MINIMUM STANDARDS FOR JUVENILE FACILITIES
Title 15-Crime Prevention and Corrections
Division 1, Chapter 1, Subchapter 5

2007 GUIDELINES

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INTRODUCTION

Guidelines for the Minimum Standards for Juvenile Facilities
Title 15, California Code of Regulations

The purpose of these guidelines is to assist facility administrators and others in understanding and meeting the minimum operational standards for local juvenile detention facilities. These standards, which relate to programs, procedures, health care, nutrition and sanitation issues, are contained in **Title 15, California Code of Regulations (CCR)**. Prior to 2003, the juvenile Title 15 regulations included standards related to holding juveniles in adult facilities; these standards are now incorporated in the adult Title 15 regulations.

Since facility operation is in large part defined by physical plant design, it is important that facility administrators be familiar with the regulations in **CCR Title 24** related to detention facility design and construction. The Corrections Standards Authority (CSA) also publishes guidelines on these regulations.[1] In addition, there are other state and federal requirements that have an impact on the physical plant (e.g., fire and life safety regulations in CCR Title 24 and Title 19, and the Americans with Disabilities Act).

The **Minimum Standards for Juvenile Facilities**, both **Title 15** and **Title 24**, are the result of careful consideration by facility administrators, managers, staff and other subject matter experts working in conjunction with CSA Board members and staff. The regulations are regularly reviewed and updated pursuant to **Welfare and Institutions Code Sections 210 and 885,** which require the CSA to establish standards for juvenile facilities.

Guidelines explain the intent of the regulations, identify issues and propose options that could be considered when developing policies and procedures for implementation. There are many ways to comply with regulations; the guidelines offer ideas from professionals in facility management, health services, nutrition and sanitation as to what facility administrators might do, or at least consider, when implementing regulations. They are neither mandatory nor limiting, nor do they cover every possible contingency. They are intended to assist administrators and others in understanding the regulations and applying them to the needs of their particular detention system.

Section 1300, Severability, provides that if any regulation or portion of a regulation is found to be unconstitutional, contrary to statute or otherwise inoperable, the remaining portions of the regulations are still valid. It is important to stay current with statutory changes and the impact of case law on detention operations. When statute differs from regulation and is more restrictive, statutory requirements prevail. Additionally, case law may impact the CSA's interpretation of a regulation.

[1] Penal Code Section 6029 requires the CSA to review all architectural plans and specifications for detention facility construction projects in excess of $15,000. The Title 24 guidelines discuss these requirements in detail.

Section 1303 allows the CSA Board to approve pilot projects and **Section 1304** authorizes the CSA Board to grant an alternate means of compliance when certain conditions are met.[2] These options should be pursued with the CSA to implement a practice that deviates from a given regulation but meets or exceeds the regulatory intent.

Written policies and procedures are required throughout the regulations. While it may be burdensome to write routine policies and procedures, they provide real benefits to the detention system – e.g., documenting needs for budget requests, providing support in litigation and clarifying operational expectations for facility staff. Written policies and procedures help promote clear, consistent practices and, in the long run, save time, money, and perhaps lives. Well written procedures that are not followed will neither improve facility safety and operation nor protect the facility from damaging lawsuits. Practice must be consistent with policies and procedures and must be monitored by management.

Regulations have numerous requirements to inform and communicate with minors regarding programs, rules, and health services. These requirements begin at intake screening and extend through orientation, discipline, and the provision of health services. Non-English speaking minors, others with language barriers, and persons with certain other disabilities will require special provisions to ensure that they understand the information.

The regulations in **Article 8, Health Services**,[3] closely relate to several areas in **Title 15, Article 5, Classification and Segregation. Article 5** addresses intake and release procedures; segregation, assessment and planning; use of force, restraints and safety rooms; and grievance procedures. These areas have critical components that require compatible medical and custody policies, with close working relationships among health care and custody personnel.

While there is no specific regulation requiring preventive care, detention facilities are encouraged to promote a holistic approach to the health and wellness of minors. For the well being of staff, as well as for the minors, it is important to provide sanitary living conditions, proper food, exercise and education about health maintenance.

Regulations related to food services establish nutritional requirements that are consistent with guidelines for good nutrition in the community. The regulations emphasize the role of the food services manager to plan and supervise the entire food service operation, from purchase and storage through preparation and meal delivery. Food safety regulations incorporate the community requirements outlined in the **California Retail Food Safety Act (CalCode), Health and Safety Code, Division 104, Part 7, Chapter 4, Articles 1-8, Sections 113700 et seq.** Implementing food safety requirements throughout the entire food services system is an administrator's best protection against outbreaks of food-borne illness.

Regulations related to facility sanitation, safety and maintenance **(Articles 10-12)** highlight the importance of ongoing vigilance to keep the physical plant and equipment in good working order, which improves the efficiency of operations and is particularly important for security

[2] Title 24, Part 1, Sections 13-201(c)7 and 8 allow parallel options for physical plant modifications that meet or exceed the intent of those regulations.

[3] Title 15 health services standards parallel those of the Institute for Medical Quality (IMQ); however, they are not identical and adherence to Title 15 standards will not automatically make a facility eligible for IMQ accreditation.

reasons. Detention systems operate 24-hour facilities and implementing plans to keep the physical plants clean and free from rodents and other vermin is essential for the safety of minors and staff. Regulations require, and inspections should reinforce, operating clean and well-maintained facilities.

Probation administrators should maintain good working relationships with their food services and health care professionals, local health departments and interested practitioners. These relationships improve operational consistency throughout the system and enhance the resources needed to provide food and health care that is consistent with the community at large, which is necessary if the system is to avoid or prevail in costly litigation. Health care is almost always a component of lawsuits and the importance of managing and providing these services cannot be overemphasized.

In addition to CSA inspections required by Welfare and Institutions Code Section 210, **Title 15, Section 1313, County Inspection and Evaluation of Building and Grounds** and **Health and Safety Code Section 101045** require annual health inspections in all places of detention. This inspection, which is the statutory responsibility of the local health officer, identifies areas of noncompliance with health care, nutritional and environmental health regulations and provides critical information for administrators in these areas. To avoid the appearance of any conflict of interest, the persons providing facility nutritional and health services should not be the individuals who conduct the nutritional or medical/mental health portions of the annual health inspection. Service providers should conduct their own internal monitoring for quality improvement, but should not inspect themselves pursuant to the above statutes. That practice makes it difficult to avoid bias. While the health officer statutorily retains the responsibility for these inspections, options for avoiding conflict of interest include having someone in the local health department who is not directly responsible for detention services do the inspection; sharing inspection teams with neighboring cities/counties; contracting with an outside consultant such as the Institute for Medical Quality (a subsidiary of the California Medical Association); or initiating the review with another medical resource in your community that has a thorough understanding of detention regulations.

Health departments forward their inspection reports to the CSA, where they become an integral component of assessing compliance with **Title 15** requirements. It is important for health departments to complete their reports in a timely manner and for detention administrators to review the reports and implement strategies to remedy identified deficiencies. These compliance strategies should be documented in a response to the health inspector, with a copy to the CSA.

State law also requires a biennial fire inspection **(Heath and Safety Code Section 13146.1)**. While statute requires the State Fire Marshal to conduct the inspection, they typically defer to local fire authorities, which would have primary responsibility to fight any fires in the facility. Regulations require facility administrators to work with their local fire authority to develop emergency plans for fire safety and evacuation. A good working relationship with your local fire authority is essential to operating a safe facility for staff and minors. For more information, an instructor's manual that contains related regulations may be obtained from the CSA **(Fire and Life Safety in Juvenile and Adult Detention Facilities: An Instructor's Manual)**.

Additionally, **Title 15, Section 1313, County Inspection and Evaluation of Building and Grounds**, requires inspections by the local building inspector to approve structural safety; the county superintendent of schools to assess the adequacy of educational services; and the juvenile court judge and the Juvenile Justice Commission to assure that facility programs are consistent with the intent of the court and community standards. Each of these inspections provides an essential link to the local community by looking at specific aspects of the physical plant and program services. These inspections reinforce that the community has obligations to minors in the facility, and that the facility is accountable to the community, as well as the minors.

CSA staff is available to provide interpretation and assistance when questions arise about the regulations or guidelines, and there are a number of resources available on the CSA's website **(www.csa.ca.gov)**. Please contact CSA staff and utilize the website to access information as needed.

ARTICLE 1. GENERAL INSTRUCTIONS

Section 1300. Severability.

If any article, subsection, sentence, clause or phrase of these regulations is for any reason held to be unconstitutional, contrary to statute, exceeding the authority of the State Corrections Standards Authority, or otherwise inoperative, such decision shall not affect the validity of the remaining portion of these regulations.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: Section 209, Welfare and Institutions Code; 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: While the regulations in **Title 15, California Code of Regulations (CCR)** and those in **Title 24, CCR**, are integrated to address all the aspects of the planning, construction and operation of local detention facilities, this section indicates that one or more individual standards may be eliminated without compromising the rest.

Changes in statute and evolving case law can have an impact on regulations. This section provides that if any regulation or portion of a regulation is found unconstitutional, contrary to statute, beyond CSA authority, or otherwise inoperable, the remaining regulations are still valid. Typically, changes in statute and established case law are incorporated into subsequent regulation revisions.

Section 1301. Other Standards and Requirements.

Nothing contained in the standards and requirements hereby fixed shall be construed to prohibit a city, county, or city and county agency operating a local juvenile facility from adopting standards and requirements governing its own employees and facilities provided such standards and requirements meet or exceed and do not conflict with these standards and requirements. Nor shall these regulations be construed as authority to violate any state fire safety standard, building standard, or applicable statutes.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: Section 209, Welfare and Institutions Code; 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Title 15 regulations are "minimum standards." This means that they establish a "baseline" for facility operations. Local juvenile facilities must operate at a level that at least meets the regulatory requirements. There is nothing that precludes facility administrators and managers from exceeding standards.

The Corrections Standards Authority (then Board of Corrections) obtained an opinion from the Office of the Attorney General, number 99-1214, issued on May 2, 2000, that affirmed the CSA/BOC is not authorized to institute a legal action or sanctions against a local agency for a

failure to bring a particular juvenile facility into compliance with the minimum standards established by the CSA.

The opinion further clarified that, when a local agency brings a particular juvenile facility into compliance with the minimum standards established by the CSA/BOC, the state is not required to reimburse the local agency for the costs incurred in meeting the standards.

Facility administrators should be familiar with Welfare and Institutions Code Sections 209 (d) and (e), which outline the process for determining a facility's suitability in the event that there are items of noncompliance with regulations or if a facility is experiencing chronic crowding.

Section 1302. Definitions.

The following definitions shall apply:

"Administering medication," as it relates to pharmaceutical management, means the act by which a single dose of medication is given to a patient by licensed health care staff. The single dose of medication may be taken either from stock (undispensed) or dispensed supplies.

"Alternate means of compliance" means a process for meeting or exceeding the intent of the standards in an innovative way as approved by the Corrections Standards Authority pursuant to an application.

"Appeal hearing" means an administrative procedure providing an appellant with an opportunity to present the facts of the appeal for the formal decision concerning matters raised pursuant to the purposes set forth in these regulations. Such hearing may be conducted using oral and/or written testimony as specified by the Executive Director of the Corrections Standards Authority or the Corrections Standards Authority.

"Appellant" means a county or city which files a request for an appeal hearing.

"Authorized representative" means an individual authorized by the appellant to act as its representative in any or all aspects of the hearing.

"CSA" means the State Corrections Standards Authority, which acts by and through its executive director, deputy directors, and field representatives.

"Camp" means a juvenile camp, ranch, forestry camp or boot camp established in accordance with Section 881 of the Welfare and Institutions Code, to which minors made wards of the court on the grounds of fitting the description in Section 602 of the Welfare and Institutions Code may be committed.

"Cell Extraction" means the forceful removal of a minor from a room.

"Child supervision staff" means a juvenile facility employee, whose duty is primarily the supervision of minors. Administrative, supervisory, food services, janitorial or other auxiliary staff is not considered child supervision staff.

"Committed" means placed in a jail or juvenile facility pursuant to a court order for a specific period of time, independent of, or in connection with, other sentencing alternatives.

"Contraband" is any object, writing or substance, the possession of which would constitute a crime under the laws of the State of California, pose a danger within a juvenile facility, or would interfere with the orderly day-to-day operation of a juvenile facility.

"Control Room" is a continuously staffed secure area within the facility that contains staff responsible for safety, security, emergency response, communication, electronics and movement.

"Court holding facility for minors" means a local detention facility constructed within a court building used for the confinement of minors or minors and adults for the purpose of a court appearance, for a period not to exceed 12 hours.

"Delivering medication," as it relates to pharmaceutical management, means the act of providing one or more doses of a prescribed and dispensed medication to a patient.

"Developmentally disabled" means those persons who have a disability which originates before an individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual. This term includes mental retardation, cerebral palsy, epilepsy, and autism, as well as disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals.

"Direct visual observation" means staff must personally see minor's movement and/or skin. Audio/video monitoring may supplement but not substitute for direct visual observation.

"Direct visual supervision" means staff constantly in the presence of the minor. Audio/video monitoring may supplement but not substitute for direct visual supervision.

"Dispensing," as it relates to pharmaceutical management, means the interpretation of the prescription order, the preparation, repackaging, and labeling of the drug based upon a prescription from a physician, dentist, or other prescriber authorized by law.

"Disposal," as it relates to pharmaceutical management, means the destruction of medication or its return to the manufacturer or supplier.

"DNA" or Deoxyribonucleic acid means a chromosomal double-stranded molecule that exists in each living cell. DNA determines an individual's hereditary characteristics and can be used to distinguish and identify an individual from another person. This becomes critical when blood, hair, skin, or any other part of the body is used to prove one's involvement or lack of involvement, in a crime scene.

"Emergency" means a significant disruption of normal facility procedure, policy or operation caused by civil disorder, single incident of mass arrest of juveniles or natural disasters such as flood, fire or earthquake; and which requires immediate action to avert death or injury and to maintain security.

"Executive Director" means the Executive Director of the Corrections Standards Authority.

"Exercise" means an activity that requires physical exertion of the large muscle group.

"Facility administrator" means chief probation officer, sheriff, marshal, chief of police or other official charged by law with administration of the facility.

"Facility manager" means director, superintendent, police or sheriff commander or other person in charge of the day-to-day operation of a facility holding minors.

"Filing date" means the date a request for an appeal hearing is received by the Executive Director of the Corrections Standards Authority.

"504 plan" means a written educational plan developed by a group of educators, administrators, parents and other relevant participants pursuant to Section 504 of the Federal Rehabilitation Act of 1973; Title 29 of the United States Code, Section 794; and Title 34 of the Code of Federal Regulations, Part 104, that addresses the needs of a disabled student, as defined under section 504.

"Furlough" means the conditional or temporary release of a minor from the facility.

"Group Punishment" means a group of uninvolved minors is denied programming due to the actions of one or more minors.

"Health administrator" means that individual or agency that is designated with responsibility for health care policy pursuant to a written agreement, contract or job description. The health administrator may be a physician, an individual or a health agency. In those instances where medical and mental health services are provided by separate entities, decisions regarding mental health services shall be made in cooperation with the mental health director. When the administrator is other than a physician, final clinical judgments rest with a designated responsible physician.

"Health care" means medical, mental health and dental services.

"Health care clearance" means a non-confidential statement which indicates to child supervision staff that there are no health contraindications to a minor being admitted to a facility and specifies any limitations to full program participation.

"Hearing panel" means a panel comprised of three members of the Corrections Standards Authority who shall be selected by the Chairman at the time an appeal is filed. A fourth

member may be designated as alternate. Members designated to the hearing panel shall not be employed by, or citizens of, the county or city submitting an appeal.

"Individual Education Program" (IEP) means a written statement determined in a meeting of the individualized education program team pursuant to Education Code Section 56345.

"Intensive Supervision Unit" within a camp means a secure unit that shall comply with all requirements for a Special Purpose Juvenile Hall.

"Juvenile facility" means a juvenile hall, juvenile home, ranch or camp, forestry camp, regional youth education facility, boot camp or special purpose juvenile hall.

"Juvenile hall" means a county facility designed for the reception and temporary care of minors detained in accordance with the provisions of this subchapter and the juvenile court law.

"Labeling," as it relates to pharmaceutical management, means the act of preparing and affixing an appropriate label to a medication container.

"Legend drugs" are any drugs defined as "dangerous drugs" under Chapter 9, Division 2, Section 4211 of the California Business and Professions Code. These drugs bear the legend, "Caution Federal Law Prohibits Dispensing Without a Prescription." The Food and Drug Administration (FDA) has determined, because of toxicity or other potentially harmful effects, that these drugs are not safe for use except under the supervision of a health care practitioner licensed by law to prescribe legend drugs.

"Licensed health care personnel" means those individuals who are licensed by the State to perform specified functions within a defined scope of practice. This includes but is not limited to the following classifications of personnel: Physician/Psychiatrist, Dentist, Pharmacist, Physician's Assistant, Registered Nurse/Nurse Practitioner/Public Health Nurse, Licensed Vocational Nurse, and Psychiatric Technician.

"Living unit" shall be a self-contained unit containing locked sleeping rooms, single and double occupancy sleeping rooms, or dormitories, day room space, water closets, wash basins, drinking fountains and showers commensurate to the number of minors housed. A living unit shall not be divided by any permanent or temporary barrier that hinders direct access, supervision or immediate intervention or other action if needed.

"Local Health Officer" means that licensed physician who is appointed by the Board of Supervisors pursuant to Health and Safety Code Section 101000 to carry out duly authorized orders and statutes related to public health within his/her jurisdiction.

"Maximum capacity" means the number of minors that can be housed at any one time in a juvenile hall, camp, ranch, home, forestry camp, regional youth education facility or boot camp in accordance with provisions in this subchapter.

"Mental Health Director" means that individual who is designated by contract, written agreement or job description to have administrative responsibility for the mental health program. The health administrator shall work in cooperation with the mental health director to develop and implement mental health policies and procedures.

"Minimum Standards for Local Detention Facilities" means those regulations within Title 15, Division 1, Subchapter 4, Section 1000 et seq. of the California Code of Regulations and Title 24, Part 1, Section 13-102, and Part 2, Section 470A of the California Code of Regulations, as adopted by the Corrections Standards Authority.

"Minor" means a person under 18 years of age and includes those persons whose cases are under the jurisdiction of the adult criminal court.

"New Generation design" means a design concept for detention facilities in which housing cells, dormitories or sleeping rooms are positioned around the perimeter of a common dayroom, forming a housing/living unit. Generally, the majority of services for each housing/living unit (such as dining, medical exam/sick call, programming, school, etc.) occur in specified locations within the unit.

"Notice of decision" means a written statement by the Executive Director or the Corrections Standards Authority which contains the formal decision of the Executive Director of the CSA and the reason for that decision.

"On-site health care staff" means licensed, certified or registered health care personnel who provide regularly scheduled health care services at the facility pursuant to a contract, written agreement or job description. It does not extend to emergency medical personnel or other health care personnel who may be on-site to respond to an emergency or an unusual situation.

"Over-the-counter (OTC) drugs," as it relates to pharmaceutical management, are medications which do not require a prescription (non-legend).

"Pilot project" means an initial short-term method to test or apply an innovation or concept related to the operation, management or design of a juvenile facility, jail or lockup pursuant to an application to, and approval by, the Corrections Standards Authority.

"Primary responsibility" is the ability of a child supervision staff member to independently supervise one or more minors.

"Procurement," as it relates to pharmaceutical management, means the system for ordering and obtaining medications for facility stock.

"Proposed decision" means a written recommendation from the hearing panel/hearing officer to the full Corrections Standards Authority containing a summary of facts and a recommended decision on an appeal.

"Prostheses" means artificial devices to replace missing body parts or to compensate for defective bodily function. Prostheses are distinguished from slings, crutches, or other similar assistive devices.

"Psychotropic medication" means those drugs whose purpose is to have an effect on the central nervous system to impact behavior or psychiatric symptoms. Psychotropic medications include but are not limited to anti-psychotic, antidepressant, lithium carbonate and anxiolytic drugs, as well as anti-convulsants or any other medication when used to treat psychiatric conditions. Drugs used to reduce the toxic side effects of psychotropic medications are not included.

"Recreation" means activities that occupy the attention and offer the opportunity for relaxation. Such activities may include ping-pong, TV, reading, board games, letter writing.

"Regional facility" means a facility serving two or more counties bound together by a memorandum of understanding or a joint powers agreement identifying the terms, conditions, rights, responsibilities and financial obligations of all parties.

"Remodeling" means to alter the facility structure by adding, deleting or moving any of the building's components thereby affecting any of the spaces specified in Title 24, Section 460A.

"Repackaging," as it relates to pharmaceutical management, means transferring medications from the original manufacturers' container to another properly labeled container.

"Request for appeal hearing" means a clear written expression of dissatisfaction about a procedure or action taken, requesting a hearing on the matter, and filed with the Executive Director of the Corrections Standards Authority.

"Responsible physician" means that physician who is appropriately licensed by the State and is designated by contract, written agreement or job description to have responsibility for policy development in medical, dental and mental health matters involving clinical judgments. The responsible physician may also be the health administrator.

"Security glazing" means a glass/polycarbonate composite glazing material designed for use in detention facility doors and windows and intended to withstand measurable, complex loads from deliberate and sustained attacks in a detention environment.

"Shall" is mandatory; "may" is permissive.

"Special purpose juvenile hall" means a county facility used for the temporary confinement of a minor, not to exceed 96 hours, prior to transfer to a full service juvenile facility or release.

"Status offender" means a minor alleged or adjudged to be a person described in Section 601 of the Welfare and Institutions Code.

"Storage," as it relates to pharmaceutical management, means the controlled physical environment used for the safekeeping and accounting of medications.

"Supervisory staff" means a staff person whose primary duties may include, but are not limited to, scheduling and evaluating subordinate staff, providing on-the-job training, making recommendations for promotion, hiring and discharge of subordinate staff, recommending disciplinary actions, and overseeing subordinate staff work. Supervisory staff shall not be included in the minor to supervision staff ratio, although some of their duties could include the periodic supervision of minors.

"Use of force" means an immediate means of overcoming resistance and controlling the threat of imminent harm to self or others.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: Section 209, Welfare and Institutions Code; 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This section establishes definitions for key terms used throughout the standards. These definitions are also included in **Title 24, Part 1, Section 13-201** and some are repeated in **Title 24, Part 2, Section 460A**. These definitions apply throughout the standards and are necessary for a common understanding of facility design, operations and programs. The definitions are the basis for determining the applicability of the standards and create a common frame of reference so that administrators, staff, funding agencies, boards of supervisors, city councils, facility inspectors and others can share a common vocabulary relative to issues facing facilities that house minors. These are the "terms of art" which underlie the **Minimum Standards for Juvenile Facilities**. While most definitions are self-explanatory and should be referenced whenever there is a question about a particular term, certain areas are highlighted below.

Facility/System Administrator: The facility administrator is usually the chief probation officer, sheriff, chief of police or other official charged by law with the administration of the facility. In a large system, the facility administrator is likely to be different from the facility manager who is the facility director, superintendent or comparable position. The facility manager has primary operational responsibility for a juvenile facility or, when minors are held in an adult facility, the local detention facility.

Pharmaceutical Management: Administering Medication, Delivering Medication, Dispensing, Disposal, Legend Drugs, Labeling, Over-the-Counter (OTC) Drugs, Repackaging, Storage, and Disposal, are limited to pharmaceutical management of legally obtained drugs covered in **Section 1438, Pharmaceutical Management**.

Health Administrator/Responsible Physician: The health administrator is responsible for health care policy pursuant to a written agreement or job description. A health administrator could be a local health officer, physician or medical administrator. There is a distinction between the health

administrator and the responsible physician. While the administrator is a trained individual who has responsibility for developing and/or managing health care services, the responsible physician must be a licensed clinician who provides health care services and is the final arbitrator of clinical decisions. They may be the same person, but it is not required.

Maximum Capacity: Maximum capacity, frequently called "Rated Capacity (RC)," describes the number of occupants that can be housed in any juvenile facility or housing unit, based on compliance with all applicable standards. The maximum capacity for a room or specific area is based on the physical plant requirements in effect at the time the facility was designed. Special use areas such as sheltered housing for minors needing medical or mental health services, safety rooms, rooms dedicated solely to disciplinary segregation and holding cell capacities, are not included in the maximum capacity.

Section 1303. Pilot Projects.

(a) The Corrections Standards Authority may, upon application of a city, county or city and county, grant pilot project status to a program, operational innovation or new concept related to the operation and management of a local juvenile facility. An application for a pilot project shall include, at a minimum, the following information:
- **(1) the regulations which the pilot project shall affect;**
- **(2) any lawsuits brought against the applicant local juvenile facility, pertinent to the proposal;**
- **(3) a summary of the "totality of conditions" in the facility or facilities, including but not limited to:**
  - **(A) program activities, exercise and recreation;**
  - **(B) adequacy of supervision;**
  - **(C) types of minors affected; and,**
  - **(D) classification procedures.**
- **(4) a statement of the goals the pilot project is intended to achieve, the reasons a pilot project is necessary, and why the particular approach was selected;**
- **(5) the projected costs of the pilot project and projected cost savings to the city, county, or city and county, if any;**
- **(6) a plan for developing and implementing the pilot project including a time line where appropriate; and,**
- **(7) a statement of how the overall goal of providing safety to staff and minors shall be achieved.**

(b) The Corrections Standards Authority may consider applications for pilot projects based on the relevance and appropriateness of the proposed project, the applicant's history of compliance/non-compliance with regulations, the completeness of the information provided in the application, and staff recommendations.

(c) Within 10 working days of receipt of the application, CSA staff shall notify the applicant, in writing, that the application is complete and accepted for filing, or that the application is being returned as deficient and identifying what specific additional information is needed. This does not preclude the Corrections Standards Authority members from requesting additional information necessary to make a

determination that the pilot project proposed actually meets or exceeds the intent of these regulations at the time of the hearing. When complete, the application shall be placed on the agenda for the CSA's consideration at a regularly scheduled meeting. The written notification from the CSA to the applicant shall also include the date, time and location of the meeting at which the application shall be considered.

(d) When an application for a pilot project is approved by the Corrections Standards Authority, the CSA shall notify the applicant, in writing within 10 working days of the meeting, of any conditions included in the approval and the time period for the pilot project. Regular progress reports and evaluative data on the success of the pilot project in meeting its goals shall be provided to the CSA. The Corrections Standards Authority may extend time limits for pilot projects for good and proper purpose.

(e) If disapproved, the applicant shall be notified in writing, within 10 working days of the meeting, the reasons for said disapproval. This application approval process may take up to 90 days from the date of receipt of a complete application.

(f) Pilot project status granted by the Corrections Standards Authority shall not exceed twelve months after its approval date. When deemed to be in the best interest of the applicant, the Corrections Standards Authority may extend the expiration date. Once a city, county, or city and county successfully completes the pilot project evaluation period and desires to continue with the program, it may apply for an alternate means of compliance. The pilot project shall be granted an automatic extension of time to operate the project pending the Corrections Standards Authority consideration of an alternate means of compliance.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: Section 209, Welfare and Institutions Code; 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996: Section 15376, Government Code.

Guidelines: Please see **Section 1304, Alternate Means of Compliance,** as well as **Title 24, Part 1, Sections 13-210(c)7 and 8** for physical plant related requests for pilot projects and an alternate means of compliance. The concepts behind operations requests **(Title 15)** and physical plant requests **(Title 24)** are similar.

Regulations provide practical standards for facility design and operation; however, since differences occur among jurisdictions, and new practices become available, this section allows for innovative experimentation with new approaches to meet the intent of these regulations. An approach may take the form of a pilot project, and after completing an evaluation period, may be considered for approval as an **Alternate Means of Compliance (Section 1304).** If the approach proves successful and if it has statewide applicability, it will be considered for incorporation into regulation during future revisions.

Both the pilot project and the alternate means of compliance require CSA Board approval; the facility administrator must also work with CSA staff to initiate this process. The regulation describes criteria by which the CSA Board will evaluate the potential project and monitor its effectiveness. To be considered, the department must demonstrate that their proposed approach at least meets or exceeds the intent of the original regulation. Pilot project status is generally granted for a one-year development and testing period; however, at its discretion, the CSA may

extend the pilot project timeframe. When a pilot project has successfully completed the period of testing and development, and within 30 days prior to expiration of the pilot, the department may apply for an alternate means of compliance **Alternate Means of Compliance (Section 1304).**

Section 1304. Alternate Means of Compliance.

(a) An alternate means of compliance is the long-term method used by a local juvenile facility/system, approved by the Corrections Standards Authority, to encourage responsible innovation and creativity in the operation of California's local juvenile facilities. The Corrections Standards Authority may, upon application of a city, county, or city and county, consider alternate means of compliance with these regulations either after the pilot project process has been successfully evaluated or upon direct application to the Corrections Standards Authority. The city, county, or city and county shall present the completed application to the Corrections Standards Authority no later than 30 days prior to the expiration of its pilot project, if needed.

(b) Applications for alternate means of compliance shall meet the spirit and intent of improving facility management, shall be equal to, or exceed the intent of, existing standard(s), and shall include reporting and evaluation components. An application for alternate means of compliance shall include, at a minimum, the following information:

(1) any lawsuits brought against the applicant local facility, pertinent to the proposal;

(2) a summary of the "totality of conditions" in the facility or facilities, including but not limited to:

(A) program activities, exercise and recreation;

(B) adequacy of supervision;

(C) types of minors affected; and,

(D) classification procedures.

(3) a statement of the problem the alternate means of compliance is intended to solve, how the alternative shall contribute to a solution of the problem and why it is considered an effective solution;

(4) the projected costs of the alternative and projected cost savings to the city, county, or city and county, if any;

(5) a plan for developing and implementing the alternative including a time line where appropriate; and,

(6) a statement of how the overall goal of providing safety to staff and minors was or would be achieved during the pilot project evaluation phase.

(c) The Corrections Standards Authority may consider applications for alternate means of compliance based on the relevance and appropriateness of the proposed alternative, the applicant's history of compliance/non-compliance with regulations, the completeness of the information provided in the application, the experiences of the jurisdiction during the pilot project, if applicable and staff recommendations.

(d) Within 10 working days of receipt of the application, CSA staff shall notify the applicant, in writing, that the application is complete and accepted for filing, or that

the application is being returned as deficient and identifying what specific additional information is needed. This does not preclude the Corrections Standards Authority members from requesting additional information necessary to make a determination that the alternate means of compliance proposed meets or exceeds the intent of these regulations at the time of the hearing. When complete, the application shall be placed on the agenda for the CSA's consideration at a regularly scheduled meeting. The written notification from the CSA to the applicant shall also include the date, time and location of the meeting at which the application shall be considered.

(e) When an application for an alternate means of compliance is approved by the Corrections Standards Authority, the CSA shall notify the applicant, in writing within 10 working days of the meeting, of any conditions included in the approval and the time period for which the alternate means of compliance shall be permitted. Regular progress reports and evaluative data as to the success of the alternate means of compliance shall be submitted by the applicant. If disapproved, the applicant shall be notified in writing, within 10 working days of the meeting, the reasons for said disapproval. This application approval process may take up to 90 days from the date of receipt of a complete application.

(f) The Corrections Standards Authority may revise the minimum standards during the next biennial review based on data and information obtained during the alternate means of compliance process. If, however, the alternate means of compliance does not have universal application, a city, county, or city and county may continue to operate under this status as long as they meet the terms of this regulation.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: Section 209, Welfare and Institutions Code; 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996: Section 15376, Government Code.

Guideline: Please see **Section 1303, Pilot Projects,** as well as **Title 24, Part 1, Sections 13-201(c)7 and 8** for physical plant related requests for pilot projects and an alternate means of compliance. The concepts behind operations requests **(Title 15)** and physical plant requests **(Title 24)** are similar.

The alternate means of compliance is initiated either by applying to the CSA 30 days prior to the conclusion of a pilot project **(Section 1303)** or upon direct application. Typically, projects will have completed an evaluation period as a pilot project prior to going before the Corrections Standards Authority to request a more permanent approval of their alternate approach to the regulation. As with pilot projects, the department must demonstrate that their approach at least meets or exceeds the intent of the original regulation and the focus is on how the pilot project goals were achieved.

An alternate means of compliance is a more permanent authorization for an alternative approach to compliance than the pilot project. Approval is typically considered "permanent" as long as the department implements the approach in the manner approved by the CSA; however, the CSA may determine another timeframe on a case-by-case basis. An alternate means of compliance is granted under an identifiable set of circumstances. If the local agency materially alters the

circumstances, the CSA retains the authority to vacate the alternate approach for compliance. If the alternate means of compliance approach has universal application, it will be taken into consideration during future regulation revisions.

ARTICLE 2. APPLICATION OF STANDARDS AND INSPECTIONS

Section 1310. Applicability of Standards.

All standards and requirements contained herein shall apply to any county, city and county, or joint juvenile facility that is used for the confinement of minors.

(a) Juvenile halls, juvenile homes, camps, ranches, forestry camps and boot camps shall comply with all regulations.

(b) Special purpose juvenile halls shall comply with all regulations except the following

1322(c) Child Supervision Staff Orientation and Training
1370 School Program
1415 Health Education
1464 Food Services Manager
1481 Special Clothing
1488 Hair Care Services

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: Section 209, Welfare and Institutions Code; 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996

Guideline: Types of facilities are addressed in **Section 1302, Definitions:** juvenile hall, special purpose juvenile hall or camp. Some regulations do not apply to all facilities and only a portion of a regulation may apply in some instances. The function and operation of a facility determine the applicability of the standard.

Section 1311. Emergency Suspension of Standards or Requirements.

Nothing contained herein shall be construed to deny the power of any facility administrator to temporarily suspend any standard or requirement herein prescribed in the event of any emergency which threatens the safety of a local juvenile facility, jail, lockup, minor, staff, or the public. Only such regulations directly affected by the emergency may be suspended. The facility administrator shall notify the Corrections Standards Authority in writing in the event that such a suspension lasts longer than three days. In no event shall a suspension continue more than 15 days without the approval of the chairperson of the Corrections Standards Authority for a time specified by him/her.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: Section 209, Welfare and Institutions Code; 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: An emergency is a significant disruption of normal facility procedure, policy or operation caused by civil disorder, single incident of mass arrest or natural disasters, which requires immediate action to avert death or injury and to maintain security **(Section 1302, Definitions)**. While regulations focus on the safe and secure detention of minors, there are circumstances when a facility administrator must vary from established standards in response to emergency situations. Emergencies can be caused by minors (e.g., a major behavior incident or contagious disease outbreak), by a natural disaster (e.g., fire, earthquake, etc.), or can be based on an immediate need to correct or repair a major facility system (e.g., locking mechanisms, kitchen facilities, etc.). A facility administrator has the ability to address these issues within the parameters of this regulation.

In emergency situations, the administrator may suspend compliance with affected regulations for up to three days. If the emergency continues beyond three days, the administrator must notify the Corrections Standards Authority. As a practical matter, this notification should occur as soon as possible, typically by telephone, with written follow-up as needed. If it appears that the emergency will require suspension of regulations for more than 15 days, the facility administrator, working with CSA staff, must obtain the approval of the Corrections Standards Authority chairperson.

This regulation is not intended to accommodate a fiscal shortfall. Chronic crowding and inadequate funding to maintain levels of operation required by minimum standards are not reasons to legitimately suspend a regulation under the authorization of this section.

Section 1312. Juvenile Criminal History Information.

Such juvenile criminal history information as is necessary for the conduct of facility inspections as specified in Section 209 of the Welfare and Institutions Code shall be made available to the staff of the Corrections Standards Authority. Such information shall be held confidential except that published reports may contain such information in a form which does not identify an individual.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: Section 204.5 and 209, Welfare and Institutions Code; 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Certain individual criminal history information must be kept confidential and may be released only as provided by law. This regulation authorizes the release of such information to the Corrections Standards Authority for studies and surveys that the CSA is statutorily or otherwise directed to conduct. The CSA is required to maintain this information in a confidential manner.

Section 1313. County Inspection and Evaluation of Building and Grounds.

On an annual basis, each juvenile facility administrator shall obtain a documented inspection and evaluation from the following:

(a) county building inspector or person designated by the Board of Supervisors to approve building safety;
(b) fire authority having jurisdiction, including a fire clearance as required by Health and Safety Code Section 13146.1 (a) and (b);
(c) local health officer, inspection in accordance with Health and Safety Code Section 101045;
(d) county superintendent of schools on the adequacy of educational services and facilities as required in Section 1370;
(e) juvenile court as required by Section 209 of the Welfare and Institutions Code; and,
(f) the Juvenile Justice Commission as required by Section 229 of the Welfare and Institutions Code or Probation Commission as required by Section 240 of the Welfare and Institutions Code.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001. Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: In some instances, this regulation reiterates statutory requirements for annual inspections (i.e., fire, health, court and Juvenile Justice Commission inspections). It establishes requirements for other annual inspections not specifically required by statute (i.e., building safety and evaluation by the superintendent of schools). The facility administrator is required to retain copies of the identified inspections. Information contained in the reports alerts the facility administrator to possible problem areas within the facility, and will be requested by the CSA during their inspections.

A suggested format for the Juvenile Justice and Delinquency Prevention inspection was developed by a statewide work group of their representatives and is available from the CSA. Guidelines for **Section 1370, Education Program** include recommendations from the regulation revision workgroup for consideration in the superintendent of school's assessment of the school program.

Section 1314. Appeal.

The appeal hearing procedures are intended to provide a review concerning the Corrections Standards Authority application and enforcement of standards and regulations governing juvenile facilities. A county, city, city and county, or joint juvenile facility may appeal on the basis of alleged misapplication, capricious enforcement of regulations, or substantial differences of opinion as may occur concerning the proper application of regulations or procedures.

(a) Levels of Appeal.
  (1) There are two levels of appeal as follows:
    (A) appeal to the Executive Director; and,
    (B) appeal to the Corrections Standards Authority.
  (2) An appeal shall first be filed with the Executive Director.
(b) Appeal to the Executive Director.

(1) If a county, city, city and county, or joint juvenile facility is dissatisfied with an action of the Corrections Standards Authority staff, it may appeal the cause of the dissatisfaction to the Executive Director. Such appeal shall be filed within 30 calendar days of the notification of the action with which the county or city is dissatisfied.

(2) The appeal shall be in writing and:

(A) state the basis for the dissatisfaction;

(B) state the action being requested of the Executive Director; and,

(C) attach any correspondence or other documentation related to the cause for dissatisfaction.

(c) Executive Director Appeal Procedures.

(1) The Executive Director shall review the correspondence and related documentation and render a decision on the appeal within 30 calendar days except in those cases where the appellant withdraws or abandons the appeal.

(2) The procedural time requirement may be waived with the mutual consent of the appellant and the Executive Director.

(3) The Executive Director may render a decision based on the correspondence and related documentation provided by the appellant and may consider other relevant sources of information deemed appropriate.

(d) Executive Director's Decision.

The decision of the Executive Director shall be in writing and shall provide the rationale for the decision.

(e) Request for Appeal Hearing by CSA.

(1) If a county, city, city and county, or joint juvenile facility is dissatisfied with the decision of the Executive Director, it may file a request for an appeal hearing with the Corrections Standards Authority. Such appeal shall be filed within 30 calendar days after receipt of the Executive Director's decision.

(2) The request shall be in writing and:

(A) state the basis for the dissatisfaction;

(B) state the action being requested of the CSA; and,

(C) attach any correspondence related to the appeal from the Executive Director.

(f) CSA Hearing Procedures.

(1) The hearing shall be conducted by a hearing panel designated by the Chairman of the CSA at a reasonable time, date, and place, but not later than 21 days after the filing of the request for hearing with the CSA, unless delayed for good cause. The CSA shall mail or deliver to the appellant or authorized representative a written notice of the time and place of hearing not less than 7 days prior to the hearing.

(2) The procedural time requirements may be waived with mutual consent of the parties involved.

(3) Appeal hearing matters shall be set for hearing, heard, and disposed of by a notice of decision within 60 days from the date of the request for appeal hearing, except in those cases where the appellant withdraws or abandons the request for hearing or the matter is continued for what is determined by the hearing panel to be good cause.

(4) An appellant may waive a personal hearing before the hearing panel and, under such circumstances, the hearing panel shall consider the written information

submitted by the appellant and other relevant information as may be deemed appropriate.

(5) The hearing is not formal or judicial in nature. Pertinent and relative information, whether written or oral, shall be accepted. Hearings shall be tape recorded.

(6) After the hearing has been completed, the hearing panel shall submit a proposed decision in writing to the Corrections Standards Authority at its next regular public meeting.

(g) Corrections Standards Authority Decision.

(1) The Corrections Standards Authority, after receiving the proposed decision, may:

(A) adopt the proposed decision;

(B) decide the matter on the record with or without taking additional evidence; or,

(C) order a further hearing to be conducted if additional information is needed to decide the issue.

(2) the CSA, or notice of a new hearing ordered, notice of decision or other such actions shall be mailed or otherwise delivered by the CSA to the appellant.

(3) The record of the testimony exhibits, together with all papers and requests filed in the proceedings and the hearing panel's proposed decision, shall constitute the exclusive record for decision and shall be available to the appellant at any reasonable time for one year after the date of the CSA's notice of decision in the case.

(4) The decision of the Corrections Standards Authority shall be final.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: In most cases, differences of opinion concerning the application of regulations are resolved informally between the jurisdiction, Corrections Standards Authority inspector, and, if necessary, the inspector's immediate supervisor. When it is not possible to resolve such differences informally, this section establishes a process by which concerns can be reviewed by the Executive Director, culminating in a hearing before the appointed Corrections Standards Authority.

ARTICLE 3. TRAINING, PERSONNEL, AND MANAGEMENT

Section 1320. Appointment and Qualifications.

(a) Appointment

In each juvenile facility there shall be a superintendent, director or facility manager in charge of its program and employees. Such superintendent, director, facility manager and other employees of the facility shall be appointed by the facility administrator pursuant to applicable provisions of law.

(b) Employee Qualifications

Each facility shall:

(1) recruit and hire employees who possess knowledge, skills and abilities appropriate to their job classification and duties in accordance with applicable civil service or merit system rules;

(2) require a medical evaluation and physical examination including tuberculosis screening test and evaluation for immunity to contagious illnesses of childhood (i.e., diphtheria, rubeola, rubella, and mumps);

(3) adhere to the minimum standards for the selection and training requirements adopted by the CSA pursuant to Section 6035 of the Penal Code.

(4) conduct a criminal records review, on each new employee, and psychological examination in accordance with Section 1031 et seq. of the Government Code.

(c) Contract personnel, volunteers, and other non-employees of the facility, who may be present at the facility, shall have such clearance and qualifications as may be required by law, and their presence at the facility shall be subject to the approval and control of the facility manager.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This section requires that each juvenile facility have a superintendent, director or facility manager. All staff must be appointed by the rules of civil service, merit system or applicable provisions of law.

Government Code Section 1029 is the applicable statute for a public or peace officer employee in this regulation. The Government Code requires a background investigation and a psychological examination. The peace officer training requirements of **Penal Code Section 832** must be successfully completed before an employee can exercise any peace officer powers. There is no provision to waive any of these requirements on the basis of the employee being "on-call" or "part-time" staff.

These investigations and examinations are critical when hiring staff that will be supervising minors in a juvenile facility. Child supervision staff interacting with and counseling minors should be carefully screened to determine that they have the background, skills, knowledge and abilities appropriate to their job classification and assignment. A psychological examination and a criminal record check on each new employee offers a degree of protection to minors, other staff and the facility in the event of a litigation.

Section 1321. Staffing.

