California Department of
State Hospitals

Involuntary Medication Order (IMO) Toolkit for Justice System Professionals and Treatment Providers

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DISCLOSURE

This Toolkit is a summary of information currently available. Although the Toolkit draws from available scientific literature: 1) there is a need for further research on this topic, 2) this Toolkit is not an exhaustive review of the available literature, and 3) this Toolkit is not a research paper or meta-analysis. This document is written to provide pearls of knowledge drawn from scientific literature, professional multidisciplinary peer consultation, and experience. This Toolkit will be updated periodically based on updated information and feedback from users.

Additionally, this Toolkit does not address all topics related to the treatment of individuals with mental illness in jails. During the development of this document, other subjects that were raised as important but that were beyond the scope of this Toolkit include protocols for observation of individuals after administration of medications, protocols on use of force, documentation of medication administration, guidelines on medication prescribing, and best practices on discharge planning and warm hand-offs from jail to the community. If you want more information on any of these topics, please contact IMOConsult@dsh.ca.gov.

INTRODUCTION

1. What is this Toolkit?

This Toolkit was created to support treatment for individuals[1] with serious mental illness (SMI) in California jails who have been deemed Incompetent to Stand Trial (IST) but can help all individuals with mental illness in jails, regardless of whether they are receiving or waiting to receive treatment in a DSH program.

This Toolkit can be used by anyone who interacts with, advocates for, treats, or is otherwise involved in the care of justice-involved individuals with SMI. This includes but is not limited to jail clinical staff, criminal justice partners, sheriffs, custody staff, court staff and court leadership (district attorneys, public defenders and defense attorneys, judges), community behavioral health providers, county supervisors and county administrators.

Across California's 58 counties, individuals with SMI are our neighbors, friends, and loved ones and some will come into contact with the criminal justice system. When this occurs, this Toolkit will assist in supporting their mental health treatment.

2. Why was this Toolkit created?

This Toolkit was made in response to a recommendation from the IST Solutions Workgroup[2], a statewide work group convened to propose solutions to the challenge of an increasing number of people with SMI in California jails who are being found incompetent to stand trial on felony charges and are waiting to be admitted to DSH for treatment. This Toolkit is intended to help staff navigate the logistical, procedural, and legal requirements to act on involuntary medication orders (IMOs) in the jail.

The IST Workgroup convened between August 2021 and November 2021 with several representatives and stakeholders from multiple state agencies, the Judicial Council, local government, and justice system partners, as well as representatives from patients' rights and family member organizations. Per the statute, the Workgroup identified short-, medium-, and long-term strategies to

[1] There are many ways to describe the individuals with SMI in jails: patients, prisoners, inmates, incarcerated persons, defendants, and more. For simplicity, we chose the term "individual" unless we are speaking directly about a person interacting with a health care provider, in which case we used the term "patient."
[2] Stiavetti v. Ahlin; Stiavetti vs. Clendenin; California Welfare and Institutions Code 4147

advance alternatives to placement in DSH restoration of competency programs.[3] These solutions were detailed in the IST Solutions Report. [4]

This Toolkit was recommended as a short-term strategy (S.3), which specifically states:

- DSH shall provide training and technical assistance and develop best practice guides (toolkits) for jail clinical staff, criminal justice partners, boards of supervisors, and county administrators for understanding and implementing effective treatment engagement strategies including:
    - Seeking treatment and medication histories from family members
    - Utilizing of incentives and other strategies to engage treatment including best practices for developing patient/clinician rapport, continuity, and securing the voluntary consent to medication whenever possible.
    - **Obtaining involuntary medication orders and administering involuntary medications, when necessary, ordered by the court, and appropriate due process procedures are followed.**

By using this Toolkit, counties can increase early treatment engagement of individuals, initiate stabilization, and reduce the symptoms of psychosis such as hallucinations, delusions, and disorganized thinking. A reduction in symptoms and increase in stabilization can provide increased opportunities for placement in Diversion or community-based restoration programs, as well as decrease the length of stay for IST individuals on the pathway to Jail Based Competency Treatment (JBCT) or State Hospital placement.

Prior to the development of this Toolkit, DSH Clinical Operations had been actively providing technical assistance and training, as well as psychopharmacology consultation, to any county partners who requested it. This service will continue to be made available on an as needed basis.

3. <u>How can counties use this Toolkit?</u>

Counties can use this IMO Toolkit to consider, develop, and implement policies and procedures to safely administer medications involuntarily to individuals who are court ordered to take psychotropic medication.[5] It is important to note that

[3] *Department of State Hospitals Incompetent to Stand Trial Solutions Proposal*, n.d.
[4] *A Report of Recommended Solutions Presented to the California Health and Human Services Agency and the California Department of Finance in Accordance with Section 4147 of the Welfare and Institutions Code*, 2021
[5] Note that the term "psychotropic medication" is used throughout this document to refer to any medication customarily prescribed for the treatment of symptoms of psychoses and other severe mental and emotional disorders. This is an updated term that is more inclusive than "antipsychotic," which is still included in the document if there is a direct quote or reference to statute.

the administration of involuntary medication is used as a last resort when needed to improve an individual's decompensating mental state. Typically, these individuals are unmedicated, gravely disabled, a danger to themselves or others, and have poor insight into the severity and deterioration of their condition. In these instances, good clinical practice including involuntary administration of medications is essential to the safety and wellbeing of the individual, peers, and jail staff.

California is a large state where custody and medical staffing resources vary by county. This Toolkit will outline recommendations for optimal custody, clinical, and medical processes and procedures necessary for safe involuntary medication administration.

The administration of involuntary medication starts with an order from the court. Occasionally, courts may need guidance and education in the language needed for an IMO to ensure safe and clinically appropriate administration of medication and delineate which entities are authorized to render this service. This Toolkit will provide examples of language courts can consider adding to IMOs to ensure efficient and clear IMO language.

