do not make progress is a best practice in mental health care. JBCTs will have access to consultants in the relevant fields of forensic mental health. The DSH Consulting Psychologist can serve as one initial point of contact for consultation in most areas relevant to treatment at the JBCT, though programs may also have their own internal or external resources. However, for issues related to psychopharmacology, JBCT prescribing clinicians have access to the DSH Psychopharmacology Resource Network (PRN) consultants. DSH PRN consultants are experts in psychopharmacology who can provide resources and recommendations for treatment when patients are not improving sufficiently to restore to trial competency. They can be accessed by the prescribing clinician or the program director via the PRN@dsh.ca.gov email address.

Consultations are documented in a patient's medical record, either in a stand-alone form or in a progress note by the clinician who sought the consultation.

DSH Consulting Psychologists may provide or request that a program obtain consultation when a patient is not progressing or prior to approving a patient for transfer to a state hospital.

Laboratory Services

All JBCTs will have access to laboratory services to include, at minimum, all standard blood panels necessary to ensure safe dosing with antipsychotic medications and the ability to obtain medication serum levels with sufficiently rapid turn-around times to inform decisions around

dosing and to ensure medication compliance. Additionally, it is preferred that services include access to urine drug screens and urine medication diversion panels.

Medical Holds

If a JBCT patient requires medical treatment that must be provided outside of the JBCT and the prognosis and expected course of treatment are such that this outside treatment is anticipated to be required for weeks to months, the JBCT will consult with the DSH Consulting Psychologist. If the program and Consulting Psychologist concur, the program will place the patient on the medical hold list on the census, allowing the JBCT to admit another patient for treatment in the interim. When the patient being treated externally is ready to return, they will be provided the first available bed in the JBCT.

Attorney Communication Procedures

Current legal recommendations are that a commitment as incompetent to stand trial does not obviate considerations around confidentiality with respect to communications with prosecutors or defense counsel. Below are the current recommendations regarding how and when the program can communicate with each party:

Defense Counsel:
In general, a Release of Information (ROI) is required prior to disclosing patient health information to the patient's attorney under Welfare & Institutions Code section 5328(a)(10). That section, however, allows the release of said information if: (a) the individual is unable to sign the release, and (b) the staff of the facility identifies the attorney as such and that the attorney does, in fact, represent the patient. An individual may be "unable to sign" an ROI due to a physical or mental impairment. In the latter case, this may be due to incapacity, for instance, either he is unable to understand the nature of the document or he is unwilling to sign it due to active psychotic symptoms. A capacity assessment should be performed to determine if, due to his mental condition, he lacks the capacity to sign an ROI. If the finding is in the affirmative, then, staff should determine whether the attorney has been appointed by the court pursuant to a court order/minute order or the attorney is private counsel and has been hired by the individual or a family member to represent the individual. If this exception does not apply, absent an ROI, the defense counsel would either need to subpoena or obtain a court order for the information.

Prosecuting/District Attorney:
Under Welfare & Institutions Code section 5328(b), patient information may be provided to district attorneys, without an ROI, in connection with and for the purpose of: (a) commitment, (b) recommitment, or (c) petitions for release proceedings for patients committed under sections 1026, 1370, 1600, 2962 and 2972 of the Penal Code and section 6600 of the Welfare & Institutions Code. If neither (a), (b) or (c) apply, then the DA must subpoena the information or obtain a court order for the information.

DSH has also released patient information to the court on the status of commitment or relative to a proceeding, with notice to the DA and PD of the filing.

A health entity may disclose protected health information to comply with a court order, including an order of an administrative tribunal. Such disclosures must be limited to the protected health information expressly authorized by the order.

SUICIDE PREVENTION AND RESPONSE

It is the goal of DSH and the JBCT program to prevent patient deaths due to suicide.

All JBCT programs will have a written process and procedure for monitoring suicide risk, suicide prevention, and program response when risk is elevated or suicidal ideation or attempts occur. This suicide prevention and response procedure will be written in the JBCT program's internal policies and procedures and/or adopted from the Sheriff's Policies and Procedures. All JBCT clinical staff will be trained in the JBCT program's suicide prevention and response procedure.

All JBCT clinical staff are required to complete a training in suicide prevention. The training must be a minimum of 1 hour every 2 years. JBCTs will submit proof of completion of this requirement to their assigned DSH Consulting Psychologist upon request.

The JBCT program will submit their suicide prevention and response procedure to DSH for review and approval whenever the policy is updated or modified, and upon request of DSH.

MORTALITY REVIEW PROCESS

It is important for JBCT programs to follow a standardized procedure when the death of a patient occurs. The following Mortality Review (MR) process will be used for the review of all patient deaths that occur in a JBCT program. The MR process provides a confidential forum for evaluation and discussion regarding facility operations and patient care.

Mortality Notification

Immediately upon notification of a patient death in the JBCT program, but no later than close of business on the day of the patient's death, the JBCT Program Director or designee will notify the assigned DSH Consulting Psychologist.

Mortality Review - Special Incident Report (SIR) Log

The JBCT Program Director will document the patient death via the SIR process, including submitting DSH form 1725a to their assigned DSH Consulting Psychologist no later than 3 business days from notification of a patient death. This will be followed by a DSH form 1725b which outlines steps, interventions, and decisions that the program made before or after a patient's death that can be used to identify gaps in processes and improve patient care.

In addition to the 1725a and 1725b, the JBCT program will submit the Coroner's Report of the patient's death to DSH as soon as it is received.

Postmortem Patient Record Charting

The JBCT Program Director will supervise necessary additions to the patient record by JBCT staff and ensure that any additional progress notes or documentation to the patient record after the patient's death are identified as being made "post-death."

Mortality Review Meeting

The MR meeting is intended to evaluate the quality of care provided to the deceased patient as well as to identify factors that may have contributed to the death and/or indicate possible gaps in services and to recommend and/or implement corrective actions to improve the performance of staff and quality of care at the JBCT program.