Each juvenile facility shall:

(a) have an adequate number of personnel sufficient to carry out its program, to provide for safety and security of minors and staff, and meet established standards and regulations;

(b) ensure that no required services shall be denied because of insufficient numbers of staff on duty absent exigent circumstances;

(c) have a sufficient number of supervisory level staff to ensure adequate supervision of all staff members;

(d) have a clearly identified person on duty at all times who is responsible for operations and activities and has completed the Juvenile Corrections Officer Core Course and PC 832 training;

(e) have at least one staff member present on each living unit whenever there is a minor or minors in the living unit;

(f) have sufficient food service personnel relative to the number and security of living units, including staff qualified and available to: plan menus meeting nutritional requirements of the gender and age groups fed; provide kitchen supervision; direct food preparation and servings; conduct related training programs for culinary staff; and maintain necessary records; or, a facility may serve food that meets nutritional standards prepared by an outside source;

(g) have sufficient administrative, clerical, recreational, medical, dental, mental health, building maintenance, transportation, control room, institutional security and other support staff for the efficient management of the facility, and to ensure that child supervision staff shall not be diverted from supervising minors; and,

(h) assign sufficient child supervision staff to provide continuous wide awake supervision of minors, subject to temporary variations in staff assignments to meet special program needs. Staffing shall be in compliance with a minimum child-staff ratio for the following facility types:

(1) Juvenile halls

(A) during the hours that minors are awake, one wide-awake child supervision staff member on duty for each 10 minors in detention;

(B) during the hours that minors are asleep, one wide-awake child supervision staff member on duty for each 30 minors in detention;

(C) at least two wide-awake child supervision staff members on duty at all times, regardless of the number of minors in detention, unless an arrangement has been made for backup support services which allow for immediate response to emergencies; and,

(D) at least one child supervision staff member on duty who is the same gender as minors housed in the facility.

(2) Special Purpose Juvenile Halls

(A) during the hours that minors are awake, one wide-awake child supervision staff member on duty for each 10 minors in detention;

(B) during the hours that minors are asleep, one wide-awake child supervision staff member on duty for each 30 minors in detention;

(C) at least two wide-awake child supervision staff members on duty at all times, regardless of the number of minors in detention, unless an arrangement has been made for backup support services which allow for immediate response to emergencies; and,

(D) at least one child supervision staff member on duty who is the same gender as minors housed in the facility, unless an arrangement has been made for immediate same gender supervision.

(3) Camps

(A) during the hours that minors are awake, one wide-awake child supervision staff member on duty for each 15 minors in the camp population;

(B) during the hours that minors are asleep, one wide-awake child supervision staff member on duty for each 30 minors present in the facility;

(C) at least two wide-awake child supervision staff members on duty at all times, regardless of the number of minors in residence, unless arrangements have been made for backup support services which allow for immediate response to emergencies;

(D) at least one child supervision staff member on duty who is the same gender as minors housed in the facility;

(E) in addition to the minimum staff to child ratio required in (c)(2)(A), consideration shall be given to the size, design, and location of the camp; types of offenders committed to the camp; and the function of the camp in determining the level of supervision necessary to maintain the safety and welfare of minors and staff;

(F) personnel with primary responsibility for other duties such as administration, supervision of personnel, academic or trade instruction, clerical, farm, forestry, kitchen or maintenance shall not be classified as child supervision staff positions.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation has several components that must be met to achieve sufficient staffing in each juvenile facility:

- Each facility must have an adequate number of personnel to carry out its program and to provide for the safety and security of the facility.
- No required services may be denied because of insufficient numbers of staff on duty.
- There must be a sufficient number of supervisory staff.
- There must be a core trained identified lead person on duty at all times.
- There must be at least one core trained staff member in each unit whenever minors are present.
- Facilities must maintain adequate administrative and support staff.
- Facilities must meet specific staff to minor ratios. Separate staff ratios are required in juvenile halls and camps. Although the standard does not include a relief factor, departments should compute and add a relief factor to ensure that the necessary number of qualified staff are budgeted and hired.

These components should not be viewed as mutually exclusive; each one of the regulation's requirements contributes to a facility's totality of conditions and overall adequate staffing level.

When determining the number of staff required to operate a juvenile facility, the staff to minor ratio must not be the only means for determining the number of staff. To accurately determine the number of staff needed for an individual facility, the characteristics of the physical plant, types of programs provided to the minors, security needs, the ability to carry out regulation requirements, and the classification of minors housed in each living unit must be considered as well.

Juvenile halls are staffed on a minimum shift ratio of one wide-awake child supervision staff member on duty for each ten minors in detention during the hours that minors are awake. This minimum staff ratio may or may not be sufficient staffing levels to meet the requirements of the other elements of this regulation (i.e., programming, safety and security). There must be at least one wide-awake child supervision staff member on duty for each 30 minors detained during the hours that minors are sleeping.

In all juvenile facilities, there shall be at least one staff present in the living unit any time minors are present on the unit. This includes both sleeping and waking hours. Facilities should develop a means for providing relief staff when assigned staff leaves the unit. The use of intercoms or video monitoring does not replace presence of staff.

Each juvenile facility will identify one staff (e.g., superintendent, manager, supervisor) as responsible for operations and activities during each shift. This person must be core trained and should possess appropriate decision making skills and have the ability to respond appropriately to emergencies. Appropriate training is essential to the acquisition of these skills.

Camps are staffed on a shift ratio of one wide-awake child supervision staff member on duty for each 15 minors in detention during the hours that minors are awake. There must be at least one wide-awake child supervision staff member on duty for each 30 minors detained during the hours minors are sleeping.

When calculating staff/child ratios contained in this regulation, supervisory staff may be included as child supervision staff if their primary duty is the supervision of minors. This situation is typically found in small juvenile facilities with small populations. In those instances, in excess of 50 percent of their time is typically spent actually supervising minors. Supervisory staff may be included in the ratio during the time they are actually providing the child supervision services.

The regulation addresses cross gender supervision. There must be at least one child supervision staff member on duty who is the same gender as minors are housed in the facility.

Section 1322. Child Supervision Staff Orientation and Training.

(a) Prior to assuming any responsibilities each child supervision staff member shall be properly oriented to his/her duties, including:
- **(1) child supervision duties;**
- **(2) scope of decisions he/she shall make;**
- **(3) the identity of his/her supervisor;**
- **(4) the identity of persons who are responsible to him/her;**
- **(5) persons to contact for decisions that are beyond his or her responsibility; and**
- **(6) ethical responsibilities.**

(b) Prior to assuming responsibility for the supervision of minors, each child supervision staff member shall receive a minimum of 40 hours of facility specific orientation, including:

(1) individual and group supervision techniques;
(2) regulations and policies relating to discipline and basic rights of minors pursuant to law and the provisions of this chapter;
(3) basic health, sanitation and safety measures;
(4) suicide prevention and response to suicide attempts
(5) policies regarding use of force, mechanical and physical restraints;
(6) procedures to follow in the event of emergencies;
(7) routine security measures;
(8) crisis intervention and mental health referrals to mental health services;
(9) documentation; and
(10)fire/life safety training

(c) Prior to assuming primary responsibility for supervision of minors, each child supervision staff member shall successfully complete the requirements of the Juvenile Corrections Officer Core Course pursuant to Penal Code Section 6035.

(d) Prior to exercising the powers of a peace officer child supervision staff shall successfully complete training pursuant to Section 830 et seq. of the Penal Code.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Training and personnel related regulations are based on the premise that a facility cannot operate properly without trained staff. Careful screening, hiring and adequate training of all personnel who work in juvenile facilities are critical. Hiring unqualified staff and the failure to provide appropriate training increases the potential for litigation. It may not be possible to avoid all lawsuits, but the department is more likely to avoid adverse decisions by making every reasonable effort to screen applicants, hire only qualified staff, and appropriately train them for the work. It is important that each of these steps is well documented.

There are progressive levels of orientation/training provided to each child supervision staff. The level of training dictates the level of responsibility. First is the orientation, which is provided before the staff assumes any responsibilities; second, the staff shall receive a minimum of 40 hours of facility specific orientation before assuming responsibility for the supervision of minors, and third, the staff member must successfully complete CORE before assuming primary responsibility for the minors followed by on-going job related training.

The regulations define primary responsibility as the ability of a child supervision staff member to independently supervise one or more minors.

Personnel who provide primary responsibility for the custody, supervision, treatment, or rehabilitation of persons accused of or adjudged responsible for criminal or delinquent conduct who are under local jurisdiction are required to complete core training **(Penal Code Section 6035, and Title 15, Subdivision 1, Chapter 1, Subchapter 1, Standards and Training of Local Corrections and Probation Officers, Sections 102 and 176). Penal Code Section 830 et. seq.** requires additional training prior to exercise of peace officer powers.

Section 1323. Fire and Life Safety.

Whenever there is a minor in a juvenile facility, there shall be at least one person on duty at all times who meets the training standards established by the Corrections Standards Authority for general fire and life safety which relate specifically to the facility.

NOTE: Authority cited: Section 6030 Penal Code; Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: There must be at least one staff member on every shift who is trained in fire and life safety. Although the regulation requires only one member of the staff on duty to be trained, it is recommended that all facility staff be trained in fire and life safety. The training should include the use of self-contained breathing apparatus if required by the local fire authority, or if this equipment is available to staff. Staff should know the location of fire doors, barriers, evacuation procedures and be able to use fire hoses and extinguishers. This should be a part of the first 40 hours orientation required in **Section 1322, Child Supervision Staff Orientation and Training**.

The facility manager should consult with the local fire authority for assistance when developing the required training. Core course training modules, discussed in conjunction with **Section 1322, Child Supervision Orientation and Training,** provide the description, performance objectives and content necessary for handling emergencies such as floods, earthquakes, etc. That training module also covers fire and life safety training. Annual training courses with in-depth fire and life safety curriculum should also be considered. Additionally, the Corrections Standards Authority, in conjunction with the State Fire Marshal, published the documents **Fire and Life Safety in Local Juvenile and Adult Detention Facilities: An Instructor's Manual** and **Regulations and Guidelines for Construction of Detention Facilities,** which address fire and life safety issues. Copies of these documents are available from the Corrections Standards Authority website (www.csa.ca.gov).

Section 1324. Policy and Procedures Manual.

All facility administrators shall develop, publish, and implement a manual of written policies and procedures that address, at a minimum, all regulations that are applicable to the facility. Such a manual shall be made available to all employees, reviewed by all employees, and shall be administratively reviewed annually, and updated, as necessary. Those records relating to the standards and requirements set forth in these regulations shall be accessible to the Corrections Standards Authority on request.

The manual shall include:

(a) table of organization, including channels of communications and a description of job classifications;

(b) responsibility of the probation department, purpose of programs, relationship to the juvenile court, the Juvenile Justice/Delinquency Prevention Commission or Probation Committee, probation staff, school personnel and other agencies that are involved in juvenile facility programs;

(c) responsibilities of all employees;

(d) initial orientation and training program for employees;
(e) initial orientation, including safety and security issues, for support staff, contract employees, school and medical staff, program providers and volunteers;
(f) maintenance of record-keeping, statistics and communication system to ensure:
(1) efficient operation of the juvenile facility;
(2) legal and proper care of minors;
(3) maintenance of individual minor's records;
(4) supply of information to the juvenile court and those authorized by the court or by the law; and,
(5) release of information regarding minors.
(g) ethical responsibilities;
(h) a non-discrimination provision that provides that all minors within the facility shall have fair and equal access to all available services, placement, care, treatment, and benefits, and provides that no person shall be subject to discrimination or harassment on the basis of actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status; and,
(i) storage and maintenance requirements for any chemical agents used in the facility.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: A policy and procedures manual outlines management polices and establishes procedures for staff to follow when providing supervision and implementing the facility programs. The manual is the statement of practice and provides accountability because it describes the basic elements for operating the facility. Each policy should describe:

1. what has to be done;
2. who is to do it;
3. when it is to be done;
4. how it is to be done;
5. who supervises whom; and,
6. who is accountable to whom.

The policy and procedure manual delineates management's expectations for operations. It establishes accountability and is a training tool. To be useful in those capacities, the manual must accurately reflect management's intent for what happens in the facility. Policies and procedures that are not implemented, and manuals that are not made available to staff, are of no value when managing the facility, training personnel or defending against litigation.

This section requires the facility administrator to implement facility policies and procedures that address, at a minimum, all standards applicable to the facility. The manual should contain everything required to efficiently and effectively operate the facility. While it can be helpful to review policies and procedures from other jurisdictions, the manual must relate to the operation of each individual facility.

If the department has only one facility, a single comprehensive manual will be sufficient. The manual may also consist of overall policies and procedures, plus a series of position orders designed to be used at the individual job sites within the facility. In multi-facility systems, differences in construction and facility operations generally make it difficult to apply a single manual to all the facilities. In those instances, there are still several common policies and department-wide procedures that provide organizational consistency.

There are several approaches to design procedures for a multi-facility system. One approach is to develop common policy and procedures for key areas that can be incorporated into the various facility manuals. This allows each facility to operate under its specific policy and procedures manual while providing consistency in key procedures. Another method is to design a single division manual that contains policy and procedures that are utilized by all facilities. This manual is supplemented with individual facility manuals that are designed around the operation and architecture of each facility. Coordinating the design and procedures is critical in order to ensure that each facility operates as intended within the system.

Regardless of the approach used in the design of the manual, staff needs to be aware of it and familiar with its use. The manual must be available to staff in the facility. Providing each staff person with a copy of the manual may be excessive or too costly; however, a current and accurate manual must be available to staff in a location where it is readily accessible. Easy electronic access ensures staff can retrieve the most up-to-date information.

Policies and procedures must be reviewed at least annually to make sure they are current and appropriate. The facility manager is responsible for review and, when necessary, revision of the manual. There should be a policy and procedure that details how the annual review is accomplished, how to document that review and what areas were revised. There should also be a method to incorporated revisions whenever the need arises. Policies and procedures should be dated and signed each time they are revised. It is important that the manual reflects management intent and supervisory staff must monitor actual practice to assure consistency with written policies and procedures. The manual provides good supporting documentation in the event of litigation, provided it is reflected in actual practice.

In addition to assuring that staff has access to the manual, they should be encouraged to use it. Staff should be trained with regard to facility policies and procedures and briefed to the extent necessary when there are changes. The manual should be incorporated into training of new employees and they should be tested to assess what they learn. Staff must be aware that they are accountable for knowing and following the procedures in the manual.

Section 1325. Fire Safety Plan.

The facility administrator shall consult with the local fire department having jurisdiction over the facility, or with the State Fire Marshal, in developing a plan for fire safety which shall include, but not be limited to:

(a) a fire prevention plan to be included as part of the manual of policy and procedures;

(b) monthly fire and life safety inspections by facility staff with two year retention of the inspection record;

(c) fire prevention inspections as required by Health and Safety Code Section 13146.1(a) and (b);
(d) an evacuation plan;
(e) documented fire drills not less than quarterly;
(f) a written plan for the emergency housing of minors in the case of fire; and,
(g) development of a fire suppression pre-plan in cooperation with the local fire department.

NOTE: Authority cited: Section 6030 Penal Code; Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Facility administrators should consult with their local fire authority to develop a fire suppression pre-plan and monthly inspection schedule. A fire suppression pre-plan gives a fire department an established approach for fighting fire in an institution. Typically, the plan will include locations of hydrants, access doors, a map of the facility, etc. The **State Fire Marshal Regulation,** found in **Title 19, CCR,** recommend the same elements of preplanning as are recommended here and in **Penal Code Section 6031.1**. Since liability increases dramatically if there is failure to comply with this section, it is imperative that proper fire plans are developed and the necessary inspections conducted.

The fire suppression pre-plan should include, but not be limited to, the following:

1. an indication from the fire department of what the normal fire equipment response will be to a first alarm of fire at the facility;
2. where the rolling stock (e.g., fire engines, trucks, etc.) will be strategically positioned to combat a fire;
3. the locations for fire department access to the secured portion of the facility;
4. personnel assignments to assist the fire department in gaining access to the various secured areas;
5. any internal equipment (e.g., hoses, standpipes, breathing apparatus, etc.) to which the fire department may need access; and,
6. protection of fire fighters, if necessary.

The fire prevention inspection requirement includes maintaining a record of biennial inspections conducted by either the local fire department or the State Fire Marshal as required by **Health and Safety Code Section 13146.1**. The State Fire Marshal will make these inspections unless the local fire chief annually notifies the State Fire Marshal in writing that they will conduct the required inspection. The purpose of this inspection is to identify hazards that may cause fire or endanger lives, and to ensure their correction so that a "fire clearance" for the facility may be issued by the inspecting agency. This inspection should not be confused with the pre-fire suppression plan previously discussed. They are separate elements of a good emergency plan.

It is important to document the inspections of internal fire alarms, smoke detectors and other equipment more frequently than once a year. Routine maintenance checks will ensure that the equipment is in proper working order, and could save lives in the event of an emergency. It is the intent of this standard to ensure that juvenile facility staff completes a monthly safety

inspection. The inspection includes: determining if fire extinguishers need to be serviced; assuring that doors function properly and are unobstructed; that exit signs are illuminated; and, determining that hose nozzles are present.

Facilities need to have emergency procedures in place that outline the steps to be taken during and after a fire, with particular emphasis on emergency housing. The emergency plan must include: floor plans indicating evacuation routes; when and how exit keys are checked; procedures for checking exit locks; locations for housing minors; location of necessary security equipment; and how emergency transportation is provided. As discussed in **Section 1324, Policy and Procedures Manual**, emergency procedures should be either a separate easily located section of the manual, or a separate document altogether.

Section 1326. Security Review.

Each facility administrator shall develop policies and procedures to annually review, evaluate, and document security of the facility. The review and evaluation shall include internal and external security, including, but not limited to, key control, equipment, and staff training.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This section requires the facility administrator to develop and implement written policy and procedures for an annual review of facility security measures. This review must be documented, and is valuable for planning, budget requests and responding to lawsuits. It also provides a chronological record of facility security status and will be requested during Corrections Standards Authority inspections. This standard provides for the safety of staff, minors and the community by preventing escapes and other incidents. Items included in the security review should be specific and unique to the facility operation, taking into consideration the requirements of the standards. Facility security includes, but is not limited to: contraband; physical counts of minors; searches; staffing; perimeter security, including fencing and lighting; and, vehicle security. The review should examine internal and external security, including: key control; equipment, training; firearms control; ammunition; duress alarm systems; chemical agents; and, mechanical restraint devices.

Section 1327. Emergency Procedures.

The facility administrator shall develop facility-specific policies and procedures for emergencies that shall include, but not be limited to:

(a) escape, disturbances, and the taking of hostages;

(b) civil disturbance;

(c) fire and natural disasters;

(d) periodic testing of emergency equipment;

(e) storage, issue and use of chemical agents, related security devices, and weapons and ammunition, where applicable; and,
(f) emergency evacuation of the facility.
(g) a program to provide all child supervision staff with an annual review of emergency procedures.

Confidential policies and procedures that relate to the security of the facility may be kept in a separate manual.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The facility administrator must develop policy and procedures that allow facility staff to respond appropriately to emergencies and a means to provide all child supervision staff with an annual review of these policies and procedures. Staff need to know how to: respond to emergencies; available emergency response resources; movement of minors and staff; and requirements for documenting events.

The regulation also requires policy and procedures for testing emergency equipment. This includes: the emergency generator; fire alarms; smoke alarms; flashlights; air-packs (if required or available); hoses; and fire extinguishers. Emergency equipment should be tested monthly and air-packs should be tested per manufacturer's requirements.

Storage, issue and use of chemical agents and security devices become important during an emergency. Staff should know where to locate emergency equipment in the event they are required.

Coordination with responding agencies such as the police, sheriff, fire department, and paramedics is also an important aspect of the emergency plan and procedures. This extends beyond the coordination with the local fire authority, as discussed in **Section 1325, Fire Safety Plan.**

An evacuation plan is a critical component of emergency planning and should include routes of egress, together with transportation of minors and staff to a secure and safe location. To ensure confidentiality, consideration should be given to placing these policies and procedures in a separate manual **(Section 1324, Policy and Procedure Manual and Section 1325, Fire Safety Plan)**.

Section 1328. Safety Checks.

The facility administrator shall develop policy and procedures that provide for direct visual observation of minors at least every 15 minutes during hours when minors are asleep or when minors are in their rooms. Supervision is not replaced, but may be supplemented by an audio/visual electronic surveillance system designed to detect overt, aggressive or

assaultive behavior and to summon aid in emergencies. All safety checks shall be documented.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guidelines: To ensure the safety and security of minors, policies and procedures must require that minimum 15-minute safety checks be conducted and documented whenever minors are confined to their sleeping rooms or dorms. When minors are under the constant direct visual supervision of staff during programming, head counts substitute for safety checks; however, room checks must continue during group programming for those minor remaining in their rooms or dorms.

Safety-check logs become critical documents in the event of an assault, serious incident or death of a minor. A written plan that includes documentation of safety checks is critical. Pre-printed logs should not include the time that checks are scheduled. Logs should include the date, name of staff, actual time the check is performed, and any significant conditions that are observable. Actual times and notation of observations should be handwritten in ink, if they are not documented electronically. Supervisors must regularly audit the logs to ensure appropriate compliance with policy.

This regulation calls for the direct visual supervision of minors. This means through the eyes of a person, not through the lens of a camera; audiovisual monitoring is not intended or acceptable. Staff must see each minor to assure that he/she is alive and not experiencing any observable trauma. Underlying this requirement is the expectation that staff will observe and respond appropriately to conditions. Monitoring devices can be effective and useful to supplement personal, direct visual supervision, but it is through personal supervision, observation and intervention that safety, order and control are maintained.

ARTICLE 4. RECORDS AND PUBLIC INFORMATION

Section 1340. Reporting of Legal Actions.

Each facility shall submit to the Corrections Standards Authority a letter of notification on each legal action, pertaining to conditions of confinement, filed against persons or legal entities responsible for juvenile facility operation.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Administrators must notify the Corrections Standards Authority of any legal action in state or federal courts pertaining to complaints about the conditions of confinement. Conditions of confinement complaints may relate to any living conditions or services while detained. Reporting the legal actions to CSA allows CSA staff to monitor conditions in the

facility, provide technical assistance if requested, and stay informed about significant legal issues that are facing juvenile facilities throughout the state.

Section 1341. Death and Serious Illness or Injury of a Minor While Detained.

In any case in which a minor dies while detained in a juvenile facility:

(a) The administrator of the facility shall provide to the Corrections Standards Authority a copy of the report submitted to the Attorney General under Government Code Section 12525. A copy of the report shall be submitted to the CSA within 10 calendar days after the death.

(b) Upon receipt of a report of death of a minor from the administrator, the CSA may within 30 calendar days inspect and evaluate the juvenile facility, jail, lockup or court holding facility pursuant to the provisions of this subchapter. Any inquiry made by the CSA shall be limited to the standards and requirements set forth in these regulations.

(c) The health administrator, in cooperation with the facility administrator, shall develop written policy and procedures to assure that there is a medical and operational review of every in-custody death of a minor. The review team shall include the facility administrator and/or the facility manager, the health administrator, the responsible physician and other health care and supervision staff who are relevant to the incident.

(d) The facility administrator, in cooperation with the health administrator and the mental health director, shall develop written policies and procedures for handling deaths, suicide attempts, suicide prevention and for notification of the Juvenile Court and the parent, guardian, or person standing in loco parentis, in the event of a serious illness, injury or death of a minor.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: Section 209, Welfare and Institutions Code; 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Policies and procedures are required for responding to the death, serious illness or injury of a minor. These policies must define the illnesses and injuries that are included and establish procedures to notify the individuals identified in the regulation. For security reasons, probation staff will typically have the lead in making this notification. For example, when a high risk minor is transported from the facility for emergency care, it is important that the timing of family notification not alert others in the community who might facilitate an escape or threaten the safety of the minor and/or transporting staff. Health care staff should provide supporting information on clinical conditions.

Government Code Section 12525 requires all detention facilities to submit a "death in custody report" to the Attorney General, California Department of Justice (DOJ) within ten (10) days of the death. There is a specific DOJ form for reporting these deaths that is available from them. The DOJ procedures require that the department attach the incident report describing the events surrounding the death. This regulation requires that a copy of the information going to the

Department of Justice also be forwarded to the Corrections Standards Authority within the 10-day timeframe.

Documenting a minor's death and the conditions surrounding it provides assistance to staff and administrators who may be called to testify about an incident months or years after it occurred. It also provides information about conditions in a facility and may indicate where additional training is needed or where procedures are not serving the purpose for which they were designed.

There are several kinds of reviews that are triggered by a death in custody. While this standard calls for a medical review, there is also an immediate review for the purpose of determining the most likely cause of death, the circumstances surrounding it, factors which may have contributed to it and what emergency procedures might need to be implemented. It is necessary to ask these questions about every death. Even in cases of death by natural causes, sick call or other routine procedures may need closer scrutiny or modification (i.e., had the minor complained about something in the past, how had the complaint been handled, etc.).

The medical review is a thorough assessment of the conditions surrounding a minor's death. The purpose is to alert the medical delivery system to any weaknesses or failures on its part that may have lead to the death or failed to prevent it. Thus, it is an additional quality control of the facility medical service. This review should be performed after all autopsy and other reports have been received, which could take more time than anticipated, especially if a criminal investigation is being conducted. Nonetheless, the medical review will be inadequate if conducted too soon; it must be a final review and must be able to incorporate all previous reports and relevant information.

Typically, the review team should include health care and custody staff that are relevant to the incident, as well as the facility manager, health administrator and responsible physician. Administrators and managers need to be aware of what is occurring in their facility and should either participate directly or designate staff to participate as their representatives, as in any other kind of investigation.

All circumstances surrounding the death should be evaluated from a medical perspective. The review may also identify areas where the integration of custody and medical policies needs improvement. Did medical personnel see the minor prior to his/her death? What was the minor's complaint? What was charted, if anything, on the medical record or in the custody log? What does the coroner's report indicate as the cause of death? Were there any time delays in seeking medical or mental health assistance for the minor? All information relative to the death gathered by medical or custody staff should be reviewed.

County counsel should be consulted when developing review committee responsibilities, obligations, immunities, and authority. This is to ensure the protection of review committee members, the probation department, and the county. Documentation of these reviews should not be taken lightly. The documents are “discoverable” during litigation, and counsel may recommend limiting the review to oral reports, with documentation noting only that the committee met.

Section 1342. Population Accounting.

Each juvenile facility shall submit required population and profile survey reports to the Corrections Standards Authority within 10 working days after the end of each reporting period, in a format to be provided by the CSA.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation requires facilities to submit population data to the Corrections Standards Authority within 10 working days of the end of each month. There is a prescribed reporting format that enables the CSA to develop statewide data on juvenile facility populations. This information is used to respond to questions from state and local administrators, the legislature, media and other inquiries. The information is valuable in determining and supporting funding needs for construction and renovation.

Section 1343. Juvenile Facility Capacity.

The Corrections Standards Authority shall establish the maximum capacity of a juvenile facility based on statute and applicable regulations. When the number of minors detained in a living unit of a juvenile facility exceeds its maximum capacity for more than fifteen (15) calendar days in a month, the facility administrator shall provide a crowding report to the CSA in a format provided by the CSA. The Executive Director of the Corrections Standards Authority shall review the juvenile facility's report and initiate a process to a preliminary determination if the facility is suitable for the continued confinement of minors. If the Executive Director determines that the facility is unsuitable for the confinement of minors, the recommendation shall be reviewed by the Corrections Standards Authority at the next scheduled meeting. Notice of the CSA's findings and/or actions shall be public record and, at a minimum, will be provided to the facility administrator, presiding juvenile court judge, chairperson of the board of supervisors and juvenile justice commission within ten working days of the CSA meeting.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation requires departments to report unit crowding of 15 days or more to the Corrections Standards Authority. Crowding is identified as exceeding the established "maximum capacity" of the housing area **(Section 1302, Definitions).** Facilities report crowding via the "Crowding Assessment Reports" (CAR) and, when crowding persists for more than three months, a "Comprehensive Crowding Assessment Report" (CCAR) must be submitted. The CSA monitors these reports and works directly with individual departments to develop a suitability plan. In most instances, these plans successfully mitigate the impact of crowding. When this cannot be accomplished at the staff level, **Welfare and Institutions Code Section 209 (e)** requires the appointed members of the Corrections Standards Authority to determine the facility's suitability to hold minors.

ARTICLE 5. CLASSIFICATION AND SEGREGATION

Section 1350. Admittance Procedures.

The facility administrator shall develop written policies and procedures for admittance of minors. In addition to the requirements of Sections 1324 and 1430 of these regulations:

(a) juvenile halls shall assure that a minor shall be allowed access to a telephone, in accordance with the provisions of Welfare and Institution Code Section 627;

(b) juvenile hall administrators shall establish written criteria for detention; and,

(c) juvenile camps shall include policies and procedures that advise the minor of the estimated length of stay, and shall develop program guidelines that include written screening criteria for inclusion and exclusion from the program.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The valid authority to hold the minor must be determined upon admittance to the juvenile hall [e.g., **Welfare and Institutions Code Sections (WIC) 601/602** or other authorized contract, such as with the U.S. Department of Immigration and Customs Enforcement]. There is a specific difference between admittance criteria and detention criteria. Because of the inherent discretion in the design of the California juvenile justice system, a detainee may be admitted (custody accepted from a peace officer) but not detained (released at intake by the probation officer). While the juvenile hall may be required to admit a certain detainee, that detainee may be discretionarily released at intake if the detention criteria are not met. Validated risk assessments designed specifically for detention needs are useful tools in ensuring objective consistent application of detention criteria.

WIC Section 627 requires that a minor be advised and have the right to make two telephone calls, at public expense, within one hour after being taken into custody. One call must be completed to his/her parent or guardian, a responsible relative, or employer and the second call to an attorney.

The initial phase of confinement is critical to a minor. A full orientation, as required in **Section 1353, Orientation,** is important in easing the transition into the custody setting. **Intake Health Screening, Section 1430**, must occur at this time to assure initial medical/mental health clearance or to identify concerns needing further attention. Facility procedures should consider the need for a confidential setting when collecting sensitive personal information.

Title 24, Section 460A.1.1, Reception/Intake Admission, requires that, upon admittance, a minor must have access to a shower and a telephone. There must also be a secure vault or storage space for the minor's valuables. **Section 460A.1.19** addresses the secure storage requirements for a minor's personal clothing and belongings.

Section 1351. Release Procedures.

The facility administrator shall develop written policies and procedures for release of minors from custody which provide for:

(a) verification of identity/release papers;
(b) return of personal clothing and valuables;
(c) notification to the minor's parents or guardian;
(d) notification to the facility health care provider in accordance with Section 1408 and Section 1437 of these regulations, for coordination with outside agencies; and,
(e) notification of school staff.

The facility administrator shall develop and implement written policies and procedures for the furlough of minors from custody.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: There is a need to properly identify the individual being released and to return personal property. There must also be procedures to notify parents or a guardian as well as health care services and school staff. It is important that this same process is followed when transferring a minor to another facility, to placement, or to a state institution. Timely notifications minimize security concerns.

Releases from a facility for the purpose of furlough need to follow these same guidelines and to include provisions for conditional release and return, if required.

Section 1352. Classification.

The facility administrator shall develop written policies and procedures on classification of minors for the purpose of determining housing placement in the facility.

Such procedures shall:

(a) provide for the safety of the minor, other minors, facility staff, and the public by placing minors in the appropriate, least restrictive housing and program settings. Housing assignments shall consider the need for single, double or dormitory assignment or location within the dormitory;
(b) consider facility populations and physical design of the facility;
(c) provide that a minor shall be classified upon admittance to the facility; classification factors shall include, but not be limited to: age, maturity, sophistication, emotional stability, program needs, legal status, public safety considerations, medical/mental health considerations and sex of the minor; and,
(d) provide for periodic classification reviews, including provisions that consider the level of supervision and the minor's behavior while in custody.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The purpose of classification is to ensure the appropriate housing and programming of minors, maintain the security of the facility and provide for the safety of staff and residents. Classification is not a tool for punishment or discipline. A preliminary classification should be done at the time of admittance. The initial classification focus is the health and safety of the minor, the safety of staff and the security of the facility. Classification consideration for each minor should be the least restrictive programming while maintaining the safety and security.

A more complete classification should be accomplished as soon as possible. The overall classification system must take into account objective information obtained at the admission screening, plus input from other sources such as the juvenile; available records; parents; victims; police; etc. Periodic reviews provide for needed flexibility and sensitivity to changing circumstances. Written documentation of the classification process aids in the coordination of minors' detention programs and consistent application of the classification system.

A facility's classification plan should consider at a minimum:

1. the physical layout of the facility;
2. the different security levels available in the facility;
3. the programs available;
4. the criteria used for classification and the minors legal status;
5. the appeal process for both staff and minors;
6. the time frames for periodic review of the classification;
7. personnel issues such as who makes classification decisions and the lines of communication for classification information;
8. maturity and sophistication of minors within the facility; and
9. the types of available housing (single/double occupancy rooms) and the locations and sizes of dormitories.

Classification systems are important in all detention settings, both camps as well as juvenile halls. The classification system should address the safety of minors in various types of housing, from single/double occupancy rooms to large dormitories.

There are several approaches to managing classification. Some facilities use formal input from probation, medical, mental health and other program staff while others use a more informal means of communicating this information when making classification decisions. Whatever the process, soliciting and incorporating credible input are key to effective classification. Staff training in the implementation of the classification plan is essential. The facility administrator should distinguish the unique differences between juvenile halls and camps when establishing a classification system.

The classification plan should be readily available in the minor's record on the living unit and be accessible to all staff. It will assist staff in appropriately assessing the group dynamics. Written records of any subsequent review and modifications should also be included in the minor's file. Requests by minors for “quiet time” and short term “time outs” for behavior control and any other removals from regular program and group activities should also be documented in the minor's file in addition to the unit log.

Documentation is especially important in cases where a minor is accused of a 707 WIC offense and is being tried as an adult. Such a minor can be transferred to an adult jail under 207.1 WIC only if the court finds that "further detention in the juvenile hall would endanger the safety of the public or would be detrimental to other minors in the juvenile hall." The decision to transfer a minor to an adult facility is significant and the rationale for transfer should be well documented. Courts have varying requirements for documentation; however, facility administrator should be sure their documentation includes but is not necessarily limited to: a summary of behavior; sanctions and programming efforts that have been made to manage the youth in the juvenile system; and consideration of escape potential (including factors that may enhance the youth's motivation to escape from the juvenile facility such as the awareness that they are facing long-term incarceration).

Section 1353. Orientation.

The facility administrator shall develop written policies and procedures to orient a minor prior to placement in a living area. Both written and verbal information shall be provided. Provision shall be made to provide information to minors who are impaired, illiterate or do not speak English. Orientation shall include:

(a) facility rules and disciplinary procedures;
(b) grievance procedures;
(c) access to legal services;
(d) access to health care services;
(e) access to counseling services;
(f) access to religious services;
(g) access to educational services;
(h) information on the court process;
(i) housing assignments;
(j) availability of personal care items and opportunity for personal hygiene;
(k) correspondence, visiting and telephone use;
(l) availability of reading materials, programs, and activities;
(m)use of restraints and chemical agents;
(n) use of force; and,
(o) emergency and evacuation procedures.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Staff must recognize that minors who are newly received in the facility are often in crisis. They may be under the influence of various substances, frightened or disoriented. They are concerned about personal and family problems and worried about the custody environment; they also may be unable to express these concerns. Staff may be able to reduce tension, ease the transition to detention and facilitate managing the minors by taking time to listen and respond to

individual concerns and needs during orientation. It is important to provide information on accessing counseling services and religious services.

Orientation provides minors with information about facility procedures, rules, behavior expectations, services, and activities that they must be familiar with to function successfully. When is visiting? How do I get to see a doctor? These and similar questions should be answered by orientation, the goal of which is to reduce rule violations and decrease staff time spent answering basic questions.

Some facilities use video presentations to orient minors. Video orientations may be shown in the receiving area or housing unit. These kinds of orientations should be available in the language or languages most commonly used by minors in the specific facility. An orientation video may eliminate repeated questions and may ensure that that each minor receives the necessary information in a uniform and consistent manner.

Handbooks or handouts are also useful tools for orientation. There should be an understanding that not all minors may be able to process written material. Minors may be unable to read or unable to read or speak English. Facility managers must be cognizant of a minor's needs and ability to understand orientation material, whether written or otherwise. Every effort must be made to ensure that no matter what a minor's limitations, that he or she receive information relative to their admission to a detention facility.

Section 1354. Segregation.

The facility administrator shall develop written policies and procedures concerning the need to segregate minors. Minors who are segregated shall not be denied normal privileges available at the facility, except when necessary to accomplish the objectives of segregation. Written procedures shall be developed which provide a review of all minors to determine whether it is appropriate for them to remain in segregation and for direct visual observation. When segregation is for the purpose of discipline, Title 15, Section 1390 shall apply.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Segregation is an option afforded to facility administrators to maintain order, safety, and security. The reasons for segregation include, but are not limited to: protective custody, medical isolation, time-out from the group or cool down. Policies and procedures that apply to different types of segregation are important. Segregated minors must not be denied normal privileges except those necessary to achieve the goal of the segregation (e.g., medical isolations may not mix with the group).

Policies and procedures that apply to disciplinary/behavioral segregation differ from those used when segregating minors for medical/mental health purposes or administrative needs. Segregation policy development and review should include the facility administrator, health care administrator, and facility managers and supervisors to ensure that policies and procedures are

consistent with regulations and sound detention practices. The facility administrator controls segregation, which must not be used in an arbitrary manner.

When segregation is used for discipline, there is a need for some degree of "due process" that includes communication with the minor and providing him/her with the opportunity to voice complaints. Allowing the minor to tell his/her "side of the story" is necessary. This may be as simple as an interview with the minor to advise him/her of the placement and the opportunity to respond to the information. If the segregation for discipline reasons exceeds 24 hours, then due process as outlined in **Section 1391, Discipline Process,** is required.

Segregation is also subject to the grievance process discussed in **Section 1361, Grievance Procedure**. The facility administrator and/or classification committee must regularly review the minor's status to confirm whether the segregation continues to be necessary.

Segregation may include restricting privileges. These restrictions should correspond to the need for segregation, the limitations of the facility, and the reasons for placement in segregation. Situations should not be allowed to develop whereby there is no fundamental difference between routine segregation and disciplinary housing.

When segregation is used as pre-disciplinary housing pending a disciplinary hearing, that decision must be based on the need to segregate rather than an attempt to limit privileges pending a hearing. This means that the minor's conduct was serious enough that it was unsafe or inappropriate for him/her to remain in general housing. Only those restrictions necessary to maintain the safety, security, and order of the facility pending disciplinary procedures should be utilized **(Section 1391, Discipline Process)**.

Segregation is often used for protective custody; either when the minor requests it or the administration determines there is reason to believe it is warranted. Minors sometimes request segregation for their own protection, generally because they feel threatened. It is important to document the reasons for placement in segregation, and if denied, the reasons for denial. Segregation for the purpose of protective custody should be maintained for the least amount of time necessary to reintegrate the minor back into the general population.

Segregation separates the minor from the general population, and staff should be especially attentive to signs of depression and/or suicide risk. Proper policies and implementation should ensure that minors are not isolated on segregation status without adequate staff supervision and monitoring, including consultation and involvement of health care staff as warranted.

In the development of segregation policies and procedures, the facility administrator must consider the conditions for segregating status offenders from minors as described in **WIC, Section 207**, and must assure compliance with **WIC Section 208**, which requires separation of minors from adult inmates.

Section 1355. Institutional Assessment and Plan.

The facility administrator shall develop written policies and procedures to provide that for minors held for 30 days or more, an assessment and plan shall be developed within 40 days of admission. The assessment and plan shall be documented.

(a) The assessment is a statement of the minor's problems, including, but not limited to, identification of substance abuse history, educational, vocational, counseling and family reunification needs.
(b) The institutional plan, for pre-adjudicated minors, shall include, but not be limited to, written documentation that provides:
(1) objectives and time frames for the resolution of problems identified in the assessment;
(2) a plan for meeting the objectives that includes a description of program resources needed and individuals responsible for assuring that the plan is implemented;
(c) In addition to the items noted above, once a minor is adjudicated, the institutional plan shall include, but not be limited to, written documentation that provides:
(1) periodic evaluation or progress towards meeting the objectives, including periodic review and discussion of the plan with the minor;
(2) a transition or aftercare plan, subject to existing resources, that is completed prior to the minor being released; and,
(3) contact with the Regional Center for the Developmentally Disabled for minors that are developmentally disabled, including provisions of Section 1413(b).

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Within 40 days of admission, a complete assessment and plan must be prepared for any minor held in the facility for a period of 30 days or more. This includes minors housed in juvenile hall while proceeding through the court process and those awaiting transfer to camp, placement or elsewhere. This regulation requires staff to begin assessing the needs of such minors and addressing those needs as soon as possible.

For post-adjudicated minors there must be a periodic review of progress toward meeting the plan's objectives as well as planning for transition to aftercare status upon release. Probation departments are also encouraged to connect the assessment and plan to services the minor will receive upon release from the facility and/or program.

"Days" as used in this regulation means actual calendar days.

The facility administrator, in consultation with the health authority, should develop policies which assure that anyone with suspected developmental disabilities is segregated when the person's behavior indicates that his/her safety would be jeopardized in general population. Although not all of those with developmental disabilities require segregation, minors with developmental disabilities are often highly susceptible to assaults and abuse. The facility's

screening and classification systems **(Section 1352, Classification)** must identify individuals with developmental disabilities and house them appropriately.

Many juvenile facilities do not have medical staff with specific training in diagnosing developmental disabilities. Regional Centers for the Developmentally Disabled are to be notified within 24 hours, excluding weekends and holidays, so appropriately trained staff will be able to make the diagnosis and determine eligibility for services (Regional Center information is available on the Internet at http://www.dds.ca.gov/rc/rclist.cfm). If it is not possible to meet the 24-hour deadline, then a phone call and a follow-up letter to the regional center should occur as soon as possible to advise the center that you may have a developmentally disabled minor in custody. A regional center is under no obligation to respond to referrals from the facility. Regional centers must be contacted regardless of the minor's adjudication status.

If the regional center does not accept a minor, there is an appeal process that custody or health care staff can initiate on the minor's behalf through the Client's Rights Office of each center.

Facilities should develop ongoing working relationships with their local regional center and provide in-service training for correctional and health care staff on developmental disabilities. This would be helpful to the minor and assist the facility's operators.

Section 1356. Counseling and Casework Services.

The facility administrator shall develop written policies and procedures ensuring the availability of appropriate counseling and casework services for all minors. Policies and procedures shall ensure:

(a) minors will receive assistance with personal problems or needs that may arise;

(b) minors will receive assistance in requesting contact with parents, attorney, clergyman, probation officer, or other public official; and,

(c) minors will be provided services as appropriate to the population housed in the facility, and may include, but not be limited to: substance abuse, family crisis and reunification, counseling, public health and mental health services.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Minors received in juvenile facilities generally bring many personal issues and problems with them from the community. This regulation is intended to ensure that staff provides counseling and casework to minors in their care. There is an expectation that child supervision staff provides such services to minors. Although not expected to handle extensive medical/mental health issues, child supervision staff is able to provide emotional "first aid" and to make appropriate referrals as needed. Minors can expect guidance in the areas of family reunification, substance abuse counseling, and behavior modification as well as other areas that may assist them in successfully handling routine issues.

Section 1357. Use of Force.

The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures for the use of force, which may include chemical agents. Force shall never be applied as punishment, discipline or treatment.