Some suggestions for getting started:

- If you are a **jail psychiatrist,** look at the prescribing and medication information in section 11
- If you oversee a **jail mental health program,** look at sections 12 and 13 regarding how to get started with IMOs
- If you work in **custody**, look at sections 9 and 10 for reasons why to medicate and how to plan to safely medicate involuntarily
- If you work in the **court** system, start with section 6

BACKGROUND

4. What is an involuntary medication order (IMO)?

When a person is arrested, they may be taken to a county jail, where they are held while they are processed by the criminal justice system. During their time in jail, defendants must be offered health care—medical, mental health, and dental—in a manner consistent with the community standard of care. However, defendants who have decision making capacity have a right to refuse any treatment that is offered to them.

Defendants who do not have decision making capacity may not have the right to refuse treatment. If a court has issued an IMO, which is an order granted by a court that requires a person to take psychotropic medication, the county jail has authority to enforce the IMO. It is used in non-emergency situations for people with mental illness who require ongoing administration of medication and have minimal insight into their need for treatment. The medications are always offered in an oral form first and are usually taken with cooperation, but if the person refuses to take the medications, they can be administered involuntarily via an injection.

There are two legal avenues by which a court can order an IMO:

- California Penal Code section 1370: Mental Competency for Trial. If a defendant is not able to participate in their defense because they are unable to understand the nature of the criminal proceedings or they are unable to assist their counsel in the conduct of a defense in a rational manner, the court process is halted, and a psychological or psychiatric evaluation is ordered. Based on the results of the evaluation, the judge may order that the defendant receive treatment to regain their competency, or ability to stand trial. When the judge commits the defendant for competency restoration, they may also authorize the involuntary administration of antipsychotic medication based on criteria being met. The main criteria in making a recommendation for an IMO according to the 1370 statute:
    - The person lacks the capacity to make decisions regarding their antipsychotic medications, and
    - The individual's mental disorder requires treatment with antipsychotics, and
    - If not treated with antipsychotic medications, there is a probability of serious harm to the individual's physical or mental health, and/or

- The individual has previously suffered these effects as a result and their condition is substantially deteriorating, and/or
- The individual is a danger of physical harm to others.[6]

Note that, in some counties, California Penal Code section 1369.1: **Designation as a Treatment Facility** was a barrier to implement involuntary medication orders**; it was repealed June 30, 2022**. Prior to July 1, 2022, a County could designate the county jail as a "treatment facility" with the approval of the County Board of Supervisors, the County Mental Health director, and the County Sheriff, and therefore provide medically approved medication to defendants found to be IST. As of July 1, 2022, designation of the jail is no longer necessary to administer involuntary medication to incompetent defendants. Any jail may administer involuntary medications to incompetent defendants if there is a valid IMO.

- California Penal Code section 2603: Administration of antipsychotic medication to a person in county jail. This order is issued by a judge if a psychologist or psychiatrist determines that because of a serious mental disorder, the person:
  - Is gravely disabled and does not have the capacity to refuse treatment with antipsychotic medications; or
  - Is a danger to self or others.

  Note that for individuals who are not found IST, the dangerousness to self or others does not need to be coupled with a lack of decision-making capacity, but the lack of decision-making capacity does need to be coupled with grave disability.

5. Why do some people with serious mental illness (SMI) refuse treatment with psychotropic medications?

Medication compliance is critical in the management of SMI—including schizophrenia, major depressive disorder, and bipolar disorder. However, medication nonadherence, where a person does not take medication in a manner consistent with recommendations from their health care provider, is very common. In a review of the available data from 2020[7], 49% of patients with SMI were not adherent to their psychotropic medication, including 56% of people with schizophrenia.

[6] See Appendix detailing Statute Code section 1370, subdivision (a)(2)(B)(i)(I)
[7] Semahegn et al., 2020

Experts agree that persons with schizophrenia are considered medication adherent if they take more than 80% of prescribed medications, and they are partially adherent if they take more than 50% of prescribed medication. Nonadherence is also defined as being off medications for one week.[8]

When individuals with SMI in the community disengage from treatment, the symptoms of their disease may lead to actions that result in arrest. Unfortunately, jails nationwide are filled with people who have been arrested secondary to criminal behavior related to untreated mental illness. The Stepping Up Initiative (www.stepuptogether.org), a nationwide effort to reduce people with mental illness in jails, was created to help counties address this widespread problem.

The specific reasons people stop taking their psychotropic medication as prescribed vary from person to person. The following are some of the reasons for medication non-adherence:

- Substance abuse
- Lack of social/family support
- Negative attitude toward medication, such as being suspicious about medication
- Distrust of the medical establishment / medical mistrust
- Lack of insight (level of awareness) into mental illness
- Side effects
- Perceived stigma by families, neighbors, health professionals, and other community members
- Health system barriers, including medication cost
- Skepticism around treatment, such as feeling that they have tried everything, and nothing works
- Trauma history
- Other clinical conditions, such as physical disorders

6. What are the benefits of medication adherence?

The goals in treating SMI are the same as treating any chronic illness: **reduce or eliminate the symptoms of disease,** prevent progressive deterioration or future episodes of decompensation, preserve functionality, and promote successful community integration and wellbeing. Medication is one important tool available to clinicians to treat patients with SMI. Because mental illness affects the brain, many individuals are unable to think clearly without medications. For

[8] El-Mallakh & Findlay, 2015

this reason, medications can be ordered by the court in select circumstances (see section 4, above).