During and after the MR meeting with the JBCT Program Director and any other relevant stakeholders, the assigned DSH Consulting Psychologist may request relevant documentation to review, such as, but not limited to:

- Any Penal Code section 1370 (b)(1) or (c)(1) or 1372(a) court reports
- Medication Administration Record (MAR)
- Discharge Summary
- DSH Psychiatric Acuity Review documentation
- Nursing notes or other documentation of medical care provided
- Clinician notes
- Psychologist notes and/or reports
- Psychiatry notes and/or evaluations
- Group notes
- Treatment team notes

The Mortality Review Report

Upon gathering information from the JBCT program regarding the patient's death, the DSH Consulting Psychologist will take part in a case consultation with the DSH JBCT Chief Psychologist, DSH JBCT Assistant Chief Psychologist, and any other appropriate DSH party to determine if the circumstances surrounding the death warrant the completion of a formal Mortality Review (MR) Report to be completed by the DSH Consulting Psychologist. Examples of these types of cases include, but are not limited to:

- Patient suicide
- Physical accident resulting in death

If it is concluded that the death meets criteria for a Morality Review Report, the DSH Consulting Psychologist will use the documents named above, in addition to interviews with JBCT staff to compile a report which may outline the following sections:

1. Files reviewed
2. The patient's identifying information including DOB, CII number, case numbers, commitment date and date admitted to JBCT program)
3. Short description of alleged offense
4. DSM-5-TR diagnosis
5. Psychotropic medication prescribed
6. Summary of psychiatric presentation
7. Chronology of events
8. Compliance review
9. Recommendations

Upon completion of the MR Report by the DSH Consulting Psychologist and approval by the DSH Chief Psychologist the finalized MR Report will be provided to the Sheriff's Department and JBCT Program Director. If the report includes any corrective action plans (ideally arrived at collaboratively with the program based on any deficiencies identified in the MR), the Sheriff's Department and/or JBCT Program Director will present DSH with an implementation timeline or a proposed alternative plan to address the deficiencies identified in the report within 10 business days of receipt of the MR Report, both subject to DSH approval. DSH will approve or deny the proposed timeline or proposed alternate corrective action plan within 10 business days of receipt. Other details regarding approved and rejected proposed correction actions from the Action Plans and Corrective Action Plan section of this manual will apply to the MR process.

Additional meetings may be scheduled as requested by either party.

DSH SITE VISITS

Purpose

DSH conducts site visits to support the JBCT programs and ensure that all program requirements relevant to safe and effective assessment and treatment are being implemented within the JBCT program.

DSH Representation

DSH site visits are led by the JBCT program's assigned DSH Consulting Psychologist. Site visits may also include other DSH JBCT Unit staff such as the DSH Community Forensic Partnerships Division Deputy Director, Assistant Deputy Director, Chief Psychologist, Assistant Chief Psychologist, Consulting Psychologists, Program Managers, or Program Analysts.

Frequency

Site visits occur on a schedule established by DSH. At the time of writing, this is approximately every fiscal quarter. However, site visits may occur more frequently as necessary and deemed appropriate by DSH. At present, two site visits will typically occur on-site and two site visits will occur virtually each year, but the number of visits and ratio of in-person to virtual visits may vary at the discretion of the Consulting Psychologist and DSH.

Pre-Visit Information

DSH may request from the Sheriff's Department and/or JBCT program reasonable information relevant to the reason for the site visit. Examples of such requests are:

- Medical or mental health information for a specific patient
- The JBCT group schedule
- JBCT staffing, staff names, and working hours/FTE
- Contact information for relevant Sheriff's Department and/or JBCT program staff
- Treatment team notes and documentation
- Treatment plan documentation
- Invoices and/or actual expenses for JBCT program items
- Relevant JBCT subcontracts
- Internal JBCT policies and procedures
- Sheriff's Department policies and procedures relevant to JBCT operation
- Program pictures

Scope of Visit

Site visits may include, but are not limited to:

- Meetings with Sheriff's Department representatives, JBCT subcontract or county staff, court personnel, as well as ancillary meetings with the State Hospitals, the Patient Management Unit (PMU), the DSH Research, Evaluation, and Data Insights (REDI) branch, and other relevant partners as deemed appropriate
- Review of patient charts and documentation
- Interviews with JBCT and relevant Sheriff's Department administrative and clinical staff
- Interviews with active JBCT patients
- Observation of program operations such as treatment groups, individual sessions, treatment team meetings, and staff meetings.
- Tour of the facility, the JBCT unit, and other relevant Sheriff's Department units (i.e., medical unit, intake, booking, etc.)
- Review of the JBCT program's overall administrative and treatment operations
- Review of the program's adherence to expected standards of practice as described in this DSH JBCT Policy and Procedures Manual
- Assessment of the program's performance and compliance with contractual scope of work and data reporting requirements
- Evaluation of the accuracy, comprehensiveness, and clinical judgement evident in documented provision of treatment services and court reports
- Inspection of the jail facility and treatment unit for compliance with contractual obligations, overall security, and conformity to JBCT policies.

Final Site Visit Summary Report

Within 30 days of a site visit, a Site Visit Summary Report will be provided to the Sheriff's Department representative(s) and/or JBCT Program Director and/or JBCT Program Director's Supervisor. The report may contain recommendations and observations related to findings from the site visit.

Action Plans and Corrective Action Plans

When a site visit or other program review identifies a need for program improvements based on adherence to the contract, patient needs and outcomes, best practices in the field, or other reasons, ongoing collaboration towards program improvement can occur in a number of ways. This may include email communication, meetings, phone calls, or written agreements or instructions. Action plans are not meant to be punitive and do not necessarily indicate a breach of contract or policy, but may reflect identified opportunities for improvement. Whenever possible, DSH will work collaboratively with the JBCT to identify the root cause of the issue and to develop plans to address it. DSH may set timelines for required responses, as well as for completion of steps to resolve the root issue.