(a) At a minimum, each facility shall develop policy statements which:
- **(1) define the term "force," and address the escalation and appropriate level of force, while emphasizing the need to avoid the use of force whenever possible and using only that force necessary to ensure the safety of minors and others;**
- **(2) describe the requirements for staff to report the use of force, and to take affirmative action to stop the inappropriate use of force;**
- **(3) define the role, notification, and follow-up procedures of medical and mental health staff concerning the use of force; and,**
- **(4) define the training which shall be provided and required for the use of force, which includes, but is not limited to, known medical conditions that would contraindicate certain types of force; acceptable chemical agents; methods of application; signs or symptoms that should result in immediate referral to medical or mental health staff; and, requirements of the decontamination of chemical agents, if such agents are utilized.**

(b) Policies and procedures shall be developed which include, but are not limited to, the types, levels and application of force, documentation of the use of force, a grievance procedure, a system for investigation of the use of force and administrative review, and discipline for the improper use of force. Such procedures shall address:
- **(1) the specific use of physical, chemical agent, lethal, and non-lethal force that may, or may not, be used in the facility; and,**
- **(2) a standardized format, time period, and procedure for reporting the use of force, including the reporting requirements of management and line staff.**

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Use of force is an immediate means of overcoming resistance to control the threat of imminent harm to self or others and may occasionally be necessary for the safety of staff and minors in custody. Use of force often brings with it the hazard of injury to staff and minors, as well as the potential for abuse and litigation. The application of force requires clear policy and procedures to provide staff with the necessary direction and parameters specifying when it is appropriate and that it should not be used as punishment. Use of force should only be used when less restrictive methods have failed. Written restrictions on the application of force and the procedures for application and follow-up are necessary.

Use of force policy development and review should include the facility administrator, health care administrator, facility managers and supervisors to ensure that policies and procedures are consistent with regulations and sound detention practices. Policies need to identify what is considered use of force and should describe the continuum of escalation that should be followed as closely as possible. Facilities may vary on the definition of force and when different interventions are appropriate.

Policy and procedures should also discuss both the need to avoid the use of force and using only the amount of force necessary to ensure the safety of minors and staff. Strong verbal intervention may be considered a type of force or may be considered a prelude to force intervention. Chemical weapons such as pepper spray may be prohibited, or the highest level of escalation allowed prior to "hands-on" force. The facility administrator must establish a clear expectation regarding the use of force, while providing for a broad range of incidents that may or may not permit adherence to a rigid continuum of escalation. Use of force options should provide a broad array of options for staff to choose from that best suit the situation. Techniques should be appropriate for the minor's stage of development. The facility purpose, available resources, and the court's expectation should weigh into the development of this policy.

Use of force brings the potential of injury. Medical procedures and documentation require the specialized input of the responsible physician, who can base restrictions and follow-up procedures on the availability and limits of medical resources as well as any needs resulting from the use of force. Follow-up can include mental health as well as physical assessments of both the minor and staff. The lack of apparent injury does not necessarily mean that injury has not occurred.

Documenting incidents involving the use of force is critical for management evaluation and control. Timely submittal of a comprehensive and structured incident report allows management to access the documentation and maintains the agency's credibility. Complete reports and log entries establish the credibility of the staff involved. Generally, reports on the use of force should be completed prior to the end of shift, and not later than 24 hours after the incident has occurred. Procedures regarding the routing and use of force reports should provide clear direction. Documentation of an incident does not take precedence over the immediate needs of an individual during or after an incident; however, staff should be sensitive that there is a degree of urgency to begin the report process as soon as possible. Provision should be made for the minor's statement to be incorporated into the documentation.

Management review should be timely and consider a range of issues including:

1. Were policies and procedures followed?
2. Did policies and procedures address the issues in this incident?
3. What is the minor's side of the incident?
4. Is the use of force a pattern that indicates a need for management action?
5. Are the documentation and follow-up steps sufficient enough to be defended in litigation?
6. Are there any pending issues or injuries that require further follow-up?

The appropriate use of force requires training that provides staff a clear understanding of the facility policy and procedures that are employed before, during and after an incident. Staff should be knowledgeable about the authorization and limitations on the use of force, and should practice the techniques of application. Policy and procedures should also address training and steps taken to use chemical force, as well as a policy statement prohibiting lethal force. Policy and procedures for training must be coordinated with the health care providers to assure that

appropriate training regarding the medical and mental health implications of using force is provided.

Staff should also be trained to respond to incidents of "gassing" within the facility, and the use of force that may be needed to control that situation. For the purposes of this guideline, gassing means intentionally placing or throwing, or causing to be placed or thrown, upon the person of another, any mixture of human excrement or other bodily fluids or substances.

Section 1358. Use of Physical Restraints.

(a) The facility administrator, in cooperation with the responsible physician and mental health director, shall develop written policies and procedures for the use of restraint devices. In addition to the areas specifically outlined in this regulation, as a minimum, the policy shall address the following areas: known medical conditions that would contraindicate certain restraint devices and/or techniques; acceptable restraint devices; signs or symptoms which should result in immediate medical/mental health referral; availability of cardiopulmonary resuscitation equipment; protective housing of restrained minors; provision for hydration and sanitation needs; and exercising of extremities.

(b) Restraint devices include any devices which immobilize a minor's extremities and/or prevent the minor from being ambulatory. Physical restraints should be utilized only when it appears less restrictive alternatives would be ineffective in controlling the disordered behavior. Physical restraints shall be used only for those minors who present an immediate danger to themselves or others, who exhibit behavior which results in the destruction of property, or reveals the intent to cause self-inflicted physical harm. The circumstances leading to the application of restraints must be documented.

(c) Minors shall be placed in restraints only with the approval of the facility manager or designee. The facility manager may delegate authority to place a minor in restraints to a physician. Reasons for continued retention in restraints shall be reviewed and documented at a minimum of every hour. A medical opinion on the safety of placement and retention shall be secured as soon as possible, but no later than two hours from the time of placement. The minor shall be medically cleared for continued retention at least every three hours thereafter. A mental health consultation shall be secured as soon as possible, but in no case longer than four hours from the time of placement, to assess the need for mental health treatment.

(d) Continuous direct visual supervision shall be conducted to ensure that the restraints are properly employed, and to ensure the safety and well-being of the minor. Observations of the minor's behavior and any staff interventions shall be documented at least every 15 minutes, with actual time of the documentation recorded. While in restraint devices all minors shall be housed alone or in a specified housing area for restrained minors which makes provision to protect the minor from abuse. In no case shall restraints be used as punishment or discipline, or as a substitute for treatment. Additionally, the affixing of hands and feet together behind the back (hogtying) is prohibited.

(e) The provisions of this section do not apply to the use of handcuffs, shackles or other restraint devices when used to restrain minors for movement or transportation reasons.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The use of restraints is a complex issue fraught with the possibility of injury to minors and potential liability. Restraints are to be applied only on those minors who present an immediate danger to themselves or others, who exhibit behavior that results in the destruction of property, or reveal intent to cause physical harm to self or others. It is not the intent of the regulation that offenses typically handled through the facility's disciplinary due process system result in the application of restraints. The use of restraints must be reserved for major, out-of-control behavior that cannot be controlled by other alternatives.

The use of physical restraints cannot be considered if known medical conditions would place the minor at risk when used. Restraints are not to be used as punishment and are applied only when less restrictive ways of controlling a minor's dangerous behavior have failed or appear likely to fail.

There is a distinction between the use of force and the use of restraints. Use of force is an immediate means of overcoming resistance to control the threat of imminent harm to self or others. Use of restraints is a more sustained, prolonged intervention. It is sometimes difficult to determine when use of force ends and application of restraints begins. Force is a custody/law enforcement function. Application of restraints for prolonged periods of time requires greater emphasis on medical concerns and involvement of medical staff. This differentiation is based on the understanding that aggressive behavior that is not the result of underlying medical/mental health causes can be dealt with swiftly and definitively by custody staff. These minors will reach a decision point where their behavior comes under control relatively quickly. More prolonged behavior disturbances may be symptomatic of underlying psychological or medical problems requiring specific intervention and monitoring. This regulation relates to restraint that is typically prolonged and applied because control over the minor's behavior cannot be maintained through less restrictive means. Shackles and handcuffs are generally used as security restraints or in conjunction with use of force; they should be avoided as long-term restraint devices in favor of devices designed for safer use over more prolonged periods of time.

This standard does not address use of force policy **(see Section 1357, Use of Force)**. It specifically states that it does not apply to force used for security reasons. This is not to suggest that there are no liability and injury concerns related to the use of force. Custodial staff frequently must temporarily restrain a minor to gain control of a situation. Many of the medical concerns related to the prolonged use of restraints can also apply to the shorter-term use for security and gaining immediate control. Facility administrators should regularly review use of restraints and use of force policies to assure that policies are followed and restraint equipment is properly utilized and controlled.

There are medications that serve as chemical restraints to control behavior **(Section 1439, Psychotropic Medications)**. These can only be prescribed and administered by licensed medical staff. There are also environmental restraints such as the rooms identified in **Section 1359, Safety Room Procedures.** This regulation speaks specifically to physical restraints. Physical restraints are devices that immobilize a minor's extremities or limit physical mobility. Examples include soft ties, padded belts and cuffs, metal hand and ankle cuffs and restraining chairs or boards. Only restraints specifically manufactured for the purpose of restraining such persons safely should be used. Restraints should not be confused with postural supports, which may be required for other medical reasons. This regulation should not be interpreted to impose a restriction on the use of handcuffs, shackles or other devices to restrain minors for security or transportation purposes. Appropriately meeting the intent of this regulation is determined by the purpose and under what circumstance restraint devices are applied. This criterion is a more significant factor than the kind of device or equipment used.

Excluding short-term use of force to gain immediate control, placing a minor in restraints requires management approval prior to taking action. Approval for putting a minor in restraints must come from the facility manager or designee. For the purpose of this regulation, the designee is the ranking management person designated by the facility manager to be responsible for this area of operation. The regulation also allows the facility manager to delegate the authority to place a minor in restraints to a physician. If delegated to a physician, the language does not preclude the facility manager from making the decision to place a minor in restraints. Medical assessment and input is required for continuing the use of restraints.

The facility administrator, in conjunction with the responsible physician, must develop policies and procedures for the appropriate use of restraint devices. The responsible physician must be involved in creating the policy and procedures because use of physical restraints carries numerous medical and mental health risks that require close monitoring. These risks include neurological or muscular injury; circulatory impairment; dehydration; exhaustion, especially as it relates to the dangers of struggling; respiratory and cardiac collapse; fractures; kidney damage; strangulation; aspiration, especially if a minor is restrained on his or her back; failure to diagnose a serious underlying medical condition; and the possibility of exacerbating the mental condition. Policies must be consistent with both medical and custody considerations and reflect the actual operation of the facility. Both a facility's **Policy and Procedures Manual (Section 1324)** and the **Health Care Procedures Manual (Section 1409)** should address the appropriate use of restraint devices.

Policy and procedures should address exercising the extremities of minors in restraints. Rather than specify what are medically known as “range of motion” procedures in the regulation, the intent here is for the facility manager and responsible physician to develop procedures that fit with the types of restraints used in the particular facility or system. Procedures, practices and staff training should outline the range of motion procedures in detail as they relate to specific restraints and circumstances. Current federal mental health regulations require range of motion exercise of alternating extremities a minimum of ten (10) minutes every two hours. Arguably, extremity exercise policies may vary for sedate versus “struggling” minors.

Local policy and procedures must identify signs and symptoms that would result in an immediate medical/mental health referral. Again, the responsible physician must be instrumental in

developing policy and procedures, because medical and mental health backgrounds are necessary to identify the range of behaviors and signs that a minor has a significant medical or mental health problem. Some of the conditions prompting, or resulting from, the use of restraints are potentially life threatening and must be dealt with by properly trained medical/mental health staff as soon as the conditions are identified.

Minors in restraints must be provided the necessary food and fluids, and provision must be made to accommodate toilet needs of minors in restraints. Each facility with minors in restraints must have access to policy and procedures addressing the availability of cardiopulmonary resuscitation equipment. The facility's emergency evacuation plan must consider the special needs of minors who lack mobility due to the restraints.

There are six kinds of checks that must be performed when a minor is held in restraints. First, every minor in restraints must be under continuous direct visual supervision. **Section 1302, Definitions,** defines this as staff being constantly in the presence of the minor. The use of physical restraints increases the risks to a minor's physical extremities. The potential for injury to the minor creates the need for constant staff observation.

Second, minors in restraints must be reviewed for continued retention a minimum of once every hour and that review must be documented. This hourly time frame is a decision-making point. The decision to continue or remove restraints at these hourly reviews is the responsibility of the facility manager or identified designee (see above discussion). This review should be done in consultation with the custody and health care staff and supervisors who have been monitoring the minor’s behavior.

Third, as soon as possible, but within two hours of placement in restraints, the minor must have a medical assessment to determine whether he/she has a serious medical condition that is being manifested by the aggressive behavior. Some acting out behavior may be symptomatic of serious or life threatening illnesses. It is imperative that licensed medically trained staff examines the minor as soon as possible, but not more than two hours after being placed in restraints. Given the liability and medical ramifications of long-term restraints, minors should not be restrained in facilities that cannot accomplish a medical assessment by licensed medically trained staff within two hours.

Fourth, the minor must be medically cleared and approved for remaining in physical restraints. This clearance must take place every three hours thereafter to determine the appropriateness of continued use of the restraints.

Fifth, as soon as possible but within four hours of placement in restraints, the minor must be evaluated by a licensed medical health professional to assess whether he/she needs immediate and/or long-term mental health treatment. While it is advisable for the mental health assessment to occur as soon as possible, not all facilities have mental health resources immediately available. Slightly more time is allowed for this evaluation because the minor has already been subjected to a medical evaluation and has had regular custody and medical reviews for retention.

Finally, while the minor must be in the constant presence of staff while in restraints (direct visual supervision), the actual times of the reviews and evaluations required by this regulation must be

documented. Further, observations of the minor's behavior and any staff intervention must be documented at least every 15 minutes. All activity should be noted in a log. Logs should be monitored by the facility manager or designee to assure entries are consistently and accurately recorded. The importance of good documentation with management and administrative oversight cannot be overemphasized.

Included in this regulation is the need to protect restrained minors from abuse by other minors. Under no circumstances should restrained minors be housed with minors who are not in restraints.

Section 1359. Safety Room Procedures.

The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures governing the use of safety rooms, as described in Title 24, Part 2, Section 460A.1.13. The room shall be used to hold only those minors who present an immediate danger to themselves or others, who exhibit behavior which results in the destruction of property, or reveals the intent to cause self-inflicted physical harm. A safety room shall not be used for punishment or discipline, or as a substitute for treatment. Policies and procedures shall:

- **(a) include provisions for administration of necessary nutrition and fluids, access to a toilet, and suitable clothing to provide for privacy;**
- **(b) provide for approval of the facility manager, or designee, before a minor is placed into a safety room;**
- **(c) provide for continuous direct visual supervision and documentation of the minor's behavior and any staff interventions every 15 minutes, with actual time recorded;**
- **(d) provide that the minor shall be evaluated by the facility manager, or designee, every four hours;**
- **(e) provide for immediate medical assessment, where appropriate, or an assessment at the next daily sick call;**
- **(f) provide that a minor shall be medically cleared for continued retention every 24 hours;**
- **(g) provide that a mental health opinion is secured within 24 hours; and,**
- **(h) provide a process for documenting the reason for placement, including attempts to use less restrictive means of control, and decisions to continue and end placement.**

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Title 24, Section 460A.1.13 describes the design, furnishings and equipment that are appropriate for safety rooms. **Title 24, Section 13-201(c) 2, Program Statement** and **Section 13-201(c) 3**, **Needs Assessment Study** relate to an administration's initial decisions regarding whether a facility will have safety rooms.

Facilities are not required to have a safety room. However, facilities that do not have a safety room must have clear policy and procedures for managing minors who present an immediate

danger to themselves or others, who exhibit behavior that results in the destruction of property, or who reveal the intent to cause self-inflicted physical harm. It is not the intent of this regulation that property offenses, which should be handled by the disciplinary due process system, result in the placement of a minor in a safety room. The use of the safety room must be reserved for major, out-of-control behavior that cannot be controlled by other alternatives.

The safety room is not to be used for "attitude adjustment," discipline, or punishment and is not a substitute for treatment. The safety room is not a detoxification/sobering cell and is not to be used for that purpose. While it is preferable to transfer these minors to another facility, many mental health units are not equipped to handle people whose criminal behavior makes them a security concern. In these instances, the juvenile facility is often the last resort.

Safety rooms are a potential source of litigation and many other problems; therefore, the construction, operation and management of safety rooms must be carefully monitored. The purpose of this regulation is to control the use of the safety rooms and thereby avoid the extensive liability that occurs from using the room without the necessary safeguards. The facility administrator must work with the responsible physician to develop policy and procedures for the appropriate use of safety rooms, as there are medical and mental health ramifications related to their use. The facility **Policy and Procedures Manual (Section 1324)** and the **Health Care Procedures Manual (Section 1409)** must describe the appropriate use of these rooms and the roles of health care and probation staff.

Placing a minor in a safety room requires prior management approval. The only exception to prior approval is in the most volatile of circumstances. In this instance, staff may place the minor in a safety room while obtaining approval to keep the minor or others from being injured. Approval for the use of the safety room can come from the facility manager or designee. Delegating safety room placement authority to a designee is permissive, and must be done by the facility manager. Policy must indicate who has this responsibility. For the purposes of this regulation, the designee is the ranking management person designated by the facility manager to be responsible for this area of operation.

Every minor in a safety room must be provided continuous direct visual supervision **(Section 1302, Definitions)**. This means that staff is constantly in the presence of the minor and that audiovisual monitoring cannot substitute for personal presence. Observations must be documented at least every 15 minutes. Direct visual supervision ensures the safety of minors who are at risk of injuring themselves or who are otherwise unstable.

Minors must be reviewed for continued retention in safety rooms at a minimum of every four hours. The intent is that the facility manager or designee, whichever one is designated by policy as having the placement authority, will conduct this review. During this review, it must be determined whether the minor can be safely removed from the safety room. It is the intention of this regulation that minors should be removed from the safety room as soon as it is safe. No minor should be retained in a safety room longer than is necessary for the protection of the minor or others.

Immediately after placement in the safety room, but no later than the next daily sick call, each minor must have a medical assessment to determine whether he/she has serious medical

conditions that are being masked by the aggressive behavior. Some acting out behavior may be symptomatic of serious or life threatening illnesses. The minor must be medically cleared for retention every 24 hours thereafter. Additionally, a mental health evaluation must occur within 24 hours of placement in the safety room to determine the minor's need for mental health services and suitability for retention in the safety room.

While the minor is in the safety room and under the continuous direct visual supervision of staff, all checks and reviews must be documented with actual time recorded. Further, observations of the minor's behavior and any staff intervention must be documented at least every 15 minutes. All activity should be noted on the log, which should be monitored by the facility manager or other designated supervisor to assure entries are consistently and accurately recorded. The importance of good documentation with management and administrative oversight cannot be overemphasized.

Specific staff procedures must be established to accommodate the minor's needs for nutritional requirements and fluid intake. Fluids are especially important given that minors in safety rooms are likely to have high fluid replacement needs due to elevated physical exertion. Paper plates, cups and other non-hazardous materials lessen the risks in addressing the nutritional and fluid needs of safety room detainees. Because safety rooms are not required to have a toilet, staff procedures must address escorting the minor from the safety room to appropriate toilet facilities.

Section 1360. Searches.

The facility administrator shall develop written policies and procedures governing the search of minors, the facility, and visitors. Searches shall be conducted to ensure the safety and security of the facility, and to provide for the safety and security of the public, visitors, minors, and staff. Searches shall not be conducted for harassment or as a form of discipline or punishment. Written procedures shall address each of the following:

(a) intake searches;
(b) searching minors who are returning from activities outside of the living unit, court, another facility, or visiting;
(c) facility searches;
(d) searches of visitors; and,
(e) cross gender supervision.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Searches are necessary to ensure the safety and security of the facility and to provide for the safety and security of the public, visitors, minors, and staff. Searches are conducted to maintain an environment as free as possible from any material prohibited by policy and procedures.

Policy and procedures should define the types of searches (e.g., pat down, strip, and visual body cavity) and clearly describe the procedures to conduct such searches. Any body search,

excluding pat down searches, should be conducted by staff of the same gender as the minor except in documented emergency circumstances. Only licensed medical staff can do an intrusive body search. Any opposite sex searches should be accomplished in the presence of another staff member. Procedures should be established for searches whenever a minor enters or leaves the facility, subsequent to visiting, and for routine institution security. Searches should not be conducted for harassment or as a form of discipline or punishment.

Each facility needs to consider the need for limited administrative searches of visitors to ensure the safety, security, and sound operation of the facility. A notice informing all visitors of the visitor search policy should be posted in a conspicuous place at both entrance and departure points of the facility.

Improper search procedures can lead to costly litigation; it is essential that the county counsel or department attorney reviews the search policy to ensure that it complies with the latest case law.

Section 1361. Grievance Procedure.

The facility administrator shall develop written policies and procedures whereby any minor may appeal and have resolved grievances relating to any condition of confinement, including but not limited to health care services, classification decisions, program participation, telephone, mail or visiting procedures, and food, clothing, or bedding. Policies and procedures shall include provisions whereby the facility manager ensures:

- **(a) a grievance form and instructions for registering a grievance, which includes provisions for the minor to have free access to the form;**
- **(b) the minor shall have the option to confidentially file the grievance or to deliver the form to any child care supervision staff working in the facility;**
- **(c) resolution of the grievance at the lowest appropriate staff level;**
- **(d) provision for a prompt review and response to grievances within a specified time limit;**
  - **(1) The minor may elect to be present to explain his/her version of the grievance to a person not directly involved in the circumstances which led to the grievance.**
  - **(2) Provision for a staff representative approved by the facility administrator to assist the minor.**
- **(e) provision for a written response to the grievance which includes the reasons for the decisions; and,**
- **(f) a system which provides that any appeal of a grievance shall be heard by a person not directly involved in the circumstances which led to the grievance.**

Whether or not associated with a grievance, concerns of parents, guardians, staff or other parties shall be addressed and documented in accordance with written policies and procedures within a specified timeframe.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: It is the responsibility of the facility administrator to assure that the grievance process is in place. This process begins with minors having free access to grievance forms. A good grievance procedure is straightforward and easy for staff and minors to use. It is valuable as a management tool because it can minimize writs and lawsuits against the facility. A good grievance procedure will assure that facility personnel listen to minors' concerns and remedy what needs correcting. This can prevent small problems from becoming big problems, and can prevent big problems from becoming lawsuits. It is appropriate that the facility manager or a designee monitor the grievance process to assure that it is operating as intended. Modifications should be made when necessary.

There are two ways a minor can file a grievance. The first is by handing it to a staff member and discussing the issue. This process is a valuable social skills learning tool in which the minors may learn to resolve problems non-violently. The second is filing a grievance confidentially (not anonymously) without fear of retribution. It is important to recognize in the case of the confidential option that it is the actual filing that is confidential not the entire investigation process. Designated lock boxes that are checked regularly can be used for this purpose.

The grievance mechanism may also serve as a self-inspection system. Along with incident reports **(Section 1362)** and the disciplinary process **(Section 1391)**, grievances provide important information for facilities to use in either formal or informal internal audits. Grievances can tell facility administrators what is working and what is not, and can serve as open line of communication from minors to staff, and from staff to management, for identifying and correcting deficiencies. Facility managers have an obligation to review grievances, along with incident and disciplinary reports, to get an overview of what is going on in the facility or system.

The grievance procedure can serve as documentation of good faith efforts to remedy difficulties and improve conditions of confinement that comply with accepted standards. In this regard, as well as for the auditing purposes mentioned above, it is helpful to retain grievances in a minor's file. Having a log or master file of grievances and their resolutions may help the facility administrator see trends and patterns as well as respond to lawsuits.

The policies and procedures for grievance review and resolution should include:

1. a discussion of staff training in the effective use of the grievance process and how to resolve matters at the lowest possible staff level;
2. the mechanisms by which minors are made aware of the grievance procedure (beginning with orientation) and how to set the process in motion;
3. acknowledgement that grievances must be handled judiciously and within the time limits set by the procedure; and
4. provision for the minor to explain his/her version of the grievance and for staff to assist when needed.

The grievance process can diffuse potential problems. Conflicts that are described in writing can be more readily resolved and often with better results than personal confrontations. Grievances are to be resolved at the lowest appropriate level in the chain of command, with the intent of addressing issues in a timely manner. Supervisory staff should be aware of grievances as they arise and move to assist in the process if necessary. In some facilities, appeals go from line staff

to first line supervisor to the facility administrator. In others, grievances are appealed from line staff to first line supervisor or shift supervisor. This regulation requires one level of appeal and review. Additional reviews and appeals may be needed in some systems and are based on management's prerogative. A facility administrator may develop policies and procedures that exceed this regulation.

This regulation requires that at each step of the process, a minor must receive written reasons for the action taken, including approvals as well as denials. The notification should be documented. Carbonless forms with the minor's and staff's signatures may be good ways to end two of the more frequently encountered complaints of minors (i.e., that staff destroyed a minor's grievance or that a minor was unaware of the grievance process). The grievance should continue to a resolution even though the minor has been released during the process. Minors deserve a response to their grievance and facility administrators should insist that the process is consistently applied.

Grievances occasionally raise the issue of jurisdictional/administrative differences. For example, there may be instances of conflict between medical and custody personnel. Since the facility administrator is the final authority on custodial and security issues and the responsible physician has the responsibility for medical decisions, there must be some established procedure for resolving jurisdictional/administrative disagreements.

This regulation also requires a mechanism to ensure that complaints and concerns of parents, guardians, staff and other concerned parties are addressed. Policy and procedures must address documentation and written responses to these complaints and concerns.

Section 1362. Reporting of Incidents.

A written report of all incidents which result in physical harm, serious threat of physical harm, or death to an employee or a minor of a juvenile facility, or other person(s) shall be maintained. Such written record shall be prepared by the staff and submitted to the facility manager by the end of the shift.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Incidents that result in physical harm or serious threat of physical harm to staff, minors or others require particular attention. In addition to helping with the investigation of crimes or rule infractions, incident reports are valuable in defending the facility against lawsuits. These reports not only provide substantive assistance to staff or facility administrators called to testify about an incident that may have occurred months or years earlier, they also provide evidence of conditions in a facility and may indicate where staff needs additional specialized training or where procedures are not serving the purposes for which they were intended. The party reporting the incident must submit the incident report by the end of his/her shift.

The policy and procedures relating to incident reports should include a definition of an incident; who is responsible for the report and information it must include; reporting timelines; and how

the report is filed and processed. These reports must be legible and comprehensible and include "who, what, when, where" as well as any corrective action taken. Incident reports by their nature integrate with other policies and procedures (e.g., instances in which staff uses force, applies restraints or places a minor in a safety room require an incident report) and should be cross-referenced. Policy and procedures should address the need to report any suspected child abuse and other mandated reports.

There are differences between an incident report (which is an internal written description of occurrences), disciplinary report and crime report. Frequently, discipline and crime reports rely on an incident report to establish what occurred. Not all incident reports result in criminal prosecution or disciplinary actions. It is important to establish a filing system that differentiates between these three reports. It is unnecessary to duplicate the information on two different forms. When reports may be used for more than one purpose, be sure to cross-reference them to facilitate retrieval of either one or both.

There are a number of ways to file/retain incident reports. Some facilities retain them in the minor's detention file; others place them in a facility central incident file. Some use multiple copy forms with copies going to the minor's file, the central file and to the staff person involved in the occurrence. Where reports are kept is less important than that they be kept. The long-term benefits of documentation cannot be realized unless the information can be retrieved and used when it is needed.

Section 1363. Use of Reasonable Force to Collect DNA Specimens, Samples, Impressions.

(a) Pursuant to Penal Code Section 298.1 authorized law enforcement, custodial, or corrections personnel including peace officers, may employ reasonable force to collect blood specimens, saliva samples, and thumb or palm print impressions from individuals who are required to provide such samples, specimens or impressions pursuant to Penal Code Section 296 and who refuse following written or oral request.

(1) For the purpose of this section, the "use of reasonable force" shall be defined as the force that an objective, trained and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable to gain compliance with this section.

(2) The use of reasonable force shall be preceded by efforts to secure voluntary compliance. Efforts to secure voluntary compliance shall be documented and include an advisement of the legal obligation to provide the requisite specimen, sample or impression and the consequences of refusal.

(b) The force shall not be used without the prior written authorization of the supervising officer on duty. The authorization shall include information that reflects the fact that the offender was asked to provide the requisite specimen, sample, or impression and refused.

(1) If the use of reasonable force includes a cell extraction, the extraction shall be videotaped. Video shall be directed at the cell extraction event. The videotape shall be retained by the agency for the length of time required by statute. Notwithstanding the use of the video as evidence in a court proceeding, the tape shall be retained administratively.

(2) Within 10 days of the use of reasonable force pursuant to this section, the facility administrator shall send a report to the Corrections Standards Authority, documenting a refusal to voluntarily submit the requisite specimen, sample or impression; the use of reasonable force to obtain the specimen, sample or impression, if any; the type of force used; the efforts undertaken to obtain voluntary compliance; and whether medical attention was needed by the juvenile offender or other person as a result of reasonable force being used.

NOTE: Authority cited: Section 298.1, Penal Code; Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Penal Code Section 298.1 authorizes the use of reasonable force to collect DNA samples. This regulation further outlines requirements for such use of force procedures. When providing written and verbal notices advising minors of the requirement to provide a specimen, sample or impression, the notice should be given in the language(s) most often used by the minor and in a vocabulary that is understandable. In addition, the notice should be available in a manner that can be understood by persons with disabilities (e.g., visual impairments, hearing impairments, etc.). Every effort should be made to ensure that minors understand the requirements.

A refusal, for purposes of reporting to the Corrections Standards Authority, may be passive or aggressive and may or may not lead to the use of force depending on departmental policy. An initial refusal in which voluntary compliance is subsequently attained is not considered a refusal for reporting purposes. Forms for reporting refusals are available on the CSA website **(www.csa.ca.gov)**.

This regulation and corresponding statute require that if reasonable use of force requires a room extraction, the extraction must be videotaped. It is not the intent that the use of a fixed or mounted camera, aimed in the general vicinity of the room extraction event be a substitute for a handheld video camera aimed at the event. Although not required by regulation, should force be applied during the collection of the specimen, sample or impression, it is recommended the collection be videotaped with audio as well (rather than limiting videotaping to room extraction events). Adequate training on the use of the video equipment, including its operation, maintenance, battery charging and known location is essential.

The primary role of facility health care staff is to provide "treatment." Due to potential conflict with this role, facility medical staff should not be utilized in the forceful collection of specimens, samples or impressions. However, nothing in this regulation or in **Section 1409, Health Care Policy Manual,** would prohibit facility health care staff from participating in the routine, voluntary collection of DNA samples as required by **Penal Code Section 298.1.**

ARTICLE 6. PROGRAMS AND ACTIVITIES

Section 1370. Education Program.

(a) School Programs

The County Board of Education shall provide for the administration and operation of juvenile court schools in conjunction with the Chief Probation Officer, or designee. The school and facility administrators shall develop written policy and procedures to ensure communication and coordination between educators and probation staff. The facility administrator shall request an annual review of each required element of the program by the Superintendent of Schools, and a report or review checklist on compliance, deficiencies, and corrective action needed to achieve compliance with this section.

(b) Required Elements

The facility school program shall comply with the State Education Code and County Board of Education policies and provide for an annual evaluation of the educational program offerings. Minors shall be provided a quality educational program that includes instructional strategies designed to respond to the different learning styles and abilities of students.

(1) The course of study shall comply with the State Education Code and include, but not be limited to, the following:

(A) English/Language Arts;
(B) Social Sciences;
(C) Physical Education;
(D) Science;
(E) Health;
(F) Mathematics;
(G) Fine Arts/Foreign Language; and,
(H) Electives (including career education).

(2) General Education Development (GED) preparation shall be provided for all eligible youth.

(3) The minimum school day shall be consistent with State Education Code Requirements for juvenile court schools.

(c) School Discipline

(1) The educational program shall be integrated into the facility's overall behavioral management plan and security system.

(2) School staff shall be advised of administrative decisions made by probation staff that may affect the educational programming of students.

(3) Expulsion/suspension from school shall follow the appropriate due process safeguards as set forth in the State Education Code including the rights of students with special needs.

(4) The facility administrator, in conjunction with education staff will develop policies and procedures that address the rights of any student who has continuing difficulty completing a school day.

(d) Provisions for Individuals with Special Needs

(1) Educational instruction shall be provided to minors restricted to high security or other special units.

(2) State and federal laws shall be observed for individuals with special education needs.

(3) Non-English speaking minors, and those with limited English-speaking skills, shall be afforded an educational program.

(e) Educational Screening and Admission

(1) Minors shall be interviewed after admittance and a written record prepared that documents a minor's educational history, including but not limited to:

(A) school progress;

(B) Home Language Survey;

(C) special needs; and,

(D) discipline problems.

(2) Not later than three school days after admission to the facility the minor shall be enrolled in school; and the educational staff shall conduct an assessment to determine the minor's general academic functioning levels to enable placement in core curriculum courses.

(3) After admission to the facility, a preliminary education plan shall be developed for each minor within five school days.

(4) If a minor is detained, the education staff shall request the minor's transcript from his/her prior school. Copies of the student's Individual Education Program (IEP) and 504 Plan will also be requested. Upon receipt of the transcripts, the minor's educational plan shall be reviewed and modified as needed.

(f) Educational Reporting

(1) The complete facility educational record of the minor shall be forwarded to the next educational placement in accordance with the State Education Code.

(2) The County Superintendent of Schools shall provide appropriate credit (full or partial) for course work completed while in juvenile court school.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation describes the required elements of the school program. This program must be flexible to address education requirements of the detained minors, taking into consideration varying learning needs and abilities. The learning plan for each minor must be designed towards completion of graduation requirements. The school program must be a safe and secure environment for detained minors and staff. Regular communication between school and facility staff is essential to provide a safer, more supportive environment on both the living units and in school. This communication may include information about learning difficulties (such as auditory processing problems), as well as family, peer, and other social problems the youth may be experiencing that would impact behavior. Facility and education staff are encouraged to share such information no less than weekly, and on a daily basis, when possible.

Core courses are provided within this regulation to identify the fundamental elements that should be present in the classroom. Additional courses that meet the needs of the minors in custody

may be added as required. Providing a mechanism for automatic review by school and facility staff for youth who have ongoing difficulties in the regular school program allows all personnel working with the youth to assess the difficulties and, if appropriate, develop interventions that will assist the youth in successfully participating in the full school program.

Education is a right that cannot be denied for disciplinary reasons. Due process must be followed when removing students from the regular school setting. Each minor must receive education in accordance with the State Code of Education. If a youth's behavior is the result of a disability, frequent removal from the school program may result in unequal treatment based on a disability. These removals may trigger due process for a new IEP.

The juvenile court schools are required to abide by the State Code of Education. This regulation requires the Superintendent of Schools to annually review each required element for compliance with statute and to provide corrective action if needed to achieve compliance. The Education Code also requires that the education record for each minor be forwarded to the next educational placement.

Providing a quality school program that is equal to that in the community requires the coordinated effort of the county board of education and the chief probation officer or designee. It is the responsibility of the facility administrator to request an annual report to certify that the school district provides a quality program that meets the requirements of this regulation. The Education Program Checklist will assist in determining whether a facility is meeting the required program elements. A copy of the checklist is available at: http://www.csa.ca.gov. Discussions with the superintendent of schools around the checklist can also assist the facility administrator in determining whether the education program is meeting the needs of the minors detained.

Section 1371. Recreation and Exercise.

(a) The facility administrator shall develop and implement written policies and procedures for recreation and exercise of minors.

(b) Equivalent programming for both female and male minors shall exist for all recreation programs.

(c) The recreation program shall include: a written daily schedule; access to approved reading materials; other programs such as television, radio, ping pong, video and games. Activities shall be supervised and include orientation and coaching of minors.

(d) The exercise program shall include the opportunity for at least one hour of outdoor physical activity each day, weather permitting. In the event weather does not permit outdoor physical activity, at least one hour each day of exercise involving large muscle activities shall be provided.

(e) Juvenile facilities shall provide the opportunity for recreation and exercise a minimum of three hours a day during the week and five hours a day each Saturday, Sunday or other non-school days, of which one hour shall be large muscle exercise, as noted in item (d) above. Such recreation and exercise schedule shall be posted in the living units.

(f) The administrator/manager may suspend, for a period not to exceed 24 hours, access to recreation. However, minors on disciplinary status shall continue to have an opportunity for a minimum of one hour of large muscle exercise. That one hour of exercise may be suspended only upon a written finding by the administrator/manager that the minor represents a threat to the safety and security of the facility.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Recreation and recreation yards or areas can be the subjects of "conditions of confinement" lawsuits. It is important for facility administrators and managers to carefully consider the use of exercise areas and to document who has access, when, and under what circumstances. This will require schedules and logs that document recreation and exercise activities. Within the policy and procedures required by this regulation, administrators should design a schedule to ensure that everyone receives at least the minimum amount of exercise and recreation time. Recreation includes exercise; however, other recreation activities may not be substituted for the minimum one-hour of outdoor large muscle exercise. Each youth shall be given the opportunity for one full hour of large muscle exercise each day.

Females and males require equivalent programming. This does not mean that the programs are necessarily the same. The intent is to provide females and males with the same opportunity for large muscle exercise and recreation in a form they prefer.

Title 24, Section 460A.1.11, Physical Activity and Recreation Areas, contains the design requirements for exercise areas. Exercise areas must be designed to assure access for minors with disabilities, taking a full range of potential disabilities (such as visual impairments, physical limitations, and use of prostheses) into account. Having toilets and wash basins located in the recreation/exercise area will save staff time and reduce the long-term operating cost of the facility.

Section 1372. Religious Program.

The facility administrator shall provide access to religious services and/or religious counseling at least once each week. Attendance shall be voluntary. A minor shall be allowed to participate in other program activities if he/she elects not to participate in religious programs.

Religious programs shall provide for:

(a) opportunity for religious services;

(b) availability of clergy; and,

(c) availability of religious diets.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Participation in religious services/counseling is voluntary. Minors who choose not to participate in religious services must have the opportunity to participate in other activities. Religious services should be provided in a manner that does not interfere with programs on the living unit. Minors cannot be penalized for electing not to participate in religious activities. Minors on disciplinary status should not be denied the opportunity to participate in religious activities, although special arrangements may be required.

The religious program must provide an opportunity for all religions, although the time and frequency may be regulated, and the size of the groups at religious services may be restricted. Some agencies have chaplains who can be valuable resources in developing the facility's religious programming, and experience has shown that there is a great deal of volunteer support for religious programming in juvenile facilities. In light of the fact that many case law decisions have resulted from denial of religious observances, facility administrators are encouraged to take advantage of the religious resources in the community and provide a full array of religious programming. However, it is also important to ensure that religious personnel who provide programming to minors in your facility are certified or approved by their religious organization.

Litigation has also arisen regarding religious diets. The preparation of special religious diets for minors may not be necessary if the range of food offered is broad enough to provide minimum nutritional needs without the consumption of religiously prohibited food. Separate arrangements to provide kosher diets may be required because of the special preparation involved.

Access to religious programs does not mean freedom to interfere with the peaceful rights of others, or freedom to disregard rules of the institution. Religious literature is permitted unless it represents a demonstrable risk to security.

Facility administrators are encouraged to preserve the communal nature of a religious service. However, the right to attend religious services may be prohibited when it compromises institutional security. The intent of a religious service is not achieved if a minor is placed alone in a room with religious reading material.

Section 1373. Work Program.

The facility administrator shall develop policies and procedures regarding the assignment of minors to work programs. Work assigned to a minor shall be meaningful, constructive and related to vocational training or increasing a minor's sense of responsibility.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: A work program should be a positive experience. This does not preclude tasks that are normal housekeeping responsibilities; these are necessary in maintaining a clean and orderly facility. A minor shall not be required to perform degrading or unnecessary tasks.

Minors require sufficient sleep to ensure good health and classroom performance. Work assignments cannot interfere with proper sleep hours or classroom schedules. Work assignments are not a substitute for school hours, but work can be a part of an approved vocational, training, or work experience program.

Section 1374. Visiting.

The facility administrator shall develop written policies and procedures for visiting that include provisions for special visits. Minors shall be allowed to receive visits by parents, guardians or persons standing in loco parentis, at reasonable times, subject only to the limitations necessary to maintain order and security. Opportunity for visitation shall be a minimum of two hours per week. Visits may be supervised, but conversations shall not be monitored unless there is a security or safety need.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The benefits of an appropriate visiting policy include reduced tension; a healthy emotional climate; developing and strengthening family relationships; and improved minor and staff morale. Visitation should be encouraged because strong family and community ties increase the probability of success for a minor after release. Programs such as the Foster Grandparents may be helpful for minors who may otherwise not receive visits.

Visiting procedures must conform to the needs of the minor and the security of the institution. Visitors need to be informed that they may be searched based on security requirements **(Section 1360, Searches** and **Penal Code Section 4030)**.

Facility administrators are encouraged to consider that some parents or guardians might take issue with an established visiting schedule if it conflicts with their work schedule. Offering visitation opportunities at varied hours and days can minimize visiting conflicts for parents or guardians. Other options include special visiting arrangements for those who have work schedule conflicts.

This regulation does not preclude visitation by children of minors in custody or by small children and infants. Special programs such as “Teen Parents” can include visits with the minors' children.

The location for visiting within the facility should be consistent with overall security requirements. Non-contact visiting should be limited to only those visits requiring increased security.

Section 1375. Correspondence.

The facility administrator shall develop and implement written policies and procedures for correspondence which provide that:

(a) there is no limitation on the volume of mail that minors may send or receive;
(b) minors may send two letters per week postage free;
(c) minors may correspond confidentially with state and federal courts, any member of the State Bar or holder of public office, and the State Corrections Standards Authority; however, authorized facility staff may open and inspect such mail only to search for contraband and in the presence of the minor; and,
(d) incoming and outgoing mail, other than that described in (c), may be read by staff only when there is reasonable cause to believe facility safety and security, public safety, or minor safety is jeopardized.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Minors must be informed that staff may open and inspect mail only when there is reasonable cause to believe that the safety of the minors, staff, facility or public is jeopardized. However, this restriction does not preclude staff from opening and inspecting mail to search for contraband, cash, checks or money orders. Where there is a confidentiality privilege, as with members of the State Bar, judges, holders of the public office or the Corrections Standards Authority, the opening and inspecting of mail must take place in the minor's presence. This requirement is set by case law and not subject to interpretation. Local jurisdictions need to define the form in which legal mail is to be received so that it will be recognized upon receipt and reduce unintentional illegal opening and inspecting. When there is no indication that a letter is legal mail, errors could occur by opening the letter.

As with all constitutional issues, a recommended practice is to document all instances and causes for reading a minor's mail. The practice of reading all mail at random (for security reasons) may not require documentation of every letter read. However, if all the mail of a particular minor is read, there should be documentation in order to protect staff and the facility manager from litigation.

Incoming and outgoing mail should be processed as expeditiously as possible. When a minor is sent material not prohibited by law, but considered contraband by the facility, the material can either be returned to the sender or held and given to the minor upon release. In either event, inform the minor. The processing of mail is simpler when specific staff is assigned responsibility for handling the mail. Getting mail from the public to minors in custody can involve several links to coordinate. Mail is important to both the sender and the recipient. When possible, mail should be forwarded to a minor who has left the facility.

To avoid misunderstandings, policies and procedures relating to mail and correspondence should be part of the minor's orientation to the facility **(Section 1353, Orientation)**.