Treatment with medication **reduces morbidity and mortality** in patients with SMI. Research shows that antipsychotic use in individuals with schizophrenia reduces mortality from all causes.[9] In addition, mood stabilizer treatment reduces self-harm and suicidality in patients with bipolar disorders.[10]

Not only are there benefits to medication treatment, such as decreasing the severity of symptoms, but studies have shown that ***prompt* treatment** with medication has clear benefits. Psychotropic medication non-adherence can reduce the effectiveness of treatments or leave the individual less responsive to subsequent treatment.[11] Prompt treatment preserves function (i.e., a person's long-term ability to think clearly, accurately perceive the world, communicate effectively, and negotiate activities of daily living), decreases the severity of symptoms, and decreases the duration of the decompensation episode.

Prompt medication treatment for people with SMI also **makes the jail safer** by decreasing violent episodes. Poor medication adherence has been shown to be a predictor of violence: in one study, violent crime fell by 45% in individuals receiving psychotropic medication.[12] In another study, schizophrenia was associated with violence only in individuals who were untreated.[13]

Lastly, prompt medication treatment may **shorten the jail length of stay** for many individuals. Studies show that mentally ill inmates remain in jail longer than other inmates.[14] The reasons for this are multifactorial and include (1) the evaluation and restoration of competency to stand trial, (2) difficulty understanding and following jail rules, and (3) increased violent episodes when not treated with medication, which can lead to additional charges. Outside of jail, duration of psychiatric hospitalization, rates of hospital readmission, and suicide attempts are all increased by partial or complete medication nonadherence.[4]

In summary, there are many advantages to medication treatment for SMI, and significant disadvantages to delays in treatment and medication nonadherence.

[9] Correll et al., 2022
[10] Hayes et al., 2016
[11] Semahegn et al., 2020
[12] Fazel et al., 2014
[13] Keers et al., 2014
[14] *Serious Mental Illness (SMI) Prevalence in Jails and Prisons*, 2016

7. Do we have to use force with IMOs?

If an individual with SMI is in jail and has a court order stating that they shall take medication, jail staff is then responsible for carrying out that order. Sometimes, by the time the order comes from the court, the individual is already taking medication voluntarily, and the court order does not need to be enforced. Other times, if an individual knows the IMO is in place, they will voluntarily comply with their medication regimen. Unfortunately, sometimes the individual continues to refuse medication.

Although the patient has an order from the court requiring that they take medication, they do retain other rights, including access to a mental health patients' rights advocate. Incarcerated people who are involuntarily medicated should be given information about their rights, including contact information for the local mental health patients' rights office.

Members of marginalized communities, specifically related to race, ethnicity, sexual orientation, and transgender identities, may be prone to medication non-adherence secondary to distrust of medical providers. There are many steps to take between the individual refusing medication and them being given an injection using a physical or mechanical hold. Use of force should be avoided whenever possible to avoid the potential for re-traumatization, as most justice-involved individuals with SMI have significant trauma histories.[15] Anecdotally, most individuals who are refusing medications will comply with medications prior to force being necessary if a clear, stepwise approach is used:

a. **First, medications must be prescribed by the provider.** This may seem obvious but is important to address. When medications are prescribed, providers discuss with the individual the medications that are recommended, including risks and benefits of treatment. This discussion must happen in all cases, even when involuntary medication is ordered by the court. With psychotropic medications, providers often have individuals sign a document indicating that they understand the risks and benefits of treatment and agree to proceed. If the individual is refusing medication, they have usually refused to sign this document as well. The provider must be informed that the court order has eliminated the need for this agreement, and providers must prescribe the medication according to their clinical judgement, even if it is against the individual's wishes. **It is important for the provider to prescribe the medications, even if the individual has stated they won't take them.** This will allow staff to continue

[15] McQuaid et al., 2018

to offer it and document any refusals in the medication administration record (MAR).

b. **Second, the medications must be offered to the individual.** Sometimes, when the health care staff pass medications to individuals, the individual is unavailable; they could be asleep, showering, in court, in a program, visiting with family or their lawyer, at an appointment, or otherwise not in their housing unit. In these cases, health care staff must try to figure out where the individual is located and offer the medication as soon as is feasible. The individual not being available when the medication was delivered is not the same as the medication being refused.

c. **Work with a trusted entity to encourage the individual to take their medication.** For some individuals, a discussion with someone they trust can help alleviate anxiety and lessen distrust of the system, which can lead to medication compliance. This person can be a family member, a peer supporter, a health care staff member, a custody team member, their attorney, or anyone requested by the individual.

d. **Determine the threshold for "noncompliance.**" As stated above, medication adherence has been defined as taking more than 80% of prescribed medication. It is common to administer medication involuntarily after 3 days of missed medication. Clarify what the definition of compliance is in your jail. What will you do with partial medication compliance?

e. **Implement a behavioral incentive program.** In their Jail Based Competency Treatment programs, DSH has seen great success in limiting the need for forceful administration of medications by using behavioral incentive programs. In fact, some early JBCT programs saw almost complete medication compliance with the use of incentives with their individuals. The use of incentives to modify behavior is often called "contingency management." In short, desired behaviors—such as taking medications—are reinforced by rewarding the individual with desirable items, such as snacks or music. Incentive programs can vary by institution, but the important principles are that the program is clear, scheduled, and dependable. See below for an example of a jail who implemented a successful behavioral incentive program.

f. **Be patient.** In some individuals, it can take many conversations to make inroads into voluntary compliance. Aim for consecutive conversations

within a short time frame, each time an individual refuses their medication.

g. **If all attempts at voluntary compliance fail, notify the individual that involuntary administration may be a next step.** Many times, an individual who has been nonadherent to their regimen will agree to take medications when they understand that medication administration is unavoidable, and before any force is used. If custody staff activate their use of force protocol to deliver medication involuntarily, often the individual changes their mind and will agree to take the medication. Ensure excellent communication between health care staff and custody staff so that the oral medication is readily available in case the individual decides to voluntarily take their oral medication.

h. **As a last resort, administer involuntary medications with minimum amount of force needed.** Administering court-ordered medications using force should only be done when all other actions have been unsuccessful and should always be a planned event. This should not be treated as an emergency. When force is necessary, it is usually only necessary once or a few times as the individual learns from the experience and medications reduce the symptoms that cause them to be non-compliant.