Major deviations from policy that cause significant or immediate risk to patient welfare or substantially undermine program processes and outcomes will result in corrective action plans. Corrective action plans will be identified by title and will always be communicated in writing to both the clinical staff (including managerial staff as appropriate) and our custody partners. The program director will also be informed of the corrective action plan either in person or via telephone on or before the day the written plan is sent. Corrective action plans require immediate response and action by the JBCT to eliminate the imminent risk or program impairment. A plan to avoid recurrence must be submitted to DSH within 14 days and is subject to approval by DSH. If a proposed response to a corrective action plan is not approved by DSH, DSH will provide explicit requirements to bring the program back into compliance. Failure to make corrections in response to a corrective action plan may constitute a breach of contract.

JBCT INTERNAL QUALITY ASSURANCE

Internal Quality Assurance

The JBCT program will maintain written procedures for internal quality assurance to monitor the provision of treatment services, timeliness, and quality of court reports and documentation.

The JBCT Program Director is responsible for ensuring that program staff are oriented to the internal JBCT policy and procedures manual as well as this DSH JBCT policy and procedures manual.

The JBCT Program Director will ensure that all new JBCT staff will be provided an orientation to the JBCT program and working in a jail setting including, but not limited to: the *Dusky* standard, relevant IST penal codes and statutes, jail safety, and suicide prevention and response.

The Sheriff's Department and/or JBCT Program Director will also ensure that all new custodial staff are oriented to the mission of the JBCT program, therapeutic needs of the population, conflict resolution skills, involuntary medication procedures, treatment team attendance and structure, and the required 4 hours of therapeutic treatment per day Monday through Friday. The Sheriff's Department will ensure that all new custodial staff complete Crisis Intervention Training (CIT).

Internal JBCT Policies and Procedures Manual

In addition to the use of this DSH JBCT Policies and Procedures Manual, the JBCT programs will maintain internal policies and procedures necessary for the administrative and clinical operation of their particular program, where local procedures are necessary for operational clarity. Internal policies and procedures must also include the JBCT program's process and procedure for suicide prevention and response.

DSH REQUIRED MEETINGS AND TRAININGS

Quarterly Program Director Meetings

DSH will host a Quarterly JBCT Program Director meeting. Three meetings will be held virtually and one meeting may be held in-person. The Quarterly Program Director meeting attendees will include all JBCT Program Directors and relevant lead Program Director designees. Attendance is strongly encouraged as information will be shared relevant to program procedures and expectations. Prior to a scheduled Program Director meeting, the JBCT Program Director or designee will notify DSH if the Program Director or designee is unable to attend. Failure to consistently attend the Quarterly Program Director meetings may result in action or corrective action plans for the Sheriff's Department and/or JBCT Program Director to respond to.

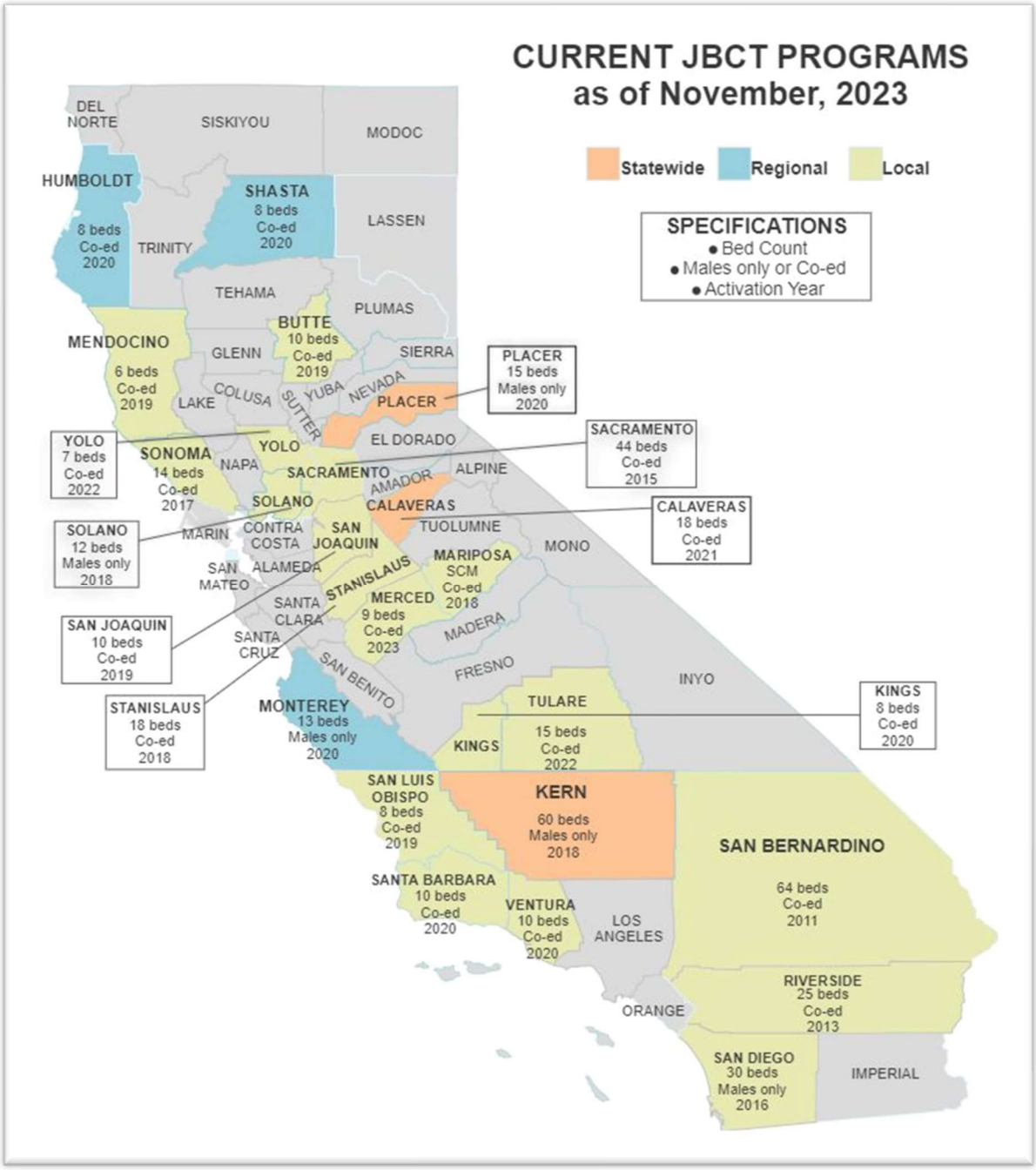
The meeting is intended to discuss topics relevant to JBCT operation and may include topics such as, but not limited to:

- Clinical best practice topics
- Legal topics
- Privacy and HIPAA
- Correctional setting topics
- Training information
- Policy updates
- New program activations and changes

DSH Sponsored Trainings

Occasionally, DSH may host virtual or in-person forensic trainings. If DSH notifies staff that the sponsored forensic training is required, the JBCT Program Directors and/or designee(s) and other identified clinicians if specified are required to attend the training. The DSH Consulting Psychologists will notify the JBCT program of the dates of any DSH sponsored, required forensic trainings.

Appendix A
Map of Jail Based Programs as of Publication



Appendix B
Court Report Content Requirements

Although psychologists organize their forensic evaluation reports in many different formats, best practices for competence to stand trial report writing[1] indicates that any competency evaluation report should contain, at a minimum, the below outlined information.

1. Relevant case and referral information	• Patient name • Case number • Date of commitment
2. Notification	• General description of the notification of rights provided to the patient
3. Summary of the alleged offense	• From official documents such as the police report, not the patient's self-report
4. Data sources	• All data sources used for the evaluation • Collateral interviews (if relevant)
5. Background information	• Just those facts pertinent to adjudicative competence and restoration
6. Clinical assessment	• Mental status exam • Any relevant clinical information • Observations about the patient's mental health and functioning
7. Response to treatment	
8. Psychological tests and assessments administered	
9. DSM-5 diagnosis	• To include consideration of malingering
10. Opinion (including reasoning to support the opinion)	• Opinion on competence pursuant to Penal Code section 1367, subdivision (a), and the *Dusky* Standard • Opinion on need for involuntary administration of psychotropic medication, if applicable
11. Signature of the evaluator	• A licensed psychologist

In order to ensure that court reports follow these guidelines and are informed by best practices in competency assessment , all reports to the court will be completed on the current DSH distributed template.

[1] Zapf, P. A., & Roesch, R. (2009). Best practices in forensic mental health assessment: Evaluation of competence to stand trial. New York: Oxford.

Appendix C
What and When to Submit

Activity	What to Submit	When to Submit
Suitability for admission	Screening Assessment completed via the JBCT EDP Application, including a screening assessment – denial form if the patient is denied.	Single County JBCT: within 3 calendar days Regional JBCT: within 5 calendar days Statewide JBCT: within 5 calendar days
Admission	Admission Letter to Court	On the day of admission (no sooner or later than the day of admission)
90-Day Progress Report	*Depends on disposition:*	
	1372(a)(1) letter and report opining a patient is restored to competency	As determined – **within 7 days of the date of the assessment finding the patient competent**
	1370(b)(1) letter and report opining a patient remains incompetent but substantially likely to be restored	See the Court Correspondence section above for required timelines
	1370(b)(1) letter and report opining that there is no substantial likelihood that a patient will restore to competency	As determined – **within 7 days of the determination that there is no substantial likelihood of restoration**
	1370(c)(1) letter and report indicating that a patient is nearing their maximum date of commitment and thus is unlikely to restore to competency	No later than 90 days prior to the expiration of the patient's term of commitment
Redirect to State Hospital	Transfer packet sent through Workspaces to DSH assigned CP for approval.	As soon as possible

Appendix D[2]

JAIL BASED COMPETENCY TREATMENT PROGRAMS SUMMARY OF REQUIRED SERVICES		
SERVICE	**FREQUENCY AND DURATION**	**MANUAL PAGE**
CORE TREATMENT		
Group Treatment/Schedule	Offered Daily • Minimum of 4 hours of group treatment Monday through Friday, with at least one hour of competency restoration training four days per week	p. 14
Individual Treatment and Competency Education	Daily Check-In • Daily check-in can range from 3-10 minutes Weekly • Individual sessions can range from 10 minutes to 50 minutes	p. 16
Treatment Team Meetings	Weekly	p. 18
Treatment Planning	Initial treatment plan = within 7 business days of admission Updated treatment plan = every 30 calendar days thereafter (plus or minus 5 days)	p. 17
Review of Charges and Police Report with patient	As determined after stabilized but typically within 2-3 weeks of admission	p. 18
PSYCHIATRIC AND NURSING SERVICES		
Initial Psychiatric Evaluation	Evaluation = within 5 business days of admission Report = within 10 business days of admission	p. 18
Psychiatric Follow-Up	Weekly individual sessions	p. 18
Nursing Services (for JBCTs that have allocated nursing staff)	Initial assessment = within 5 business days Re-assessment = every 30 calendar days	p. 19