Section 1376. Telephone Access.

The administrator of each juvenile facility shall develop and implement written policies and procedures to provide minors with access to telephone communications.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The telephone is an effective tool for reducing tension and anxiety in a detention facility. An adequate number of telephones and a reasonable telephone policy will allow minors to maintain contact with family and the community, thereby reducing many incarceration and reentry problems. This requirement is an addition to **WIC Section 627**, which requires minors be allowed two free telephone calls, at public expense, within one hour of being taken into custody.

A system should be established to assure access to telephones while providing for the security of the facility. Technology developed by telephone vendors contains a broad spectrum of security and access features, including the ability to exclude certain telephone numbers as well as to monitor and track calls. A careful review of the options available through each vendor will allow the facility administrator to integrate the system with the needs of the facility.

Staff should be aware of telephone use to ensure that minors do not misuse or exert control over the phones. It is suggested that a cut off switch be in the staff control area that would allow staff to terminate all phone use during an emergency or high security event

Section 1377. Access to Legal Services.

The facility administrator shall develop written procedures to ensure the right of minors to have access to the courts and legal services. Such access shall include:

(a) access, upon request by the minor, to licensed attorneys and their authorized representatives;

(b) provision for confidential consultation with attorneys; and,

(c) unlimited postage free, legal correspondence and cost free telephone access as appropriate.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Minors have a constitutional right to unimpeded access to attorneys and legal representation. Upon request, staff must make minors available to their attorneys or authorized representatives at reasonable times. However, these visits may be in conflict with institutional schedules and security (e.g., school, visiting, or meals). The constraints of facility schedules and the limitations of staff availability determine the best times for interviews. The facility administrator can work to avoid scheduling conflicts by arranging meetings with the public defender, district attorney, the courts and local attorneys. Efforts for mutual understanding and cooperation should help relieve pressures and reduce some conflicts that occur when attorneys demand to see their clients at unusual times. **Penal Code Section 825** establishes penalties for not allowing appropriate access to an attorney.

Facilities must have space designated for the confidential interviewing of clients by their counsel **(Title 24, Section 460A.1.24, Confidential Interview Room)**. The needs of attorneys vary from a short contact at the visiting window to space needed for paperwork in preparation for a hearing or trial. The visit must be confidential and may be a contact visit. Generally, contact includes the ability to have a conversation without a microphone and to pass documents. Not every attorney will need or want a contact visit, and the facility administrator can require special security arrangements based on valid interests.

Section 1378. Social Awareness Program.

Programs designed to promote social awareness and reduce recidivism shall be provided. Social Awareness Programs shall take into consideration the needs of male and female minors. Such programs may be provided under the direction of the County Board of Education or the chief probation officer and may include: victim awareness; conflict resolution; anger management; parenting skills; juvenile justice; self-esteem; building effective decision making skills; appropriate gender specific programming; and, other topics that suit the needs of the minor. There will be a written annual record review of the programs by the responsible agency to ensure that program content offered is current, consistent, and relevant to the population.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Social awareness programs should be an integral part of the overall treatment plan; such programs may also be part of the institutional assessment and plan required by Section 1355. The importance of these programs for this population is critical. Social awareness programs can be provided through a variety of sources including the education program, probation staff, volunteer groups, or contract agencies. Programs should be provided in a location that promotes effective program delivery and safety for staff and minors. A written annual review will assist in assuring the program content is appropriate for the population. If the programming is provided through the education program then the annual review may be included in the annual education certification and evaluation.

ARTICLE 7. DISCIPLINE

Section 1390. Discipline.

The facility administrator shall develop written policies and procedures for the discipline of minors that shall promote acceptable behavior. Discipline shall be imposed at the least restrictive level which promotes the desired behavior. Discipline shall not include corporal punishment, group punishment, physical or psychological degradation or deprivation of the following:

(a) bed and bedding;

(b) daily shower, access to drinking fountain, toilet and personal hygiene items, and clean clothing;
(c) full nutrition;
(d) contact with parent or attorney;
(e) exercise;
(f) medical services and counseling;
(g) religious services;
(h) clean and sanitary living conditions;
(i) the right to send and receive mail; and,
(j) education.

The facility administrator shall establish rules of conduct and disciplinary penalties to guide the conduct of minors. Such rules and penalties shall include both major violations and minor violations, be stated simply and affirmatively, and be made available to all minors. Provision shall be made to provide the information to minors who are impaired, illiterate or do not speak English.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: It is important that there be standards of behavior that guide the safe, orderly and efficient operation of a juvenile facility to protect both staff and minors. There must be a clear and consistent disciplinary process ready to be initiated when a rule is violated. Prevention of rule violations is preferable to correcting misbehavior.

The disciplinary process is an administrative versus a judicial process. While the rules of evidence in an administrative proceeding differ from those in a criminal matter, administrators should be aware that there is no prohibition against both referring a matter for prosecution and treating it internally as a disciplinary matter.

A facility's rules and disciplinary penalties must be clear, consistent and uniformly applied. They must be written and available to minors, both as a fair warning of the consequences of inappropriate behavior and in order to ensure due process and equal protection as guaranteed by the United States and California State Constitutions.

Group discipline is defined as "where a group of uninvolved minors are denied programming due to the actions of one or more minors, except when the safety and security of the unit and/or facility may be in jeopardy." It is important to distinguish between "group punishment" and the need to control a group of detainees. It is not the intent of this regulation to restrict staff's ability to control the group for security purposes. The security needs of controlling an unruly group is not within the punishment realm; it is a security issue, not a punishment issue.

Although school officials within the facility may remove a minor from the school program for just cause, the minor is still entitled to receive an education. When the behavior of a minor warrants isolation/segregation, child supervision staff is responsible for notifying the education program and ensuring that educational services are provided to that minor.

As referenced in **Section 1372, Religious Program**, religious services may not be withheld as a form of discipline. However, to ensure the religious freedom of others, separate arrangements may be made to provide individual services to a minor who is too disruptive to remain in the general population during his/her religious services.

Child supervision staff must ensure that any minor placed on a restricted program is allowed the minimum of one hour of large muscle activity per day. The exercise allowance must be provided in a way that ensures the safety and security of the facility and provides the minor with sufficient opportunities to exercise.

The disciplinary process must be fair and consistent. Rules should be regularly reviewed to ensure that they are reasonable and have a valid base. When rules are changed, all posted copies and facility rule books must be changed. Staff must be informed about any changes.

It is advisable to keep the number of rules to a minimum. Too many rules can cause disciplinary problems, waste staff time and create an overly repressive atmosphere. Too many rules also weaken the effectiveness of the important rules that are necessary for the facility to operate efficiently and effectively.

Section 1391. Discipline Process.

The facility administrator shall develop written policies and procedures for the administration of discipline which shall include, but not be limited to:

- **(a) designation of personnel authorized to impose discipline for violation of rules;**
- **(b) prohibiting discipline to be delegated to any minor;**
- **(c) definition of major and minor rule violations and penalties, and due process requirements;**
- **(d) minor rule violations which may be handled informally by counseling or advising the minor of the expected conduct or by the imposition of a minor penalty; segregation for a minor violation shall not exceed 24 hours; discipline shall be accompanied by written documentation and a policy of review and appeal to a supervisor; and,**
- **(e) major rule violations which include but are not limited to: any violation that results in segregation for 24 hours or more, or extension of time in custody. Major rule violations and the discipline process shall be documented and require the following:**
  - **(1) written notice of violation prior to a hearing;**
  - **(2) hearing by a person who is not a party to the incident;**
  - **(3) opportunity for the minor to be heard, present evidence and testimony;**
  - **(4) provision for minor to be assisted by staff in the hearing process;**
  - **(5) provision for administrative review.**

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Maintaining discipline within a juvenile facility is critical to safe, secure, and efficient operations. Although the discipline system will vary at individual facilities, this regulation establishes the key elements that are required to satisfy current legal and operational needs. An important aspect of the disciplinary process is to ensure that the minors are aware of the potential consequences of negative and/or unacceptable behavior. This awareness begins with the minor's orientation, as described in **Section 1353**.

Counseling can be an effective tool in the disciplinary process and is among the first actions to be taken in response to lesser rule violations. Counseling is personal and informal and encourages the minor to respond in a mature, responsible manner. Counseling relies on the skill and sensitivity of staff to diffuse potential disciplinary problems before they escalate. This kind of informal handling of lesser infractions does not require documentation; however, a series of lesser violations can constitute a major violation. For this reason, some notation of accumulating violations could later be helpful in documenting the more serious or cumulative disciplinary problem.

When lesser sanctions are imposed for rule violations, there is a need for review by supervisory level staff. Counseling and lesser sanctions do not require the hearings and formal notices that are necessary when major infractions and penalties are at issue.

Major violations are those that have an impact on the safety, security, efficiency or operation of the facility and its personnel, staff and/or minors. Segregation or other sanctions resulting from major violations will require that the staff member observing the act submit a written report to the disciplinary officer and provide a formal notice to the minor. Major violations require a timely hearing where the minor is allowed to appear on his/her own behalf and have access to staff assistance. A timely hearing should not be delayed for the convenience of staff and should be relevant and meaningful to the minor. Any discipline that results in segregation of 24 hours or more, or an extension of custody time requires a disciplinary hearing. This is an automatic process initiated by staff; the minor does not have to request it or submit a grievance to have a hearing.

Major violations may even result in charges being filed with the district attorney. There is no double jeopardy in disciplining a minor for a violation of facility rules and referring the case to the district attorney for prosecution.

To ensure the safety and security of the facility, an administrative decision may be made to remove a minor from general housing pending the outcome of either the disciplinary process or prosecution. This typically occurs when the offense is aggravated, or if it could recur or incite other misconduct if the minor remains in the housing area. In this type of situation, pre-disciplinary housing does not amount to prejudging the results because it is not a disciplinary action. Rather, it is an administrative option intended to ensure the safety and security of minors, staff and the facility by removing the minor from the environment where the incident occurred, preventing a continuation of that behavior and/or discouraging others to follow. When a minor is placed in lock-down status pending a hearing, completion of the hearing within the required time constraints assumes greater significance. To prevent theft or destruction, the minor’s personal belongings should be secured when an unplanned change of housing assignment occurs.

In order for discipline to be effective, there must be a correlation between the severity of an infraction and the severity of the punishment. Staff should be trained in the practical application of a fair and objective disciplinary process that includes progressive levels of discipline. Consistency is important and can become problematic when the decision for punishment rests with various staff located at one or more facilities. To establish both fairness and consistency, facility managers frequently develop a policy that includes specific penalties or a range of penalties for various rule violations.

A standardized report form for rule violations will facilitate investigations and provide necessary documentation of violations. The form should include all essential information relating to the incident, including the people involved, times and location where the incident occurred, witnesses, and injuries or damage to property. This regulation requires that the minor receive written notice of the violation(s). The notice need only include the rule(s) violated; supporting documentation need not be included.

The facility manager should review all disciplinary actions. Disciplinary reports and written statements of actions provide the facility administrator with an overview of how the facility is functioning. A review of disciplinary actions can help to assess tensions and the atmosphere of the facility, as well as monitor the performance of the disciplinary officer and all facility staff relative to administering facility rules and procedures.

ARTICLE 8. HEALTH SERVICES

Section 1400. Responsibility for Health Care Services.

The facility administrator shall ensure that health care services are provided to all minors.

The facility shall have a designated health administrator who, in cooperation with the mental health director and facility administrator and pursuant to a written agreement, contract or job description, is administratively responsible to:

(a) develop policy for health care administration;

(b) identify health care providers for the defined scope of services;

(c) establish written agreements as necessary to provide access to health care;

(d) develop mechanisms to assure that those agreements are properly monitored; and,

(e) establish systems for coordination among health care service providers.

When the health administrator is not a physician, there shall be a designated responsible physician who shall develop policy in health care matters involving clinical judgments.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation, which applies to all juvenile facilities, establishes that the facility administrator has the ultimate responsibility for ensuring that health care is provided to all minors. Health care encompasses a wide range of services associated with providing medical, mental health and dental care.

In facilities providing on-site health care services, a health care administrator must work in cooperation with the facility administrator to develop health care policies that are consistent with the scope of services **(Section 1402, Scope of Health Care)**. The health administrator's responsibilities include identifying service providers, establishing and monitoring necessary agreements, and coordinating services among providers to facilitate cooperative relationships. This individual should advocate for health services at a broad level within the system. When developing administrative policies and procedures, this administrator should adopt a collaborative approach that incorporates input from relevant supervision and health care staff, together with other agencies that may be affected by the decisions.

The regulation requires that a responsible physician develop policy and procedures related to the clinical aspects of health care. While the health administrator and responsible physician may be the same person, some systems may have a non-physician as an administrative head for health policy. When this occurs, a physician must also be identified as having responsibility for clinical policy. This sets a policy-level basis for clinical independence in patient care decisions while keeping administrative policy within the purview of the facility administrator **(Section 1401, Patient Treatment Decisions)**. Many situations require a close working relationship between the health administrator and responsible physician, as there are both clinical and administrative aspects of the same issue.

As discussed in **Section 1402, Scope of Health Care**, the extent and manner of delivering health care services will vary among facilities, with some facilities providing all or most of their health care off-site. Regardless of the service delivery method chosen, one individual should be designated as the health "authority" with responsibility for overseeing, planning, coordinating, developing and/or implementing health care delivery to the jail or jails (in conjunction with the facility administrator). A written agreement, which delineates areas of responsibility, is necessary between the facility's funding source and the health authority. If the health authority is not a physician, there must also be a responsible physician available to the facility to make those decisions that, by law, only a physician can make. While **Section 1400** requires a responsible physician, this individual does not necessarily need to be an employee of the facility. The physician may be available pursuant to a written agreement, contract or job description.

Section 1401. Patient Treatment Decisions.

Clinical decisions about the treatment of individual minors are the sole province of licensed health care professionals, operating within the scope of their license and within facility policy defining health care services.

Security policies and procedures that are applicable to child supervision staff also apply to health care personnel.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Licensed health care professionals, operating within the scope of practice defined by their license, have the sole authority to make clinical decisions for individual minors under their

care. Those decisions must be consistent with facility health care policy. When there are policy conflicts betweensupervision and health care staff, the health administrator would be expected to be the administrative voice for health care. This individual would also coordinate efforts and resolve conflicts among health care disciplines.

The unique environment of detention facilities is also addressed in this regulation, which clarifies that health care staff is subject to the same security policies and procedures as supervision staff. The regulation envisions a cooperative relationship between child supervision and health care providers. This cooperation is essential because it takes the expertise of both to maintain order, assure safety and provide health care and programs in a detention facility.

Section 1324, Policy and Procedures Manual, requires that health care staff (as well as school and support staff, contract employees, program providers and volunteers) be provided an initial orientation that includes safety and security issues. Health care staff should also receive training on specific supervision and security policies for which they are held accountable and within which they are expected to function (e.g., key control, lockdown, transportation security, etc.). Likewise, child supervision staff needs to understand the duties and responsibilities of health care providers. Transport security is the responsibility of supervision staff; however, minors need to be transported to off-site providers in a timely manner when directed by the authorized health care staff. The failure to transport to a designated health care appointment can be interpreted as not following patient treatment directives.

Section 1402. Scope of Health Care.

(a) The health administrator, in cooperation with the facility administrator, shall develop written policy and procedures to define the extent to which health care shall be provided within the facility and delineate those services that shall be available through community providers. Each facility shall provide:
  (1) at least one physician to provide treatment; and,
  (2) health care services which meet the minimum requirements of these regulations and be at a level to address acute symptoms and/or conditions and avoid preventable deterioration of health while in confinement.

(b) When health services are delivered within the juvenile facility, staff, space, equipment, supplies, materials, and resource manuals shall be adequate to the level of care provided.

(c) Consistent with security requirements and public safety, written policy and procedures for juvenile facilities shall provide for parents, guardians, or other legal custodians, at their own expense, to authorize and arrange for medical, surgical, dental, mental health or other remedial treatment of minors that is permitted under law.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation applies to all juvenile facilities and requires health and facility administrators to define the scope of services provided within the facility and by community resources. Juvenile facilities are a "catching" point for important health care interventions and prevention. The minor's health care in the facility should be part of a continuum that extends into the community upon release.

It is critical that immunizations, comprehensive health appraisals, medical exams and related testing be incorporated into juvenile health care. Because all needs cannot be anticipated or specified in regulation, it is required that health care be at a level necessary to address acute symptoms and/or conditions and avoid preventable deterioration of the minor's health while confined. It is important that health care services respond to symptoms such as pain, even though those symptoms may not be readily associated with an identifiable condition. The decisions about what care is necessary may relate to the anticipated length of stay. Some health care interventions are better handled in the community upon release.

This broad spectrum of health care services must be addressed in facility policies and contracts with private providers. The regulation does not require that all agreements necessarily be in writing; however, both written contracts with private providers as well as interagency memorandums of understanding (MOUs) provide greater assurance that there is a clear understanding of expectations and coordination of services within the delivery system. Mechanisms for monitoring contracts need to be established in coordination with the facility administrator and consistent with county policies.

Health care services must meet the needs of detained minors and be consistent with community standards, but this regulation allows considerable latitude for administrators to determine how health care will be provided. Factors to consider when designing service delivery systems for each facility include the type of facility and population held (e.g., juvenile hall, special purpose juvenile hall or camp); available physical space to provide care (e.g., exam rooms, interview space and health care housing); proximity to local hospitals and emergency services; and staff time and transportation costs associated with taking minors off-site for care.

It is important to have the necessary staff, space and support for health care programs, if services are to be delivered effectively. While these considerations are relevant for planning services at any time, they are particularly critical when planning for new construction. The **Needs Assessment Study [Title 24, Section 13-201(c)2]** and the **Operational Program Statement [Title 24, Section 13-201(c)3]** for new construction provide an early opportunity to determine what services will be provided on-site, and which ones will be provided in the community.

Responding to certain key questions will help determine the appropriate staffing level for nurses, mental health workers, dentists and other health services staff:

1. *What is the Average Daily Population (ADP)?* The ADP may be higher than the "maximum capacity" and medical coverage should address the true population. This requires that the ADP (and the ADP projections, if planning for the future) be broken down into specific subcategories by service needs. Examples include the number of minors requiring special mental health housing other mental health services; dental care; the number of emergencies per month; the number of requests for minor

medical attention; and the number of minors per month exhibiting signs of depression etc., which might require suicide prevention monitoring.

2. *How many minors are receiving medication?* This question will also help when determining the level of pharmaceutical staffing or the extent of the pharmaceutical contract.

3. *What is the facility design?* Are services delivered to the housing units or do minors report to a central clinic area?

4. *What is the level of security in the institution?* In a lower security area, minors can present themselves to a central location and move through a line rapidly. In a high security area, a nurse may go to each housing area, thus increasing staff time.

5. *What is the child supervision staffing level?* Health personnel may require custody escort. If staffing is limited, health providers may be delayed in carrying out their duties, thus further increasing the number of health care providers needed.

6. *What are other potential impacts to the medical program?* How many minors require frequent court appearances? If these minors are taking medications, this may mean increased staffing is necessary during peak hours and could vary greatly if all the residents are post adjudicated.

7. *How many tasks are performed during sick call and "pill" call?* More tasks mean more time in a unit, but perhaps fewer interruptions through the day.

The health authority and the facility administrator should explore these questions jointly and determine an appropriate staffing level. In addition to physical space requirements, personnel considerations will help determine if it is most viable to:

1. hire medical personnel to work in the facility as employees of the probation department;
2. contract with a local hospital, private physician, private psychiatrist, medical group, health maintenance organization, or medical center;
3. develop a written agreement with the county health department to provide health care;
4. develop a regional agreement among several small counties to provide "roving physicians" and support personnel; or
5. develop some other method of ensuring provision of health services in the most effective and cost efficient manner possible for a facility and/or system.

While services of licensed professionals who are not physicians can be utilized, the regulation incorporates the minimum requirement that at least one physician be available to provide treatment. This assures that not only is there a physician designated for clinical policy (the responsible physician identified in **Section 1400, Responsibility for Health Care Services**) but also one who is available to provide patient care. This can and often will be the same individual. The physician(s) can provide services on-site or, pursuant to policies and procedures, be

available via transport to a local emergency room, a local physician's office or other facilities providing health care within the detention system.

The regulation requires procedures to allow parents, guardians or other legal custodians to make off-site arrangements for health care. This regulation also clarifies that this care would be at the parents', guardians' or other legal custodians' own expense and with consideration for security and public safety. These procedures should incorporate the participation of facility staff.

Section 1403. Health Care Monitoring and Audits.

(a) In juvenile facilities with on-site health care staff, the health administrator, in cooperation with the facility administrator, shall develop and implement written policy and procedures to collect statistical data and submit at least annual summaries of health care services to the facility administrator.

(b) The health administrator, in cooperation with the responsible physician and the facility administrator, shall establish policies and procedures to assure that the quality and adequacy of health care services are assessed at least annually.

(1) Policy and procedures shall identify a process for correcting identified deficiencies in the medical, dental, mental health and pharmaceutical services delivered.

(2) Based on information from these assessments, the health administrator shall provide the facility administrator with an annual written report on medical, dental, mental health and pharmaceutical services.

(c) Medical, mental and dental services shall be reviewed at least quarterly, at documented administrative meetings between the health and facility administrators and other staff, as appropriate.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Health care issues are a frequent point of litigation and represent a substantial portion of budgets. Facility administrators rely on health care providers to keep them apprised of concerns and recommended resolutions. The intent is that facilities develop internal procedures to assess the quality and adequacy of services, identify and resolve problems, and assure that the facility administrator, who is ultimately responsible to ensure that services are delivered, is systematically apprised of problems and concerns.

The regulation is applicable to all facilities with on-site health care staff, however limited those services may be and regardless of whether they are funded through the detention budget, are city or county employees, or are private providers working in the facility. The regulation does not apply to facilities that rely only upon an emergency room or community physicians to provide services outside the facility. These licensed providers would have their own internal mechanisms for monitoring and quality control. This limitation notwithstanding, it may be useful for administrators to prepare statistical summaries on outside health care services to assure oversight of related costs.

The health administrator is responsible for developing the reporting procedures and a system for maintaining the statistics that assist in the future planning, cost control and identifying changes in patterns of providing service. For example, information regarding excessive use of specialty clinics may be used as support to hire a specialist to hold on-site clinics, or high rates of emergency department utilization may justify the addition of on-site health staff to improve coverage at the facility.

The content of the statistical data collection and summaries should be developed with input from both supervision and health care staff. Although the content should reflect the needs and operation of each facility, the following list suggests several considerations:

- Sick call visits by physician assistant/nurse practitioner, nursing staff, and physicians
- Child abuse reports
- Treatment for accidents/fights
- Health appraisals/medical examinations
- Mental health evaluations
- Referrals to mental health services
- Health care services arranged by parent/guardian
- Substance abuse identified
- Transport services (ambulance/car)
- Laboratory tests performed
- Pharmacy services
- Types and numbers of communicable diseases diagnosed
- Emergency department visits
- Specialty clinic services
- Pregnancies identified
- Diagnostic services (laboratory, x-ray, EKG, etc.)
- Profile of hospital and mental health admissions
- Dental services
- Suicide attempts

The health administrator must submit a report, at least annually, to the facility administrator. This report is to outline statistical data on the frequency of services provided and highlight problems identified by the internal process that assess the quality and adequacy of clinical services. The report should analyze the data to identify trends and, in addition to including recommendations for resolving identified problems, should give the administrator an overall understanding of issues facing the health services system. Established mechanisms should assure that the facility administrator is aware of significant issues related to providing health care and that problems are resolved promptly.

Internal mechanisms for assuring ongoing consistency, quality and adequacy of the services need to be developed with the responsible physician, as there are significant clinical implications. Monitoring of internal quality control is central to this regulation. Even though only annual assessment reports are required, quality review and control must occur on an ongoing basis. Except in unusual circumstances, this process of internal quality improvement can be accomplished only by on-site monitoring, and it is recommended this ongoing monitoring be documented as an internal quality assurance report. The importance of incorporating pharmaceutical services into the monitoring and audit process should be emphasized **(Section 1438, Pharmaceutical Management)**.

Quality control documentation should be considered a health care function and should be maintained within the health care services unit. While medical records are probably the main source, other possible means of generating audit information include:

1. studying outbreaks of illness such as diarrhea, flu, etc. (e.g., morbidity review);
2. studying deaths in custody (e.g., mortality review);
3. individual case review;
4. monitoring activities of clinical staff (e.g., review of use of restraints, seclusion, etc.);
5. review of similar diagnoses (e.g., all diabetics);
6. review drug use (e.g. psychotropics, antibiotics, narcotics, etc.);
7. review of policies and practices;
8. study of all suicides and attempts;
9. liability claims review;
10. data obtained from incident reports, together with staff interviews and observations of health care services;
11. review of implementation and status of standing orders; and
12. review of minors' grievances.

Health and facility administrators are to discuss health care issues at least quarterly in documented administrative meetings. This does not preclude these individuals from delegating this responsibility or including additional personnel. Neither does it require that meetings be solely dedicated to health care. While meetings among line-level child supervision and health care staff are critical for effective service delivery, this regulation focuses on administrative policy level personnel and communication systems that contribute to problem resolution.

The purpose of audits and reports is to ensure quality care and optimum service delivery. A plan and the timely correction of identified deficiencies are essential. Documented efforts to correct problems will be valuable if the juvenile facility is involved in litigation. The audit process can also facilitate future planning and affords both custody and health care staff a means to document services provided and identify areas that require additional attention.

Section 1404. Health Care Staff Qualifications.

(a) The health administrator shall, at the time of recruitment for health care positions, develop education and experience requirements that are consistent with the community standard and the needs of the facility population.

(b) In all juvenile facilities providing on-site health care services, the health administrator, in cooperation with the facility administrator, shall establish policy and procedures to assure that State licensure, certification, or registration requirements and restrictions that apply in the community, also apply to health care personnel who provide services to minors.

(c) Appropriate credentials shall be on file at the facility, or in another central location where they are available for review. Policy and procedures shall provide that these credentials are periodically reviewed and remain current.

(d) The health administrator shall assure that position descriptions and health care practices require that health care staff receive the supervision required by their license and operate within their scope of practice.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation applies to all facilities with on-site health care staff and clarifies that licensing, certification and registration requirements in the community also apply to those who provide services to minors in the facility. The health administrator must ensure that medical and mental health services are provided by qualified staff working within the scope of their license or certification as defined in the **Business and Professions Code**. There is a potential for criminal prosecution if providers perform procedures beyond those allowed by their licenses, and individuals can lose their licenses for doing so. Health care personnel working in the facility must:

1. have appropriate and valid California licenses and/or are certified to provide care;
2. work within the scope of practice described by their particular license or certificate; and
3. keep their licenses and/or certificates current.

While the task of verifying the validity of licenses and/or certificates may properly belong to the health administrator, the facility administrator should participate in the development of the written policies and procedures for verification. These policies and procedures should require that the license be presented to the health administrator for inspection; that it be reviewed, verified and recorded; that special note be made of the requirements for renewal; and that a schedule be established for the appropriate periodic inspection. This information, along with a copy of the licensing or certification credentials, is to be kept on file in the facility or, in a multi-facility system, at a central location where the documents are available for review. Written verification procedures can include requests for copies of educational certificates and course content to verify scope of practice.

Health personnel required to have California licenses through the Department of Consumer Affairs include, but are not limited to:

physicians
pharmacists
dentists
dental hygienists
registered nurses
nurse midwives
clinical social workers
vocational nurses
physicians' assistants
medical assistants
psychiatric technicians
clinical psychologists
psychological assistants

Some allied health personnel categories are not licensed, such as paramedics, emergency medical technicians, etc. The health authority and facility administrator must take every precaution to guarantee that members of such categories do not practice medicine or perform duties for which they are not legally qualified. The liability associated with unqualified and/or unlicensed

personnel or allowing staff to work beyond the scope of their licenses greatly exceeds any cost savings that may be produced by lower salaries. Staff who work beyond the scope of their license could lose their license and be criminally prosecuted if an inmate is injured by their actions.

When recruiting for health care positions, facilities must solicit individuals who not only have the required credentials but also have experience and training consistent with what would be expected in similar health care settings in the community. To the degree possible, these individuals' backgrounds should be relevant to adolescent populations and meet the facility's needs. Background checks on employees are important to protect the minor's health and to protect the facility from liability. With the exception of proper credentials, the regulation stops short of specifying who can be hired, recognizing that there are often limitations to the pool of applicants. Many juvenile facilities are primary care clinics by default for large numbers of youth. These clinics are critical "catching," points for identifying and treating health conditions that would not otherwise be identified until they became increasingly debilitating. It is important that the level, as well as qualifications of the health care staff, reflects the sophistication and training necessary to function as diagnostic and treatment centers for medical, dental and mental health problems.

This regulation is not intended to limit the appropriate use of volunteers or other non-licensed individuals who perform services that would not require licensing or other credentials in the community. These programs need to be supervised and monitored. The "rehabilitation model" in mental health services requires that non-licensed staff be appropriately supervised by properly licensed personnel. The absence of this supervision would present a serious liability to the facility. Mental health programs cannot rely solely on non-licensed staff.

Health care staff must complete the required continuing education to maintain their licenses. This continuing training requirement is essential to maintain the quality of care necessary in the facility. Facility and health administrators should provide whatever support possible to help staff maintain their credentials, particularly with respect to educational opportunities that are relevant to the juveniles being served.

The Licensing Boards for health care professionals are under the jurisdiction of the State Department of Consumer Affairs. Regulations governing the practice of registered nurses, licensed vocational nurses, and physician assistants, etc., can be found on the Web at www.dca.ca.gov/. (Please see **Appendix A** for a list of licensing boards, including their websites.)

Section 1405. Health Care Staff Procedures.

The responsible physician for each facility providing on-site health care may determine that a clinical function or service can be safely and legally delegated to health care staff other than a physician. When this is done, the function or service shall be performed by staff operating within their scope of practice pursuant to written protocol, standardized procedures or direct medical order.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Whenever the responsible physician determines that a clinical function or service can be safely and legally delegated to health care staff other than a physician, it must be performed by staff operating within their scope of practice pursuant to a written protocol or medical order. The responsible physician writes protocols or orders to non-physician health care providers for the specific treatment of identified minors, self-limiting conditions and for on-site treatment of emergencies. While these orders allow for flexibility, they must occur within the parameters of statute and the facility's clinical policies. Nothing in this regulation prohibits health care staff from independently performing functions that are within their scope of practice.

This regulation relates to protocols, which must be distinguished from direct orders. Direct orders are those from a physician to qualified medical personnel, allied health personnel or medically trained corrections staff that instruct them to carry out a specific treatment, test or medical procedure on a given patient. Protocols refer to the procedure to be followed when performing a clinical function.

A physician should delegate services only if the designated staff is properly:

1. qualified and legally permitted to perform such service;
2. trained in the provision of such services; and
3. trained in the appropriate procedures for ensuring safety and confidentiality.

Whenever the physician determines that a clinical function can be safely delegated, that function must be performed pursuant to a protocol that:

1. is written, dated and signed by the physician in charge (the medical administrator and/or nursing administrator should also sign the protocol);
2. specifies and outlines the procedure to be performed;
3. establishes the required training for personnel initiating the protocol;
4. establishes the method for evaluating continued competence of persons authorized to perform clinical functions;
5. states the limitations or conditions/settings in which protocols may be performed; and
6. is reviewed and updated at least annually.

Since most facilities will not have a physician on duty in the facility 24 hours a day, seven days a week, protocols and direct orders will be a crucial part of medical service delivery. Practice and procedure must be consistent with accepted medical professional standards and scope of practice.

The facility administrator and facility manager must work closely with the health authority and responsible physician to clarify any roles which child supervision staff may have in health care service delivery. Child supervision staff must be trained if they are used to perform a health related function. Therefore, it is especially important that the facility administrator work with the health authority and responsible physician to establish proper training and to delineate what activities may be required of trained child supervision staff and under what circumstances.

Section 1406. Health Care Records.

In juvenile facilities providing on-site health care, the health administrator, in cooperation with the facility administrator, shall maintain complete individual and dated health records that include, but are not limited to:

(a) intake health screening form;
(b) health appraisals/medical examinations;
(c) health service reports (e.g., emergency department, dental, psychiatric, and other consultations);
(d) complaints of illness or injury;
(e) names of personnel who treat, prescribe, and/or administer/deliver prescription medication;
(f) location where treatment is provided;
(g) medication records in conformance with Title 15, Section 1438;
(h) progress notes;
(i) consent forms;
(j) authorizations for release of information;
(k) copies of previous health records;
(l) immunization records; and,
(m)laboratory reports.

Written policy and procedures shall provide for maintenance of the health record in a locked area separate from the confinement record. Access to the medical/mental health record shall be controlled by the health administrator and shall assure that all confidentiality laws related to the provider-patient privilege apply to the health record. Minors shall not be used to translate confidential medical information for other non-English speaking minors.

Health care records shall be retained in accordance with community standards.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation is intended to assure that formal medical records are established and their confidentially is maintained in facilities that provide on-site health care services. Written policy and procedures must address the content of health care records, their separation from the confinement record and controlled access only by authorized personnel. While the content of the medical record may vary, it should contain all information relative to the minor's health care from the intake health screening **(Section 1430, Intake Health Screening)**, through health appraisals/medical examination **(Section 1432, Health Appraisals/Medical Examinations)**, requests for health care services **(Section 1433, Requests for Health Care Services)**, and all contact with medical and mental health services.

A combined medical, dental and mental health record is encouraged; however, there is a need for a separate, identifiable section for mental health services, whose release is governed by different statutes. Despite unique charting requirements, mental health information should be available in the medical record. This is especially true with respect to prescribed medications. A combined record promotes continuity and consistency. If a minor is detained on successive occasions, existing health care records should be reactivated whenever possible.

The problem oriented medical record format should be considered, but whatever the record structure, every effort should be made to establish uniformity of record forms and content throughout the juvenile system. The record is to be complete and all findings recorded, including notations concerning psychiatric, dental, emergency department and other consultative services. It is important, from a liability standpoint, that records reflect the time as well as date of health care encounters. In instances where encounters take place away from the usual treatment area, the place of encounter should be documented as well.

The confidential relationship of provider and patient extends to minors. The principle of confidentiality protects the minor from disclosure of confidences entrusted to a health care provider during the course of treatment. Thus, it is necessary to maintain health record files under security, completely separate from confinement records and inaccessible to child supervision staff. The health administrator should coordinate with the chief probation officer and juvenile court to develop procedures that assure compliance with various laws relative to confidentiality, release and disclosure of health care records.

A separate file for health records is not necessarily established on every minor. Even in facilities with on-site health care staff, some minors will not be in the facility long enough to require the 96-hour health appraisal/medical examination and will not have any conditions that come to the attention of health care staff. The initial receiving screening form is not a confidential document unless facility policies incorporate evaluations by health care staff into this screening. Any health intervention after the initial screening requires the initiation of a health care record.

While the intake health screening form is mentioned as being included in the medical records, it is also a supervision document and is found in confinement records as well. Some systems develop the screening instrument as a “multiple copy” form for this distribution. The screening form itself is usually based on a minor's self-report and staff observations. Follow-up screening or intervention by health care staff is confidential within the medical record.

The intake screening form is administered as part of the intake process and can be completed by trained child supervision staff pursuant to a procedure approved by the responsible physician. Some larger facilities may utilize licensed medical staff to complete the form, but where this occurs, it does not necessarily imply that it is a confidential medical document. Its purpose is to detect problems that might require immediate referral to an emergency room or hospital for a clearance, might require separation within the facility for safety reasons, or might influence classification and housing. If medical staff completes the intake health screening, and if the screening form itself is not forwarded to child supervision staff, then information needed for proper classification, housing and management must be communicated by some other established means.

Facilities that do not have on-site health care staff should not have access to health care information considered part of the confidential medical record. However, facilities without licensed health care staff will have non-confidential physician's orders instructing child supervision staff about care of the minor. Those instructions are not protected by the same level of confidentiality as the health care record and are not covered by this regulation.

Section 1407. Confidentiality.

(a) For each juvenile facility that provides on-site health services, the health administrator, in cooperation with the facility administrator, shall establish policy and procedures, consistent with applicable laws, for the multi-disciplinary sharing of health information. These policies and procedures shall address the provision for providing information to the court, child supervision staff and to probation. Information in the minor's case file shall be shared with the health care staff when relevant. The nature and extent of information shared shall be appropriate to treatment planning, program needs, protection of the minor or others, management of the facility, maintenance of security, and preservation of safety and order.

(b) Medical and mental health services shall be conducted in a private manner such that information can be communicated confidentially.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: Section 209, Welfare and Institutions Code; 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Confidentiality laws protect the exchange of information and written documentation of medical and mental health treatment from unauthorized disclosure. For this reason, written records of medical, mental health and substance abuse treatment are maintained separate from the confinement record and kept secure to prevent unauthorized disclosure. Confidentiality protections further extend to prohibit verbal discussions of this material.

This regulation addresses the need for probation, medical and mental health professionals to share health information for the well being of the minor. The minors also have a right to discuss medical and mental health concerns with health professionals in a confidential manner. This regulation is to remind probation and health care professionals of their responsibility to afford privacy during health care encounters.

It is recognized that private interview rooms may not be available in every facility. This regulation was designed to allow compliance using a wide variety of techniques such as moving to a more remote area of a dayroom, utilizing an area in intake/receiving away from other minors and staff, etc.

In the case of juveniles, the additional role of a parent or guardian makes management of confidential information complex. For most routine general health care, parents have the right to be aware of (and give consent to) examinations and treatment of the minor. Furthermore, it is the parent who generally authorizes providing copies of heath care records to others. However, it is important to know that a variety of statutes protect the privacy of minors who seek treatment for certain types of conditions such as pregnancy, contraception, sexually transmitted diseases, mental health treatment (excluding psychotropic medications) and substance abuse counseling. In such cases, parents/guardians do not have access to the medical record information, nor can they authorize disclosure to a third party. A simple rule of thumb is to assume that in those cases where the minor has legal authority to consent to treatment, control of the medical record

information lies in the hands of that minor. When parental consent is required, the parent has authority with respect to medical record disclosure.

Because the laws in this area are numerous, it is recommended that each facility consult legal counsel in formulating policy on confidentiality issues and in dealing with any case where there is a question regarding confidentiality. Laws relating to confidentiality of records include **Welfare and Institutions Code, Sections 5328, et seq., 18961, 369**, and **739; Civil Code, Sections 798, et seq., 56, et seq.; Family Code, Sections 6910, et seq.; Evidence Code, Section 1013.5; Code 42 of Federal Regulations, Section 2.1, et seq.;** and **Health and Safety Code, Section 1795**.

Juvenile facilities are unique in that management of minors often places child supervision staff in a "parent-like" role. It is recognized that sharing of health-related information with supervision staff can be to the benefit of the minor and allows for a comprehensive, multi-disciplinary team approach. A certain amount of health-related information can be shared with facility staff and the probation officer without obtaining explicit consent of the parent or minor. This is limited to facts that necessarily must be shared in order to safely and properly manage the minor within the facility or to plan for future placement and programming (but not for prosecution). It is important to limit the sharing of this type of information to that which is directly relevant to the stated purpose. Further elaboration would require specific consent. The greatest flexibility in releasing information occurs with a signed consent.

It is also vital that policy and training approaches assure that health care staff are made aware of the necessity to share any information, regardless of the setting in which it was obtained, if it indicates a serious threat to facility security, safety or order.

Section 1408. Transfer of Health Care Summary and Records.

The health administrator, in cooperation with the facility administrator, shall establish written policy and procedures to assure that a health care summary and relevant records are forwarded to health care staff in the receiving facility when a minor is transferred to another jurisdiction, and to the local health officer, when applicable. Policies shall include:

- **(a) a summary of the health record, or documentation that no record exists at the facility, is sent in an established format, prior to or at the time of transfer;**
- **(b) relevant health records are forwarded to the health care staff of the receiving facility;**
- **(c) advance notification is provided to the local health officer in the sending jurisdiction and responsible physician of the receiving facility prior to the release or transfer of minors with known or suspected active tuberculosis disease;**
- **(d) written authorization from the minor and/or parent-legal guardian is obtained prior to transferring copies of actual health records, unless otherwise provided by court order, statute or regulation having the force and effect of law; and,**
- **(e) confidentiality of health records is maintained.**

After minors are released to the community, health record information shall be transmitted to specific physicians or health care facilities in the community, upon request and with the written authorization of the minor and/or parent/guardian.

In special purpose juvenile halls and other facilities that do not have on-site health care staff, policy and procedures shall assure that child supervision staff forward non-confidential information on medications and other treatment orders prior to or at the time of transfer.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation requires that a health care summary accompanies or precedes each minor who is transferred to a facility in another jurisdiction. The regulation applies to all juvenile facilities where reception and transfer occur but does not preclude facilities from having additional requirements for health care information prior to admission. The intent of the regulation is that facilities convey whatever relevant information they know about the minor's health care needs when the minor is transferred elsewhere. Even though the health appraisal/medical examination typically accompanies the minor, the health summary is important because it provides the most current information related to medication and other treatment. Documentation that there is no health care information needs to be forwarded if there is no health care record at the facility.

This information should accompany the minor prior to or at the time of transport to assure continuity of care and to avoid the duplication of tests and examinations. A consistent summary format should be used to document care provided, medical problems, tests (including tuberculosis), treatments, allergies, immunizations, mental health concerns, suicidal ideation and other relevant information. The transfer summary should not only include the current diagnoses and treatment but also indicate if there has been an exposure to communicable disease that requires follow-up observation and/or treatment. This information must be compiled by designated health care personnel at the originating facility and forwarded to the attention of the health care staff at the receiving facility.

Each facility and health administrator must coordinate supervision and health care policies to incorporate procedures assuring that health care staff of the sending facility is notified in advance of transporting minors and that the information reaches health care staff upon arrival at the receiving facility. Advance notification to health care staff is essential if they are to have sufficient time to prepare the summary. Confidentiality can be maintained in various ways, including transporting the information in a sealed envelope that is designated for health services at the receiving facility. If confidential information is faxed, it is critical that the sending and receiving facilities are aware of the need to maintain the required confidentiality.

For minors transferring to or from facilities without on-site health care staff, child supervision staff would forward and receive available instructions for the minor's treatment requirements. This would normally be non-confidential physician directions for the minor's care and include medication delivery instructions. As relevant, these treatment requirements would also be forwarded from facilities with health care staff; however, more detailed confidential health care records should be sent only to a licensed health care provider.

While universal precautions are recommended at all times, special attention should be given to transport instructions, including additional health safety precautions that should be followed by

transporting staff. The importance of procedures for maintaining minors on their medications during transport and upon receipt at a facility cannot be overlooked.

Health and Safety Code Sections 121361 and **121362** require sending facilities to notify the local health officer and the receiving facility prior to transferring or releasing an adult inmate known or suspected to have active tuberculosis disease. While this statute does not technically apply to local juvenile facilities, this regulation parallels the adult statute and requires advance notification and forwarding a treatment plan on minors, pursuant to procedures established by the local health officer. Incorporating local juvenile facilities into this requirement by regulation improves continuity of care and increases the level of protection for other minors, staff and the community. Local health officers should have policies, procedures and established formats for conveying tuberculosis information. The State Department of Health Services, Tuberculosis Control Branch is also available to assist local health departments in developing implementation procedures for this notification.

Summary information forwarded to health care staff does not require a signed release of medical information but is part of the confidential medical file **(Civil Code Section 56.10)**. Release of additional health records requires consent, unless otherwise provided by court order, statute or regulation. Minors can consent to the release of medical information related to treatment for which they are authorized to consent. (See **Section 1434, Consent for Health Care**, for a discussion of statutes and circumstances that would require a consent to release of confidential information to another health care provider.)