    i. Schedule the administration at a time when key staff are available. Staff participating should have a clear plan for how they will work together in administrating the medication. Do a practice run beforehand and educate involved staff that involuntary administration should not be treated as a crisis. It is recommended that the treatment provider is able to alter the course of medication administration should any concerns about the health or safety of the patient arise.
    ii. Ensure all medications (by injection and oral options) are available in case the patient agrees to take the medication by mouth. **Please note that oral medication should never be given involuntarily because of the risk of choking.**
    iii. Determine the best place to deliver the medication, preferably in a private setting.
    iv. Explain each step being taken during the involuntary administrations, especially those involving physical contact, in a calm and respectful tone.
    v. Monitor the individual after administration.
    vi. If a short-acting once-daily medication was given, create a plan for administration the following day, if necessary. (See Medication

Section for suggestions around medication choice. Long-acting medications, when used properly, can eliminate the need for force multiple days in a row.)

One jail studied the impact of an **incentive program** within a specialized housing unit dedicated to treating jail inmates with special needs, including SMI. This incentive program rewarded inmates for maintaining hygiene and cell/common area cleanliness, engaging in programs, complying with medication regimen, attending health care appointments, and associating with peers. Individuals received points for each task completed, and incentive items could be "purchased" with points on a weekly basis. Over the course of a year, the jail saw a decrease of safety cell placement hours by 9.8% and a **decrease in jail assaults by 19.4%.** In addition, the length of stay in the jail was reduced significantly.[16]

Of note, many patients' rights groups have pushed back against the use of incentives for voluntary treatment because of the concern that using incentives goes against the principles of informed consent. In the context of this Toolkit, behavioral incentive programs are mentioned as a way to encourage medication compliance in patients with involuntary medication orders. However, positive behavioral incentive programs can be successful in facilitating voluntary compliance as well, while maintaining the principles of informed consent.

8. What are the risks of involuntary medications?

All medications have side effects, whether they are given voluntarily or involuntarily. The psychotropic medications used in involuntary medications do not necessarily have more side effects than voluntary medications. Protocols should include an observation period by health care staff to ensure there are no acute adverse effects secondary to allergy or a reaction.

In most cases, individuals will voluntarily take their medication orally when provided a court order, even if they disagree with the order or will agree to take it after a provider takes the time and makes multiple attempts to encourage the individual to take them. However, sometimes enforcement of the order with a medication delivered via intramuscular injection is necessary. The most obvious risk to administering medications involuntarily is the same as the risk with any use of force: injuries to staff or to the individual. The best ways to avoid any injuries are to plan, including creating policies and procedures, and to make sure that the plan is coordinated with and well communicated to key staff. In DSH's

[16] *2020 CSAC Challenge Award San Luis Obispo (SLO) County Sheriff's Department: Behavioral Health Incentive Program*, 2020

experience, custody leadership takes the lead on organizing these involuntary administrations, working closely with mental health and medical staff.

9. Medication guidance: medication histories, long-acting medication, supratherapeutic dosing, and more

Individuals in the criminal justice system with SMI tend to have complicated disease requiring sophisticated prescribing. Psychiatrists have many choices when it comes to what medication to use to treat individuals' symptoms. These medications have varying uses, side effects, costs, monitoring requirements, and availability. This Toolkit is not designed to offer specific prescribing guidance for psychiatrists; however, there are some general principles that your team may find helpful:

- Use the individual's **medication history.** Past medical records are often available from both psychiatric hospitalizations and outpatient clinics. In addition, consulting with a family member or friend familiar with the individual's treatment can provide insight into what has worked in the past. (This communication would require consent from the patient.) Was there a time that the individual was stable on a certain regimen? Have there been side effects to certain medications that led to their discontinuation?

- If possible, **continue the medications prescribed by Department of State Hospitals** after the individual returns to the Jail. Individuals who have been chronically or repeatedly institutionalized often have serious mental illness that is treatment resistant and require complex medication regimens.

- DSH has a group of Psychiatrists, referred to as **"PRN Psychiatrists"** on the "DSH Psychopharmacology Network (PRN) Consultation Team" who has published multiple books, papers and guidelines about treating this population. Members of this team are available to assist counties in prescribing and monitoring medications in individuals with complicated treatment regimens. These psychiatrists have experience in treating individuals with SMI and can guide jail clinicians on how to take care of individuals with complicated disease. This group can be reached at PRN@dsh.ca.gov. In addition to providing prescribing support including how to monitor the plasma levels of psychotropic medications, these clinicians can provide technical assistance on supratherapeutic doses of medication and justifications, when they are needed. Please see the Appendix for a list of resources for prescribers.

- **Seek medication histories from family members**. Before contacting any family member, ensure that there is a Health Insurance Portability and

Accountability Act (HIPAA) compliant signed release of information (ROI) from the individual. Without a signed HIPAA compliant ROI, clinicians are not permitted to reach out to family members, even if the individual has been deemed incompetent to stand trial. (Incompetency to participate in court is not the same thing as being incompetent to make health care decisions.) However, in the event a family member reaches out to a clinician, health care providers may *receive* information from a family member without a signed release—if information is not shared back with that family member. Many jails have developed online tools to allow family or loved ones to submit information to jail health staff directly. (Please note that this recommendation assumes that arrest information is made public.)