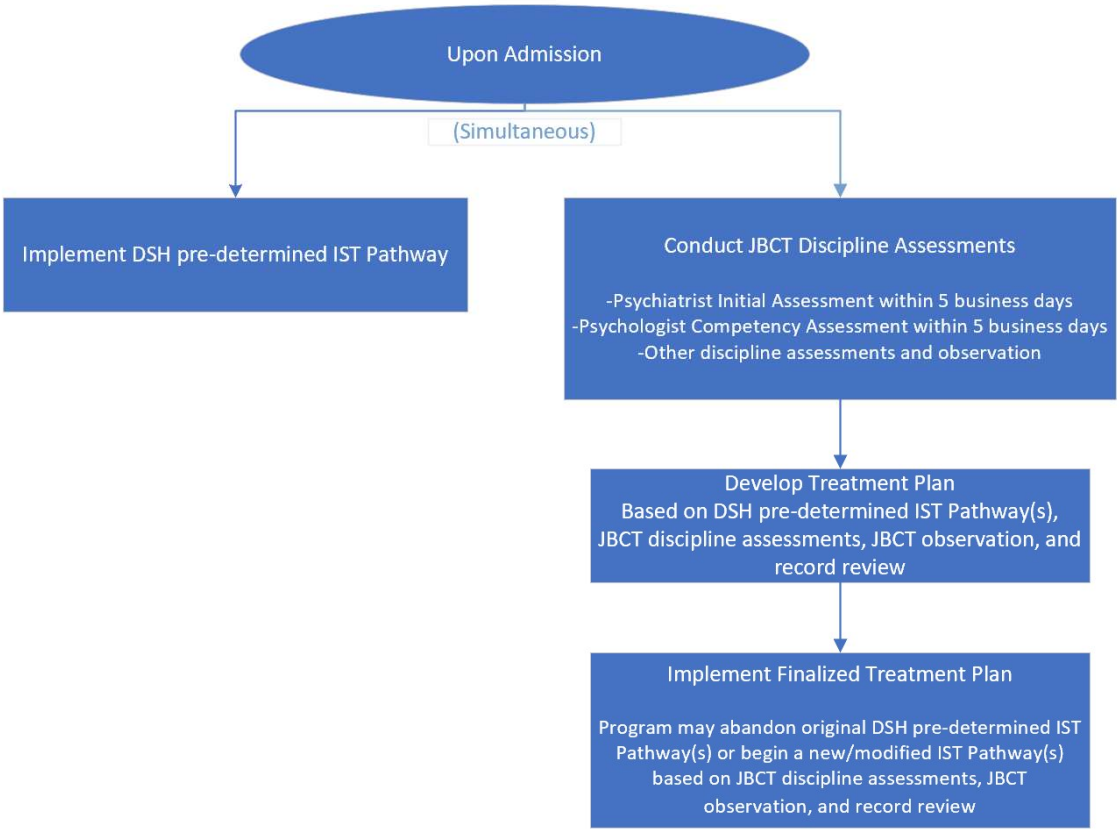
[2] Please note that this list is non-exhaustive, but instead covers the core and common requirements. Please review the entire Policies and Procedure Manual as needed for additional requirements.

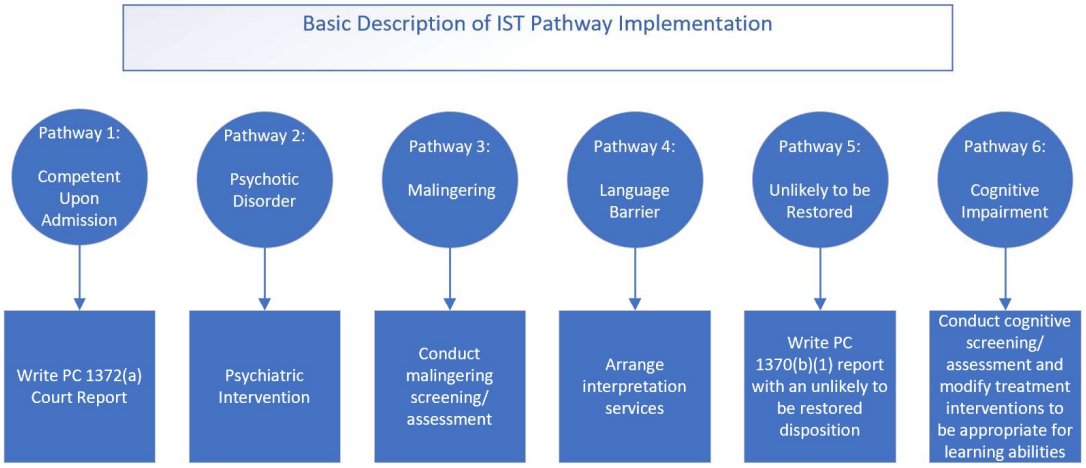
PSYCHOLOGICAL AND COMPETENCY ASSESSMENT		
Initial Competency Assessment	Initial Assessment = within 5 business days of admission Report = within 10 business days of admission	p. 19
30-Day Competency Re-assessment	Every 30 calendar days (from the date of the initial assessment)	p. 20
TRIAGE		
Screening Assessment	Local Programs = patient screened, and decision rendered no later than 3 days of receipt from PMU Regional and Statewide Programs = patient screened, and decision rendered no later than 5 days of receipt from PMU	p. 8, 9
COURT CORRESPONDENCE		
Admission Letter	On day of admission (no sooner or later than the day of the admission)	p. 26
1372 Restored Letter and Report	At any time during treatment	p. 27
1370 (b)(1) Retain and Treat Letter and Report	90 days from the commitment date (and every 6 months thereafter, either from the date of the 90 day report or from 90 days after the date of commitment, whichever is earlier)	p. 26
Unlikely to Restore Letter and Report	At any time during treatment	p. 27
1370(c)(1) Max Commitment Letter and Report	No later than 90 days prior to the maximum commitment date	p. 27
OTHER REQUIREMENTS		
Treatment Progress Notes	Following the provision of any service, progress notes are recorded in the patient's chart.	p. 33
Competency Workbook	All patients are provided a competency education workbook upon admission.	p.13
Interpretation Services	• Workbooks for non-English speaking patients are available. • The JBCT has access to interpretation services.	p. 37