The amount of health care information forwarded to outlying camps or ranches at the time a minor is transferred will depend on the needs of the minor, the level of on-site health care staff at the facility and the local policies and procedures for providing overall health care. In some instances, minors may be brought from the camps to a central facility in the detention system for health care. The primary health record should remain where the health care is provided. Camps, ranches, or other facilities that do not have licensed on-site health care staff cannot have the confidential medical record. Child supervision staff should, however, receive the health care clearance and any relevant summary information on health conditions that could have an impact on the minor's programming in the new facility. The clearance document is critical for child supervision staff. (See **Section 1432, Health Appraisals/Medical Examinations**, for a discussion of this transfer clearance.)

Section 1409. Health Care Procedures Manual.

For juvenile facilities with on-site health care staff, the health administrator, in cooperation with the facility administrator, shall develop and maintain a facility-specific health services manual of written policies and procedures that address, at a minimum, all health care related standards that are applicable to the facility.

Health care policy and procedure manuals shall be available to all health care staff, to the facility administrator, the facility manager, and other individuals as appropriate to ensure effective service delivery.

Each policy and procedure for the health care delivery system shall be reviewed at least annually and revised as necessary under the direction of the health administrator. The health administrator shall develop a system to document that this review occurs. The

facility administrator, facility manager, health administrator and responsible physician shall designate their approval by signing the manual.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The health care procedures manual is an essential document describing relevant aspects of health services. The health administrator has the responsibility for the development, dissemination and update of the manual in all facilities with on-site health care staff. Notwithstanding needs for autonomy in clinical policy and decisions, it is important that the health administrator work closely with the facility administrator and manager to insure that the policies and procedures of the health care system are consistent with the overall policies and procedures of the facility. The most effective manual will have policies and procedures for every health regulation as well as for other matters not covered in standards. In other words, the health care procedures manual should be a comprehensive document that addresses all areas relevant to providing health care, regardless of whether those areas are governed by regulation. In facilities that do not provide on-site health care services, the facility administrator must assure that relevant emergency policies and procedures, as well as those addressing how health care will be accessed, are in the custody manual.

Health care policies define both the actual delivery of service and the scope of the facility's responsibility. Care must be taken to be realistic and explicit about each policy and its attendant practice. Policies and procedures that are clearly and completely expressed and properly carried out are the best protection against liability.

Because supervision personnel and health care staff work closely together, the facility administrator should set up a process whereby supervision staff are kept aware of and have input into health care policies, procedures and revisions that have an impact on them. Similar processes need to be in place for health care staff to stay current with supervision policies and procedures. A system should also be established to resolve conflicts between supervision and health care personnel. Early input and collaboration between health care and supervision staff should help ensure that policy and procedures do not create unnecessary conflicts; however, establishing a system for conflict resolution should also be considered.

The health care procedures manual and related processes and programs must be reviewed at least annually so that they continue to reflect practice and meet the needs of the facility. The intent is that policy and procedure manuals remain current. To accomplish this, facilities may elect to update their manuals more frequently. An effective method for documenting each review and revision should include provision for the date and the signature of the reviewer, facility administrator and responsible physician. There should be a process for disseminating changes and for ensuring that all staff understands and implements revisions.

It is not required that each policy and procedure in the original manual be signed to confirm review. It is sufficient to place a declaration paragraph at the beginning or end of the manual stating that the entire manual has been reviewed and approved, followed by the proper signatures. Alternatively, the detention system can develop another mechanism for

documentation. When changes are made to individual policies in the manual, they would need to be initialed and dated by the responsible parties.

The annual review of policies and procedures would, in effect, result in a review of the health care delivery system and programs, which is considered a good management practice. This review process provides the opportunity for changes made during the year to be formally incorporated into the manual instead of accumulating a series of scattered documents. The process also facilitates decision making regarding previously discussed but unresolved matters.

Section 1410. Management of Communicable Diseases.

The health administrator/responsible physician, in cooperation with the facility administrator and the local health officer, shall develop written policies and procedures to address the identification, treatment, control and follow-up management of communicable diseases. The policies and procedures shall address, but not be limited to:

(a) intake health screening procedures;
(b) identification of relevant symptoms;
(c) referral for medical evaluation;
(d) treatment responsibilities during detention;
(e) coordination with public and private community-based resources for follow-up treatment;
(f) applicable reporting requirements; and,
(g) strategies for handling disease outbreaks.

The policies and procedures shall be updated as necessary to reflect communicable disease priorities identified by the local health officer and currently recommended public health interventions.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Minors held in juvenile detention facilities may have higher incidences of infectious diseases than the population at large. These diseases include: tuberculosis; sexually transmitted diseases; hepatitis; HIV/AIDS; measles; meningitis; and others that pose serious management issues for both custody and health care staff. One aspect of maintaining a safe facility is communicable disease control. This begins with recognition of suspected communicable disease and appropriate action to prevent its spread. **Section 1354, Segregation,** and **Section 1430, Intake Health Screening** addresses this subject more specifically. Policies and procedures should address a wide range of considerations necessary to a comprehensive approach to the subject, including:

1. intake health screening;
2. identification of relevant symptoms;
3. referral for medical evaluation;
4. treatment responsibilities during detention;
5. coordination with public and private community-based resources for follow-up treatment;

6. applicable reporting requirements; and[4]
7. strategies for handling disease outbreaks.

This regulation calls for a written plan to address the identification, treatment, control and follow-up management of communicable diseases. Because there are wide ranges of communicable diseases that can affect minors and incidence rates vary among jurisdictions, this regulation directs that facilities have a plan that responds to those infectious diseases that are most prevalent in their local areas.

The regulation specifies that the plan must reflect "current" local incidence of communicable diseases. There should be a plan for regular review, update and response to emergent diseases. The plan should also identify key custody and health care staff positions that are responsible to ensure that the plan is implemented and that there is timely communication to resolve issues. It is important to schedule regular discussion among the concerned parties in order to develop an effective plan and maintain working relationships that assure that the plan remains "current" and that its provisions are implemented. The DHS website includes specific references to a variety of communicable diseases, along with applicable reporting forms, etc. (http://www.dhs.ca.gov/ps/dcdc/dcdcindex.htm).

Each jurisdiction's local health officer should be involved in developing the communicable disease plan. The local health officer has responsibilities in communicable disease control throughout the jurisdiction, including institutions located within it. In addition, **Health and Safety Code Section 101045** requires the local health officer to conduct an annual inspection of detention facilities, and communicable disease control is an important area to address.

Developing a relationship with the local health officer will bring valuable information and resources to the juvenile facility. The health officer will be able to identify communicable disease priorities of importance to the facility, based on disease statistics collected from the surrounding community population. In addition, the health department will be able to provide valuable technical advice and assistance, both in anticipation and response to communicable disease concerns.

The benefits of communicable disease management extend to staff, visitors and the local community. Likewise, the communicable disease plan should consider the possibility of infections being introduced through contact with family, visitors and staff. In general, minors should be immunized, educated and treated with their future placement in the overall community in mind.

There are related regulations pertaining to communicable diseases **Section 1432, Health Appraisals/Medical Examinations** discusses recommended immunizations and screening (e.g., tuberculosis screening) for communicable diseases for which adolescents are at high risk. In addition, age-appropriate communicable disease education should be provided and is addressed more specifically under **Section 1415, Health Education.**

[4] Includes California Code of Regulations, Title 17, Sections 2500-2511, and Health and Safety Code, Section 121070.

Section 1411. Access to Treatment.

The health administrator, in cooperation with the facility administrator, shall develop written policy and procedures to provide unimpeded access to health care.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996

Guideline: This regulation applies to all juvenile facilities and requires policy and procedures for minors to have access to health care. It is critical that neither staff nor other minors prevent individuals from requesting and receiving this care. Unimpeded access applies to minors in lockdown, those with behavior problems, and those in general housing.

To demonstrate access, minors must be advised of health care options and procedures for requesting care and must be able to express concerns about the health care system. Orientation to health care services and procedures for accessing care must be provided by designated staff at the time of the minor's orientation to the facility programs and procedures and in a language and vocabulary that is understandable and age-appropriate for the minor **(Section 1353, Orientation)**. The ability for minors to register grievances about the health care system is incorporated into **Section 1361, Grievance Procedure**.

Access to treatment includes options within the institution and provision for outside appointments **(Section 1402, Scope of Health Care)**. Health care personnel should be the individuals to determine when or if health care should be limited. Access for minors implies that parents or guardians are also aware of the options and procedures. The minor's parent or guardian can also register complaints and obtain resolution about health care services through direct access to facility administrators and court remedies.

Section 1412. First Aid and Emergency Response.

The health administrator/responsible physician, in cooperation with the facility administrator, shall establish facility-specific policies and procedures to assure access to first aid and emergency services.

(a) First aid kits shall be available in designated areas of each juvenile facility.

(b) The responsible physician shall approve the contents, number, location and procedure for periodic inspection of the kits.

Child supervision and health care staff shall be trained and written policies and procedures established to respond appropriately to emergencies requiring first aid.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The purpose of the first aid kit and procedures is to provide emergency intervention. The first aid kit should contain selected medical supplies that would allow child supervision staff to treat minor injuries that do not require attention from health care staff (e.g., band-aids for

minor cuts) or provide immediate aid pending arrival of health care staff. This regulation requires physician approval for the contents and location of first aid kits. Staff must understand their responsibilities with respect to providing first aid and have the necessary skills and training to perform these responsibilities. It is important that child supervision staff be trained to use items in the kit and that this training be updated regularly to maintain the necessary skills.

The contents of the first aid kit, together with the type of first aid equipment, procedures and necessary training, will vary depending upon the need to respond to potential types of injuries (e.g., a kitchen first aid kit differs from that of a work camp). Procedures for maintaining the kit should include the steps for inventorying and restocking, and would typically outline roles of child supervision and health care staff in this regard.

Some facilities may choose not to have first aid kits available to child supervision staff because they have health care staff on the premises 24 hours a day, seven days a week who are available to provide the first aid response. When this is the case, the responsible physician must approve the absence of first aid kits and the **Health Care Procedures Manual (Section 1409)** must describe how this first aid response is to occur. Policies should define child supervision and medical staff responsibilities.

The estimated time of arrival of trained emergency medical personnel and the possibility that immediate emergency personnel may not be available should be considered in the facility first aid plan. In the usual detention setting, excluding kitchens or other work crew areas, emergencies that can be anticipated include bee stings; allergic reactions; fights and/or falls resulting in hemorrhage, sprains or broken bones; and shock resulting from trauma, hemorrhage or fractures. Facilities need to maintain those supplies necessary to respond to these expected and any other emergencies identified in their written procedures on first aid.

Emergency response plans need to include written plans for evacuation of ill or injured youth; designated responsibility for notification of emergency personnel; and pre-determined access routes **(Section 1327, Emergency Procedures)**.

Section 1413. Individualized Treatment Plans.

With the exception of special purpose juvenile halls, the health administrator/responsible physician, in cooperation with the facility administrator, shall develop policy and procedures to assure that health care treatment plans are developed for all minors who have received services for significant health care concerns.

- **(a) Policies and procedures shall assure that health care treatment plans are considered in facility program planning.**
- **(b) Health care restrictions shall not limit participation of a minor in school, work assignments, exercise and other programs, beyond that which is necessary to protect the health of the minor or others.**
- **(c) Medical and mental health information shall be shared with child supervision staff in accordance with Section 1407 for purposes of programming, treatment planning and implementation.**

(d) Program planning shall include pre-release arrangements for continuing medical and mental health care, together with participation in relevant programs upon return into the community.

Policy and procedures shall require that any minor who is suspected or confirmed to be developmentally disabled is referred to the local Regional Center for the Developmentally Disabled for purposes of diagnosis and/or treatment within 24 hours of identification, excluding holidays and weekends.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation addresses the management of minors with health conditions that may have an impact on their ability to function within the established facility routine or to participate in programs for which they are being considered. Examples range from asthma that may only require special consideration during outdoor physical activities to complex mental, developmental or physical disabilities that have an impact on every level of management of the minor.

In most cases, the health care staff conducting the **Health Appraisal/Medical Examinations (Section 1432)** will identify the need for formal treatment planning. Occasionally, the need will be evident as soon as the minor is admitted to the facility. In either case, it is important to assure that one clearly identified health provider takes responsibility for formulating and coordinating the treatment plan.

The treatment plan should address all aspects of the minor's management that are likely to be impacted by the identified health condition. Examples include housing; participation in school, sports and work assignments; and eligibility for eventual placement in programs being considered by the juvenile court. Health care providers must also coordinate with child supervision staff to incorporate these and other conditions into overall planning **(Section 1355, Assessment and Plan)**.

It is intended that the treatment plan developed by health care staff be shared with facility and probation department staff as one element of a multi-disciplinary approach to the minor. This assumes that there will be a sharing of health-related information to the extent necessary to carry out essential elements of the plan. More extensive disclosure requires specific consent of the minor and/or parent, depending on the nature of the information **(Section 1407, Confidentiality)**. When appropriate for release planning or continuity of care within the facility, family members and community service providers may be consulted during planning. This would typically be done through the probation officer, with sensitivity to family member limitations and any history of abuse.

It is desirable to encourage a minor to participate in unrestricted programming to the degree he or she is capable. Therefore, treatment plan recommendations should not be excessively limiting, and reasonable accommodations to promote participation should be undertaken whenever possible.

In the case of minors who are known or suspected to be developmentally disabled, contact must be made with the local regional center within 24 hours, excluding holidays and weekends. The term developmentally disabled technically applies to persons with an I.Q. of 69 or lower, or with epilepsy, autism, or a significant neurological disability that occurred prior to age 18 and resulted in substantial disability. The regional center can be helpful in evaluating minors and contributing to a plan of management. An evaluation can be particularly helpful in cases who have not yet been identified or diagnosed, as such minors may be eligible for special services both during and after confinement **(Section 1355, Assessment and Plan)**.

Section 1414. Health Clearance for In-Custody Work and Program Assignments.

The health administrator/responsible physician, in cooperation with the facility administrator, shall develop health screening and monitoring procedures for work and program assignments that have health care implications, including, but not limited to, food handlers.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation requires all juvenile facilities to have procedures for screening, education and monitoring when work assignments have health implications. This includes food service workers and may also include other assignments as identified by the responsible physician. For example, there are implications for minors with allergies, such as bee stings or poison oak, who are assigned to outdoor work crews.

To promote a balance of health, security and practical operational concerns, the responsible physician, in cooperation with the facility administrator and the food services manager, must develop procedures for screening food service workers. A medical screening program for food handlers prior to initial assignment in a facility food preparation or serving area is necessary to minimize exposure of minors and staff to food borne diseases. A food handler is any person who works with food or food preparation utensils in a facility kitchen or area where food is prepared or distributed to minors or staff. Persons who distribute catered, individually packaged meals are exempt from this screening procedure.

It is necessary to have a clear and specific written protocol for screening food handlers, approved by the responsible physician and administered by a staff person trained specifically for this function. At a minimum, the protocol should include the following:

1. the absence of exposure to and symptoms of food borne contagious diseases, especially hepatitis and diarrheal disease by history; and
2. a physical examination to exclude infected skin lesions, tenderness of the liver and jaundice.

The protocol should also include a referral process for follow-up care of minors with a positive finding on the food handler screening. No minor should be assigned to work as a food handler until the medical screening is completed and there should be periodic reassessment of the health

status of food service workers. While the protocol under discussion addresses minors, it is recommended that civilian food service employees undergo similar screening prior to starting work as food handlers as well. (**Appendix B** provides a sample screening form for food service workers.)

In combination with the medical screening, the responsible physician should work in cooperation with the facility administrator and the food service manager to develop written procedures for the ongoing supervision and cleanliness of food service workers in accordance with **Section 1465, Food Handlers Education and Monitoring**.

Section 1415. Health Education.

With the exception of special purpose juvenile halls, the health administrator for each juvenile facility, in cooperation with the facility administrator and the local health officer, shall develop written policies and procedures to assure that age- and sex-appropriate health education and disease prevention programs are offered to minors.

The education program shall be updated as necessary to address current health priorities and meet the needs of the confined population.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: One step in the process of preparing minors to assume a responsible and healthful lifestyle is to equip them with accurate information on health issues. Despite any appearance of experience and sophistication that minors may convey, they are frequently misinformed about many aspects of personal health and risk factors for disease.

With the exception of special purpose juvenile halls, this regulation requires that all juvenile facilities work with their local health officer to develop a program of regular health education. Even though special purpose juvenile halls are exempt from this requirement, consideration should be given to including health education as a component of programming for those minors who are committed to these facilities for a series of weekends.

The local health department should be viewed as a resource to assist in planning a curriculum that is age and culturally appropriate and reflects locally identified health priorities. In addition, the health educator associated with the health department may be able to provide classes within the juvenile facility.

Facilities can be creative in finding effective and cost-efficient methods for delivering health education services. The State Department of Social Services administers Temporary Aid to Needy Families (TANF) funds, which can be expended for health education programs. Health education can be incorporated into the regular school curriculum, offered in the form of audio or video materials, or provided by some other means that meets the needs of the confined population. For example, some facilities have utilized food services personnel to address the subjects of nutrition and obesity.

Recommended subject areas for inclusion in a health education program include, but are not limited to:

1. chemical dependency, including tobacco use;
2. sexually transmitted diseases;
3. sexuality, including methods of birth control;
4. pregnancy and parenting skills;
5. nutrition;
6. exercise;
7. oral hygiene; and
8. mental health and suicide prevention.

Regardless of the method of delivery of health education, it is recommended that each facility maintain a record of classes, including the overall plan for what will be offered.

Section 1416. Reproductive Services.

For all juvenile facilities, the health administrator, in cooperation with the facility administrator, shall develop written policies and procedures to assure that reproductive health services are available to both male and female minors.

Such services shall include but not be limited to those prescribed by Welfare and Institutions Code Sections 220, 221 and 222 and Health and Safety Code Section 123450.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: Section 209, Welfare and Institutions Code; 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: All juvenile facilities must develop policies and procedures to address reproductive services for detained minors. The extent of such services will depend on the length of confinement and eligibility criteria for the facility (e.g., camp facilities may choose to exclude pregnant girls). In any case, all facilities must meet statutory requirements having to do with access to reproductive services.[5]

Procedures must provide for continuation of any contraceptive method that a minor has established prior to admission into a juvenile facility. There is a high liability to facilities when a pregnancy occurs following release of a minor whose contraceptive method has not been continued.

Pregnancy testing should be readily available. When a pregnancy is diagnosed, the full range of options for treatment that are available in the community must be offered. These generally include prenatal care, adoption and therapeutic abortion services. Special considerations include requirements for parental consent in the case of a requested abortion **(Health and Safety Code, Section 123400)**.

[5]Welfare and Institutions Code, Sections 220, 221 and 222; and Health and Safety Code, Section 25958.

Health care staff should be sensitive to the possibility of child abuse in the case of diagnosed pregnancy or sexually transmitted diseases. While the presence of one of these conditions in a minor is not sufficient to confirm sexual exploitation, more information may lead to identification of reportable child abuse that calls for additional interventions.

Other facility policies and procedures should also take pregnancy issues into account. One example is the safe use of restraint devices during pregnancy. Some facilities prohibit waist or ankle chains during advanced pregnancy and allow only for the use of handcuffs in front of the body in order to limit the possibility of abdominal injury in the event of a fall. It is also important to provide for appropriate prenatal diets, including the provision of snacks to assure an adequate frequency of food intake **(Section 1462, Therapeutic Diets)**.

In the community, minors have access to family planning services without a requirement for parental consent. These services should be similarly available to detained minors. Whenever possible, attention should be given to addressing contraceptive concerns sufficiently far in advance to establish a method that will be fully effective at the time of release.[6] Some juvenile facility health programs are designated as a clinic site under the state Office of Family Planning program. In such cases, all program requirements established under the state Department of Health Services would apply.

In addition to offering specific services, juvenile facilities should consider inclusion of education concerning reproductive health. Topics to consider include nutritional issues, breast feeding, parenting, sexually transmitted diseases, and personal responsibility in reproduction. Whenever appropriate, boys should be included in all aspects of reproductive education and programs.

Section 1430. Intake Health Screening.

The health administrator/responsible physician, in cooperation with the facility administrator and mental health director shall establish policies and procedures defining when a health evaluation and/or treatment shall be obtained prior to acceptance for booking. Policies and procedures shall also establish a documented intake health screening procedure to be conducted immediately upon entry to the facility.

(a) The responsible physician shall establish criteria defining the types of apparent health conditions that would preclude acceptance of a minor into the facility without a documented medical clearance. The criteria shall be consistent with the facility's resources to safely hold the minor. At a minimum, such criteria shall provide:
  (1) a minor who is unconscious shall not be accepted into a facility;
  (2) minors who are known to have ingested or who appear to be under the influence of intoxicating substances shall be cleared in accordance with Section 1431;
  (3) written documentation of the circumstances and reasons for requiring a medical clearance whenever a minor is not accepted for booking; and,
  (4) written medical clearance shall be received prior to accepting any minor referred for a pre-booking treatment and clearance.

[6]Welfare and Institutions Code, Section 221, requires all juvenile facilities to offer family planning services to each female minor at least 60 days prior to a scheduled release date.

(b) Procedures for an intake health screening shall consist of a defined, systematic inquiry and observation of every minor booked into the juvenile facility. The screening shall be conducted immediately upon entry to the facility and may be performed by either health care personnel or trained child supervision staff.

(1) Screening procedures shall address medical, dental and mental health concerns that may pose a hazard to the minor or others in the facility, as well as health conditions that require treatment while the minor is in the facility.

(2) Any minor suspected to have a communicable disease that could pose a significant risk to others in the facility shall be separated from the general population pending the outcome of an evaluation by health care staff.

(3) Procedures shall require timely referral for health care commensurate with the nature of any problems or complaint identified during the screening process.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Intake health screening is a process of structured inquiry and observation designed to prevent newly arriving minors who pose a health or safety threat to themselves or others from being admitted to a facility's general population, and to provide necessary health care when indicated. Intake health screening must occur at the time a minor enters the facility and should not be confused with the more comprehensive health appraisal and medical examination, which occurs later pursuant to **Section 1432, Health Appraisals/Medical Examinations**. This screening regulation establishes the importance of pre-admission screening for observable health care needs that should be identified and addressed prior to acceptance into the facility. These minors should be referred for medical clearance prior to acceptance. Minors who are accepted may also present needs for a health care referral. Consequently, the regulation also requires that referrals be made to appropriate health care staff for evaluation, with prompt and continuous care provided as warranted.

The screening can be performed by appropriately licensed or certified health personnel or by child supervision staff who are trained to administer the screening questionnaire. Facility staff must find out at the earliest possible time who is suspected of carrying a contagious disease, who is in need of medical attention and who should not be admitted without a medical/mental health clearance. This process protects the minor, the facility, other minors and staff from both contagious disease and from potential litigation.

The health administrator/responsible physician must work with the facility administrator to establish policy and procedures identifying when minors must have health evaluations and/or treatment prior to acceptance into the facility. Policies regarding the condition of minors accepted into the facility are expected to vary depending upon the level of care available on-site. Facilities with 24-hour health care staff may have a different threshold for acceptance than facilities without that level of resources. There must also be procedures to document why a minor was not immediately accepted but instead was referred for a health clearance. The regulation is silent about whether this health clearance can be conducted by on-site health care staff or if the minor must be referred to a community resource, usually an emergency room or local urgent care center. Either option complies with regulations. Minors who are unconscious, semi-conscious, bleeding or otherwise obviously in need of immediate medical attention upon

arrival at a facility must be referred immediately for emergency medical care. Additionally, those who are known to have ingested or who appear to be intoxicated must be medically cleared prior to acceptance. Their admission or return to the facility must be based on written medical clearance from the health care provider.

Medi-Cal will reimburse community health care facilities for emergency services, outpatient care and inpatient treatment for Medi-Cal covered detained minors prior to booking and once they are released from custody. Additionally, minors are eligible for Medi-Cal reimbursement while in the facility awaiting placement. The state's definition of "released from custody" is that the individual is no longer incarcerated and includes home detention with or without electronic monitoring; parole; released for time served; probation; or individuals released on their own recognizance. A stay in sentence is not considered being released from custody for purposes of Medi-Cal reimbursement. Medi-Cal does not pay city and county jurisdictions for needed health care services provided by staff in local detention facilities. Local agencies may wish to review their acceptance for custody policies and release procedures because of these interpretations of Medi-Cal eligibility.

The findings of the intake health screening are to be recorded on a printed form approved by the responsible physician. If the screening is automated, provision should be made during programming to accommodate needs for internal quality assurance monitoring.

A medically licensed or certified person such as a registered nurse, physician's assistant, nurse practitioner or registered nurse may administer the checklist; however, facilities may use non-medical staff per the written order of the health administrator/responsible physician. Non-medical personnel must be properly trained by a health practitioner or other qualified professional in the use of the screening form, symptom recognition and other observations the screener should make, documentation of observations, method of referral and any additional concepts which clarify both facility policy and procedures for receiving minors.

The screening checklist is best administered in a reasonably private setting to facilitate open communication and improve the chances of the minor notifying staff of any potential problems. The more information garnered through the screening, the more likely that that important issues will surface and can be addressed in classification, housing and medical service decisions. Screening forms should be maintained for future reference if the minor is readmitted, but the process itself must be repeated every time the minor is accepted into custody.

The areas included below are examples of the kinds of questions and observations that may be considered when developing a receiving screening process. Each facility should include questions that might be helpful in the management and appropriate treatment of minors. It is important for screening personnel to be trained to identify each detainee's suicide risk and complications associated with drug or alcohol usage. Questions should be asked concerning any history of suicidal or erratic behavior, including delusions; hallucinations; communication difficulties; impaired level of consciousness; disorganization; memory defects; depression; trauma; or evidence of self-mutilation or substance abuse **(Section 1450, Suicide Prevention Program)**. The screening should inquire about medications taken and special health requirements. This includes chronic medical problems necessitating regular maintenance therapy such as insulin for diabetes, seizure medications, inhalers and other treatment for asthma.

While screening for STDs is a priority for many facilities, this issue is probably most important at the 96-hour **Health Appraisal/Medical Examinations (Section 1432)**, unless symptoms are identified at the receiving screening. Staff should pay particular attention to signs of trauma and recall the responsibility for reporting all instances of suspected child abuse.

Inquiry:

1. current illness and health problems, including medical, dental, psychiatric history and communicable diseases;
2. medications taken and special health requirements, including chronic medical conditions necessitating regular maintenance therapy;
3. use of alcohol and other drugs, including types, methods, amounts, frequency, date or time of last use, and a history of complications related to usage;
4. history of suicide attempts and presence of current suicidal ideation;
5. history of developmental disability;
6. inquiry about physical or sexual abuse;
7. for females, a history of gynecological problems, possibility of current pregnancy, and present use of birth control; and
8. specific inquiry about current symptoms suggesting communicable diseases, such as tuberculosis and sexually transmitted diseases.

Observation:

1. behavior, which includes state of consciousness, mental status, appearance, conduct, tremors and sweating;
2. physical disabilities and ease of movement;
3. condition of skin, including trauma markings, bruises, lesions, jaundice, rashes and evidence of infestations, needle marks or other indications of drug abuse; and
4. slowness in speech or lack of comprehension of questions, suggesting developmental disabilities.

Facilities should have procedures for obtaining information from a juvenile detainee as to whether the minor is emancipated or living with a parent, guardian or in a foster home. Including this information in the health chart where it is easily accessible may be helpful in the event that consents are needed for medical services. It may prove worthwhile to call the parent, guardian or foster parent for additional health information about the juvenile and to make inquiries about the minor's immunization status and medication allergies.

This regulation does not require a new intake health screening on minors who are transferred to another juvenile facility within the same detention system. Local policies and procedures for internal clearance for transfer would prevail. The importance of a health care clearance prior to transfer within a detention system is discussed in **Section 1432, Health Appraisals/Medical Examinations**. This clearance for transfer is critical, as illnesses acquired in one detention setting might become an epidemic if the individual is transferred to an open camp or dormitory. While a new intake health screening is not required on these internal transfers, it is recommended that the receiving facility have an admission process that includes verification that the necessary health care clearance has been received and an interview with the minor has been conducted to verify and confirm key health related information.

Section 1431. Intoxicated and Substance Abusing Minors.

(a) The responsible physician, in cooperation with the health administrator and the facility administrator, shall develop written policy and procedures that address the identification and management of alcohol and other drug intoxication in accordance with Section 1430.

(b) Policy and procedures shall address:

(1) designated housing, including use of any protective environment for placement of intoxicated minors;

(2) symptoms or known history of ingestion that should prompt immediate referral for medical evaluation and treatment;

(3) determining when the minor is no longer considered intoxicated and documenting when the monitoring requirements of this regulation are discontinued;

(4) medical responses to minors experiencing intoxication or withdrawal reactions;

(5) management of pregnant minors who use alcohol or other drugs;

(6) initiation of substance abuse counseling during confinement and referral procedures for continuation upon release to the community consistent with Section 1413 and Section 1355; and,

(7) coordination with mental health services in cases of substance abusing minors with known or suspected mental illness.

(c) A medical clearance shall be obtained prior to booking any minor who displays outward signs of intoxication or is known or suspected to have ingested any substance that could result in a medical emergency. Supervision of intoxicated minors who are cleared to be booked into a facility shall include monitoring by personal observation no less than once every 15 minutes until resolution of the intoxicated state. These observations shall be documented, with actual time of occurrence recorded. Medical staff, or child supervision staff operating pursuant to medical protocols, shall conduct a medical evaluation for all minors whose intoxicated behavior persists beyond six hours from the time of admission.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation applies to all juvenile facilities to varying degrees, depending upon whether minors are accepted into custody from the street or transferred from another facility, and how long they are detained. The regulation establishes requirements related to intoxication and substance abuse management that range from medical clearance and observation of intoxicated juveniles to subsequent treatment planning and educational considerations. In the majority of facilities, procedures for identifying and managing substance abusing minors will be established by the responsible physician.

Juveniles who are arrested while intoxicated are at risk for serious medical consequences, including death. Examples include acute alcohol poisoning, seizures and cardiac complications

from cocaine, and markedly disordered behavior related to amphetamines or hallucinogenic drugs. This regulation requires that a medical clearance be obtained prior to acceptance into a facility whenever the minor displays outward signs of intoxication or is known or suspected to have ingested any substance that could result in a medical emergency. Important examples of the latter include a history of sequestration of a balloon containing drugs in a body cavity, or juveniles who may have ingested large quantities of drugs immediately prior to arrest in order to eliminate evidence. These minors may initially appear normal, but their condition can rapidly deteriorate.

The determination of the level of intoxication and other substance ingestion concerns will need to be made at the time of the initial intake screening or by the arresting officer before bringing the minor to a police or probation facility. Law enforcement officers have wide and substantial experience recognizing the symptoms of intoxication and are expected to differentiate between a minor who is at risk and needs this medical clearance, and one who has ingested a small amount of an intoxicant. Clearly, minors who are intoxicated to the extent that they are unable to care for themselves would need a medical clearance; however, other minors who have not reached this level may also require a clearance. Consideration must be given to the length of time since they were known or suspected to have ingested the substance.

When in doubt, the officer should obtain a clearance, particularly if the minor is being transported to a facility without medical staff available on-site. The minor's presenting symptoms, not the amount of alcohol consumption, should guide the decision for a clearance. Examples of symptoms pointing to a medical clearance include but are not limited to:

1. drowsiness and/or confusion;
2. body tremors or shakes;
3. a described a history of diabetes or has an ID indicating diabetes;
4. apparent injuries;
5. the minor does not know who or where he/she is and/or the date, time;
6. eyes involuntarily shift back and forth rapidly (horizontal gaze nystagmus);
7. eyes are bloodshot, watery or glassy;
8. poor coordination, staggering and/or swaying;
9. belligerent/combative and/or other self-destructive behaviors are observed;
10. speech is incoherent or slurred;
11. strong odor of alcohol or other intoxicant;
12. vomiting; and/or
13. breathing/respiration is altered.

A medical clearance will most likely be obtained through a local hospital emergency department. While some emergency departments may choose to observe these minors until they are no longer intoxicated, most departments will discharge the minors to the juvenile facility once they have been examined. When this occurs, a written medical clearance is essential for liability protection of the facility, even though it should be recognized that medical clearance is not an absolute guarantee that problems will not occur. Medical facilities that provide clearance examinations should be familiar with the extent of on-site health services at the juvenile facility in order to best determine when intoxicated minors can be safely monitored there.

Once accepted into the facility, a safe setting for the minor to recover under observation must be determined. Juvenile facilities will vary with respect to use of regular housing rooms versus specially designed "safe" rooms that provide varying types of safeguards and ease of observation. Policy and procedures must designate the housing options for these minors, including any protective locations for observation. Documented personal observation by staff must be conducted at least every fifteen minutes. Many facilities opt for more frequent observation, especially during the first few hours. When it is clear that recovery is progressing, the intensity of observation may relax slightly, but must remain at fifteen-minute intervals until the minor is determined to no longer be intoxicated. Regardless of whether health care or child supervision staff conducts the checks, the responsible physician must identify the signs and symptoms that prompt immediate referral for medical care. Although camera monitoring may be a useful adjunct, it cannot be used as a substitute for direct observation through which ease of breathing, level of consciousness, and other critically important criteria can be assessed.

Policy and procedures also need to provide guidance to staff in determining when a minor has recovered from the intoxicated state sufficiently to be removed from this special observation status and placed in regular housing. If a minor remains intoxicated after six hours from the time of admission, a medical evaluation must be done. On-site medical staff can do this evaluation. Child supervision staff can be trained in the use of a protocol developed by the responsible physician to distinguish minors who "just need a little more time" from those whose recovery appears abnormal and warrants more formal medical examination.

Policy and procedures must address when and how medical referral and treatment will be rendered to minors whose state of intoxication or withdrawal requires more than observation (i.e., medical intervention). Examples include symptomatic heroin withdrawal, with special consideration if this should occur in a pregnant minor. Additionally, amphetamine-induced psychosis, stimulant drug intoxication with neurological or cardiovascular complications, and alcohol withdrawal syndrome warrant more medical intervention than observation alone.

Once a minor in a juvenile facility has progressed beyond the immediate circumstances surrounding intoxication, consideration needs to be given to addressing the broader issues of substance abuse and related needs. **Sections 1413, Individualized Treatment Plans, 1415, Health Education,** and **1355, Assessment and Plan** relate to these concerns. All substance-abusing minors should be offered substance abuse counseling, which ideally would be initiated within the facility with arrangements for continuation after release. Those minors who are known or suspected to suffer from mental health disorders have special treatment needs that should be coordinated with mental health staff. Minors who are pregnant, or at high risk of becoming pregnant, would also benefit from substance abuse education and may, in some cases, require specific medical treatment.

Section 1432. Health Appraisals/Medical Examinations.

The health administrator/responsible physician, in cooperation with the facility administrator for each juvenile hall, shall develop written policy and procedures for a health appraisal/medical examination of minors and for the timely identification of conditions necessary to safeguard the health of the minor.

(a) The health appraisal/medical examination shall be completed within 96 hours of admission to the facility and result in a compilation of identified problems to be considered in classification, treatment, and the multi-disciplinary management of the minor while in custody and in pre-release planning. It shall be conducted in a location that protects the privacy of the minor and conducted by a physician, or other licensed or certified health professional working within his/her scope of practice and under the direction of a physician.

(1) At a minimum, the health evaluation shall include a health history, examination, laboratory and diagnostic testing, and necessary immunizations as outlined below:

(A) The health history includes: Review of the intake health screening, history of illnesses, operations, injuries, medications, allergies, immunizations, systems review, exposure to communicable diseases, family health history, habits (e.g., tobacco, alcohol and other drugs), developmental history (e.g., school, home, and peer relations), sexual activity, contraceptive methods, reproductive history, physical and sexual abuse, neglect, history of mental illness, self-injury, and suicidal ideation.

(B) The examination includes: Temperature, height, weight, pulse, blood pressure, appearance, gait, head and neck, a preliminary dental and visual acuity screening, gross hearing test, lymph nodes, chest and cardiovascular, breasts, abdomen, genital (pelvic and rectal examination, with consent, if clinically indicated), musculoskeletal, neurologic.

(C) Laboratory and diagnostic testing includes: Tuberculosis testing, together with pap smears and testing for sexually transmitted diseases for sexually active minors. Additional testing should be available as clinically indicated, including pregnancy testing, urinalysis, hemoglobin or hematocrit.

(D) Immunizations shall be verified and, within two weeks of the health appraisal/medical examination, a program shall be started to bring the minor's immunizations up-to-date in accordance with current public health guidelines.

(2) The health examination may be modified by the responsible physician, for minors admitted with an adequate examination done within the last 12 months, provided there is reason to believe that no substantial change would be expected since the last full evaluation. When this occurs, health care staff shall review the intake health screening form and conduct a face-to-face interview with the minor.

(b) For adjudicated minors who are confined in any juvenile facility for successive stays, each of which totals less than 96 hours, the responsible physician shall establish a policy for a medical evaluation and clearance. If this evaluation and clearance cannot be completed at the facility during the initial stay, it shall be completed prior to acceptance at the facility. This evaluation and clearance shall include screening for tuberculosis.

(c) For minors who are transferred juvenile facilities outside their detention system, the health administrator, in cooperation with the facility administrator, shall develop policy and procedures to assure that a health appraisal/medical examination:

(1) is received from the sending facility at or prior to the time of transfer;

(2) is reviewed by designated health care staff at the receiving facility; and,

(3) absent a previous appraisal/examination or receipt of the record, a health appraisal/medical examination, as outlined in this regulation, is completed on the minor within 96 hours of admission.

(d) The responsible physician shall develop policy and procedures to assure that minors who are transferred among juvenile facilities within the same detention system, receive a written health care clearance. The health appraisal/medical examination shall be reviewed and updated prior to transfer and forwarded to facilities that have licensed on-site health care staff.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The regulation requires the health administrator/responsible physician to develop policy and procedures for a routine health appraisal/medical evaluation of minors to be conducted within 96 hours of admission to the facility. The facility must maintain good intake health screening procedures **(Section 1430, Intake Health Screening)** and make provision for minors to request health care attention at any time **(Section 1433, Request for Health Care Services)**. The regulation allows flexibility in conducting health appraisals/examinations of minors who already have had one completed within the last twelve months. In those instances, the minimum requirement is a face-to-face interview with licensed health care staff. Requirements for a medical clearance are imposed on juveniles who are committed to multiple, successive brief stays (e.g., "weekenders"). The regulation also specifies that receiving a copy of the health appraisal on a minor transferred from another jurisdiction can satisfy the requirement, but a full health appraisal is required within 96 hours if the information is not received. Finally, for intra-jurisdictional transfers, a non-confidential health care clearance must be completed and forwarded to the receiving facility.

The health appraisal/medical examination is a systematic approach to evaluating the health care needs of minors, regardless of whether they have requested attention. The regulation calls for completion of the evaluation within 96 hours of arrival at the facility. The time frame is <u>not</u> modified due to weekends, holidays, or other factors.

Facilities should not depend upon the health appraisal to identify conditions that require immediate or early attention. The intake health screening, prompt response to requests for care, and careful ongoing observation by child supervision staff are essential to accomplishing necessary treatment within appropriate time frames. The need for immediate treatment may be recognized even before the minor is accepted into the facility (i.e., in the "pre-booking" phase), and referral should not be delayed **(Section 1430, Intake Health Screening)**.

The health appraisal/medical examination addresses health issues that become increasingly important as the minor's period of detention continues and is intended to detect illness that is of significance to the institution or individual yet may have symptoms that would otherwise be disregarded (e.g., tuberculosis, some sexually transmitted diseases, etc.). The health appraisal should take a "holistic" approach that includes dental and mental health concerns. Because immunization of the juvenile population is a significant factor in maintaining the health of both minors and persons with whom they are in contact, updating of vaccines is an important part of the process. Juveniles are also at significant risk for sexually transmitted diseases, such as

chlamydia. Consultation with the local health officer regarding current recommendations for screening is recommended. Screening while in custody will benefit the individual as well as persons in the community with whom the minor will interact after release.

In general, juvenile facilities serve as important "catching" points where interventions of significant public health importance occur. Approaches should consider the special needs of this adolescent population, including the understated effects of lead exposure that can result from environmental factors and/or retained lead from gunshot wounds. Conditions that affect the functional status of the minor deserve specific emphasis, as hearing and visual acuity disorders can greatly impact school performance and adjustment in society.

The outcome of the health appraisal/medical evaluation should be a compilation of health issues of significance to the minor[7] that provide the basis for making recommendations to child supervision staff regarding classification issues and any limitations that may affect current and future programming **(Section 1355, Assessment and Plan, and Section 1413, Individualized Treatment Plans)**. In addition, the health appraisal/medical examination is the starting point for updating immunization status, planning other medical testing, and preventive health measures (e.g. health education, family planning, etc.). This approach benefits the juvenile facility and community as a whole, in addition to assisting in an effective, comprehensive approach to managing the health care of the individual minor.

The health appraisal/examination must be conducted by a physician or qualified designee who is working within the appropriate scope of practice and under the direction of a physician. This could be a physician's assistant, nurse practitioner or registered nurse with additional training in physical assessments.

The health appraisal/medical examination must be conducted in privacy, limited only by significant security considerations. At a minimum, the following must be included:

1. Health history, including: review of the intake health screening; history of illnesses; operations; injuries; medications; allergies; immunizations; systems review; exposure to communicable diseases; family health history; habits (e.g., tobacco, alcohol and other drugs); developmental history (e.g., school, home, and peer relations); sexual activity; contraceptive methods; reproductive history; physical and sexual abuse; neglect; history of mental illness; self-injury and suicidal ideation.

2. Physical examination, including: temperature; height; weight; pulse; blood pressure; appearance; gait; head and neck; a preliminary dental and visual acuity screening; gross hearing test; lymph nodes; chest and cardiovascular; breasts; abdomen; genital (pelvic and rectal examination with verbal consent, if clinically indicated); musculoskeletal and neurological.

3. Laboratory and diagnostic testing, including tuberculosis testing, pap smears and testing for sexually transmitted diseases for sexually active minors. Other testing

[7]In the Problem Oriented Medical Record, this would comprise the "Problem List" (Section 1406, Health Care Records).

should be provided as clinically indicated, including pregnancy testing, urinalysis, hemoglobin or hematocrit.

4. Immunizations shall be verified and, within two weeks of the health appraisal/medical examination, a program shall be started to bring the minor's immunizations up-to-date in accordance with current public health guidelines.

It is recognized that accurate verification of immunization status can often be difficult. While schools may be able to assist with information, their records may not be complete. Whenever possible, information should be obtained from parents. A two-week time frame is allowed for establishing a plan to update immunizations in order to avoid the "over-immunization" that occurs when vaccines are arbitrarily given in situations where a history cannot be obtained immediately. Consent issues need to be considered when immunizing minors. Requirements for provision of a Vaccine Information Pamphlet (VIP) apply when parents give consent for immunization; the requirement does not apply when the court supplies consent. Potential contraindications to immunization, such as pregnancy and immunosuppression, should not be overlooked.

A dental screen is an essential part of the health appraisal. While this need not be conducted by a dental professional, the dental screen should include a general inspection of the oral cavity with notation of broken teeth, cavities, abnormal conditions of the gums, and dental prostheses or orthodontics, with referral to an appropriate dental professional as needed. Because of the importance of dental health to self-image and overall well-being, emphasis should be given to potentially correctable conditions.