- Consider **long-acting injectable medication (LAI)**, where an individual gets an injection at 30-day intervals, or longer. These medications can be used voluntarily or involuntarily. Many individuals like receiving an injection once per month instead of having to remember to take medications every day. If used involuntarily, ideally the individual will agree to take the medication voluntarily after the first dose. To use LAI under a court order, staff must ensure that the duration of the medication action does not exceed the duration of the IMO. For example, if the court order expires in 6 months, a medication lasting 30 days can be given involuntarily because the medication will leave the system before the court order expires. In addition, a medication lasting three months cannot be given if the order has only two months before expiration. DSH acknowledges that LAI are expensive and are often not on formulary at the jail. It may be an administrative hassle to get the medication approved. DSH is working with jail healthcare providers to try to streamline the ordering of LAI and to reduce the cost to counties.
    - Note, if your county currently contracted with DSH for a JBCT, an Admission Evaluation and Stabilization (AES) program, or an Early Access to Stabilization Services (EASS) program, funding is available to support your continued clinical use of LAIs.

- **Continuity of care after jail discharge:** Helping an individual remain medication compliant after release from jail is critical to maintain psychiatric stability and prevent re-arrest. This is a complicated logistical topic that cannot be fully addressed in this Toolkit. In addition, most individuals being released from jail into the community will no longer have an IMO because they will have been restored to competency. However, there are some important steps the jail can take to provide a "warm hand-off" to the community and increase the chances that the person will continue to take their medication:
    - Whenever possible, prescribe medications that are available in the community and covered by Medi-Cal insurance,

- Provide a supply of medications in-hand at release,
- Partner with a local mental health provider who will assume care for the individual at release,
- Work with the local social services department to enroll the individual in Medi-Cal prior to release,
- Create a written discharge plan that is updated during the person's incarceration and review it with the individual regularly and at discharge, and,
- If permitted by the individual, contact loved ones prior to release to inform them of the plans in place.

PRACTICAL RESOURCES AND MATERIALS

10. Getting Started with IMOs: Questions to ask

Answering these questions with yes/no/unsure will help you start to identify the resources your county may have around IMOs and will help tailor the assistance DSH can provide. If you need help and would like consultation as you begin to answer these questions, reach out to DSH (see contact information, below).

- Has your jail ever administered medications involuntarily?
    - If yes, does it happen in emergencies only?
- Do your courts order involuntary medications? If yes,
    - Do courts issue an IMO when they declare an inmate incompetent to stand trial (Penal Code section 1370)?
    - Is it all the time, or does it depend on the judge?
    - Have you ever pursued a Penal Code section 2603 order?
    - Have you ever used an administrative law judge (ALJ) for a medication order?
- If the jail has an IMO while someone is waiting to be admitted to JBCT/DSH, is anything done with that order? For example, will the jail enforce that order prior to DSH/JBCT admission?
- How comfortable is the jail prescribing psychiatrist /nurse practitioner /physician assistant in ordering involuntary medication?
- How comfortable are custody staff with using force to administer medication? Is there a policy that you know of?
- Does your Jail use long-acting injectable psychotropic medication?

11. Addressing common barriers and myths to IMO administration in jails

Every county jail is different. However, in working with various jails to implement IMOs, we have identified some common barriers. These are referenced below, along with some proposed solutions for consideration:

Barrier	Category	Solution(s)
Need for "Treatment Facility" Designation by Board of Supervisors to administer IMO in Jail (PC 1369.1)	Legal	No longer required. Senate Bill (SB) 184 repealed Penal Code section 1369.1, effective July 1, 2022. This section had previously required the concurrence of a county's board of supervisors, the county mental health director, and the county sheriff to designate a county jail as a treatment facility to provide medically approved medications to an IST defendant. This applied to psychotropic medications provided in a county jail pursuant to Penal Code section 1370. With the repeal of section 1369.1, such designation as a treatment facility is no longer required. SB 184 also established in Penal Code section 1370, that an involuntary medication order (IMO) is enforceable in a county jail for psychotropic medications prescribed by the treating psychiatrist.
Court does not typically provide IMO with Penal Code section 1370 commitment order	Legal	- Outreach to DSH IMO Consultation Team (see below for contact info) - Outreach to judges to identify barriers to issuing IMO - Provide Penal Code section 1369 templates to alienists requiring their clinical opinion regarding the need for an IMO - Ensure that all alienists (both psychiatrists and psychologists) provide opinions related to capacity to consent to medications and dangerousness - DSH IMO Consultation Team can provide consultation in how to obtain an IMO via Penal Code section 2603
Sometimes court does not provide IMO with 1370 order, sometimes it does	Legal	- Outreach to DSH IMO Consultation Team - Outreach to courts to identify reason for inconsistency
County does not provide "restoration treatment" (language often included in	Legal	DSH IMO Consultation Team can meet with County Counsel and stakeholders to clarify

IMO) therefore cannot administer medications		
Concern regarding active consent decree and potential scrutiny of this practice	Legal	IMO implementation is congruent with constitutional-level healthcare
County history of bad outcome using IMO	Legal	Identify challenges or barriers that led to poor outcome last time and revise policies or practices to support improved outcomes for the future. Seek consultation with DSH IMO Consultation Team
Liability concern: if IMO present in the chart, must it be used if there are documented medication refusals?	Legal	If an individual is cooperating with medication administration and relevant blood draws, then nothing else is necessary. However, failure to utilize an IMO when medication is medically necessary may *create* liability for the provider and the institution.
Lack of willingness by Sheriff's Office (various reasons, including political)	Stakeholder position	- Outreach to IMO Consultation Team - Provide data on benefits of using IMOs (decreased violence) - Connect Sheriff with peer who has implemented program - Engage with California State Sheriffs' Association (CSSA)
Advocacy groups opposed to involuntary treatment of inmates	Stakeholder position	Meet with advocacy groups and hear their concerns. Consider partnering with these groups when developing IMO policies.
Psychiatrist unwilling to order medication involuntarily	Stakeholder position	- Consult with DSH PRN team - Outreach and education, connect with peers and DSH IMO Consultation Team - Utilize the psychiatrist's chain of command to establish clinically appropriate behavioral expectations
Stakeholder resistance	Stakeholder position	Customize education to address group
Some practitioners may feel that once an individual is committed to DSH as an IST the jail may no longer be responsible for providing treatment	Stakeholder position	- Establish relationships with DSH - DSH IMO Consultation Team can offer support and resources - DSH can provide presentation on IST treatment programs and available funding