Incentive Program	Maintain a contingency management program for voluntary medication compliance and other treatment engagement.	p. 38
Involuntary Medication	JBCTs implement and enforce IMO's as appropriate and have a policy covering this process. JBCTs evaluate patient need for an IMO and pursue one through the ALJ process as appropriate.	p. 35
Subpoena Procedure	JBCTs inform DSH of any subpoena duces tecum received and any subpoena related to anything other than the patient's current trial competency to receive instruction and guidance. DSH is available to provide consultation on any subpoenas related to trial competency.	p. 37
Redirect to the State Hospital	If patient is no longer making progress in the JBCT program and would be more suitable for treatment in a State Hospital, the JBCT can initiate a transfer by requesting a redirect through the assigned JBCT Consulting Psychologist	p. 30
Special Incident Reports (SIRs)	• Document SIRs via the currently approved method (at the time of publication via monthly reports to Workspaces) • Report significant incidents that occur in the JBCT program to DSH staff and complete a 1725(a) form within 72 hours of the incident. Follow up with a 1725(b) form within 15 days of the incident.	p. 31

Appendix E:
IST Pathways Implementation and Determination

1. Upon a patient's admission to the JBCT, the Treatment Team will review, discuss, and implement the DSH pre-determined IST Pathway(s).
2. Simultaneously, the Treatment Team will conduct discipline-specific assessments, observation, and a record review to evaluate and determine the patient's IST Pathway(s).
3. Also, upon admission, the Treatment Team will begin delivery of competency restoration services based on the DSH pre-determined IST Pathway(s).
4. No later than 30 days after admission, the Treatment Team will reconvene to discuss the results of each disciplines' initial impressions and assessments. The Treatment Team will review the support/evidence that the patient meets criteria for one or more IST Pathway(s) and will make a final decision to select the patient's IST Pathway(s).
5. Finally, the Treatment Team will implement the final, determined IST Pathway(s), which may include maintaining or abandoning the DSH pre-determined IST Pathway(s).





*Interventions should continue to elaborate based on this basic diagram

Appendix F
Quick Reference Guide:
JBCT Program Director notifications to DSH Consulting Psychologist

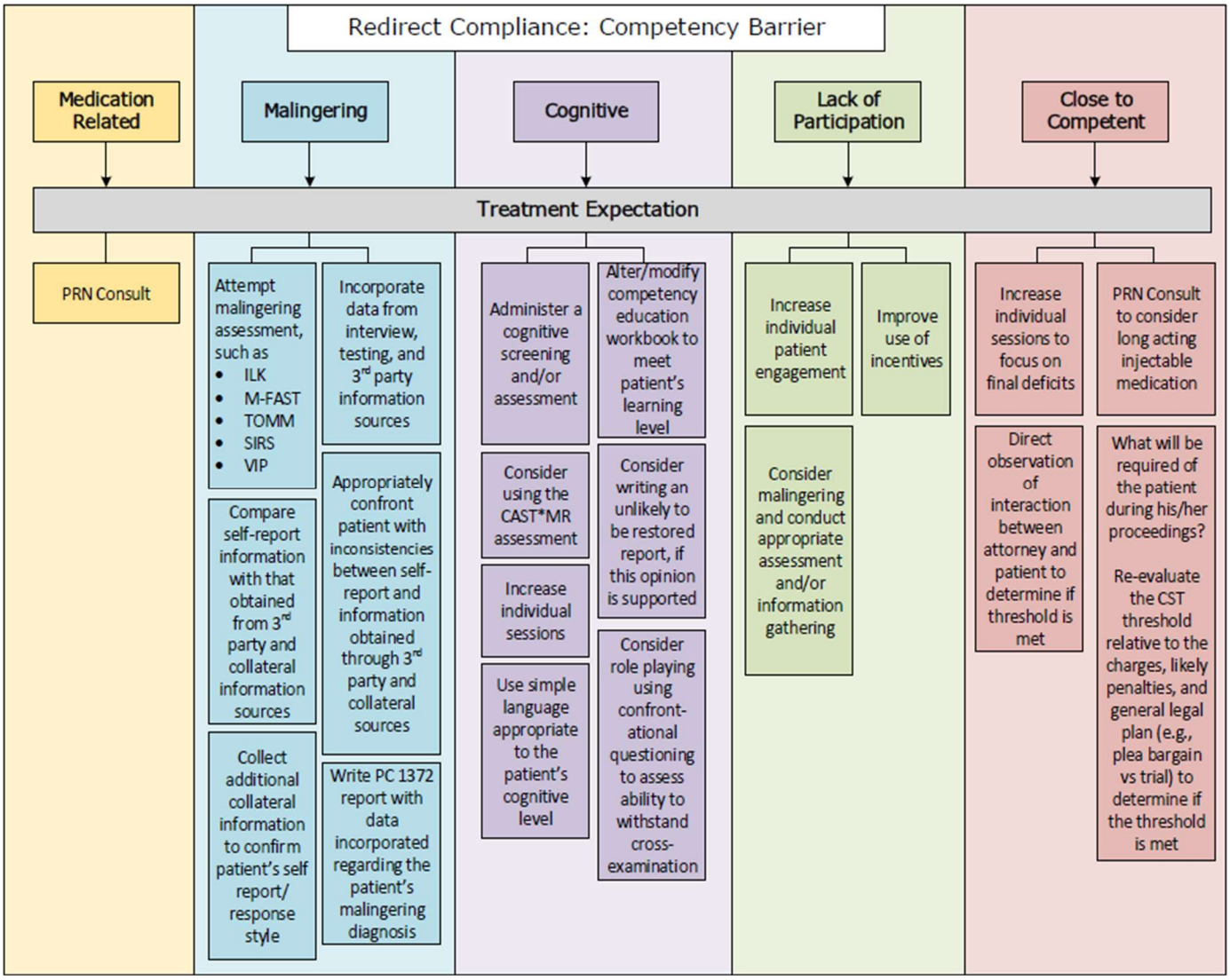
Topic	Description	Reason for consultation
Direct court correspondence that has not been sent to DSH	Program Director becomes aware that DSH may have not received pertinent legal case material (e.g. minute orders)	Provide to DSH via current approved method (currently via uploading to the Documents for PMU folder in Workspaces *and by checking the notify all box*). Also provide any time sensitive or highly important documents to the CP.
Major SIR incident	E.g. Patient death, serious injury, serious staff assault, etc.	CP should be aware of serious episode occurring in the program, and to provide immediate support for the program and any eventual corrective feedback if needed. At minimum this is via the 1725a form.
Staff coverage issues	Vacancies/Employee Leave of Greater than One Week	CP should be aware of staff vacancies which may impact program operations and treatment delivery to patients on or before the date of absence or separation, and of the program's coverage plan
COVID quarantine/outbreak	Confirmed COVID illness of staff and patients	CP should be aware of staff and patient illness that impact program operations
Redirect Request	Request to transfer current JBCT patients to DSH	CP will review redirect requests and will either approve or deny the transfer based on clinical necessity
Last Minute Maximum Commitment Report	Notification received by the program of updated maximum commitment date & report submission to court	CP should be made aware of changes in patients release dates and requests made by