The regulation allows the responsible physician to modify the extent of the health appraisal for minors who have had one completed within the past 12 months. This can be done as long as there is no reason to believe that a substantial change has occurred since that time. However, it is still necessary for health care staff to conduct a face-to-face interview with the minor and document the results. Emphasis should be given to any new symptomatology, known or suspected exposure to communicable diseases, new medications or development of drug allergies and the possibility of pregnancy in females.

In addition, a health appraisal/examination from another jurisdiction can be accepted if a copy is received when a juvenile transfers from another facility; however, this does not preclude facilities from performing their own assessment if they choose to do so. Similarly, a copy of the health appraisal/medical exam must either accompany minors who are transferred to jail facilities or the jail must conduct its own evaluation within 96 hours.

As is the case in all non-emergency health care interventions, minors have the right to refuse a health appraisal/medical examination. It is recommended that any consequences resulting from a refusal be based on specific rationale. For instance, a minor with a chronic cough who refuses tuberculosis screening may be isolated from others, whereas isolation of an apparently healthy individual may be more difficult to justify. Disciplinary procedures should not be instituted as the result of refusal of health screening.

While there is no specific requirement for periodically updating health appraisal/medical examinations, facilities should consider policy that takes into account the significant physical changes experienced by the adolescent age group. It may be beneficial to develop procedures for periodic re-evaluation of minors whose detention is unusually prolonged.

In some instances, minors are required to report to juvenile facilities for multiple, successive stays of less than 96 hours each (e.g., "weekenders"). Although these minors are not subject to the health appraisal requirement as detailed above, it is necessary for the responsible physician to define a policy for medical evaluation and clearance. If desired, on-site health care staff can provide the assessment, if it can be accomplished during the initial stay. However, many smaller facilities will not have on-site health care staff, or they may not be available during the initial stay. The option exists to require completion of the examination at parental expense prior to admission. The responsible physician must specify the details of the clearance examination, with emphasis on those aspects that are most relevant to facility safety, such as tuberculosis testing and necessary continuation of medications. There is no provision for allowing parents or guardians to sign "waivers of responsibility" that bypass the clearance process, as these waivers would increase medical risks to the minor and liability to facility.

Whenever a minor is transferred to a facility within the same jurisdiction, the health appraisal/medical examination should be updated as needed to assure that it is current, and a copy forwarded to health care staff at the receiving institution. Facilities without licensed health care staff on-site cannot legally maintain these records; in these instances, a health appraisal/medical examination is not sent **(Section 1406, Health Care Records)**. In the case of all intra-jurisdictional transfers, a non-confidential health care clearance form is required to verify for child supervision staff that the minor has been medically cleared for transfer to the facility. The health care clearance represents a simple statement that there are no health conditions that preclude the minor from being housed at the facility and specifies any unusual needs of which supervision staff should be aware.

When minors transfer to facilities outside the county's juvenile detention system, a copy of the health appraisal/medical examination should be forwarded for review by licensed health care staff at the receiving facility. If a health appraisal is not sent, the receiving facility must perform one within 96 hours of admission. This approach also applies to jails, whether or not the juvenile came from their own or another county. Even if the copy of a health appraisal has been received, it should be carefully reviewed to assure that it is current. It is recommended that the minor be interviewed to clarify any concerns about identified conditions or recent developments in health status.

Section 1433. Requests for Health Care Services.

The health administrator, in cooperation with the facility administrator, shall develop policy and procedures to establish a daily routine for minors to convey requests for emergency and non-emergency health care services.

(a) There shall be opportunities for both written and verbal communications, including provision for minors who have language or literacy barriers.

(b) Child supervision staff shall relay requests from the minor, initiate referrals when a need for health care services is observed, and advocate for the minor when the need for services appears to be urgent.
(c) Designated staff shall inquire and make observations regarding the health of each minor on a daily basis and in the event of possible injury.
(d) There shall be opportunities available on a twenty-four hour per day basis for minors and staff to communicate the need for emergency health care services.
(e) Provision shall be made for any minor requesting health care attention, or observed to be in need of health care, to be given that attention by licensed or certified health care personnel.
(f) All health care requests shall be documented and maintained.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation applies to all juvenile facilities and requires designated staff to inquire and make observations regarding the health of each minor on a daily basis. Opportunity must be provided for the minor to request clinic visits and for staff to request health services on behalf of the minor, based on their observation that it is needed. There must be a system to maintain documentation of verbal and written health care requests, regardless of whether they originate from the minor or from staff. Both emergency and non-emergency requests must be responded to in a timely manner. The guiding principle should be that any minor requesting or needing medical attention shall receive such attention as soon as is reasonable and possible.

Local policy will determine which designated staff makes daily inquiry and observation of health care needs as specified by this regulation. Child supervision or health care staff may do it, but there should be an established routine, with provision for additional requests whenever needed. Minors need to be informed of these procedures during their orientation in a manner, language and vocabulary that is understood by them **(Section 1353, Orientation).** Consideration should be given to posting signs in appropriate languages at key locations in the facility.

When child supervision personnel conducts the inquiry and makes observations concerning health care needs, the objective is not to decide who needs medical attention but to appropriately refer everyone making a request for medical/mental health attention. Sometimes child supervision staff makes a judgment about the urgency of referral, but must be careful to avoid making diagnostic decisions about the minor's condition. It is up to health care personnel to determine the kind of attention a minor requires. That attention may include review of the request slip; review of the minor's file; referral; and treatment. Requests from minors do not mandate a level of care or type of service but should be viewed as a means of getting the attention of health care personnel who will then determine what intervention best fits the situation.

It is important for child supervision staff to maintain sensitivity to minors who need mental health attention and may be unwilling or unable to identify this need themselves. Mental health staff can support this staff development by training and outreach when making mental health rounds or when conducting similar activities. Minors with “internalizing” mental disorders

cannot be counted on to express concerns or speak up at sick call. Staff observation skills and referrals are particularly critical if these minors are to get the attention they need.

Local policy, taking into account the size and type of facility, will determine how requests for health care should be documented and maintained. In some facilities, it could be appropriate to put "sick call" slips in the health care file and note verbal requests there as well. Other facilities, particularly those without on-site health care staff, may consider documentation in a log, together with noting the follow-up provided. Procedures need to take into account that not all requests will be in writing.

Although the recognition of illness is an extremely important function, an overall philosophy of "wellness" should be emphasized. Approaches that reward minors who take on unnecessary roles of illness or policies that allow medical conditions to unnecessarily excuse or serve as a basis for non-participation are discouraged.

Section 1434. Consent for Health Care.

The health administrator, in cooperation with the facility administrator, shall establish written policy and procedures to obtain informed consent for health care examinations and treatment.

(a) All examinations, treatments, and procedures requiring verbal or written informed consent in the community also require that consent for confined minors.

(b) There shall be provision for obtaining parental consent and obtaining authorization for health care services from the court when there is no parent/guardian or other person standing in loco parentis.

(c) Policy and procedures shall be consistent with applicable statutes in those instances where the minor's consent for testing or treatment is sufficient or specifically required.

(d) Conservators can provide consent only within limits of their court authorization.

Minors may refuse, verbally or in writing, non-emergency medical and mental health care.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: All juvenile facilities must establish policy and procedures to obtain consent to examine and treat minors. This regulation identifies the health administrator as having the lead in developing written policy and procedures for consent, in cooperation with the facility administrator. This lead role for the health administrator is appropriate due to the complexity of consent statutes for minors and the importance for health services; however, local procedures will determine the responsibilities of probation and health care staff with respect to actually obtaining consent. While probation staff may have greater ability to carry out the logistics of obtaining general consent, it is up to the health care professionals to assure that the obtained consent is adequate for the proposed treatment.

While this may appear to be a straightforward task, it is complicated by a bewildering array of statutes concerning the authority to give consent in certain circumstances. For this reason, it is strongly advised that administrators obtain legal review of procedures and legal advice in any specific instances that are not clear. Further, these statutes are subject to change over time, so policies should be regularly reviewed to assure that they are consistent with current law. Statutes that are relevant to consent include **Health and Safety Code, Section 199.27**, together with **Family Code, Sections 7050, 6922, 6924** through **6929** and **6911**.

While emergency, life-saving treatment can always be rendered without specific consent, a minor may choose to refuse any non-emergency treatment, regardless of who gave consent in the first place. Only a court order can override a minor's desire to refuse treatment.

The initial form of consent that a facility should pursue is one that would allow general, routine health care services. It is highly desirable that parental or guardian consent be obtained, whenever possible. This allows for the appropriate involvement of parents, as well as an opportunity to gain additional important information about the minor, such as a history of medication allergies. Only when attempts to obtain parental consent are ineffective should the court be utilized as a substitute.

Caution should be exercised in adopting any policy that relies on "blanket consent" from the parent, guardian or court for all types of health care, as it is not likely to be valid in some circumstances. Whenever treatment goes beyond a routine level of care, such as in the case of invasive procedures, surgery, or initiation of psychotropic medications, specific informed consent is required. This involves a full discussion of the recommended treatment, its risks and benefits, alternatives, and consequences of refusing the treatment. In general, this would require consent of a parent, guardian, or court, if no parent or guardian is involved. In the event that a conservator has been appointed for the minor, the courts will specify the extent to which the conservator may or may not provide consent to health care.

In certain specified situations, minors have the ability to consent to care without parental involvement. These provisions would apply equally within juvenile facilities as in the open community. Examples include examinations/treatment for pregnancy (with some restrictions on requests for therapeutic abortion services); family planning; treatment for communicable diseases reportable to the local health officer including sexually transmitted diseases; mental health treatment (except for psychotropic medications); and substance abuse treatment.

In the case of immunizations, consent from the parent or court is generally required. When parental consent is involved, vaccine information consistent with requirements of the Vaccine Injury Reform Act must be provided. Minors may consent to receipt of Hepatitis B vaccine if they are determined to be at risk for sexual transmission of that infection.

Section 1435. Dental Care.

The health administrator, in cooperation with the facility administrator, shall develop written policy and procedures to require that dental treatment be provided to minors as necessary to respond to acute conditions and to avert adverse effects on the minor's health. Such treatment shall not be limited to extractions.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guidelines: This regulation applies to all juvenile facilities, though the extent of services will, at times, depend upon the anticipated length of stay. The regulation requires the health administrator to develop policies that result in the provision of dental care, not limited to extractions, in order to treat acute and other conditions that, if left untreated, would have an adverse effect on the health of the minor.

Initial screening for dental pathology involves a basic inspection of the oral cavity as described under **Section 1432, Health Appraisals/Medical Examinations**. It is expected that arrangements for referral would be made for conditions requiring treatment during the period of confinement.

Determining the need for referral involves exercising judgment that balances the acuity and progressive nature of the condition with the anticipated length of stay in the juvenile facility. Longstanding and stable conditions do not generally demand immediate intervention. On the other hand, a tooth that is severely fractured while the minor is in custody may require emergency intervention to prevent irreversible loss. Intermediate situations may be less clear. In any case, it is important that facilities not adopt the stance of limiting treatment to extractions. The importance of dental health to self-esteem and even future employability is of particular significance to the juvenile population and needs to be taken into account in treatment decisions. While there is no expectation of extensive restorative treatment, decisions on "gray area" situations should err on the side of preserving salvageable teeth.

Child supervision and on-site health care staff should be trained in the recognition of dental emergencies, dental first aid procedures, and the time frame within which interventions are required. This is particularly important in situations of injuries to the mouth and face.

Dental services may be provided either on-site or in community-based offices. While the latter is most common, on-site dental offices are justifiable in larger facilities, and portable dental equipment makes on-site dental care realistic for many medium-sized facilities.

While this regulation does not call specifically for professional dental hygiene services and preventive maintenance examinations, consideration should be given to provision of such treatment to minors with unusually long periods of confinement in order to prevent deterioration of dental health over the extended time frame. Instruction in dental hygiene is an important element of health education and can be considered within the context of **Section 1415, Health Education.**

Section 1436. Prostheses and Orthopedic Devices.

(a) The health administrator, in cooperation with the facility administrator and the responsible physician shall develop written policy and procedures regarding the

provision, retention and removal of medical and dental prostheses, including eyeglasses and hearing aids.

(b) Prostheses shall be provided when the health of the minor would otherwise be adversely affected, as determined by the responsible physician.

(c) Procedures for retention and removal of prostheses shall comply with the requirements of Penal Code Section 2656.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation requires that prostheses be provided if the treating physician determines that the health of the minor would otherwise be adversely affected. It also requires that **Penal Code, Section 2656** be followed with respect to retention and removal of prostheses. Prostheses may not be removed unless there is probable cause to believe that they present risk of bodily harm to someone in the facility or threaten facility security. They must be returned to the minor when the risk no longer exists.

Prostheses are artificial devices to replace missing body parts or to compensate for defective bodily function. Prostheses are distinguished from slings, crutches, or other similar assisting devices. Care should be taken so as not to place minors in a situation where prostheses may be used as weapons.

This regulation includes dental prostheses, eyeglasses and hearing aids among the types of prostheses that must be provided to the minor if prescribed by the treating physician. It is anticipated that policies related to the provision of prostheses would parallel what would be done under a similar circumstance in the community and also consider the minor's length of stay in a facility. Minors who are expected to remain in the facility for several months may reasonably have different requirements than minors who will be released back to the community in a matter of days.

Inappropriate removal of some devices (e.g., artificial limbs, etc.) can result in injury to the minor. **Penal Code, Section 2656** relates specifically to adult inmates. While there is no comparable statute specifically for juveniles, those requirements are incorporated by regulation (with clarifying language concerning dental prostheses, eyeglasses and hearing aids) because the same principles are applicable to juveniles and likely to be upheld in any challenge. The law is very specific; it says if the facility manager:

> "…has probable cause to believe possession of such orthopedic or prosthetic appliance constitutes an immediate risk of bodily harm to any person in the facility or threatens the security of the facility, such appliance may be removed.
>
> If such appliance is removed, the prisoner shall be deprived of such appliance only during such time as the facts which constitute probable cause for its removal continue to exist; if such facts cease to exist, then the person in charge of the facility shall return such appliance to the prisoner.

When such appliance is removed, the prisoner shall be examined by a physician within 24 hours after such removal."

Facilities cannot deprive minors of these devices without a security or safety reason. Policies and procedures should discuss the security parameters that might constitute cause for withholding such an appliance, for how long, and with what recourse. How individuals with artificial limbs and other prostheses are to be accommodated in the facility should also be addressed.

Section 1437. Mental Health Services and Transfer to a Treatment Facility.

The health administrator/responsible physician, in cooperation with the mental health director and the facility administrator, shall establish policies and procedures to provide mental health services. These services shall include, but not be limited to:

(a) screening for mental health problems at intake;
(b) crisis intervention and the management of acute psychiatric episodes;
(c) stabilization of persons with mental disorders and the prevention of psychiatric deterioration in the facility setting;
(d) elective therapy services and preventive treatment where resources permit;
(e) medication support services;
(f) provision for timely referral, transportation, and admission to licensed mental health facilities, and follow-up for minors whose psychiatric needs exceed the treatment capability of the facility; and,
(g) assurance that any minor who displays significant symptoms of severe depression, suicidal ideation, irrational, violent or self destructive behaviors, or who is receiving psychotropic medication shall be provided a mental status assessment by a licensed mental health clinician, psychologist, or psychiatrist.

Mentally disordered minors who appear to be a danger to themselves or others, or to be gravely disabled, shall be evaluated pursuant to Penal Code Section 4011.6 or Welfare and Institutions Code Section 6551. The minor may be evaluated by licensed health personnel to determine if treatment can be initiated at the juvenile facility.

Absent an emergency, unless the juvenile facility has been designated as a Lanterman-Petris-Short (LPS) facility, and minors meet the criteria for involuntary commitment under the LPS Act in Welfare and Institutions Code Section 5000 et seq., all services shall be provided on a voluntary basis. Voluntary mental health admissions may be sought pursuant to Penal Code Section 4011.8 or Welfare and Institutions Code Section 6552.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Every juvenile facility must define and provide for essential mental health services. The range and extent of services will depend on the type of facility and level of need of the minors it holds. At a minimum, facilities must have a method to screen for mental disorders upon intake and provide for both crisis intervention and stabilization of acute psychiatric

episodes. Facilities must also intervene as necessary to prevent avoidable deterioration of the minor's mental health while in custody, provide medication support services and provide a method for transferring minors to a licensed facility when a higher level of care is needed. Where resources permit, access to counseling on an elective basis and preventive mental health services are highly desirable.

A mental health program may include a variety of licensed professionals, including physicians, psychologists, Licensed Clinical Social Workers, Marriage and Family Therapists, registered nurse specialists, and psychiatric technicians. In general, where there is a team consisting of a variety of professionals, a physician would be the designated "leader," especially where a formal psychiatric diagnosis and psychotropic medications are involved.

Procedures should address how to provide for continuation of those psychotropic medications prescribed in the community once the minor is in the detention facility. Consideration needs to be given to verifying parental consent and arranging for psychiatric follow-up.

There is a high prevalence of psychiatric illness and situational stress in minors who are confined in juvenile facilities. Acting out and other delinquent behavior may be a sign of a mental disorder and need for treatment. It is vital that minors exhibiting suicidal or other self-destructive behavior, or who appear to be mentally disordered based on irrational or bizarre behavior, be promptly and adequately evaluated by a licensed mental health professional. The speed with which such an evaluation is conducted should be appropriate to the apparent acuity of the problem. Markedly disordered behavior should be treated as an emergency in most cases.

When necessary, a minor can be transferred from a juvenile facility to a licensed inpatient mental health facility on an involuntary basis utilizing the provisions of **Penal Code, Section 4011.6,** or **Welfare and Institutions Code, Section 6551**. Under both of these codes, an evaluation utilizing the "5150" criteria of the **Welfare and Institutions Code** is initiated. There are also some circumstances in which a transfer can be accomplished on a voluntary basis utilizing **Penal Code, Section 4011.8,** or **Welfare and Institutions Code, Section 6552**. In either case, it is important to establish arrangements whereby transfer to a licensed level of treatment is possible whenever the treatment capabilities at the juvenile facility are exceeded.

With dwindling community resources, responding to seriously mentally disordered persons is an increasingly acute problem for detention administrators at both the juvenile and adult level. Inpatient mental health beds are at a premium and often not readily accessible to persons who are already held in locked facilities. However, it is important that juvenile facilities do not acquiesce to pressures to become substitute inpatient facilities when they are not licensed, equipped or trained to do so. However, a minor can be evaluated by qualified licensed health care personnel at the juvenile facility prior to transfer, to determine whether he or she meets the statutory definition for admission to a community mental health facility.

Furthermore, absent an emergency, psychotropic medications may not be given to minors in a juvenile facility on an involuntary basis. When consent for medication cannot be obtained from both the parent and the minor, transfer to a licensed facility is a necessary prerequisite to treatment. Administrators must work proactively and cooperatively with mental health officials

and others in the community to improve availability of mental health services for minors in lieu of having detention facilities serve as the mental health service provider of last resort.

Section 1438. Pharmaceutical Management.

For all juvenile facilities, the health administrator, in consultation with a pharmacist and in cooperation with the facility administrator, shall develop written policy, establish procedures, and provide space and accessories for the secure storage, controlled administration, and disposal of all legally obtained drugs.

(a) Such policies, procedures, space and accessories shall include, but not be limited to, the following:
- **(1) securely lockable cabinets, closets, and refrigeration units;**
- **(2) a means for the positive identification of the recipient of the prescribed medication;**
- **(3) administration/delivery of medicines to minors as prescribed;**
- **(4) confirmation that the recipient has ingested the medication;**
- **(5) documenting that prescribed medications have or have not been administered, by whom, and if not, for what reason;**
- **(6) prohibition of the delivery of medication from one minor to another;**
- **(7) limitation to the length of time medication may be administered without further medical evaluation;**
- **(8) the length of time allowable for a physician's signature on verbal orders;**
- **(9) training for non-licensed personnel which includes, but is not limited to: delivery procedures and documentation; recognizing common symptoms and side-effects that should result in contacting health care staff for evaluation; procedures for consultation for confirming ingestion of medication; and, consultation with health care staff for monitoring the minor's response to medication; and,**
- **(10) a written report shall be prepared by a pharmacist, no less than annually, on the status of pharmacy services in the institution. The pharmacist shall provide the report to the health authority and the facility administrator.**

(b) Consistent with pharmacy laws and regulations, the health administrator shall establish written protocols that limit the following functions to being performed by the identified personnel:
- **(1) Procurement shall be done only by a physician, dentist, pharmacist, or other persons authorized by law.**
- **(2) Storage of medications shall assure that stock supplies of legend medications shall only be accessed by licensed health personnel. Supplies of legend medications that have been properly dispensed and supplies of over-the-counter medications may be accessed by both licensed and trained non-licensed personnel.**
- **(3) Repackaging shall only be done by a physician, dentist, pharmacist, or other persons authorized by law.**
- **(4) Preparation of labels can be done by a physician, dentist, pharmacist or other personnel, both licensed and trained non-licensed, provided the label is checked and affixed to the medication container by the physician, dentist, or pharmacist**

before administration or delivery to the minor. Labels shall be prepared in accordance with Section 4047.5 of the Business and Professions Code.

(5) Dispensing shall only be done by a physician, dentist, pharmacist, or other person authorized by law.

(6) Administration of medication shall only be done by licensed health personnel who are authorized to administer medication and acting on the order of a prescriber.

(7) Licensed health care personnel and trained non-licensed personnel may deliver medication acting on the order of a prescriber.

(8) Disposal of legend medication shall be done in accordance with pharmacy laws and regulations and requires any combination of two of the following classifications: physician, dentist, pharmacist, or registered nurse. Controlled substances shall be disposed of in accordance with Drug Enforcement Administration disposal procedures.

(c) The responsible physician shall establish policies and procedures for managing and providing over -the-counter medications to minors.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation reflects the thinking of a special task force in the late 1980's. In response to litigation, former Senator Presley authored legislation submitted by the State Pharmacy Association regarding the management of medications in detention and corrections settings. The bill directed the Board of Pharmacy, State Pharmacy Association, California Youth Authority, Corrections Standards Authority, Department of Health Services, California Nurses Association, California Medical Association, and Department of Corrections to study the issue of pharmaceutical management. The language in this regulation parallels that which was developed by the initial task force, with the addition of requiring policies and procedures related to over-the-counter (OTC) medications.

In essence, this regulation parallels Board of Pharmacy regulations governing the management of pharmaceuticals in the community related to the ordering, storing, prescribing, dispensing, administration and delivery of drugs in the facility. As with other regulations, this one calls for written policies and procedures developed by the health administrator and the responsible physician in consultation with the facility administrator and a pharmacist. Key terms related to this regulation are addressed in **Section 1302, Definitions.**

The issues related to pharmaceuticals are complex and pose the potential for significant liability. It is important to spell out as clearly as possible how prescription and other medications are to be securely stored and administered, together with disposal methods. Each facility should have procedures that assure compliance with all applicable state and federal laws and regulations regarding acquisition, storage, labeling, packaging, disposal and administration of drugs. The same laws and regulations that govern health care services as in the community, including the management of pharmaceuticals, apply to detention facilities.

To assure that prescription and nonprescription drugs are managed properly in the facility, it is advisable to hire a pharmacist consultant or, in large facilities, it may be cost effective to hire an on-site pharmacist. The pharmacist or pharmacist consultant can work in conjunction with the health administrator and make recommendations regarding the facility formulary, assure appropriate storage, handling and inventory control, provide for destruction of old medication, provide regular chart reviews on medication utilization and, in larger systems, participate on various committees.

All pharmaceutical supplies are to be kept in a secure area of the facility with access limited by proper key control. A close inventory must be kept of these supplies to ensure that unauthorized use or removal will be promptly discovered. While all medications must be maintained in secure locations and under the appropriate environmental conditions to assure their effectiveness, legend drugs must be kept in securely locked cabinets. Access to medications must be limited by policy. In larger jurisdictions with designated pharmacies, the facility manager may have a key to the pharmacy or drug area for security reasons, but not to the controlled substance storage area.

When stock medications are maintained within a detention facility, there must be a formulary of medications stored in that facility. A formulary serves two major purposes: 1) cost containment is improved by eliminating costly duplication of expensive treatment alternatives; and 2) a reference list of readily available medications is maintained for the treatment staff. The physical isolation of some facilities can make it difficult to obtain medications promptly, so keeping a stock of commonly used medications may improve efficient treatment in a cost effective manner. It is acceptable to administer stock legend (prescription) medications by removing single doses at a time, provided this is done by licensed health care staff; preparation of multi-dose packages of medication from bulk stock can be done only by a physician or pharmacist.

Carefully adhere to procedures for the proper disposal of legally obtained drugs and supplies. Dated medications should be routinely purged from stock after their period of use or expiration dates. Facilities that rely on community pharmacies should work with those pharmacists to develop written policies and procedures for destruction of unused drugs. Consideration should be given to incorporating this responsibility into the facility's contract for pharmaceutical services. In larger systems with in-house pharmacies, an inventory of controlled medications to be destroyed must be developed and signed by two licensed health professionals in accordance with the State Board of Pharmacy regulations. This record must be maintained for three years. Policies and procedures for returning unused medications to the pharmaceutical company may be more advantageous than in-house destruction. Community regulations and statutes in this area may change, and establishing a disposal plan with a licensed pharmacist appears to be the best way to remain current with requirements.

Equipment such as used needles and syringes should be disposed of in puncture-resistant containers and discarded according to currently accepted medical waste disposal procedures. Because of increasing awareness of risks for acquiring Hepatitis B and HIV infections through cutaneous injury by blood-contaminated sharp instruments, it is no longer recommended that contaminated disposable needles be either resheathed or broken prior to disposal. Each county's Division of Environmental Health is a resource to assist in developing policies in this area.

It is crucial that the minor for whom a dose of a particular medication is intended is the one who receives that medication; thus, there must be clear policy, consistently followed, regarding positive identification of recipients of medication. Some systems opt for hospital-type identification wrist bands or photographs on medical records or I.D. cards; these options, while not required, should be seriously considered because, particularly in receiving facilities and facilities with more than a handful of minors, it is impossible to identify individuals by recognition only. Staff should not rely on knowing minors by face.

It is important to distinguish between "dispensing," "administering" and "delivering" medications. Licensed health care personnel are not the only staff who can deliver medications but they are the only ones who can dispense and administer them.

1. Dispensing medications can be defined as compounding, packaging, preparing, counting, labeling or in any way filling a prescription. Only a licensed physician or pharmacist can dispense medications.

2. Administering refers to the act in which a single dose of a prescribed drug is given to the patient from a bulk container of medication. Only a licensed medical person can administer medications. Supervision staff cannot administer a dose of prescription medication from a bulk container.

3. Delivery can be done when there is a properly labeled prescription container (i.e., a dated container which includes the name of the individual for whom the drug is prescribed, the name of the medication, dose and instructions for taking the medication, the name of the prescribing physician and expiration dates). Under these circumstances, a single dose at a time can be delivered to the minor according to the written instructions by any licensed nursing personnel or by child supervision staff.

Under any of these circumstances, when a minor is given medication, it is important to verify the dose with the prescriber's orders, give the individual dose to the proper minor and promptly record the time, dose and name of the person giving the medication. Some medications require that they be taken with food, typically to prevent digestive upset. Whenever this is the case, the physician's prescription will specify that the medication be taken with food.

Given the realities of the detention setting, it is often difficult to provide medications on an ideal schedule. Some medications must be given more frequently than others and some must be taken on an empty stomach; these and other issues mean health and child supervision staff must have agreed upon written policy and procedure for melding security and control concerns with the medical and mental health needs of minors. Movement of minors, court appearances, and conflicting activities all interfere with scheduled "pill calls." Facilities should consider methods for providing important medications to those individuals attending court, working in areas not routinely accessible to medical staff or embarking on lengthy transports, and it may be helpful for the prescribing physician to indicate in the medication orders how much leeway is reasonable and safe for a given medication and patient.

Long acting formulations of medications are becoming increasingly available and are attractive for use in detention settings because they are given less frequently and allow for reduced staff

involvement. If such long acting formulations are used, it is important to realize that "soaking" medications in water prior to administration for security purposes is likely to affect the absorption pattern, thus interfering with sustained release characteristics of some drug preparations.

Generally speaking, it is not advisable to use medications brought by or with a minor on admission to a facility. However, sometimes the best way to provide needed medication is from the minor or the minor's family. Such medications should not be used unless the prescription is current (dated within the last two weeks or, for chronic medications, within the past three months) and the contents of the container(s) have been examined for positive identification and approved by the facility's responsible physician or designee. For security reasons, it is preferable that no medication from any source other than the facility or system be used; however, this is not always possible in smaller facilities. For larger systems, unusual medications not stocked in the facility pharmacy can be special ordered. Prescription medications brought from outside can be recorded on the minor's property record and stored in a secure area until release. It is appropriate to use medications transferred from other detention facilities if there is a secure method for ensuring that the minor's prescriptions are not tampered with in transit and that containers are properly labeled.

Procedures for confirming that the recipient has ingested the medication given to him or her are required. Watching a minor take his/her prescription medications is known as "directly observed therapy" (DOT). This regulation requires DOT to ensure that the drugs are ingested. Since nursing staff often cannot get to the locations of work crews, court, etc., there must be policy related to DOT for those minors as well. It is important to the treatment of many illnesses, tuberculosis prime among them, that medications be ingested on a regular schedule and that staff observe the ingestion. Further, ensuring that minors take their medications when administered is an issue related to facility security and the minor's safety. Minors must not be sequestering their prescription medications for later use as currency or for accumulation and ingestion in an overdose. Staff should guard against the opportunity for minors to intimidate others into saving and sharing medications.

The use of liquid formulations may be considered for psychotropic and other controlled medications, as these are more difficult to sequester; however, there are some downsides to liquid formulations. For example, not all drugs are available in liquid form, the bad taste of most liquids or powders could discourage minors from accepting treatment, and the high cost of liquid forms of medications could be prohibitive. Nonetheless, liquid medications solve some ingestion problems that may make the additional cost worthwhile in some instances.

Record keeping related to prescription medications is a key part of the operation of a facility's health services program. **Business and Professions Code Section, 4232** requires that pharmaceutical records, including inventories of those medications not used and therefore destroyed, be kept for three years and, as noted above, drug companies require detailed records of unused drugs which are returned to them. The health administrator is responsible for overseeing medications and monitoring records of medications dispensed. Recording must be thorough, including reasons why a prescribed medication was not administered, (e.g., minor was in court, minor slept through pill call, minor refused medication, etc.). The more detailed the documentation, the greater protection it affords the facility's dispensing personnel.

Rapid turnover of facility populations and the resulting possibility of individuals being "lost in the system," as well as good medical practice, dictate that there be a policy that limits the length of time medication may be administered without further evaluation. Medication should not be administered over extended periods of time without routine follow up to assure medication efficacy, continued need for treatment and absence of complications. At a minimum, follow-up should be scheduled with the same frequency as is customary in the community for the particular condition and, given the destabilizing effects of the facility environment (e.g., changes in diet and exercise, situational stress, relative enforcement of medication compliance, etc.), more frequent medical visits are often warranted. The ordering of chronic medications for an indeterminate time (e.g., until release) fails to meet usual standards of care. For patients on stable medication regimens, follow up visits at least every one to three months is recommended.

For drugs with recognized abuse potential it is recommended that there be special consideration of "stop orders." With the high rate of substance abuse among detained minors, it is essential that practices to discourage the development or continuation of drug dependency be incorporated into the prescribing habits of facility practitioners. Policies may need to include a requirement to reevaluate the need for habit-forming medications every seven to fourteen days.

There must be policy describing the length of time within which a physician must sign his/her verbal orders. Signing of medical orders pertaining to the general medical care of minors should be compatible with community standards (usually 72 hours). In the case of psychotropic medications **(Section 1439, Psychotropic Medications)**, initiation of non-emergency therapy must include obtaining informed consent from the patient and/or parent/guardian by a qualified professional **(Section 1434, Consent for Health Care)**. As a general rule, the use of verbal orders is limited to minor aspects of care and cannot take the place of on-site evaluation and treatment. Review of the number and types of telephone orders is an important aspect of the quality review or management process **(Section 1403, Health Care Monitoring and Audits)**.

For stocks of controlled substances to be maintained in a facility, the facility must be registered with the Drug Enforcement Agency (DEA). If there is no qualified registered pharmacist, the responsible physician may use his/her registry number to obtain stock supplies of controlled substances, if the number is registered with the DEA for that facility. A physical inventory of controlled substances is required every two years or more frequently at the demand of the Board of Pharmacy.

Subsection (a)(8) requires that a pharmacist prepare at least annual reports on the status of pharmacy services in the institution. The importance of pharmaceutical management and related concerns are also incorporated into the monitoring procedures and annual reporting for internal quality control in **Section 1403, Health Care Monitoring and Audits**. It is vital that any problems with regard to pharmaceutical management be discussed in the annual audit report. The Board of Pharmacy licenses pharmacies in some facilities and performs inspections that include a review of pharmacy services. When this occurs, the Board of Pharmacy report may be considered the annual pharmacist report for purposes of this regulation. The mismanagement of medications presents considerable risk to minors as well as liability to detention systems.

Automation of pharmaceutical records can provide some relief to a burdened manual record keeping system, especially in larger facilities. Automated record keeping increases the ability to monitor patterns of prescribing, to detect patterns of minors' requests for drugs, and to monitor the efficiency of the pharmacy service. An automated record keeping system may reduce record storage problems and retrieval time for patient medical histories, increase accuracy in record keeping overall, and even make the monitoring of over-the-counter drugs easier.

Subsection (b)(10) requires policies and procedures related to OTC medications. This is intended to addresses concerns about lack of policy for what drugs can be provided (by licensed or non-licensed staff), potential over-use of OTCs, inconsistent documentation, and lack of notification to health care staff when certain medications are provided to the minor. Frequent use of OTCs may mask symptoms of more serious health conditions that should be brought to the attention of health care staff. The OTCs made available and procedures for their delivery may vary greatly among facilities. When there are no on-site health care services, policies may be considerably different from facilities where health care staff is accessible to evaluate requests on a 24-hour basis. Although it is cumbersome, it is recommended that the delivery of OTC medication be documented. Doing so helps in the identification and referral of minors with chronic complaints that have not been evaluated, helps avoid untoward drug interactions or complications, and helps prevent hoarding and trading medications.

Detention facilities with full-time pharmacy and medical staff may decide to maintain a "Pharmacy and Therapeutics" committee as part of the total quality management process. Included on the committee would be the responsible physician, a pharmacist, the director of nursing services and the director of mental health services. This committee should be responsible for developing written policies and procedures to establish safe and effective systems for the procurement, storage, distribution, dispensing and use of drugs. The committee would also develop and maintain a formulary of drugs for use throughout the local detention system. Using such a committee is an effective method of ensuring quality through annual audit of procedures, chart reviews and monitoring of prescription practices.

Section 1439. Psychotropic Medications.

The health administrator/responsible physician, in cooperation with the mental health director and the facility administrator, shall develop written policies and procedures governing the use of voluntary and involuntary psychotropic medications.

(a) These policies and procedures shall include, but not be limited to:

(1) protocols for physicians' written and verbal orders for psychotropic medications in dosages appropriate to the minor's need;

(2) requirements that verbal orders be entered in the minor's health record and signed by a physician within 72 hours;

(3) the length of time voluntary and involuntary medications may be ordered and administered before re-evaluation by a physician;

(4) provision that minors who are on psychotropic medications prescribed in the community are continued on their medications pending re-evaluation and further determination by a physician;

(5) provision that the necessity for continuation on psychotropic medications is addressed in pre-release planning and prior to transfer to another facility or program; and,

(6) provision for regular clinical/administrative review of utilization patterns for all psychotropic medications, including every emergency situation.

(b) Psychotropic medications shall not be administered to a minor absent an emergency unless informed consent has been given by the legally authorized person or entity.

(1) Minors shall be informed of the expected benefits, potential side effects and alternatives to psychotropic medications.

(2) Absent an emergency, minors may refuse treatment.

(c) Minors found by a physician to be a danger to themselves or others by reason of a mental disorder may be involuntarily given psychotropic medication immediately necessary for the preservation of life or the prevention of serious bodily harm, and when there is insufficient time to obtain consent from the parent, guardian, or court before the threatened harm would occur. It is not necessary for harm to take place or become unavoidable prior to initiating treatment.

(d) Assessment and diagnosis must support the administration of psychotropic medications. Administration of psychotropic medication is not allowed for coercion, discipline, convenience or retaliation.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The responsible physician, in cooperation with the mental health director and facility administrator, must develop policy and procedures governing the use of psychotropic medications. The involvement of the mental health director is essential to obtain his/her specialized expertise during policy development. Involving all key administrators helps to assure that there is consensus among clinical departments and facility administration, all of whom are involved in implementation.

A wide variety of drugs are now considered "psychotropic medications." The defining feature is the purpose for which the medication is given. In terms of this standard, psychotropic medications are those drugs whose purpose is to have an effect on the central nervous system to impact behavior or psychiatric symptoms. These medications include but are not limited to anti-psychotic, antidepressant, lithium carbonate, anxiolytic drugs and anti-convulsants as well as other medications when used to treat a psychiatric condition.

Because child and adolescent psychiatry are specialized areas of clinical practice, and because poor prescribing patterns can result in adverse physical and social consequences for minors, it is important that clinical staff adhere to recognized and accepted guidelines for use of psychotropic medications. Examples include those published by the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry. While a physician should order psychotropic medications, that physician may not necessarily be specialized in psychiatry. However, at a minimum, the facility should utilize a physician who is knowledgeable in the diagnosis and treatment of mental disorders, with additional understanding of their applications in child and adolescent patients. In general, psychotropic medications should be used only for those conditions known to be responsive to such treatment. Psychotropic medications are never

to be used as punishment or for simple restraint of undesired behavior and the administration of psychotropic medications must be guided by appropriate clinical judgment.

Voluntary treatment of minors requires the informed consent of the parent (or entity with equivalent authority). Since the minor also has the right of refusal of any non-emergency care, he or she must also be agreeable to treatment.

Consistent with the philosophy described under **Section 1413, Individualized Treatment Plans**, the mere fact that minors take psychotropic medications should not automatically exclude them from participation in facility programs. Such minors should be allowed to participate unless the physician specifically orders a restriction based on additional rationale.

Only in the case of an emergency can a minor be treated with psychotropic drugs on an involuntary basis. Such situations are limited to those in which there is an urgent threat of serious bodily harm or death and it is not practical to seek consent. Because the administration of involuntary medications is a situation fraught with risks of over-use and/or adverse physical effects, this approach should be carefully monitored and reviewed for appropriateness. Consideration should be given to transfer of minors in need of such extreme measures to a licensed treatment facility, as discussed in **Section 1437, Mental Health Service and Transfer to a Treatment Facility**. Long acting "depot" formulations of psychotropic medications are not considered appropriate for emergency treatment. Minors should be observed carefully following administration of psychotropic medication in order to monitor changes in behavior and respond to any unanticipated reactions to the medication.

When a minor who takes psychotropic medications is transferred to another juvenile facility, it is important to assure that arrangements are made for timely continuation of the medication. All too often, lapses in communication during the transfer process result in discontinuation of the medication and decompensation of the minor's condition, ultimately resulting in disruptive behavior that is misinterpreted and leads to discipline rather than treatment.

In addition to the considerations above, policy and procedures should address time frames for re-evaluation of patients prior to renewal of medications, training of staff in recognition of adverse effects of psychotropic medication, and procedures for arranging for discharge medications and follow-up at the time of release.

Section 1450. Suicide Prevention Program.

The health administrator, in cooperation with the mental health director and the facility administrator, shall develop a written suicide prevention plan, with policies and procedures to prevent and respond to crisis. Staff training shall include, but not be limited to, identification of minors who present a suicide risk, appropriate monitoring of their condition, necessary treatment and follow-up and emergency response protocols for self-injurious behaviors.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001,

Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996

Guideline: This regulation applies to all juvenile facilities and specifies the need for a written, organized approach to suicide prevention that addresses identification of minors at risk, monitoring and treatment, and staff training. Nationally, suicide is the third leading cause of death for 10 – 24 year olds, with increases seen in 15 – 19 year old males. It is important to note however, that suicide occurs among all genders, age groups and across all socioeconomic, racial, and ethnic backgrounds. The causes of suicide are complex, and include an array of biological, psychological, social, environmental, and cultural risk factors. Not all suicide victims fit common profiles, making the importance of a comprehensive approach all the more critical. The tragic cost of a successful suicide is devastating to all involved. An interdisciplinary collaboration of supervision, medical and mental health staff is important in optimizing suicide prevention strategies within juvenile facilities.

Suicide prevention should begin with evaluating the physical plant for hazards with respect to opportunities for self-harm. A national study of juvenile suicides in confinement between 1994 and 1999 found that 98.7% were by hanging.[8] With this sobering fact in mind, when structural features which create an opportunity for hanging are found, consideration must be given to altering or removing them.

The suicide prevention plan should include a means of identifying minors at risk. Suicides can occur at any point in a minor's stay, and assessing for risk of suicide should not be limited to a single point in the detention process. The suicide prevention plan should also include procedures for monitoring youth at intervals consistent with the degree of suicide potential. The documentation of this monitoring is vital. A facility's strategy should incorporate referral for mental health intervention and care. Consistent with **Section 1413, Individualized Treatment Plans**, pre-release planning may include advisement of parents/guardians of concerns about suicidal ideation at the time of release, as well as arrangements for mental health follow-up in the community In the event of a successful or near-successful suicide attempt, follow-up should also include de-briefing for other minors in custody as well as for custodial staff.

Suicide prevention training is critical and best practice requires ongoing training, along with increased vigilance to identify minors at risk for suicide. Under these regulations counties have the latitude to develop training programs based on facility specific needs. Training and protocols should encompass methods of recognizing and responding to signs of suicidality and specific emergency responses to suicide attempts, successful or not. Other topics to be covered should include, predisposing factors for suicide, high-risk suicide periods, warning signs and symptoms and the unique characteristics of detention that enhance suicidal behavior. When choosing or designing a suicide prevention training curriculum, consider current research not just on adolescent suicide but also juvenile suicides in confinement.

From the minor's perspective, the detention setting increases personal stressors including:

- Fear of the unknown;
- Authoritarian environment;

[8] Hayes, Lindsay M., M.S., *Juvenile Suicide in Confinement: A National Survey*, National Center on Institutions and Alternatives, February 2004

- No apparent control over the future;
- Isolation from family and significant others;
- Shame; and
- Dehumanizing aspects of detention.

In examining potentially suicidal behavior, common predisposing factors in juveniles are

- A history of mental illness, particularly depression;
- History of suicidal behavior;
- Substance abuse history;
- History of trauma or abuse; and,
- Family history of suicide.

Signs and symptoms exhibited by the minor can foretell a possible suicide and, if detected, could prevent such an incident. What a youth says and how he/she behaves while being arrested, transported, booked and later during routine activities is vital for detecting suicidal behavior. An individual may exhibit warning signs and symptoms that include:

- Threatening to hurt or kill themselves;
- Looking for ways to kill themselves;
- Talking or writing about death, dying, or suicide if this is unusual for the person;
- Hopelessness;
- Rage, anger or seeking revenge;
- Acting recklessly;
- Feeling trapped;
- Withdrawing;
- Anxiety, agitation, inability to sleep or sleeping all the time;
- Dramatic changes in mood; and,
- Expressing no reason for living, no purpose in life.[9]

Section 1452. Collection of Forensic Evidence.