		- Focus on treatment of individuals as a professional duty, ethical responsibility, and Title 15 requirement
No JBCT program in jail so county unfamiliar with idea or process of IMOs	Admin	- JBCT is not a pre-requisite for IMO implementation. - DSH IMO Consultation Team can advise on relevant policies, procedures, and templates for the county to consider.
Lack of detailed medical/ mental health procedures including how to offer medications, use of incentives, documenting medication refusals, ordering medications, etc.	Admin	DSH IMO Consultation Team can provide examples
Lack of detailed custody procedure around use of force in non-emergency	Admin	- DSH IMO Consultation Team can provide example policies and procedures
Lack of tracking medication refusals to justify involuntary administration	Admin	- Education and/or training to med pass staff - Education regarding all relevant behaviors (e.g., refusing necessary blood draws, declining necessary medication changes while actively complying with insufficient treatment) - Medication Administration P&P update
Lack of tracking IST list to know who has an order, who is taking meds, who needs IMO	Admin	- Help develop internal tracking by county - Address privacy considerations in sharing list - Consider Patient Management Unit (PMU) as a resource
Policies in place but not enough custody and/or health care staff to administer IMOs	Admin	- Demonstrate (using data if available) that more resources are spent on unstable unmedicated individuals - Explore use of long-acting injectable medications to extend medication effects past one day - DSH can provide presentation on IST programs and available funding

Lack of understanding of difference between emergency and non-emergency (court-ordered) involuntary medications	Best Practices	Education, Training, Presentation, call with DSH, technical assistance
Custody / Sheriff resistance to using force	Education	Connect with peers, DSH IMO Consultation Team assistance with developing plan, reluctance improves over time, emphasize that this is standard of care
Skepticism around benefits of IMO administration in individuals	Education	See "Benefits of IMO" section
County lacks connection with DSH for support	Education	Connect with DSH partners and DSH IMO Consultation Team
Lack of understanding of IMO administration role in big picture (versus offramp, DSH psychiatrist consultation, MH Diversion, JBCT, etc.)	Education	- This Toolkit can help - Connect with DSH IMO Consultation Team - Connect with DSH Psychopharmacology (PRN) Consult Team

12. County checklist for IMO implementation

- ☐ Enlist support of Sheriff, Jail Health Care provider, County Counsel, and County Behavioral Health
    - Consider a kickoff meeting / meet and greet of stakeholders
    - Prepare a "canned" presentation to address educational barriers
    - Consider connecting with peers in other Counties
- ☐ Reinforce availability of DSH as backup support system and consultation, including
    - Development of policies
    - Connecting counties to peers
    - Giving or assisting with presentations
    - Meeting with stakeholders
    - Providing training
    - Obtaining IMOs via an administrative law judge
    - Prescribing support and assistance
    - DSH IST Re-Evaluation Services Program
- ☐ Determine how the IMOs are obtained
    - 1370 – IMO accompanies the IST commitment order to restore the individual to competency
    - 2603 – separate process based on dangerousness or grave disability, can be obtained through county court or via an Administrative Law Judge (ALJ) with consultation from DSH
    - Who takes the lead in this process? How involved do the psychiatrists need to be?
- ☐ Write and approve policy for IMO administration
    - One page workflow recommended for easy reference
    - Provide templates / examples, especially for IMO Certificate
    - Determine capacity of system, how many individuals per week can be treated?
    - Include information about requesting an "acuity review" for someone needing urgent admission to DSH
- ☐ Establish team, consider the following members:
    - Custody leadership (e.g., Sergeant)
    - Mental Health leadership (e.g., MH Manager)
    - Medical leadership (e.g., Director of Nursing)
    - Court liaison (e.g., Correctional Technician, Legal Clerk, Custody Deputy)
    - Diversion point person (e.g., Behavioral Health Clinician)
    - County Counsel
- ☐ Establish communication flow and tracking system across systems

- Who will manage the list of individuals – Jail team? (Custody, Medical or Mental Health?) Court team?
- Where will the list be kept?
- How often will it be distributed?
- Who will it be distributed to?
- Address HIPAA /privacy concerns
- Cross-check with DSH list – coordinate with Patient Management Unit (PMU)

☐ Ensure coordination with other DSH programs that are also treating ISTs:
- EASS Program,
- IST Re-Evaluation Services Program
- Mental Health Diversion
- JBCT or AES Program
- Community Based Restoration (CBR) Program

☐ Documentation:
- Who checks for the IMO? Where is it kept?
- Psychiatrist order in chart
- Refusals of medication documented in chart
- Use of Force documentation by custody

13. Tracking Your Jail's IST Census

An important part of managing the medication compliance of IST individuals is keeping up with documentation:

- Is there an involuntary medication court order?
  - If so, where is the court order kept? Is the order still valid?[17]
- Is medication ordered?
  - If not, has the prescriber seen the individual?
- Is the individual taking the medication as ordered?
  - If not, is it all medications or certain ones? Does it depend on time of day or any other factors?
- Have incentives been tried?
- Is the individual being considered for a DSH program, such as Mental Health Diversion, where medication compliance is a pre-requisite?

[17] Unless otherwise stated, involuntary medication orders under PC 1370 are valid for one year or until criminal proceedings resume.

ADDITIONAL CONSULTATION RESOURCES AND CONTACT INFO

14. Acuity Review Process

If a Felony IST individual in your care continues to maintain a high level of acuity, even after the strategies outlined in this Toolkit have been attempted, you may want to consult with DSH to determine if the individual meets criteria for prioritized admission to a DSH facility through the Acuity Review Process outlined below. The definition of "**Psychiatric acuity**" means that an individual's mental illness is causing complications which put the individual at risk of death or serious injury while awaiting admission. An individual's aggressive behavior alone shall not be sufficient to support a finding of psychiatric acuity.