		the court for report submissions
Any suspension or reduction in treatment services	Any instance of less than 3 hours of group treatment provided daily, or individual clinical contact disruptions (psychiatrist, clinician, etc.)	CP should be aware of any reduction/changes/ modifications to routine clinical programming
Request For a Tour of the JBCT Program From a Stakeholder Other Than DSH	Any requests made by non-Sheriff's department or DSH entity to tour the JBCT unit	CP should be aware of JBCT tour requests prior to approving or facilitating a tour
Data or PHI breach	Disclosure of PHI or other protected data to non-authorized entity	CP should be aware of the details of the data breach and will provide corrective feedback if needed
Request for Administrative Law Judge (ALJ)	Administrative Law Judge hearing for involuntary medication order (IMO)	Follow the steps in Appendix H
Sheriff's/Administrative Request for Discharge	Any time a request is made to discharge or remove a patient from JBCT without court or DSH approval	CP should be aware of any discharges or program removals of patients that are not authorized by a court and will coordinate with DSH Legal to ensure legal treatment guidelines are being followed
Patient Management Unit (PMU) communication	Pertinent correspondence with PMU regarding waitlists, admissions, etc.	CP should be aware of any coordination and communication with PMU to ensure all parties are working with the same information
Mortality Review/Death of Patient in JBCT or On the Waitlist	Death of current or waitlist JBCT patient (natural, suicide, murder, etc.)	CP should be aware of significant episode and to provide any corrective feedback if needed
Request for Records	Request for DSH health records	Email to DSHSacSDT@dsh.ca.gov and the consulting psychologist

* *Please note that the above are examples of common reasons a JBCT Program Director must reach out to their assigned DSH Consulting Psychologist. This list is not all inclusive and JBCT Program Director's should contact their assigned DSH Consulting Psychologist at any point if questions arise about program operation.*

Appendix G
JBCT Redirect Tool

When a redirect request is made to transfer a patient from a JBCT to a state hospital, the DSH Consulting Psychologist (CP) will utilize the redirect tool to triage the patient's case to determine if the reason for redirect/transfer is clinically indicated. The DSH CP will identify if one of the areas noted below is the main reason for referral, and if so, may recommend to the JBCT Program Director to implement some best practice interventions to address the reason for referral and barrier(s) to competency prior to approving a redirect.



Appendix H
IMO Request Process

Administrative Law Judge Involuntary Medication Order Process

- JBCT Program, hereafter referred to as "Program" submits an ALJ certification package to DSH Legal for review, including:
  - A draft IMO Certification
  - Availability from the Program Psychiatrist for a hearing (Wednesday, Thursday, or Friday at 10:00am or 1:30pm)
    - Please provide all days and times of availability so DSH Legal has flexibility in scheduling
  - Discovery documents that support the certification, such as:
    - Commitment order
    - Physicians' notes documenting evaluations or direct observations included in the certification
    - Alienist reports if cited in the certification
    - Any notes from other disciplines cited in the certification
    - Any other documentation of any events relied upon to support lack of capacity (if opined)
    - Any other documentation to support dangerousness (if opined)
  - Instructions for how the Patient's counsel can contact the patient at the facility prior to the hearing, including who would be able to coordinate a virtual meeting for the Patient's counsel.

- The certification package is submitted via email to SacLegal1370@dsh.ca.gov, CC'ing CFPD_CSU@dsh.ca.gov AND their assigned Consulting Psychologist

- DSH Legal reviews IMO Certification and returns draft for any further review/edits needed from the Program

- The Program finalizes IMO Certification based on DSH Legal's feedback
  - NOTE: After all necessary reviews/edits are made to the IMO certifications, it must be submitted to DSH Legal for review by Monday COB of any given week in order for DSH Legal to schedule the ALJ hearing for that week.[3]

- Once a hearing date is set, the IMO Certification is signed, no earlier than 72 hours before the hearing and submitted to DSH Legal, CC'ing the Consulting Psychologist
  - NOTE: DSH will accept either a wet or digital signature.

[3] Note that due to new DSH programs coming online with EASS, JBCTs and now IMDs, the demand for ALJ hearings and Superior Court IMO hearings has increased greatly. Therefore, even if certifications are finalized and submitted by Monday COB there may be situations, due to lack of attorney availability and lack of availability of Judges for these hearings or other related factors, that the hearing must take place the following week.