The health administrator, in cooperation with the facility administrator, shall establish policies and procedures assuring that forensic medical services, including drawing of blood alcohol samples, body cavity searches, and other functions for the purpose of prosecution are collected by appropriately trained medical personnel who are not responsible for providing ongoing health care to the minor.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

[9] *California Strategic Plan for Suicide Prevention: Every Californian is Part of the Solution*, Recommendations of the Suicide Prevention Plan Advisory Committee to the California Department of Mental Health, Draft for Review January 11, 2008

Guideline: This regulation applies to all juvenile facilities that have on-site health care staff and clarifies that such staff are prohibited from the performance of specific functions for the purpose of obtaining evidence for prosecution. While it is often tempting for law enforcement staff to seek the help of on-site health care staff in collecting certain specimens for evidence, the benefits of convenience are far outweighed by serious disadvantages.

When health care staff who provide treatment to juveniles are also used for assistance in prosecution, an untenable conflict in roles results. Minors subjected to evidentiary examinations by treatment staff are likely to develop mistrust that will interfere with subsequent therapeutic interactions.

Another conflict that arises from participation in evidence collection is competition for staff time. Demands for health personnel to perform evidence collection and examinations are compounded by ensuing requirements for related court appearances - all of which detract from their ability to effectively deliver health care services.

Alternatives for accomplishing necessary forensic functions may include use of a local emergency department or clinic that would not otherwise be expected to have an ongoing role in health care of the juvenile. Large facilities may be able to justify hiring or contracting with a medically trained individual who is separate from the treatment team. Facilities should consider the medical risks associated with some evidentiary procedures, such as urine collection and body cavity searches, when deciding whether to arrange for on- or off-site examinations.

Section 1453. Sexual Assaults.

The health administrator, in cooperation with the facility administrator, shall develop policy and procedures for treating victims of sexual assaults and for reporting such incidents to local law enforcement when they occur in the facility.

The evidentiary examination and initial treatment of victims of sexual assault shall be conducted at a health facility that is separate from the custodial facility and is properly equipped and staffed with personnel trained and experienced in such procedures.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation applies to all juvenile facilities and specifies that procedures must be developed to address the reporting, examination and treatment of minors who are victims of sexual assault while in custody.

Sexual assaults raise serious medical, mental health and criminal issues. Statute **(Penal Code, Sections 11160-11161)** requires treating health care personnel to report such incidents to law enforcement. In addition, this regulation requires that policy and procedure call for the facility itself to report any sexual assaults that occur in the institutional setting. Separate statute **(Penal Code, Section 208.1)** applies to minors held in jails and requires that assaults of any kind be reported to the Corrections Standards Authority.

Because a properly conducted sexual assault examination requires special training and knowledge of procedures that go beyond the capabilities of the ordinary juvenile facility, this regulation requires referral of victims to medical facilities that are adequately prepared to carry out this function. **Penal Code, Section 13823.5,** and **Section 13823.7** require the use of protocols and forms approved by the Office of Criminal Justice Planning when health professionals conduct medical examinations for evidence of a sexual assault. Hospital emergency departments are generally best prepared to perform sexual assault examinations.

Additional benefits are to be gained by referral of victims to such facilities. Removal of the minor from the juvenile facility may be perceived as a more treatment-oriented approach and will also introduce an important element of objectivity to the investigation of the incident. Many communities have special sexual assault response teams that, in addition to providing an expert examiner, offer added psychological support services to the victim.

Medical and mental health follow-up subsequent to the initial emergency evidentiary examination is essential. Nothing in this regulation precludes this from being provided by the on-site health services at the juvenile facility. It is, however, important for health staff to communicate adequately with the initial treatment team in order to assure that all necessary follow-up care is completed.

Consistent with **Section 1403, Health Care Monitoring and Audits**, instances of sexual assault are important to track internally. While such assaults are likely to be few in number, any trend suggesting an increase in rate should raise serious concern and prompt a review of supervision procedures in the facility.

Facility administrators should also be aware of the requirements of the federal Prison Rape Elimination Act of 2003 (PREA, P.L. 108-79). Major provisions of PREA include:

- Development of standards for detection, prevention, reduction, and punishment of prison rape;
- Collection and dissemination of information on the incidence of prison rape; and
- Award of grant funds to help state and local governments implement the purposes of the Act.

The Act applies to all public and private institutions that house adult or juvenile offenders. More information can be found at the National Institution of Corrections website for the National Prison Rape Elimination Commission: http://www.nicic.org/Library/020686.

Section 1454. Participation in Research.

The health administrator, in cooperation with the facility administrator, shall develop policy and procedures governing biomedical or behavioral research involving minors. Such research shall occur only when ethical, medical and legal standards for human research are met. Written policy and procedure shall require assurances for the safety of the minor and informed consent.

Participation shall not be a condition for obtaining privileges or other rewards in the facility. This regulation does not preclude the collection and analysis of routine facility

data or use of Investigational New Drug protocols that are available in the community. Neither does it prohibit blind studies of disease prevalence performed under the auspices of the local health officer. The court, health administrator, and facility administrator shall be informed of all such proposed actions.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation applies to all juvenile facilities and clarifies the necessity of assuring that adequate protections for juveniles are in place whenever biomedical or behavioral research projects are considered.

While research can ultimately lead to significant benefits in the care of juveniles on a collective basis, there must be safeguards to protect individuals from undue risk and to assure that their participation represents an informed decision based on free choice. It is also necessary to obtain consent of the minor's parent, guardian, or other legally responsible authority, and this should be obtained in writing for each participant. It is important that no special inducements or restrictions are offered or imposed by either the facility or study group in order to influence a decision to participate in a given project.

Review and approval of all proposed research studies should be obtained from an impartial review board that is experienced in the evaluation of study designs and ethical issues associated with human research. Such review boards are most often associated with universities and medical schools.

It is important to consider the perspective of the presiding judge when determining whether to allow a research study to take place within the facility. Although they may vary in approach to this issue, judges may wish to be apprised of any research being conducted; some may even insist on ultimate approval authority over whether a project is allowed.

This regulation is not intended to prevent facilities from maintaining and analyzing data that is routinely collected for management purposes. The key distinguishing factor between ordinary data management and research is whether the juvenile's experience within the institution is somehow modified by virtue of the manipulation of a variable that is the subject of the study. This is most obvious when an invasive procedure, such as collection of blood, hair or other samples, is done. However, more subtle interventions, such as structured interviews or dietary manipulations, also constitute interventions which, when undertaken solely for the purpose of analysis within an organized study, must be evaluated for safety and appropriateness under this regulation.

Blinded disease surveillance studies conducted under the authority of the local health officer are not subject to this regulation. Such studies involve non-invasive assessments for the presence of diseases within populations without linking findings with individuals.

This regulation also does not apply to participation in Investigational New Drug (IND) protocols available in the community. Such studies offer significant advantages to individual participants.

This is particularly true in the case of otherwise hopelessly ill persons who might be helped by access to new drugs that are offered only on the basis of an investigational protocol.

ARTICLE 9. FOOD

Section 1460. Frequency of Serving.

Food shall be served three times in any 24-hour period. At least one of these meals shall include hot food. Supplemental food shall be offered to minors at the time of initial intake; shall be served to minors if more than 14 hours pass between meals; and shall be served to minors on medical diets as prescribed by the attending physician.

A minimum of twenty minutes shall be allowed for the actual consumption of each meal except for those minors on medical diets where the responsible physician has prescribed additional time.

Provisions shall be made for minors who may miss a regularly scheduled facility meal. They shall be provided with a substitute meal and beverage, and minors on medical diets shall be provided with their prescribed meal.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The regulation requires only one hot meal a day; however, the facility manager should consider the costs and benefits associated with serving more than one hot meal. An assumption that it is cost effective to prepare and serve only one hot meal may not be accurate. Two cold meals each day may require additional costs for cold storage. There may also be added costs associated with containers and wrapping not required with hot meals. Climate is another factor to consider. In areas that experience cold weather it may be especially beneficial to provide two hot meals. If the temperature is very hot, one hot and two cold meals may be a more reasonable approach.

Minors must have a minimum of 20 minutes to consume each meal. This time frame may need to be extended for minors on a medical diet. The minimum time can be extended for any meal at the discretion of the facility manager.

The regulation describes situations in which supplemental food or a substitute meal and beverage must be served in addition to, or in place of, a regularly scheduled meal. Supplemental food shall be provided to minors if more than 14 hours elapses between meals, and when prescribed by a physician for those minors on medically prescribed diets. Supplemental food shall also be offered to minors during the initial intake process. Examples of supplemental foods include soup, a sandwich, fruit, or other nutritious food. A substitute meal and beverage is required whenever a regularly scheduled meal is missed. For the purposes of this section a substitute meal is considered to be one third of the Recommended Daily Allowance (RDA) **(Section 1461, Minimum Diet)**.

The regulation also requires that facilities plan for those times when minors may miss a regularly scheduled meal. Examples of minors who might fall within this provision are those: on work

assignments; out to court; transferring from one facility to another; at a medical appointment, or otherwise legitimately not available at the regularly scheduled mealtime.

Section 1461. Minimum Diet.

The minimum diet provided shall be based upon the nutritional and caloric requirements found in the 1999-2002 Dietary Reference Intakes (DRI) of the Food and Nutrition Board, Institute of Medicine of the National Academies; the 1990 California Daily Food Guide, and the 2005 Dietary Guidelines for Americans. Facilities electing to provide vegetarian diets, and facilities that provide religious diets, shall also conform to these nutrition standards.

The nutritional requirements for the minimum diet are specified in the following subsections. Snacks may be included as part of the minimum diet. A wide variety of foods should be served and spices should be used to improve the taste and eye appeal of food served.

(a) Protein Group. Includes: beef, veal, lamb, pork, poultry, fish, eggs, cooked dry beans, peas, lentils, nuts, peanut butter, and textured vegetable protein (TVP). One serving equals 14 grams or more of protein; the daily requirements shall equal two servings. In addition, there shall be a requirement to serve a third serving from the legumes three days a week. One serving equals, but is not limited to, one of the following examples:

- **2 to 3 oz. (without bone) lean, cooked meat, poultry or fish**
- **2 medium eggs**
- **1 cup cooked dry beans, peas, or lentils**
- **4 Tbsp. peanut butter**
- **8 oz. tofu**
- **2 1/4 oz. dry, or 1 cup rehydrated, canned, or frozen TVP**
- **1/2 cup seeds**
- **2/3 cup nuts**

(b) Dairy Group. Includes milk (fluid, evaporated or dry; nonfat; 1% or 2% reduced fat, etc.); cheese (cottage, cheddar, etc.); yogurt; ice cream or ice milk, and pudding. A serving is equivalent to 8 oz. of fluid milk and provides at least 250 mg of calcium. All milk shall be pasteurized and fortified with vitamins A and D. For persons 9-18 years of age, including pregnant and lactating women, the daily requirement is four servings.

One serving equals, but is not limited to, one of the following examples:

- **8 oz. fluid milk (nonfat, 1% or 2% reduced fat)**
- **1 1/2 oz. natural cheese**
- **2 oz. processed cheese**
- **1 1/2 cups of lowfat, or nonfat cottage cheese**
- **1 1/2 cups of ice milk, or ice cream**
- **1/3 cup nonfat dry milk**
- **1/2 cup nonfat, or lowfat evaporated milk**
- **1 cup nonfat, or lowfat plain yogurt**
- **1 cup pudding**

(c) Vegetable-Fruit Group. Includes: fresh, frozen, dried, and canned vegetables and fruits. One serving equals: 1/2 cup vegetable or fruit; 6 oz. of 100% juice; 1 medium apple, orange, banana, or potato; 1/2 grapefruit, or 1/4 cup dried fruit.

The daily requirement shall be at least six servings; at least one serving shall be from each of the following three categories:

(1) One serving of a fresh fruit or vegetable.

(2) One serving of a Vitamin C source containing 30 mg. or more. One serving equals, but is not limited to, the following examples:

Broccoli	**Orange juice**
Brussels Sprouts	**Potato (baked only)**
Cabbage	**Strawberries**
Cantaloupe, or honeydew melon	**Tangerine, large**
Cauliflower	**Tomato paste**
Green and red peppers (not dehydrated)	**Tomato puree**
Greens collards including kale, turnip, and mustard greens	**Tomato juice**
Grapefruit	**Tomato sauce (6 oz.)**
Grapefruit juice	**Vegetable juice cocktail**
Orange	

(3) One serving of a Vitamin A source fruit or vegetable containing 200 micrograms Retinol Equivalents (RE) or more. One serving equals, but is not limited to, the following examples:

Apricot nectar (6 oz.)	**Peas and carrots**
Apricots	**Pumpkin**
Cantaloupe	**Red peppers**
Carrots	**Sweet potatoes or yams**
Greens, including kale, beets, chard, mustard, turnips, or spinach	**Vegetable juice cocktail (6 oz.)**
Mixed vegetables with carrots	**Winter squash**

(d) Grain Group. Includes: bread, rolls, pancakes, sweet rolls, ready-to-eat, or cooked cereals, corn bread, pasta, rice, tortillas, etc., and any food item containing whole or enriched grains. At least three servings from this group must be made with some whole grains. The daily requirement for minors shall be a minimum of six servings. One serving equals, but is not limited to, one of the following examples:

Bread, white (including French and Italian), whole wheat, rye, pumpernickel, or raisin	**1 slice**
Bagel, small	**1/2**
English muffin, small	**1/2**
Plain roll, muffin or biscuit	**1**
Frankfurter roll	**1/2**
Hamburger bun	**1/2**
Dry bread crumbs	**3 Tbsp.**
Crackers:	
Arrowroot	**3**
Graham, 2 1/2 “	**2**
Matzo, 4” x 6”	**1/2**

Oyster	**20**
Pretzels, 3 1/8" long, 1/8" diameter	**25**
Rye wafers, 2" x 3 1/2"	**3**
Soda, 2 1/2" sq.	**6**
Ready-to-eat unsweetened cereal	**3/4 cup**
Cereal, cooked	**1/2 cup**
Barley, couscous, grits, macaroni, noodles, pastas, rice, spaghetti, etc.	**1/2 cup**
Cornmeal, dry	**2 Tbsp.**
Flour (wheat, whole wheat, carob, soybean, cornmeal, etc.)	**2 1/2 Tbsp.**
Wheat germ	**1/4 cup**
Pancakes, 5"	**1**
Waffle, 5"	**1**
Tortilla, 6" (corn/flour)	**1**

The following are examples of whole grains and whole grain products:

- **Barley**
- **Bran**
- **Brown rice**
- **Corn meal**
  - **tortilla**
  - **baked taco/tostada shell**
- **Cracked wheat (bulgur)**
- **Flour**
  - **carob**
  - **soybean**
  - **whole wheat**
- **Oatmeal**
- **Popcorn**
- **Pumpernickel bread**
- **Rolled oats**
- **Rye**
- **Whole grain**
  - **bagels, muffins, and crackers, graham**
  - **hot cereal**
  - **pancakes and waffles**
  - **ready-to-eat cereal**
- **Whole wheat**
  - **bread**
  - **rolls**
  - **tortilla**

(e) Calories. The average daily caloric allowances shall be as follows: 2200 calories for females 11 to 18 years of age; 2500 to 3000 calories for males 11 to 18 years of age.

(1) Providing only the minimum servings outlined earlier in this regulation is not sufficient to meet the minors' caloric requirements. Based on activity levels, additional servings from dairy, vegetable-fruit, and bread-cereal groups shall be provided in amounts to meet caloric requirements. Pregnant minors shall be provided with a supplemental snack, if medically indicated.

(2) In keeping with chronic disease prevention goals, total dietary fat should not exceed 30 percent of total calories on a weekly basis. Fat shall be added only in minimum amounts necessary to make the diet palatable.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The menus and requirements described in this regulation reflect the current sources of information found in the 1999-2002 Dietary Reference Intakes (DRI) of the Food and Nutrition Board, Institute of Medicine of the National Academies; the 1990 California Daily Food Guide, and the 2005 Dietary Guidelines for Americans.

It may be possible (and cost effective) to replace some of the more expensive protein in minors' diets with protein in milk and milk products, provided that requirements for other essential nutrients are still met. However, when planning meals the fat content of dairy products need to be taken into consideration.

From the Dairy Group of this regulation, minors must receive at least 32 ounces of milk or milk equivalents daily. (It should be noted that the National School Meals Program requires 8 ounces of fluid milk at breakfast and lunch). Examples of milk equivalents include soy, or a similar product if it meets the nutritional standards of calcium, and Vitamins A and D. There are other products that include calcium and Vitamins A and D, however, those products (fortified fruit juices, breads, cereals, etc.) do not include other nutrient levels found in dairy products, e.g., protein, phosphorus, magnesium, etc; therefore, for the purpose of this section these products are not considered to be milk equivalents.

Levels of activity and growth patterns of minors vary; therefore, a range of calorie levels is needed. This regulation lists a minimum and maximum calorie range plus or minus 20%. It is the discretion of the dietitian to determine the correct caloric value needed for the population. Consideration should be given to providing a variety of meals for the various age and gender groups. Providing the minimum daily servings from the various food groups will meet the basic nutrition standards but may not meet the minor’s caloric requirements; however, providing meals meeting the highest minimum caloric requirements for all groups cited in this regulation will exceed the caloric needs of certain groups and may result in unnecessary weight gain and associated health issues.

When planning meals the following daily caloric ranges should be considered: females 11 to 18 years of age should receive 2200 calories plus or minus 20%, e.g., 1760 to 2640 calories; males 11 to 14 years of age should receive 2500 calories plus or minus 20%, e.g., 2000 to 3000 calories, and males 15 to 18 years of age should receive 3000 calories plus or minus 20%, e.g., 2400 to 3600 calories.

Local health officials reviewing the nutritional content of facility menus need to have a basic familiarity with the RDA's. Some of the vitamin requirements that appear in the RDA's are calculated over a seven-day period, yet appear in the form of a daily intake need. Because of the way that these RDA's are calculated, it is appropriate for menu evaluators to consider the weekly menu before determining that any single meal or day is out of compliance with the daily intake standards. It is not expected that precisely one-third on the RDAs will be provided at each meal. A nutritional analysis would be beneficial to food services managers when assessing the caloric and nutrient adequacy of the daily and weekly menu.

This regulation reflects a 30 % limitation on calories from fat, meeting the federal requirements for the School Meals Program. With the limitation of calories from fat, emphasis should be given to other food sources to achieve the required energy values. Questions related to

implementation of the federal requirements should be directed to the State Department of Education, School Nutrition Programs Unit.

Meal planners should work closely with facility staff to improve diets. Food is a morale issue in facilities and often a high point in the day for the minors. Eye appeal and to some extent presentation can impact its acceptance as well as the content and flavor of the meals themselves. Acceptance is an important factor, as food that is not accepted by the minors tends to be discarded. Fresh fruit that might otherwise be discarded may be more acceptable if incorporated into recipes. The absence of candy and sweets will enhance the acceptability of fresh fruit, either as a portion of the meal or as a snack. Related issues such as greasy trays can also have an adverse effect on acceptance. To ensure appropriate action, it is important for staff to share information regarding food-related grievances and food waste with food services managers. Attention to food related complaints and the amount of food being discarded should offer dividends to the cost conscious facility manager.

Good nutrition need not be expensive and can be cost effective in several ways. Good nutrition can promote health, and prevention may be less expensive than health care. Some juveniles, especially those abusing alcohol and drugs, have neglected their nutrition to the point that they have immediate health needs at the time of intake. The FDA and other health conscious scientific groups advocate the daily consumption of at least five servings of fruits and vegetables. To ensure that the vitamin, mineral, and other nutrient needs of the juvenile population are met it is important to maintain six servings of fruits and vegetables.

Cost savings may be realized through better food choices. There can be savings in serving less fatty and sugary foods. Dietitians and health care professionals recommend reducing or eliminating cakes, pies, cookies, ice creams and puddings in favor of fresh fruit in season. Fatty processed meats are expensive and can be dramatically reduced or eliminated. Reduction in fat intake should be facilitated by the federal regulations for participation in the School Meals Program.

See **Appendix C** for sources of Vitamins A and C from the **17th edition of Bowes and Church Food Values of Portions Commonly Used**, New York, Lippincott-Raven Publishers, 1998, and from Table 6 of the 1990 **California Daily Food Guide** for Children, Adolescents, and Young Adults.

Regulation references to Vitamin A reflect changes from International Units (IU) to Retinol Equivalents (RE), e.g., 2000 IU equals 200 micrograms (mcg) RE.

Section 1462. Medical Diets.

Only the attending physician shall prescribe a medical diet. The medical diets utilized by a facility shall be planned, prepared, and served with the consultation of a registered dietitian. The facility manager shall comply with any medical diet prescribed for a minor. Diet orders shall be maintained on file for at least one year.

The facility manager and responsible physician shall ensure that the medical diet manual, with sample menus for medical diets, shall be available in both the medical unit and the food service office for reference and information. A registered dietitian shall review, and the responsible physician shall approve the diet manual on an annual basis.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: It is important to plan in advance for the need to supply minors with medically prescribed therapeutic diets. This begins with evaluating the special dietary needs of the population, defining a list of medical diets available in the facility, and assessing the specific means by which the diet order will be implemented by those persons responsible for food service. Medical diets needs to be incorporated into a medical diet manual that is annually reviewed by the registered dietitian and approved by the responsible physician. Regulations require that medical diet manuals be available in the medical unit and the food services office for reference by staff.

The menus for implementing medical diets need to be written in a manner that is sufficiently flexible and practical to allow food service staff to meet the requirements with available resources. While it may be necessary to make substitutions in a given menu, it is important that the diet manual provide guidance to assure that substituted items are permissible. It is not acceptable to leave kitchen staff, under the duress of time constraints to produce a meal, to use their own judgment in modifying medical diet menus. Each facility that houses minors who require medical diets must ensure that current sample menus and acceptable substitutions are included in the medical diet manual. With respect to females who are known to be pregnant, the responsible physician should consider having a policy that permits routine initiation of a pregnancy diet, even prior to medical evaluation.

The importance of having facility policy and procedures in place to ensure medical diets are delivered to the intended minor cannot be over emphasized. It is critical that the medically prescribed diets are actually delivered to the designated minor. To accomplish this, the individuals involved in the development, planning, preparation and delivery of these meals must work closely together. Food service staff must be notified when minors receiving medical diets are transferred (inter- and intra-facility) and/or released from custody (either temporarily or permanently).

The health authority or responsible physician, is responsible for developing the facility's written policy and procedures for medical diets, which must include a means for documenting that minors have received their prescribed diets. Diet orders must be maintained on file for a least one year so that they can be monitored by the facility managers and by the local health officer during their annual inspection **(Health and Safety Code Section 101045)**. Small facilities and those that do not have full scale feeding programs should seek advice from whoever develops the food service plan, or the local hospital, to determine how best to accommodate medical diets. The facility manager may elect to consult with a county dietitian or the dietitian from a local hospital, or could consider purchasing prepared meals from the local hospital.

Even the most careful advance planning cannot anticipate all possible medical diet needs. In recognition of this, each facility should identify a resource to contact for assistance whenever the need arises for an unusual medical diet.

Section 1463. Menus.

Menus shall be planned at least one month in advance of their use. Menus shall be planned to provide a variety of foods considering the cultural and ethnic makeup of the facility, thus, preventing repetitive meals. Menus shall be approved by a registered dietitian before being used.

If any meal served varies from the planned menu, the change shall be noted in writing on the menu and/or production worksheet.

Menus, as planned and including changes, shall be retained for one year and evaluated by a registered dietitian at least annually.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation requires that menus must be planned at least one month in advance of their use. A registered dietitian must approve these menus before they are used. A sample menu planning worksheet is provided in **Appendix D**.

It is important that the person preparing menus be aware of the facility's preparation and serving equipment, serving utensils and methods, in order to plan menu items the facility can readily prepare and serve. Sometimes this is not possible, and a nutritionist or dietitian who is not directly connected to the facility prepares the menus, and might not be familiar with the equipment and practices. In these instances it is particularly important that the menu preparer should consult with kitchen staff and serving personnel. If any meal served varies from the planned and approved menu, that those changes must be noted on the menu.

There are many prepared and convenience foods that might be used to effectively save time and money. The modern institutional menu should reflect both traditional items and convenience foods in a reasonable combination, with choices being guided by cost-per-serving, preparation time and acceptance by minors.

Menus describing what was served must be saved until the next evaluation by the registered dietitian as required in this regulation. (Archiving menus will also prove useful for budget development, menu cycle planning, training new food service personnel and, documentation in the event of litigation.)

The facility manager must ensure that the registered dietitian's annual evaluation of the facility's menus occurs. Optimally the evaluation will be completed through on-site visits from an independent consultant or someone from an outside agency, such as a public health nutritionist, a hospital dietitian, or contract dietitian. In the event an on-site evaluation is not feasible, an evaluation can be accomplished by mailing copies of menus to a nutritionist or dietitian. After

completing the review, an evaluation will be returned to the facility manager. In either event, every effort must be made to ensure that evaluated menus match the menus that were served. Any deficiencies revealed in the evaluation should be corrected as soon as possible.

The evaluation report should be kept on the file in the facility, for internal management and review by the local health officer during their annual inspection.

Section 1464. Food Service Plan.

Facilities shall have a written food service plan that shall comply with the applicable California Uniform Retail Food Facilities Law (CURFFL). In facilities with an average daily population of 50 or more, there shall be employed or available, a trained and experienced food services manager to prepare a written food service plan. In facilities of less than an average daily population of 50, that do not employ or have a food services manager available, the facility administrator shall prepare a written food service plan. The plan shall include, but not be limited to the following policies and procedures:

(a) menu planning;
(b) purchasing;
(c) storage and inventory control;
(d) food preparation;
(e) food serving;
(f) transporting food;
(g) orientation and on-going training;
(h) personnel supervision;
(i) budgets and food costs accounting;
(j) documentation and record keeping;
(k) emergency feeding plan;
(l) waste management; and,
(m) maintenance and repair.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Under this regulation facilities must have a food service plan. This regulation identifies those persons held accountable for establishing the food service plan. It is the intent of this regulation to provide the food services manager the latitude needed when developing a food service plan for his/her facility. Consequently, the requirements of this regulation avoid prescriptive language yet provide the food services manager with a broad scope of responsibilities to be included in the food service plan.

The food service plan should include meals that are nutritionally balanced, palatable, seasonable, presentable, and cost effective. Meal planning decisions should take into consideration the National School Lunch Program.

The food services manager (or facility administrator in facilities with an average daily population less than 50) should be cognizant of how the food is served to and received by the minors. To accomplish this, the food services manager should, among other things: randomly observe minors when food is being served, monitor what food(s) are not eaten, solicit feedback from custody staff and minors, and review food grievances from minors.

The food service plan must include an annual budget; it must identify food costs, and have an inventory system. The food services manager should organize and maintain written specifications of the food being purchased (to include formal bids) and a list of current and potential vendors. Also, there is inherent cost effectiveness when implementing a portion control system and portion controls are aided by the use of standardized recipes and by training staff to serve appropriate amounts of food.

The food service plan should identify transportation and meal service logistics, and meal service scheduling procedures. It should provide for routine documented inspections of food and equipment temperatures, food service operations and food service equipment. The food service plan should help facilitate safe and efficient plant operation by identifying locations of equipment utilized (potential weapons, e.g., knives, and seldom used equipment, e.g., ice chests).

The food services manager should identify and document pertinent training topics relative to all food service staff, including custody staff and minors. Plans for training should ensure that food service staff, custody staff, and minors are all trained in areas such as hygiene and sanitation, and that on-going training be provided to food service staff. Examples of training include: emergency preparedness, safety and security, proper lifting techniques, and other work related training.

The food services manager should work closely with the facility administrator when developing emergency feeding plans. Plans should include procedures for, or adaptable to, all anticipated emergencies.

The food service plan should address the core responsibilities of the food services manager. The following are examples provided to assist food services mangers when developing a food service plan. By reference to the subsections of this regulation these examples include:

(a) menu planning: cycle menus; seasonal menus; nutritional analysis; menu distribution; production worksheet; snacks; supplemental food, and dietary adjustments, e.g., therapeutic, religious, and vegetarian.
(b) purchasing: specifications; quote/bid process; identifying vendors; delivery; schedules; billing process; nutritional fact sheets; payment expectations, and ordering procedure.
(c) storage and inventory control: receiving procedures; rotation; label and date; opened case policy; cycle menu usage; usage documentation, and unused portion procedure.
(d) food preparation: cook/chill or serve; bakery; prep room; on-site preparation, and standardized recipes.
(e) food serving: safe and sanitary manner; portion control; set-up line; clean up; ServSafe (a CURFFL trademark safety program); supervision, and time meal schedule.
(f) transporting food: bulking; hot/cold food; supplemental food; disaster food, and dietary adjustment.

(g) orientation and on-going training: dress code; timecard procedure; sick slips; job standards; expectations; job advancement/career ladder; training schedule; chain-of-command; continuing on-the-job training, and training of food service staff, custody staff, and minors.
(h) personnel supervision: place of employment; times; check-in procedures; site requirements, and sick call/vacation requests.
(i) budgets and food costs accounting: food costs; salary costs; non-food costs; indirect costs; costs per serving; meal cost, and revenue.
(j) documentation and record keeping: inventory and location of equipment, e.g., number of knives and where stored, location of seldom used items (ice chests); incident reports; report writing; on-site forms, and Hazard Analysis and Critical Control Point (HACCP) documentation.
(k) emergency feeding plan: lock-down; disaster, and disruption.
(l) waste management: recycling, garbage disposal, and hazardous material.
(m) maintenance and repair: inventory of equipment, vendor and repair contacts, and regular and routine documented inspection of facilities and equipment.

When developing a food service plan, related policies and procedures, and when conducting audits, food services managers and facility administrators may find useful the inspection checklists used by Registered Dietitians (RD) and Registered Environmental Health Specialists (REHS) when conducting annual health inspections. The checklist attachment for the California Uniform Retail Food Facilities Law (CURFFL), i.e., the CURFFL attachment, should also be useful.

Section 1465. Food Handlers Education and Monitoring.

The facility administrator, in cooperation with the food services manager, shall develop and implement written procedures to ensure that supervisory staff and food handlers receive ongoing training in safe food handling techniques, including personal hygiene, in accordance with Section 114020 of the Health and Safety Code, California Uniform Retail Food Facilities Law. The procedures shall include provisions for monitoring compliance that ensure appropriate food handling and personal hygiene requirements.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation addresses education and monitoring requirements. Education should ensure that supervisory staff overseeing food handlers be aware of health and safety issues related to preparing, storing and handling food. (It should be noted that supervisory staff may include custody staff and food handlers may include minors). Monitoring should ensure personal hygiene and compliance with regulations.

This regulation is related to the requirements for food service workers to have a health care clearance as outlined in **Section 1414, Health Clearance for In-Custody Work and Program Assignments**. When developing procedures for the education, supervision and cleanliness of

food service workers, input from the responsible physician should be considered. This will ensure consistency with medical screening and with referrals for further medical evaluation, if there is reason to be concerned about a worker's health. Persons who distribute catered, individually packaged meals are exempt from this screening procedure.

A critical factor in preventing outbreaks of food borne illness is the education and ongoing supervision of juvenile workers. It is recommended that a basic food handling training program for kitchen staff includes the elements of proper food handling and personal hygiene. Whether or not formal training is offered, food handlers must know acceptable sanitary practices and must assist in all efforts to minimize the chances of food contamination and the outbreak of food-related illness.

The workers should be inspected daily by the kitchen supervisor to ensure there is no sign of illness. At a minimum, the protocol should include the following:

1. the absence of exposure to and symptoms of foodborne contagious diseases, especially hepatitis and diarrheal disease by history, and
2. a physical examination to exclude infected skin lesions, tenderness of the liver and jaundice.

When possible, consideration should be given to placing hand washing facilities in a location where staff can observe juvenile workers washing their hands. Institutions using juvenile workers in food preparation for multiple facilities should pay particular attention to their supervision policy and procedures.

To comply with **Health and Safety Code, Section 114020**, agencies should ensure that food handlers:

1. wear clean, washable outer garments or other clean uniforms and keep their hands clean;
2. wash their hands and arms with cleanser and warm water immediately after using toilet facilities and before commencing work and at such other times as are necessary to prevent contamination of food (legible signs are to be posted in each toilet room directing attention to this requirement);
3. wear hairnets, caps or other suitable covering to confine all hair when required to prevent the contamination of food or utensils;
4. use tongs or other implements rather than their hands, and
5. refrain from spitting or using tobacco in any form in any area where food is prepared, served or stored or utensils are cleaned or stored.

Food handlers must not commit any act that may result in contamination or adulteration of any food, food contact surface, or utensil. **Appendix B** provides a sample screening format for food service workers, together with recommended rules for the workers to follow. The regulation requires all food handlers to comply with **HSC Section 114020,** and the facility must comply with training requirements in **HSC Section 113716**.

When an outside agency or individual provides the facility's food services, the facility should have written verification that the outside provider complies with the state and local regulations regarding food service.

Section 1466. Kitchen Facilities, Sanitation, and Food Storage.

Kitchen facilities, sanitation, and food preparation, service, and storage shall comply with standards set forth in Health and Safety Code, Division 104, Part 7, Chapter 4, Articles 1-8, Sections 113700 et seq. California Uniform Retail Food Facilities Law (CURFFL).

In facilities where minors prepare meals for self-consumption or where frozen meals or pre-prepared food from other permitted food facilities (see Health and Safety Code section 113920) are (re)heated and served, the following applicable CURFFL standards may be waived by the local health officer:

(a) section 114065, Equipment Standards;

(b) section 114090 (b) through (e) Dishwashing Equipment. If a domestic or commercial dishwasher, capable of providing heat to the surface of the utensils of a temperature of at least 165 degrees Fahrenheit, is used for the purpose of cleaning and sanitizing multi-service kitchen utensils and multi-service consumer utensils;

(c) section 114140 Ventilation except that, regardless of such a waiver, the facility shall provide mechanical ventilation sufficient to remove gases, odors, steam, heat, grease, vapors and smoke from the kitchen;

(d) section 114150 (a) Floors; and,

(e) section 114165 (b) Mop Sinks.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The **California Uniform Retail Food Facilities Law (CURFFL; Health and Safety Code, Division 104, Part 7, Chapter 4, Articles 1-8, Sections 113700 et seq.)** in the **Health and Safety Code (HSC)** is an important resource to facility administrators and food managers. In addition to the CURFFL sections listed in the regulation or those listed in the CURFFL attachment to the environmental health inspection checklist, the following CURFFL sections are also important:

Section 113725 gives primary responsibility for enforcement to the State Department of Health Services, which acts through local health agencies.

Section 113780 defines a food establishment as "…any room, building, or place, or portion thereof, used for the purpose of storing, preparing, serving, manufacturing, packaging, transporting, salvaging or otherwise handling food..."

Section 113880 defines satellite food distribution facility as "A location where only prepackaged, unit servings of food are distributed, that have been prepared or stored in an approved food facility operated by a school, governmental agency, or nonprofit organization."

Section 113903 defines a vending machine and thereby addresses facilities that use vending machines for delivery of food other than snacks (e.g., candy, cookies, crackers, beverages, etc.).

Section 113920 requires a valid permit, issued by local enforcement agency pursuant to an investigation, for any food facility to operate.

Section 113925 allows any enforcement officer "…to enter, inspect, issue citations and secure any sample...or other evidence from any food facility...for purposes of enforcing this chapter."

Section 113935 makes it a misdemeanor to violate any of these provisions.

Section 113950 allows health officers to suspend permits and close food facilities which don't comply.

Article 7, Sections 113990-114070 describe the sanitation requirements for food facilities.

Article 8, Sections 114075-114180 describe the sanitation requirements for food establishments. Food services managers, facility administrators, Registered Dietitians (RD) and Registered Environmental Health Specialists (REHS) are encouraged to use the environmental health inspection checklist **CURFFL** attachment as a reference to assist in meeting and evaluating compliance with this regulation.

Among other things, **CURFFL** requirements and good judgment permit the use of single-service, disposable paper and plastic utensils and flatware, particularly for minors who are ill with communicable diseases and minors who are in segregation or disciplinary isolation and are likely to abuse normal service ware. Single service items should be used only once.

The second paragraph of this regulation relates to food from "permitted food facilities," this means facilities that have a food service permit pursuant to **CURFFL** and are thereby subject to inspection by the Department of Health Services.

This regulation permits some facilities to have less than a full commercial kitchen and provides enhanced flexibility for food service area design and operation, while maintaining all necessary and relevant health and safety regulations. While facilities may be eligible to have a kitchen with reduced features, this cannot occur unless, and until, the local health officer reviews the request and specifically identifies which **CURFFL** regulations are to be waived. Facility managers should also be aware that if they are granted waivers from identified **CURFFL** requirements and thereafter change their feeding program, they might be required to modify their kitchen to more closely conform to **CURFFL** requirements.

Facility cooking staff needs to be aware of the cooking temperature requirements adopted by AB 396, Kaloogian, known as the **Lauren Beth Rudolph Food Safety Act of 1997 (HSC Section 113996)**. This law affects the cooking temperature requirements for: meat; comminuted meat; egg and food containing raw eggs; and, poultry.

Section 1467. Food Serving and Supervision.

Policies and procedures shall be developed and implemented to ensure that appropriate work assignments are made and food handlers are adequately supervised. Food shall be prepared and served only under the immediate supervision of a staff member.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: This regulation requires that food handler work assignments are identified and food handlers are supervised. This is to ensure each item on the menu is served, proper utensils are used to serve equal portions of food, and that proper food temperatures are maintained. Each step of preparation and service must be developed in detail to ensure that meals are appealing and wholesome.

For public health reasons, **CURFFL** requires that food be kept hot (140 degrees Fahrenheit or above) or cold (41 degrees Fahrenheit or below), as appropriate, until it reaches the minor. If the kitchen is located some distance from the dining area, food should be transported in insulated, heated or cooled food carts or other containers. They may be loaded with pre-served trays or with bulk food containers and all necessary utensils, and then taken directly to the dining area. To protect from contamination and to maintain safe temperatures food transported on serving plates or containers should be covered and served as rapidly as possible.

Food must be served under the immediate supervision of a staff member (a food service employee or a child supervision staff) to ensure that fair and equal portions are given to each minor in a sanitary manner. Some jurisdictions report adulteration of food served to rivals and enemies of kitchen workers as well as providing extra portions of desirable food items to their friends and allies. Minors should be required to finish their meals in the dining area and not be allowed to store food in their living quarters. Besides being unsanitary, such storage encourages pilfering, brings disciplinary problems, and invites vermin in the living quarters.

It is imperative that staff responsible for serving understand food time and temperature requirements, health and safety risks that exist with food that reaches “dangerous” temperature levels, and their responsibility to notify food service staff when the temperature has not been maintained. When the temperature of food/meals falls within a specified range (for a period of time) it can promote foodborne illnesses. When the time and temperature of the regular meal falls outside acceptable limits, the food service plan should require staff to provide minors with a substitute (nutritious and safe) meal and beverage, as required in **1460, Frequency of Serving**, of these regulations.

ARTICLE 10. CLOTHING AND PERSONAL HYGIENE

Section 1480. Standard Facility Clothing Issue.

The minor's personal clothing and footwear may be substituted for the institutional clothing and footwear specified in this regulation. The facility has the primary responsibility to provide clothing and footwear. Clothing provisions shall ensure that:

(a) clothing is clean, reasonably fitted, durable, easily laundered, and in good repair; and

(b) the standard issue of climatically suitable clothing for minors shall consist of but not be limited to:

(1) socks and serviceable footwear;

(2) outer garments; and,

(3) undergarments, that are freshly laundered and free of stains, including shorts and tee shirts for males, and bra and panties for females.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: At the discretion of the facility administrator, minors may be allowed to wear their own clothing as long as such clothes are clean and appropriate. Whether clothing is the minor's own or standard issue, it should be easily recognizable so that minors can be distinguished from staff and visitors. In addition, clothing should not be demeaning or overly revealing. Similarly, clothing must be neutral in terms of gang identification. Clothing should be in keeping with the norms of the community and may be made of inexpensive but serviceable materials, easily washed and dried, and adequate for seasonal comfort, health and protection. The facility manager has the primary responsibility to provide personal undergarments and footwear; the facility cannot compel the minor to supply such items. Where personal clothing is allowed, the manager will need resources to allow the clothing to be properly laundered on a regularly scheduled basis.

If it is the facility's policy to issue clothing, then it must occur when it becomes apparent that a minor will remain in the facility for more that 96 hours excluding holidays. Typically, minors are issued clothing following booking.

Undergarments, when issued, are to be freshly laundered and substantially free of stains. Facility managers are to remove heavily stained undergarments from their inventory to ensure that minors in custody are not required to wear items that are personally objectionable.

Sandals or sneakers are practical footwear that are also inexpensive and washable. Minors working specialized jobs in or outside the facility should wear shoes or boots appropriate for the work being done. Shoes or boots issued to minors must be cleaned, or at a minimum receive a thorough dusting with foot powder or some type of fungicide between uses. Facility managers may wish to consult with their health authority regarding methods of sanitizing footwear.

In facilities that do not regularly issue institutional clothing, there should be a plan to provide emergency clothing to minors who may be in need. Circumstances that might necessitate issuing emergency clothing include vermin infested clothing taken from a juvenile during admittance; destroyed or badly soiled clothing; or inappropriate clothing (e.g., a bathing suit, etc.).

Section 1481. Special Clothing.

Provision shall be made to issue suitable additional clothing essential for minors to perform special work assignments where the issue of regular clothing would be unsanitary or inappropriate.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Specialized clothing or personal protective clothing (e.g., gloves, shoes or boots) is frequently required for minors performing work assignments in, around, or outside a facility. In certain circumstances, specialized clothing is considered essential to provide for the minor's safety and security, as well as the minor's hygiene and the facility's sanitation. Special clothing must be suited to the type of work and climatic conditions that exist at the workplace. A written plan for providing special or safety clothing should be developed. Knowingly assigning juveniles to jobs that expose them to some risk without the necessary clothing, equipment or training unnecessarily exposes the facility to liability and does not adequately protect the minor.

Section 1482. Clothing Exchange.

The facility administrator shall develop written policies and procedures for the cleaning and scheduled exchange of clothing. Unless work, climatic conditions, or illness necessitates more frequent exchange, outer garments, except footwear, shall be exchanged at least once each week. Undergarments and socks shall be exchanged daily.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: All clothing must be issued clean, freshly laundered, in good repair and free of vermin. Outer clothing (e.g., pants, shirts, etc.) must be exchanged at least once a week, with undergarments and socks exchanged daily. More frequent exchanges may be necessary depending on work, climatic conditions, illness, or **CURFFL (HSC Section 114020)**. Facility managers should consider discarding undergarments when they become heavily stained due to the effect this situation could have on morale. Managers have reported that minors have refused to wear stained undergarments, although clean, due to their disturbing appearance.

When minors are permitted to wear their own clothing, there must be policy and procedures for laundering and repairing those clothes on a regular and as needed basis.

The question of whether to operate a laundry in the facility is addressed in the facility's planning and design phase and is subject to the needs assessment and program statement required by **Title 24, Sections 13-201(c) 1 and 2.** It may be more economical to use a private vendor or another nearby institutional laundry; however, if the administration plans to operate or add a laundry, space must be allocated for the following:

1. soiled clothing storage;
2. washer, extractor, dryer;
3. clean laundry storage, and,
4. laundry supplies (soaps, bleaches, etc.) storage.

All of these basic elements are essential regardless of the size of the laundry. In addition, attention must be paid to the movement of clean and soiled laundry through the facility. Failure to take into consideration the movement and storage of laundry as well as the location of the laundry itself can severely impact facility operations. This may be a special problem in high-rise facilities, as it increases demand for elevator usage.

Dry cleaning equipment or a contract with a qualified private vendor may be considered to clean a minor's personal clothing before it is stored and/or to clean blankets and other non-washable items. The decision for dry cleaning is optional for detention facilities.