- An Acuity Review (Expedited Review Request) is necessary when the committing county's clinician who is responsible for the individual's clinical assessment or its designees, or a DSH designated employee or DSH designated contractors who is responsible for case consultation or the patient's clinical assessment or evaluation, determines that the patient's mental illness is causing complications which put the patient at risk of death or serious injury while awaiting admission.

- When an Acuity Review (Expedited Admission Request) needs to be submitted, the referring party, will reach out to the PMU Case Manager (depends on which county) via email. Always include PMU's global email address to ensure the request is handled in an expeditious manner courtreferrals@dsh.ca.gov.

    - In the email subject line indicate ACUITY REVIEW REQUEST.
    - In the body of the email (or in an attachment) provide a rationale regarding the patient's current condition and the reasoning for the request.
    - In addition to the rationale, provide current medical records for the patient:
        - Any notes on use of safety cell;
        - Current medication and dosage or lack of medication;
        - Medical laboratory results; or
        - Any additional treatment records from local health care providers.

- Please note, before an Acuity Review can be processed, the patient's Commitment Packet must also be provided to PMU, this is sent by the courts to PMU via Workspaces. If there is an instance where PMU has not yet received the patient's Commitment Packet, we will notify the requester, and reach out to the court for a status of the packet.

- Once PMU receives both the written request and the current medical records, PMU will then send the information to PMU Clinical for preliminary review. Once PMU Clinical completes their preliminary review, the PMU Case Manager will forward the request to two State Hospitals for the Acuity Review. Once the State Hospital(s) receives the Acuity Review, they will have three business days (72 hours) to render a decision. The Case Manager will get back to the county as soon as PMU is made aware of the outcome of the review from both hospitals.

15. Department of State Hospitals (DSH) Support, Resources, Contact info

DSH is committed to assisting Counties in all aspects of caring for people with SMI in the criminal justice system. DSH has resources to assist Jails for every topic identified in this Toolkit:

- IMO Implementation Assistance, General questions or Toolkit feedback:
  - DSH IMO Consultation Team IMOConsult@dsh.ca.gov
  - Dr. Carolina Klein Carolina.Klein@dsh.ca.gov
  - Dr. Christy Mulkerin Christy.Mulkerin@dsh.ca.gov
- Jail Based Competency Treatment (JBCT) Program:
  - Stacey Camacho Stacey.Camacho@dsh.ca.gov
  - Dr. Melanie Scott Melanie.Scott@dsh.ca.gov
- Early Access and Stabilization (EASS):
  - Stacey Camacho Stacey.Camacho@dsh.ca.gov
  - Dr. Melanie Scott Melanie.Scott@dsh.ca.gov
- Diversion Programs:
  - Stacey Camacho Stacey.Camacho@dsh.ca.gov
  - Ashley Breth Ashley.Breth@dsh.ca.gov
- IST Re-evaluation program:
  - Dr. Melinda Diciro Melinda.Diciro@dsh.ca.gov
  - Dr. Parker Houston Parker.Houston@dsh.ca.gov
  - Dr. Katie Messerol Katie.Messerol@dsh.ca.gov
- Court Orders, including use of Administrative Law Judge (ALJ):
  - DSH Legal SacLegal1370@dsh.ca.gov
- Prescribing Assistance:
  - DSH PRN Consult PRN@dsh.ca.gov
  - Dr. Carolina Klein Carolina.Klein@dsh.ca.gov
- Waitlist management / Patient Management Unit:
  - Jaci Thomson Jaci.Thomson@dsh.ca.gov
  - Erin Hoppin Erin.Hoppin@dsh.ca.gov
- Acuity Review Process
  - courtreferrals@dsh.ca.gov
  - Dr. Shawna Leppert Shawna.Leppert@dsh.ca.gov

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APPENDIX A: Legal Resources

PC 1370 (a)(2)(B)(i)(I)

1. The defendant lacks capacity to make decisions regarding antipsychotic medication.

2. The defendant's mental disorder requires medical treatment with antipsychotic medication.

3. If the defendant's mental disorder is not treated with antipsychotic medication, it is probable that serious harm to the physical or mental health of the patient will result.

Probability of serious harm to the physical **or** mental health of the defendant requires evidence that:

A. the defendant is presently suffering adverse effects to their physical **or** mental health,

or

B. the defendant has previously suffered these effects as a result of a mental disorder and their condition is substantially deteriorating.

The fact that a defendant has a diagnosis of a mental disorder does not alone establish probability of serious harm to the physical or mental health of the defendant.

PC 1370 (a)(2)(B)(i)(II) Criteria (Dangerousness)

1. (a) The defendant has inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another while in **custody**,

or

1. (b) The defendant had inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another **that resulted in the defendant being taken into custody**,

and

2. The defendant presents, as a result of mental disorder or mental defect, a demonstrated danger of inflicting substantial physical harm on others. (Demonstrated danger may be based on an assessment of the defendant's present mental condition, including a consideration of past behavior of the defendant within 6 years prior to the time the defendant last attempted to inflict, inflicted, or threatened to inflict substantial physical harm on another, and other relevant evidence)

Certification Form Suggestions (PC 1370 Involuntary Medication)

III. CRITERIA FOR INVOLUNTARY MEDICATIONS:

The defendant meets the criteria delineated in PC 1370 (a)(2)(B)(i)(I) and/or PC 1370 (a)(2)(B)(i)(II). (choose one or both criteria)

PC 1370 (a)(2)(B)(i)(I) Criteria: (Please address the following and provide supporting evidence as applicable)

1. The patient lacks capacity to make decisions regarding antipsychotic medication. (Please provide examples)

In this section, describe the patient's inability to rationally engage in a discussion about the benefits and risks of accepting versus rejecting treatment. Using direct patient quotes from discussions which took place on specific dates will be helpful. This criterion is commonly met due to the patient's lack of understanding regarding the seriousness of their mental illness and their inability to appreciate the potential risks associated with rejecting treatment (including all of the sequelae of uncontrolled psychosis)

2. The patient's mental disorder requires medical treatment with antipsychotic medication.
(Please provide examples)

In this section, simply briefly describing the mental disorder and explaining that the symptoms of the disorder are not expected to appreciably improve without antipsychotic medication should suffice.