- Virtual hearing meeting invitation is sent out to Program
    - Program can send names/emails to DSH Legal to include in the meeting invitation (at minimum the psychiatrist who completed the certification); if not sent in advance, forward the meeting invitation to all parties you need to attend
- DSH Legal submits 1370 Petition Package Documents to the Program

- Patient must be served the documents - can be served by the Administrative Assistant (or any other team member)
    - Proof of Service must be filled out and signed by the Program and returned to DSH Legal prior to the hearing

- Hearing is held
    - Judge either grants or does not grant IMO
        - NOTE: If granted, administration of short acting involuntary medication can and should begin immediately, but long-acting injectables should not be used.
    - If granted, a hearing in Superior Court takes place within 18 days (this timeframe can be extended – work with DSH attorney to obtain an extension if needed)
        - DSH Legal will provide the Program with a new Patient Proof of Service (POS) which will need to be served to the patient by the Program
            - Program scans signed POS back to DSH Legal
            - Original POS needs to be mailed to DSH Legal:
                - Legal Division
                  Attn: 1370 IM Team Department of
                  State Hospitals 1215 O. Street MS5
                  Sacramento, CA 95814
    - If the Superior Court concurs and grants the IMO, it is typically in place for one year or until criminal proceeding resume.
        - Long-acting injectable medications can be initiated at this time.
    - If <u>not</u> granted, any administration of involuntary medication initiated prior to the hearing must be discontinued

- Expiration of Superior Court Order
    - No less than 90 days prior to the expiration of a Superior Court order authorizing involuntary medication, the Program must send DSH Legal a Renewal Certification, CC'ing the Consulting Psychologist
    - DSH Legal will review the certification and return with edits/comments as needed
    - Program finalizes and returns to DSH Legal for filing

Appendix I

Special Incident Report (SIR) Categories and Major SIR Categories

SIR Category	Incident Definition
Aggression	• Physically Aggressive Act to JBCT Patient • Physically Aggressive Act to Non-JBCT Inmate • Physically Aggressive Act to Custody • Physically Aggressive Act to Other Staff/Visitors • JBCT Patient Injured by Others Not Requiring Hospitalization • Serious Threat Triggering Tarasoff Warning • Physical Aggression Resulting in Property Damage • JBCT Patient Injured BY Others Requiring Admission to an Outside Hospital • JBCT Patient Injury OF Others Requiring Admission to an Outside Hospital • Patient Found In Possession Of A Weapon
Substance Abuse/Med Diversion	• Positive Drug/Diversion Screen • Patient Overdose • Patient Found with Diverted Medications - Prescribed • Patient Found with Diverted Medications - Not-Prescribed • Patient Found with Illicit Drugs/Tobacco/Alcohol
Institutional Violation	• Refusal To Follow Orders Creating Danger (e.g. cell extraction, refusal to lock down, inciting peers) • Unauthorized Movement Outside of the Housing Unit • Escape Attempt • Other Discipline Under Title 15, Chapter 7 Not Addressed Elsewhere
Sexual Behaviors	• Sexual Exhibitionism/Public Masturbation • Sexual Aggression - Physical • Other Sexual Behaviors Impacting the Safety or Comfort of Others
Self-Injurious/Suicidal Behaviors	• Reported Suicidal/Self-Harm Ideation without Action

	• Non-Suicidal Self-Injury/Suicide Attempt with Low Potential Lethality and No Treatment Needed in Excess of Basic First Aid • Non-Suicidal Self-Injury/Suicide Attempt with Moderate Potential Lethality and/or Off-Site Medical Clearance Needed without Admittance to an Outside Hospital • Non-Suicidal Self-Injury/Suicide Attempt with High Potential Lethality • Non-Suicidal Self-Injury/Suicide Attempt Requiring Admittance to an Outside Hospital • Safety Cell Placement/Suicide Watch > 3 Days • Suicide Letter Found (even without self-injurious behavior)
Medical	• Patient Diagnosed with Serious Medical Condition Impacting Trial Competency or Likelihood of Restoration • New Patient Pregnancy While In Program • Patient Admitted to Medical Hospital for Treatment of a Serious Medical Condition 1-3 days • Patient Admitted to Medical Hospital > 3 days • Medication Administration Error or Variance
Patient Death	• Patient Completed Suicide • Patient Death by Homicide • Patient Death by Accident • Patient Death by Illness - Expected Death • Patient Death by Illness - Unexpected Death • Patient Death - Cause Unknown
Patient Privacy/Safety	• Serious Breach of Confidentiality Involving Patient PHI • Actions by a JBCT Patient Leading to Public Media Coverage (e.g. lawsuit, coverage of new charges for JBCT assault, etc.) • Allegation of Abuse of a JBCT Patient By Staff/Custody • Substantiated Finding of Abuse of a JBCT Patient By Staff/Custody
Other	• Other

Major SIRs Triggering Forms 1725a and 1725b (unless noted)

- Patient Injured BY Others Requiring Admittance at an Outside Hospital
- Patient Injury OF Others Requiring Admittance at an Outside Hospital
- Patient Overdose
- Patient Found With Illicit Drugs/Tobacco/Alcohol
- Escape Attempt
- Non Suicidal Self-Injury/Suicide Attempt with High Potential Lethality
- Non Suicidal Self-Injury/Suicide Attempt Requiring Admittance to an Outside Hospital
- Safety Cell Placement/Suicide Watch > 3 Days
- New Patient Pregnancy While In Program
- Patient Admitted to Medical Hospital > 3 Days (1725a only unless a 1725b is requested)
- Patient Death - Any
- Serious Breach of Confidentiality Involving Patient PHI
- Actions by a JBCT Patient Leading to Public Media Coverage (e.g. lawsuit, coverage of new charges for JBCT assault, etc.)
- Allegation of Abuse of a JBCT Patient by Staff Custody (1725a only unless a 1725b is requested)
- Substantiated Finding of Abuse of a JBCT Patient by Staff/Custody