Section 1483. Clothing, Bedding and Linen Supply.

There shall be a quantity of clothing, bedding, and linen available for actual and replacement needs of the facility population. Each facility shall have a written procedure for acquisition, handling, storage, transportation and processing of clothing, bedding and linen in a clean and sanitary manner.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: There should be a regular review of the clothing inventory to determine if there are an adequate number of items, and in the proper range of sizes, to meet the clothing exchange requirements described in **Section 1482, Clothing Exchange.** Each facility must have a written procedure for purchasing, handling, storage, transportation, and processing of clothing, bedding and linen.

There must be an appropriate and clean supply on hand at all times. The supply must take into account actual use and replacement needs. An adequate supply of clothing, bedding, and linen will differ from one facility to another. A number of variables affect this, not the least of which is whether the facility does laundry on-site. Handling or transportation delays might occur if clothing and linen are laundered at a remote facility; thus, a larger inventory might be necessary than if the facility does laundry on the premises. It might be more costly to do laundry on-site given equipment, space, and energy costs. Facility administrators may want to consult with experts in making decisions about laundry facilities.

When handling laundry, special care must be taken to ensure total separation of clean from soiled items. Soiled items are not to be in contact with cleaned items, either in storage areas or during clothing exchange. The intent of separation is to ensure that soiled items remain separate from clean items in all situations.

Laundry procedures must also take into account contamination with potentially infectious materials, such as blood, feces, wound drainage, and other substances. This might be evident as visible soiling, or it may not be apparent to the naked eye. In either case, procedures need to provide for either adequate decontamination through appropriate laundering techniques or disposal. The safety of staff and minors must be addressed.

While it is a good idea to adopt procedures that assume contamination of all linen and clothing (analogous to applying "standard precautions" in the case of body fluids), this regulation is specifically applicable to a more narrow range of circumstances. At minimum, facilities need to address handling linens which become contaminated with large quantities of body substances (e.g., blood, amniotic fluid, etc.), as well as linens used by minors who have been in isolation for infectious diseases for which special handling of linens is recommended (e.g., hepatitis). The former situation is likely to occur anywhere in the facility as the result of an emergency, whereas the latter is likely to be associated with designated medical housing. In either case, all staff needs to be aware of how to handle contaminated articles.

Procedures need to include methods for the separate collection and labeling of contaminated laundry. Special laundry bags for this purpose may be purchased for convenience. Precautions to safeguard juvenile workers should include protective gloves and handling methods that minimize the possibility of contact with suspected contaminated materials. While proper laundering techniques are highly effective in sanitizing contaminated linens and clothing, it is essential to assure that practices are actually carried out as specified in procedure. These practices include the proper measurement of detergents and other additives; as well as assuring that cycle lengths and temperatures for hot water washing and drying are achieved. In cases where gross saturation or contamination is sufficient to justify disposal, procedures need to be in place for proper handling as medical waste. Local environmental health departments are a resource to facility administrators for establishing policy and procedure

Section 1484. Control of Vermin in Minors' Personal Clothing.

There shall be written policies and procedures developed by the facility administrator to control the contamination and/or spread of vermin in all minors' personal clothing. Infested clothing shall be cleaned or stored in a closed container so as to eradicate or stop the spread of the vermin.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Vermin is a term given to species such as insects and rodents that may carry disease. The policy and procedures required by this section should be developed in consultation with the

responsible physician, and should reference and include medical protocols for the treatment of infested clothing. This regulation allows the facility manager the option of cleaning or storing infested clothing. The other option of securing the clothing in a sealed container might be achieved by simply placing the articles in a plastic bag and taping it shut; however, conditions can exist that allow for damp clothing to mildew. Procedures should ensure that infestations of lice, mites, and other vermin do not enter the facility on minor's clothing that is improperly cleaned or stored. Proper handling and storage of infested clothing is extremely important to control and eradicate vermin. The local health department is a resource available to help develop appropriate procedures.

If juveniles wear personal clothing to court and then return it to the institution for re-storage, the facility will want to decide whether or not to clean that clothing each time it is worn. Some facilities allow minors' families to have a role in providing clean clothing for court appearances. Security issues notwithstanding, these regulations do not preclude this practice.

Please see **Section 1410, Management of Communicable Diseases,** and **Section 1510, Facility Sanitation, Safety, and Maintenance.** Additionally, **Appendix E** discusses treatment options for controlling lice and scabies on the minor's person.

Section 1485. Issue of Personal Care Items.

There shall be written policies and procedures developed by the facility administrator for the availability of personal hygiene items. Each female minor shall be provided with sanitary napkins and/or tampons as needed. Each minor to be held over 24 hours shall be provided with the following personal care items:

(a) toothbrush;
(b) dentifrice;
(c) soap,
(d) comb; and,
(e) shaving implements.

Minors shall not be required to share any personal care items listed in items (a) through (d). Liquid soap provided through a common dispenser is permitted. Minors shall not share disposable razors. Double edged safety razors, electric razors, and other shaving instruments capable of breaking the skin, when shared among minors, shall be disinfected between individual uses by the method prescribed by the State Board of Barbering and Cosmetology in Sections 979 and 980, Chapter 9, Title 16, California Code of Regulations.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The policy and procedures called for by this regulation should outline how minors are made aware that personal care items are available on an as-needed basis. This notification can be accomplished by, but is not limited to, providing a handout, posting a notice in living areas, and/or including the information in the minor's orientation. Some facilities prefer to issue these items at admission as a matter of routine. Safety concerns and security issues, such as

suicide risk, construction of weapons by minors or development of escape devices, allow staff the discretion of making personal care items available to minors as needed versus issuing them.

Sanitary napkins and tampons must be available so female minors can continue to use whichever form of protection is more effective for them, pursuant to **Penal Code, Section 4023.5(a)(1).**

Providing liquid soap to minors through a dispenser in areas of common use is an approved and acceptable practice in facilities.

As noted in the guideline to **Section 1410, Management of Communicable Diseases**, there is reason to believe that the sharing of electric razors and razor blades is a route for the transmission of some contagious diseases such as AIDS and hepatitis. It is important that minors not share these devices unless they are carefully disinfected between uses. Disposable razors cannot be effectively disinfected; therefore, they must be disposed of after an individual's use.

In special housing units where security is a critical issue, it is possible to devise a method to allow repeated use of a disposable razor by the same individual. This may take the form of a board or cabinet with numbered slots that correspond to individual minors or their respective rooms. Considering the low cost of plastic disposable razors, it may not be cost effective to collect and reissue them. It may be less expensive to discard them after each use and issue a fresh razor. It is important to develop policy and procedures for the safe and secure discarding of disposable razors, as improper or unsafe practices may compromise facility safety and security.

The local environmental health department can provide information about current, approved methods for sanitizing the equipment. A former method of using a phenol-based dip or phenol containing soaking solutions (often a blue colored solution) is not acceptable.

Section 1486. Personal Hygiene.

There shall be written policies and procedures developed by the facility administrator for showering/bathing and brushing of teeth. Minors shall be permitted to shower/bathe upon assignment to a housing unit and on a daily basis thereafter and given an opportunity to brush their teeth after each meal.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: It is essential that minors be able to shower or bathe daily. Virtually all of the newer podular-designed facilities have showers in the dayroom areas that allow staff to easily supervise showering. Minors whose jobs or work assignments cause them to require more frequent showers should be permitted to shower whenever necessary. Please see **Title 24, Sections 460A.1.1**, relating to showers in reception/booking areas, and **Section 460A.2.4,** for the design requirements for shower/bathing areas.

Section 1487. Shaving.

Minors shall be allowed to shave daily, unless their appearance must be maintained for reasons of identification in Court. The facility administrator may suspend this requirement in relation to minors who are considered to be a danger to themselves or others.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The facility manager should ensure that female juveniles are provided the same opportunities (access and time) for shaving as provided to males. When safety is a concern (e.g., in situations where minors pose a danger to themselves or to others), the facility administrator may control or suspend access to shaving instrument. Parameters may be established that prohibit gang identification amongst minors (e.g., full or partial head shaving or other identifying techniques known to be used by gang members).

Please refer to **Section 1485, Issue of Personal Care Items,** for discussion of issuance, control and cleansing of shaving implements.

Section 1488. Hair Care Services.

Written policies and procedures shall be developed by the facility administrator to comply with Title 16, Chapter 9, Sections 979 and 980, California Code of Regulations. Hair care services shall be available in all juvenile facilities. Minors shall receive hair care services monthly. Equipment shall be cleaned and disinfected after each haircut or procedure, by a method approved by the State Board of Barbering and Cosmetology.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The facility manager has the discretion to determine how hair care services are provided. This regulation states that the services must be available. It purposely leaves open the options of minors caring for their own and/or other minors' hair, barbers being assigned, and/or other personnel being used. There is no expectation that the facility must use barbers licensed by the State Bureau of Barbering and Cosmetology.

This regulation does not require a sink in every area in which hair care occurs. Places that do not have sinks, or similar special apparatus, can be designated for hair cutting and other hair care.

Section 1485, Issue of Personal Care Items, states that equipment shared among minors must be disinfected before each individual use. Emphasis needs to be placed on the importance of training personnel who provide hair care services. Such training should include specific instructions on the cleaning and disinfecting of equipment after each individual's hair care

service. Regulations that apply in the community also apply to hair care services in detention facilities. The California Bureau of Barbering and Cosmetology publication, "Cosmetology Performance Criteria," is available online at: http://www.barbercosmo.ca.gov/forms_pubs/pc2001.pdf and is a useful resource for facility administrators.

The facility administrator needs to ensure that practices remain in compliance with **Title 16, Chapter 9, Sections 979 and 980, California Code of Regulations** in order to reduce risks related to the transmission of disease. Local environmental health departments can provide information about current, approved methods for sanitizing the equipment addressed here. A former method of using a phenol-based dip or phenol containing soaking solutions (often a blue colored solution) is not acceptable.

ARTICLE 11. BEDDING AND LINENS

Section 1500. Standard Bedding and Linen Issue.

Clean laundered, suitable bedding and linens, in good repair, shall be provided for each minor entering a living area who is expected to remain overnight, shall include, but not be limited to:

(a) one mattress or mattress-pillow combination which meets the requirements of Section 1502 of these regulations;
(b) one pillow and a pillow case unless provided for in (a) above;
(c) one mattress cover and a sheet or two sheets;
(d) one towel; and,
(e) one blanket or more depending upon climatic conditions.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The number of blankets a facility issues will vary with the geographical location, the season of the year and the presence or absence of climate control equipment in the facility. A second sheet, pillow, and pillowcase may be issued, in addition to the required mattress cover or sheet. A mattress-pillow combination is approved for use in juvenile facilities. The decision to use either the traditional mattress and pillow or the mattress-pillow combination is left to the discretion of the facility administrator.

The intent of this regulation is to provide adequate bedding for minors. It is imperative that all items provided be clean and in good repair when issued. Facility policies and procedures for minors on suicide watch should address how bedding and linen is handled in those situations **(Section 1450, Suicide Prevention)**.

Section 1501. Bedding and Linen Exchange.

The facility administrator shall develop written policies and procedures for the scheduled exchange of laundered bedding and linen issued to each minor housed. Washable items such as sheets, mattress covers, pillow cases and towels shall be exchanged for clean replacement at least once each week.

The covering blanket shall be cleaned or laundered once a month.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: The intent of this regulation is to stress the importance of each detained minor receiving clean, laundered bedding and linen that are in good repair. The bedding and linen are to be exchanged regularly. Providing clean bedding is a relatively easy way to avoid management problems. Facility administrators are required to keep minors in clean blankets and bedding; however, administrators should identify those circumstances where issuing bedding would be contraindicated by other standards (e.g., minors on suicide watch; **Section 1450, Suicide Prevention Plan; Section 1500, Standard Bedding and Linen Issue)**. The suicide prevention plan should address how bedding and linens are handled in this situation.

Blankets used in health care areas or by minors who are ill pose a health risk and should be cleaned more frequently than those used in general housing. Since communicable diseases can be transmitted via bedding and blankets, facilities have an obligation to clean the items for the protection of both minors and facility staff. Consult with the facility's health authority or public health officer to determine the best ways to handle this bedding.

Section 1502. Mattresses.

Any mattress issued to a minor in any facility shall conform to the size of the bed as referenced in Title 24, Section 460A.2.5 and be enclosed in an easily cleaned, non-absorbent ticking. Any mattress purchased for issue to a minor in a facility, which is locked to prevent unimpeded access to the outdoors, shall be certified by the manufacturer as meeting all requirements of the State Fire Marshal and Bureau of Home Furnishings test standard for penal mattresses, Technical Information Bulletin Number 121, dated April 1980.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: Mattresses pose a significant fire and smoke hazard in detention facilities. This standard requires that mattresses used in any facility that is locked to impede access to the outdoors must meet the standard established by the California Bureau of Home Furnishing's test for penal mattresses **(Technical Information Bulletin 121)**. Because this test was developed in early 1980, mattresses purchased before that date would probably not pass the test. Consideration should be given to discontinuing use of any mattresses that predate 1980 and have

not been tested for fire and life safety. It is recommended that facility administrators consult with their local fire and life safety authorities when considering mattresses.

Supply catalogs often claim their mattresses meet specified federal or other non-California standards. Only mattresses that meet the California standard are approved for juvenile facilities. When purchasing mattresses, the facility manager should be certain they are safe by verifying that the contract includes certification by the manufacturer that the mattresses received have satisfactorily met the penal mattress test criteria established in the California Bureau of Home Furnishing **Technical Information Bulletin Number 121**, dated April 1980. The letter of certification is to be kept on file for review by the fire marshal during his/her annual inspection. To determine the fire safety of existing mattresses, ask the vendor to describe the contents of the mattress and consult with your local fire authority. The mattress is likely to be safe if it is borate treated cotton, neoprene, or polyurethane foam known as Hypol. Regular polyurethane, untreated cotton, fiber pad, and some types of foam are not acceptable in secure facilities.

The size of the mattress shall conform to the size of the bed as defined in Title 24, Section 460A.25 Beds, California Code of Regulation. Mattresses that are torn, ripped or worn out, or those that become highly compressed, are not considered in good repair and are considered to be in non-compliance with this standard. Maintaining mattresses in good repair requires regular internal review and exchange in the operation of a juvenile facility.

ARTICLE 12. FACILITY SANITATION AND SAFETY

Section 1510. Facility Sanitation, Safety and Maintenance.

The facility administrator shall develop written policies and procedures for the maintenance of an acceptable level of cleanliness, repair and safety throughout the facility. The plan shall provide for a regular schedule of housekeeping tasks, equipment and physical plant maintenance and inspections to identify and correct unsanitary or unsafe conditions or work practices in a timely manner.

Medical care housing as described in Title 24, Section 13-201(c)6 shall be cleaned and sanitized according to policies and procedures as established by the health administrator.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; and Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; and Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: It is important to maintain a clean and safe facility. The facility administrator is required to ensure the facility is well maintained and is responsible for developing policy and procedures to maintain an acceptable level of cleanliness. The intent is not that each facility is spotless all the time, but that the facility is maintained in a clean, safe, and healthful manner.

A plan to ensure appropriate cleanliness, maintenance/repair and safety should include:

1. policy and procedures to ensure the environmental health and safety of facility operations;

2. designation of the responsibilities and duties necessary to implement the plan, including internal inspections;
3. schedules of functions (e.g., daily, weekly, monthly, or seasonal cleaning, maintenance, pest control, and safety surveys);
4. lists of equipment, cleaning compounds, chemicals and related materials used in the facility and instructions on storage and labeling, as well as how to operate, dilute or apply the material in a safe manner;
5. special instructions for managing bodily fluids and other potentially bio-hazardous materials;
6. regular training for facility staff about environmental health and safety issues, including health risks and benefits; and
7. maintenance of records and forms used during self-inspections, and documentation of actions taken to correct deficiencies.

Medical areas are often overlooked during inspections for sanitation and cleanliness. All restrooms in medical areas pose major health concerns and require special attention to ensure cleanliness and proper maintenance.

Additionally, consideration should be given to general job descriptions and/or limitations related to personnel assigned to carrying out the plan. The necessary training for accident prevention and the avoidance of hazards relating to the maintenance of the facility should be provided.

When juvenile work crews are used, additional controls should be implemented to account for all equipment and cleaning materials. Specialized tasks (e.g., changing air filters, cleaning ducts, and facility pest control) are more appropriately handled by a maintenance department or by contract with private firms.

Pest control and eradication is crucial to keeping a facility clean and safe. **Section 1484, Control of Vermin in Minors' Clothing** and **Appendix E, Lice and Scabies Control,** discuss aspects of this issue.

The local Environmental Health Inspector, the facility's health administrator, the facility's responsible physician and the State Department of Health Services are excellent resources for information and assistance to ensure appropriate sanitation, safety and maintenance procedures.

Section 1511. Smoke Free Environment.

The facility administrator shall develop policies and procedures to assure that State laws prohibiting minors from smoking are enforced in all juvenile facilities, related work details, and other programs. Policies and procedures shall assure that minors are not exposed to second-hand smoke while in the facility or in the custody of staff.

NOTE: Authority cited: Sections 210 and 885, Welfare and Institutions Code; Assembly Bill 1397, Chapter 12, Statutes of 1996. Reference: 1995-96 Budget Act, Chapter 303, Item Number 5430-001-001, Statutes of 1995; Assembly Bill 904, Chapter 304, Statutes of 1995; Assembly Bill 1397, Chapter 12, Statutes of 1996.

Guideline: While state law clearly prohibits minors under the age of 18 from using tobacco products, a growing body of evidence also points to the adverse health effects of environmental tobacco smoke. While many local ordinances prohibit cigarette smoking in government buildings, state law (Labor Code Section 6404.5) prohibits smoking in places of employment. Additional considerations may be necessary to address other situations in which in-custody minors may come into close proximity with tobacco smoke.

This regulation establishes an expectation that minors will be protected from the effects of secondhand smoke and requires policy and procedures to assure compliance with federal and state laws, as well as local ordinances.

APPENDICES

APPENDIX A

RESOURCE LIST BY CATEGORY

Alcohol, and other Drugs
Includes Methadone, and related treatment information and resources
Department of Alcohol and Drug Programs, 1700 K Street, Sacramento, CA 95814, Resource Center, (916) 327-3728, 1-800-879-2772, http://www.adp.cahwnet.gov

This search engine will help you find a specific alcohol and other drug treatment provider within California. The State of California Department of Alcohol and Drug Programs Data Management Services Section have prepared this Directory. http://txworks.adp.ca.gov/tww.asp

California Society of Addiction Medicine
74 New Montgomery, Suite 230, San Francisco, CA 94105, 415/927-5730 • FAX: 415/927-5731, http://www.csam-asam.org/

Drug Enforcement Administration
The federal website is http://www.usdoj.gov/dea/, includes list of schedule drugs, etc. Division Offices in California are San Diego Division, **(858) 616-4100,** San Francisco Division, **(415) 436-7900.**

Prescribing Pain Medications
Guidelines: see http://www.medbd.ca.gov/Controlled_Substances.htm

Ambulance and related Emergency Personnel
Paramedics, Emergency Medical Technicians 1 & 2
Emergency Medical Services Authority, 1930 9th Street, Suite 100, Sacramento, CA 95814, (916) 322-4336, Paramedic Licensure (916) 323-9875 http://www.emsa.cahwnet.gov/

Barbers and Cosmetologists
State CSA of Barbering and Cosmetology, 400 R Street, Room 4080, Sacramento, CA 95814, 916/445-7061, 1-800-952-5210, http://www.barbercosmo.ca.gov/

Communicable Diseases
Includes both National and State resources for HIV, Hepatitis, Tuberculosis, etc.

The California Division of Communicable Disease Control is a branch of the California Department of Health Services, Prevention Services. Their website is http://www.dhs.ca.gov/ps/

The **National Center for Disease Control** (CDC) provides on-line information regarding various diseases, injury prevention, and updates on communicable diseases. You can assess information on-line at http://www.cdc.gov. If you do not find the information you need from their Health Topics page, or categories of Frequently Asked Questions, their phone number is 1-800-311-3435.

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Dentists, and related professionals
Board of Dental Examiners, 1430 Howe Avenue, Suite 85B, Sacramento, CA 95825, 916/263-2292, http://www.dbc.ca.gov

Dental Hygienist & Dental Assistants (Dental X-ray), Committee on Dental Auxiliaries, 1430 Howe Avenue, Suite 58, Sacramento, CA 95825 (916) 263-2595 ,Fax (916)263-2709, http://www.comda.ca.gov

Environmental Health
Environmental Health Specialist, Registered (formerly Sanitarian) Department of Health Services, REHS Program, 1616 Capitol Avenue, Building 174-2nd Floor, Sacramento, CA 95899, Environmental Management Branch – Robin Hook, Chief, (916) 449-5667, rhook@dhs.ca.gov,

Environmental & Occupational Disease Control is a division of the California Department of Health Services. Included in this Division are Environment Health Investigations, Environmental Health Laboratory's, Occupational Health, etc. There are offices located throughout the State of California. Their website is http://www.dhs.ca.gov/ps/deodc/

Hearing Aid Dispensers
Contact Hearing Aid Dispenser Examining Committee, Medical Board of California, 1430 Howe Avenue, Suite 12, Sacramento, CA 95825, 916/263-2288, http://www.dca.ca.gov/hearingaid

Hospital And Psychiatric Facilities
Hospitals, Department of Health Services, 744 P Street, Sacramento, CA 95815 (916) 552-8700 (or local DHS office), http://www.dhs.ca.gov/lnc

State Mental Health Hospitals, Department of Mental Health (Headquarters) 1600 9th Street, Rm. 151, Sacramento, CA 95814, Voice (800) 896-4042 or (916) 654-3890, Fax (916) 654-3198, http://www.dmh.cahwnet.gov/Statehospitals

Psychiatric Health Facilities (PHFs) were established in 1978 as a low cost, high quality alternative to acute hospitalization facilities for individuals with major mental disorders. The Department of Mental Health currently licenses sixteen PHFs. Additional information can be found at http://www.dmh.cahwnet.gov/PsychFac

Inhalation Therapists
Respiratory Care Board, of California, 444 N. 3rd St., Suite 270, Sacramento, CA 95814, Phone (916) 323-9983, Fax (916) 323-9999, http://www.rcb.ca.gov

Laboratory &Clinical Technologists
Department of Health Services, Laboratory Field Services, 1111 Broadway 19th Floor Oakland, CA 94607, (510) 873-6360, http://www.dhs.ca.gov/ps/ls

APPENDIX A

Mental Health Counselors

Board of Behavioral Sciences (BBS), License verification, scope of practice regulations, and consumer complaints regarding Marriage, Family Therapists, Licensed Clinical Social Workers, Educational Psychologist, and Associate Clinical Social Workers. The BBS is located at 400 R Street, Suite 3150, Sacramento, CA 95814, (916) 445 – 4933, http://www.bbs.ca.gov

Nursing Related
Board of Registered Nursing (BRN), License verification, scope of practice regulations, and consumer complaints regarding, Registered Nurses, Nurse Practitioners, Nurse Anesthetists, **Certified Nurse Mid-Wives**. The BRN is located at 400 R Street, Suite 4030, Sacramento, CA 95814, (916) 322-3350. License Verifications: 1-800-838-6828,or http://www.rn.ca.gov

Board of Vocational Nursing and Psychiatric Technicians (BVNPT), License verification, scope of practice regulations, and consumer complaints regarding Licensed Vocational Nurses (LVNs) or Psychiatric Technicians (PTs). The BVNPT is located at 2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833, (916) 263-7800 http://www.bvnpt.ca.gov

Medical Assistants are unlicensed health professionals that perform non-invasive routine technical support services under the supervision of a licensed physician and surgeon or podiatrist in a medical office or clinic setting. Certification information, scope of practice issues and consumer complaints regarding Medical Assistants are provided by the Medical Board of California, Affiliated Healing Arts, Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236, http://www.medbd.ca.gov/MA.htm

Licensed Midwife is an individual who has been issued a license by the Medical Board of California to practice midwifery. Licensed midwives differ from certified nurse midwives. Certification information, verification of certification, and consumer complaints regarding Licensed Midwifes are provided by the Medical Board of California, Affiliated Healing Arts, Medical Board of California, Attn: Midwifery Program, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236, (916) 263-2382.

Non-licensed Technician Certification, Certification information, verification of certification, and consumer complaints regarding Certified Nurse Assistants, Home Health Aides and Hemodialysis Technicians. The certification program is incorporated into the Department of Health Services, Licensing and Certification Program, 1615 Capitol Avenue, P.O. Box 997416, MS 3301, Sacramento, CA 95899-7416, http://www.dhs.ca.gov/lnc.

Radiology and X-ray Related
Certification information, verification of certification, and consumer complaints regarding radiology technicians Department of Health Services, Radiologic Health Branch, 1500 Capitol Avenue, 5th Floor, MS 7610, Sacramento, CA 95814-5006, http://www.dhs.ca.gov/rhb

Radiology Equipment Registration and Certification
Department of Health Services, Radiologic Health Branch, MS 7610, P.O. Box 997414, Sacramento, CA 95899-7414 , (916) 327-5106, http://www.dhs.ca.gov/rhb

Osteopaths
Certification information, verification of certification, and consumer complaints regarding Osteopaths, Contact Osteopathic Medical Board of California, 2720 Gateway Oaks Drive, Suite 350, Sacramento, CA 95833, 916-263-3100, http://www.dca.ca.gov/osteopathic

Pharmacist and Pharmacy
Licensing information regarding both pharmacies and pharmacists. Includes certification information, verification of certification, and consumer complaints regarding pharmacists. It also includes an excellent continuum of statutes and regulations governing the management of medications. http://www.pharmacy.ca.gov

Physicians, and Psychiatrists
Certification information, verification of certification, and consumer complaints, contact the Medical Board of California, 1426 Howe Avenue, #54, Sacramento, CA 95825, (916) 263-2382, http://www.medbd.ca.gov/MW.htm

Physician Assistants
Certification information, verification of certification, and consumer complaints, contact the Medical Board of California 1424 Howe Avenue, Suite 35, Sacramento, CA 95825 (916) 263-2670, extension 202, http://physicianassistant.ca.gov

Psychologists
Certification information, verification of certification, and consumer complaints, contact the Medical Board of California 1424 Howe Avenue, Suite 35, Sacramento, CA 95825, (916) 263-0712, http://www.psychboard.ca.gov

Screening Questionnaire And Information For Food Service Workers

Questionnaire

Have you recently or are you currently experiencing any of the following:

	Yes	No	If yes, when
Open sores on your skin	_____	_____	_____
Runny nose/sore throat/cough	_____	_____	_____
Vomiting/diarrhea	_____	_____	_____
Loss of appetite	_____	_____	_____
Change in color of urine	_____	_____	_____
Change in color or texture of bowel movements	_____	_____	_____
Fever	_____	_____	_____
History or recent exposure to hepatitis/tuberculosis	_____	_____	_____

Rules

In order to function as a food services worker, you must comply with the following rules:

1. You must wash your hands immediately upon reporting for work in the kitchen and after using the restroom.

2. You will wear disposable plastic gloves whenever handling food directly for serving.

3. You must have completed this health questionnaire.

4. If you develop any of the above symptoms, you must report them immediately to the supervising staff.

5. You must wear a protective hair net or hat at all times while in the kitchen. Combing your hair while working is prohibited. Shoes (not sandals) are required.

6. You may not smoke at any time.

If you break one of these rules, you will immediately be taken off kitchen duty.

By signing this form I acknowledge that I understand and agree to abide by the above rules and regulations, and that the information I have provided is true.

_____

Signature / Printed Name Date

Cleared for food service work [ ] yes [ ] no

Signature/Title/Date_____

Sources of Vitamin A and C

Sources of Vitamin A

Vitamin A Vegetables	Serving Size	Micrograms RE	IU
Broccoli, Frozen, Chopped Boiled	1/2 cup	174	1741
Broccoli, Raw, Chopped	1/2 cup	68	678
Cabbage, Raw, Shredded	1/2 cup	105	47
Cabbage, Boiled, Shredded	1/2 cup	6	99
Cabbage, Chinese, Boiled, Shredded	1/2 cup	58	2183
Carrots, Raw	1 med.	2025	20253
Carrots, Boiled, Sliced	1/2 cup	1915	19152
Carrots, Canned, Sliced	1/2 cup	1006	10055
Carrots, Frozen, Boiled, Sliced	1/2 cup	1292	12922
Chard, Swiss, Boiled, Chopped	1/2 cup	276	2762
Greens, Beet, Boiled	1/2 cup	367	3672
Greens, Collards, Frozen, Boiled	1/2 cup	508	5084
Greens, Collards, Boiled, Chopped	1/2 cup	175	3491
Greens, Kale, Boiled, Chopped	1/2 cup	481	4810
Greens, Kale, Frozen, Boiled	1/2 cup	413	4130
Greens, Mustard, Frozen, Boiled	1/2 cup	335	3353
Greens, Mustard, Boiled, Chopped	1/2 cup	212	2122
Greens, Turnip, Raw	1/2 cup	213	2128
Greens, Turnip, Boiled, Chopped	1/2 cup	396	3959
Greens, Turnip, Canned	1/2 cup	420	4196
Greens, Turnip, Frozen, Boiled	1/2 cup	654	6540
Lettuce, Romaine, Shredded	1/2 cup	73	728
Mixed Vegetables, Canned	1/2 cup	995	9551
Mixed Vegetables, Frozen	1/2 cup	389	3892
Peas and Carrots, Canned	1/2 cup	739	7386
Peas and Carrots, Frozen	1/2 cup	621	6209
Peppers, Jalapeno, Canned, Chopped	1/2 cup	116	1156
Potato, Sweet, Baked with Skin	4 oz.	2487	24877
Potato, Sweet, Boiled w/o skin, Mashed	1/2 cup	2796	27969
Potato, Sweet, Candied	1 piece (2-1/2X2”dia.)	440	4398
Potato, Sweet, Canned, Mashed	1/2 cup	1929	38571
Potato, Sweet, Canned, Syrup Packed	1/2 cup	702	7014
Pumpkin, Boiled, Mashed	1/2 cup	132	1320
Pumpkin, Canned	1/2 cup	2691	17500
Pumpkin Pie Mix, Canned	1/2 cup	1121	11202
Spinach, Raw, Chopped	1/2 cup	188	1880
Spinach, Canned	1/2 cup	939	9390
Spinach, Frozen, Boiled	1/2 cup	739	7395
Squash, Butternut, Baked	1/2 cup	714	7141

Sources of Vitamin A

Vitamin A Vegetables	Serving Size	Micrograms RE	IU
Squash, Butternut, Boiled, Mashed	1/2 cup	473	4007
Squash, Hubbard, Baked, Cubed	1/2 cup	616	6156
Tomato, Boiled	1/2 cup	89	892
Vitamin A Fruits	**Serving Size**	**Micrograms RE**	**IU**
Apricot Nectar	1/2 cup	165	1651
Apricots, Raw	3 med.	277	2769
Apricots, Canned, Heavy Syrup	4 halves	111	1107
Apricots, Canned, Juice Pack	3 halves	142	1420
Apricots, Canned, Light Syrup	3 halves	112	1124
Cantaloupe, Raw, Pieces	1/2 cup	258	2579
Mango, Raw	1 med.	805	8061
Papaya, Raw	1 med.	85	863
Persimmon, Japanese, Raw	1 med.	365	3641
Prunes, Dried	3 med.	167	1669
Tangerine, Raw	3 oz.	77	773
Vegetable Juice Cocktail	1/2 cup	142	1000
Vitamin A Misc. Food Items	**Serving Size**	**Micrograms RE**	**IU**
Braunschweiger Sausage	18 grams	760	2529
Cheese, American	1 oz.	82	343
Cheese, Cream	1 oz.	124	405
Eggs, Boiled	1 large	84	280
Margarine	1 tsp.	47	141
Milk, Fluid, 1%, 2%, or skim	8 oz.	140-149	420-447
Liver, Beef, Braised	3 oz.	9087	35679
Pudding, from reg. mix w/lowfat milk	1/2 cup	70	200

Source: Pennington, Jean, A.T. Bowes and Church Food Values of Portions Commonly Used. 17th ed. New York, Lippincott-Raven Publishers, 1998.

Sources of Vitamin C

Vitamin C Vegetables	Serving Size	Mg Vit. C
Beans, Lima, Baby, Frozen, Boiled, Immature	1/2 cup	5
Beans, Lima, Fordhooks, Frozen, Boiled	1/2 cup	11
Beans, Lima, Canned, Drained	1/2 cup	0
Beans, Refried, Canned	1/2 cup	7.5
Bean Sprouts, Fresh	1/2 cup	10
Broccoli, Raw, chopped	1/2 cup	41
Broccoli, Boiled	1/2 cup	58
Brussel Sprouts, Boiled (4 Sprouts)	1/2 cup	48
Brussel Sprouts, Frozen, Boiled	1/2 cup	36
Cabbage, Chinese, Boiled, Shredded	1/2 cup	22
Cabbage, Chinese, Raw, Shredded	1/2 cup	16
Cabbage, Green, Raw, Shredded	1/2 cup	11
Cabbage, Green, Boiled, Shredded	1/2 cup	18
Cabbage, Red, Raw, Shredded	1/2 cup	20
Cabbage, Red, Boiled, Shredded	1/2 cup	26
Cabbage, Savoy, Raw, shredded	1/2 cup	11
Cabbage, Savoy, Boiled, Shredded	1/2 cup	12
Cauliflower, Raw, Pieces	1/2 cup	23
Cauliflower, Boiled, Pieces	1/2 cup	27
Cauliflower, Frozen, Boiled	1/2 cup	28
Chard, Swiss, Boiled, Chopped	1/2 cup	16
Corn, Canned, Vacuum Pack	1/2 cup	9
Beet Greens, Boiled	1/2 cup	18
Greens, Chicory, Raw, Chopped	1/2 cup	22
Greens, Collards, Frozen, Boiled	1/2 cup	22
Greens, Kale, Frozen, Boiled, Chopped	1/2 cup	16
Greens, Kale, Boiled, Chopped	1/2 cup	27
Greens, Mustard, Boiled, Chopped	1/2 cup	18
Greens, Mustard, Frozen, Boiled	1/2 cup	10
Greens, Turnip, Frozen, Boiled	1/2 cup	18
Greens, Turnip, canned	1/2 cup	18
Greens, Turnip, Canned	1/2 cup	14
Jicama	3 oz.	14
Kohlrabi, Raw	1/2 cup	5
Kohlrabi, Cooked	1/2 cup	44
Lettuce, Loose-leaf	1/2 cup	5
Lettuce, Romaine	1/2 cup	7
Okra, Boiled	1/2 cup	10
Onions, Boiled	1/2 cup	6
Parsnips, Boiled	1/2 cup	10
Peas and Carrots, Canned	1/2 cup	8

Sources of Vitamin C

Vitamin C Vegetables	Serving Size	Mg Vit. C
Peas and Carrots, Frozen	1/2 cup	6
Peas, Canned or Frozen, Boiled	1/2 cup	8
Peppers, Chili, Hot, Canned, Chopped	1/2 cup	46
Peppers, Sweet, Boiled	1/2 cup	51
Peppers, Sweet, Raw, Chopped	1/2 cup	45
Peppers, Sweet, Canned	1/2 cup	33
Peppers, Sweet, Freeze Dried	1/4 cup	30
Pimientos	1 Tbsp.	10
Potatoes (Vit. C content declines w/storage)		
Potatoes, Baked, Flesh & Peel in oven	1 potato	26
Potatoes, Baked, Flesh only	1 potato	20
Potatoes Boiled Cooked in Peel	2-1/2” diameter	17.6
Potatoes, Boiled cooked w/o skin	1 potato	10
Potatoes, Canned, w/o skin	1/2 cup	5
Potatoes, French Fries	10 pieces	5
Potatoes, Mashed from Flakes	1/2 cup	10
Potatoes, Mashed from Granules	1/2 cup	3
Potatoes, Sweet, Baked w/skin	4.1 oz.	28
Potatoes, sweet, Boiled w/o skin	1/2 cup	28
Potatoes, Sweet, Canned, Mashed	1/2 cup	6
Pumpkin, Canned	1/2 cup	5
Rutabaga, Boiled, Cubed	1/2 cup	16
Sauerkraut, Canned	1/2 cup	17
Spinach, Raw	1/2 cup	8
Spinach, Boiled	1/2 cup	9
Spinach, Canned	1/2 cup	15
Spinach, Frozen, Boiled	1/2 cup	12
Squash, Summer, Scallop, Boiled	1/2 cup	11
Squash. Acorn, Boiled, Mashed	1/2 cup	8
Squash, Hubbard, Baked, Cubed	1/2 cup	10
Squash, Hubbard, Boiled, Mashed	1/2 cup	8
Squash, Summer, Scallop, Boiled	1/2 cup	10
Squash, Summer, Zucchini, Raw	1/2 cup	6
Succotash, Boiled	1/2 cup	8
Tomato, Raw	2-1/2” diameter	23
Tomato, Stewed, Canned	1/2 cup	15
Catsup	2 Tbsp.	4

Source: Pennington, Jean, A.T. Bowes and Church Food Values of Portions Commonly Used. 17th ed. New York, Lippincott-Raven Publishers, 1998.

Sample Menu Planning Worksheet

DAY	MENU WORKSHEET (JUVENILE)				
CYCLE					
SEASON					
	BREAKFAST	**LUNCH**	**DINNER**	**SNACK**	TOTAL
PROTEIN GROUP (2)					
6 OUNCES OR MORE /					
* Lean Meat & Poultry					
* Legumes (3x/sk)					
MILK GROUP (4)					
32 ounces / day					
* 8 oz Milk - 250 mg Ca					
* Reduced Fat					
* 400 IU Vit. D / qt					
* 200 RE Vit. A / qt					
FRUITS & VEGETABLES (6)					
6 SERVINGS					
* Daily Fresh Fruit or					
* 30 mg Vit. C / serving					
* 200 RE Vit. A / serving					
GRAIN GROUP (6)					
6 SERVINGS					
* 3 Servings Whole Grains					
FAT					
1 Tbsp Fat or Oil / day					
ADDED SERVINGS					
Milk					
Fruits & Vegetables					
Grains					
Other					

Lice and Scabies Control

Lice and scabies are infestations that can provide significant management problems within the custody environment. In many situations, inflated fears of acquiring the conditions are as much a problem as an infestation itself. There are many misconceptions about lice and scabies, which contribute to a tendency of both staff and minors to overreact to possible infestations. At the same time, it is important to understand what measures are necessary to adequately treat identified cases and how to prevent spread to others. While infestations are usually more of a nuisance than medically serious, persons who also have HIV infection can be severely affected by scabies. In addition, a facility that does not promptly and effectively contain and treat infestations will likely be subjected to severe criticism for maintaining "unsanitary" conditions. Efforts to adequately control infestations may be hampered by the development of resistance to available treatments, as well as the improper application of otherwise effective agents. Local health departments can serve as resources to facility staff in guiding treatment according to the most current recommendations.

It should be noted that treatment options include both prescription and non-prescription medications. Facility procedures should assure that properly licensed medical staff are involved in the use of prescription items. Further, procedures should also take into account precautions that apply to any of the available treatments, such as their use on pregnant women or persons with allergic reactions to the medication (even those which are applied topically to the skin). It is also critically important to remember that sprays designed for use on clothing and other surfaces are not to be used on people, and that this practice can result in serious adverse reactions. The practice of treating all new intakes into a facility for lice based upon a vague suspicion of the possibility is outmoded. Instead, treatment should be based upon more definite findings. When in doubt, it is recommended that the individual be separated from other minors until a medical examination can establish or rule out a diagnosis more definitively.

Despite the fact that all forms of infestation tend to cause itching and scratching, scabies and the various forms of lice are each unique in their characteristics. They should be recognized and treated as distinctly different forms of infestation. Common myth has suggested that one form of louse can turn into another, and this is simply not true. The three commonly recognized types of lice infestations of humans have highly specific preference for their location on the human body. Furthermore, while lice are tiny but visible blood-sucking insects, an entirely different type of organism causes scabies - a mite that cannot be readily seen without a microscope. The following is a summary of the common types of infestations that affect humans.

HEAD LOUSE		
Description	**Transmission**	**Treatment**
3-mm long insect that is found on the scalp hair and produces nits (egg cases), which adhere to the hair shaft.	Transmitted by direct contact or on shared objects (e.g., combs, towels, headphones, etc.).	Permethrin 1% creme rinse (Nix™) is the treatment of choice. It should be applied for 10 minutes, and then rinsed off. Alternatives include several over-the-counter pyrethrins (e.g., RID™). Removal of nits (manually or using a fine-toothed comb) is optional. Treatment, if properly applied will usually render the nits non-viable. Wash clothes, bed linens, and towels in hot water and dry on hot cycle for at least 20 minutes. Soak combs, brushes, hair bands, etc. in water at least 130 degrees F. for at least 10 minutes. Items that come into contact with the head that cannot be washed (e.g., headphones) should be sealed in a plastic bag for at least 2 weeks.
BODY LOUSE		
Description	*Transmission*	*Treatment*
Slightly larger in size than the head louse. Not found on the body itself, but clings to fibers in the seams of clothing.	Transmitted through direct body contact or sharing of contaminated clothing or bedding. Crowded living conditions, poor hygiene, and infrequent laundering enhance transmission.	Improved hygiene. Wash and dry clothing and bed linens on hot cycles. Pediculocides not essential, but may be used in epidemic situations.
PUBIC LOUSE		
Description	*Transmission*	*Treatment*
1 mm long, shaped like a crab. Adheres to pubic hair and may also affect hair on the trunk, beard, eyelashes, and axillary (armpit) areas. Produce nits that are visible on hair shafts.	High rate of transmission, but only through intimate contact.	Permethrin 1% creme rinse (Nix™) is the treatment of choice. It should be applied for 10 minutes, and then rinsed off. Pediculocides should not be applied to eyelashes. Alternative treatments for this area may include application of petrolatum five times a day or gentle removal with baby shampoo. Resistant cases should be referred to an ophthalmologist. Clothing and bed linens should be washed and dried on hot cycles for at least 20 minutes.

SCABIES		
Description	*Transmission*	*Treatment*
0.3 mm - 0.4 mm eight-legged mite, which burrows into human skin. Although it eventually produces a generalized itchy rash, it particularly affects the web spaces of the fingers, flexor aspects of the wrists, waistline, and skin fold areas including the genitalia, axillae (armpits), umbilicus, and upper thighs. Some infested persons may have no symptoms. Persons with HIV infection may have a severe form of infestation with thick crusting of the skin.	Direct contact. The mite may survive 24-36 hours at room conditions, but is unlike to spread via inanimate objects.	Permethrin 5% cream (Elimite™) applied to all skin surfaces (per package instructions) for 8-12 hours. A second treatment in 1 week is recommended. Should not be used in pregnant or nursing women. Less effective alternatives include lindane 1% lotion for 8 hours, precipitated sulfur 6% in petrolatum for three consecutive nights (treatment of choice in pregnant or nursing women), and crotamiton (Eurax™). Oral treatment with a single dose of ivermectin has been described in the literature, but has not been approved by the Food and Drug Administration for this indication. Clothing and bed linens should be washed and dried on hot cycles for at least 20 minutes on the morning after each treatment. Alternatively, they may be sealed in plastic bags for at least one week.

Deciding whether roomates of persons with lice or scabies should also receive treatment depends on their degree of contact (keeping in mind the mode of transmission), coupled with an assessment of anxiety levels of those at risk. It is important to remember that close contact with persons with scabies may be infested, but may not always develop symptoms. Although the routine practice of treating entire housing units on a precautionary basis is excessive, if there are no contraindications, one should not be overly restrictive about treating persons whose degree of contact is uncertain.