3. If the patient's mental disorder is not treated with antipsychotic medication, it is probable that serious harm to the physical or mental health of the patient will result. Probability of serious harm to the physical or mental health is supported by the following evidence: (Please provide examples)

Keep in mind here that one should avoid interpreting the meaning of "probability of serious harm to the physical or mental health," because the law has defined it as either a. or b. below:

a. The patient is presently suffering adverse effects to their physical **or** mental health, **or**
   - *This highlighted "or" is important to keep in mind because it is commonly easier to support the argument that the patient is suffering adverse effects to their mental health as compared to their physical health.*
   - *Remember to provide specific examples to support the adverse effect on the patient's mental health.*
   - *Evidence supporting that the patient is suffering adverse effects to their physical health could include refusing insulin leading to increased blood glucose, refusing anti-hypertensives leading to elevated blood pressure, excessive water consumption causing hyponatremia,*

increasing seizure risk, or refusing showers making the patient prone to skin infections.

b. The patient has previously suffered these effects as a result of a mental disorder and their condition is substantially deteriorating.
   - *For example, if a patient has a history of paranoid delusions which were experienced as unpleasant and therefore caused suffering (which would support that they previously suffered adverse effects to their mental health) and there is clear evidence that their symptoms are increasing (i.e., appears to be responding to internal stimuli more often), then this criterion should be met.*
   - *Likewise, if the patient has a history of excessive water consumption with hyponatremia when their symptoms are poorly controlled and we have clear evidence that their symptoms are worsening, then this criterion should be met.*

PC 1370 (a)(2)(B)(i)(II) Criteria: (Please address the following and provide supporting evidence as applicable)

1. The patient has inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another while in custody. (Please provide examples)

In this section, "while in custody" can refer to any assault, attempted assault, or serious threat which took place at any point subsequent to the arrest up to the time that you are completing the certification. So, violence, attempted violence, or serious threats at the jail or hospital count toward fulfilling this criterion. Yelling "I hate you mother f---er" is impolite, but it is not a serious threat.

or

The patient had inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another that resulted in the patient being taken into custody. (Please provide examples)

This section allows you to reference the charges against the defendant if the charges involved a threat, attempted violence, or inflicted violence. Remember that just because the patient has not been convicted of their charges doesn't mean we cannot reference them for purposes of satisfying this criterion.

and

2. The patient presents, as a result of mental disorder or defect, a demonstrated danger of inflicting substantial physical harm on others. (Demonstrated danger may be based on as assessment of the defendant's present mental condition, including a consideration of past behavior of the defendant within 6 years prior to the time defendant last attempted to inflict, inflicted, or threatened to inflict substantial physical harm on another, and other relevant evidence). (Please provide examples)

- *The key to meeting this criterion is establishing a link between the patient's mental disorder and dangerous behavior.*
- *This can be established if we have solid evidence that their most recent violence, attempted violence, or serious threat was a result of their mental disorder (see example a. below). It could be emphasized with the ALJ judges and in court that the "demonstrated danger" criterion includes the language "based on the defendant's present mental condition."*
- *Regardless of whether there was a link between the mental illness and violence in the most recent event, any information (which supports a link between the individual's mental illness and their dangerous behavior) covering the 6-year period prior to the most recent incident which was addressed in 1. above would help support this criterion. See examples b, c, and d.*
- *Some possible examples to satisfy "demonstrated danger" are as follows:*

  a. A patient with a history of treatment refractory schizophrenia who had no rational reason for being upset with a peer stabs them in the eye with a pencil and explains their actions stating, "I just wanted to see what makes them tick."
  b. A patient is in jail on charges of assault and has been declared incompetent to stand trial (IST). They have a sister who says they have a history of exhibiting aggressive behavior when they are off of their medication. The history of exhibiting aggressive behavior off of their medication should satisfy "demonstrated danger."
  c. A patient is in jail on assault charges and has been declared incompetent to stand trial. They have an extensive history of psychiatric hospitalizations as well as multiple past charges for violent offenses. While we may not have access to details regarding the nature of their past violence, we can reasonably infer that their mental illness likely had some contribution to their past violence in support of meeting the "demonstrated danger" criterion.

APPENDIX B: Resources for Prescribers

Literature supporting supratherapeutic dosing of psychotropics:

1. Use of very-high-dose olanzapine in treatment-resistant schizophrenia https://pubmed.ncbi.nlm.nih.gov/25278103/
2. Dopamine antagonist antipsychotics in diverted forensic populations https://pubmed.ncbi.nlm.nih.gov/31060635/
3. Clozapine and therapeutic drug monitoring: is there sufficient evidence for an upper threshold? https://pubmed.ncbi.nlm.nih.gov/23179967/
4. Monitoring and improving antipsychotic adherence in outpatient forensic diversion programs https://pubmed.ncbi.nlm.nih.gov/31120002/
5. A rational approach to employing high plasma levels of antipsychotics for violence associated with schizophrenia: case vignettes https://pubmed.ncbi.nlm.nih.gov/24865765/
6. California State Hospital Violence Assessment and Treatment (Cal-VAT) guidelines https://pubmed.ncbi.nlm.nih.gov/28480838/
7. Management of Complex Treatment-resistant Psychotic Disorders Cambridge University Press