SECTION - ADMINISTRATION
ADMINISTRATIVE DIRECTIVE NO. 134
(Replaces A.D. No. 134 dated 3/8/07)

Effective Date: June 14, 2007

SUBJECT: FACILITY PLAN FOR SERVICES

I. PURPOSE

This Plan for Services describes the scope of services, which have been planned to accomplish the mission of Coalinga State Hospital (CSH), as described in the "Facility Declaration Administrative Directive". It describes the clinical, demographic and forensic characteristics of the population served, as well as the services and human and physical resources provided to meet the identified needs.

II. AUTHORITY

California Code of Regulations, Title 22; Welfare & Institutions Code 6600 et. seq; and Penal Code Section 2684.

III. POLICY

In response to changes in the needs of the population and in requirements of external customers, this Plan shall be evaluated and revised, as appropriate, as a component of the hospital's annual strategic planning processes.

IV. METHOD

A. Hospital Description:

1. CSH is a self-contained, maximum security forensic facility. It has a capacity of 1500 beds which are Acute Care (AC), Intermediate Care Facility (ICF) and Residential Recovery Unit (RRU). The Individual's living area is divided into 32 units.

2. Each unit is comprised of individual rooms and/or dormitories with provision for privacy, storage of personal effects, and personal hygiene facilities. An Individuals' day room is provided for socializing, table games, reading, and television. Each unit has group and rehabilitation therapy rooms. A nursing station is centrally located on each unit, and each unit has a Doctor's exam room. Contiguous to each unit are two courtyards for outdoor activities. All units are equipped with a quiet activity room for socializing, reading, writing and table games, without the distraction of the television. In addition, each unit has a staff conference room, a staff lounge, and office space for professional staff.

3. Space outside the unit is available for specific activities and services including: central courtyard for personal activities; gymnasium; arts and crafts center; music listening and practice rooms; dining facilities; canteen; chapels and religious service areas; large meeting room for entertainment events; a school and substance abuse service areas for educational and psycho educational services; library; vocational instruction and work experience areas; a barber shop, and medical and clinical assessment centers.

4. The units are organized into eight buildings as follows:

Building	Unit	Total Bed Capacity
I	MA1, MA2	50
I	MA3, MA4	50
II	TO1, TO2	100
II	TO3, TO4	100
III	5, 6, 7, 8	200
IV	9, 10, 11, 12	200
V	13, 14, 15, 16	200
VI	17, 18, 19, 20	200
VII	21, 22, 23, 24	200
VIII	25, 26, 27, 28	200
Total	32 Units	1500

B. Wellness and Recovery Program:

1. CSH uses a wellness and recovery model that is defined by its person-centered attitudes, beliefs, and actions. There are various definitions of recovery offered by mental health professionals, family members and Individuals within the mental health community. Each definition is almost as varied as the unique life journeys of those who have experienced recovery. Those living with severe and persistent mental illness have offered a number of recovery narratives that include the following themes:

   a. Recovery is the reawakening of hope, after despair.

   b. Recovery is moving from withdrawal to engagement, to active participation in life.

   c. Recovery is a journey from alienation to purpose.

   d. Recovery is active coping rather than passive adjustment.

   e. Recovery means no longer viewing oneself primarily as a mental Individual, and reclaiming a positive sense of self.

f. Recovery is not accomplished alone - it involves support and partnership.

2. The above themes highlight the concepts that form the basis for our approach to providing service. The important concepts include:

   a. Hope – This is the desire accompanied by confident expectation. Hope is foundational to recovery from mental illness and mental disorders. Having a belief that things can get better is a powerful force and can fuel the recovery process.

   b. Medication and Psychosocial Rehabilitation (PSR) Services – Many consumers report that both medications and PSR Services play an important role in their recovery. This is especially true when they are engaged in a partnership with their provider and are involved in their PSR planning.

   c. A Sense of Empowerment – This means that Individuals have a belief that they have power and control in their life, including over the effects of their illness. As empowerment grows, they begin to take responsibility for self and advocating for themselves and others.

   d. Support – An important ingredient in recovery is that of support from peers, family, friends and mental health professionals. Multiple sources of support are especially helpful as it decreases isolation.

   e. Education and Knowledge – Information about illness, medications, best wellness and recovery practices, and available resources is a necessary element of a recovery program.

   f. Self Help - Although professional "treatment" is a valuable component of the recovery process, self-help is often viewed as the conduit to growth in recovery.

   g. Spirituality and Culture – For many Individuals, spirituality and culture provide hope, solace during their illness and a source of social support.

3. A leader in the field of Psychiatric Rehabilitation and Recovery, William Anthony offers the following definition of recovery: "Recovery is a continuing, deeply personal, individual effort that leads to growth, discovery and change of attitudes, values, goals and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

4. At CSH, the delivery of active treatment interventions consistent with a recovery model is provided using a collaborative team approach. Each Wellness and Recovery (WR) Team is comprised of the Individual served and members of the following disciplines: medicine, psychiatry, psychology, social work, rehabilitation therapy, and nursing. The WR Team is responsible for developing the Individual's Wellness and Recovery Plan and when necessary securing consultations from other internal and external care providers to meet the needs of the Individual served.

V. POPULATION SERVED

All Individuals admitted to CSH are reviewed for appropriateness as related to admission criteria outlined by CSH's Admission Policy. The Individual population consists of adult males. Treatment is provided to the following commitments:

A. Mentally Ill Prisoner (MIP):

1. This program provides mental health services for inmates referred to CSH from the California Department of Corrections and Rehabilitation (CDCR) under Penal Code Section 2684. MIP commitments admitted under this code usually have a severe mental disorder that seriously impacts their daily functioning and requires a recovery milieu that is not available in CDCR. The MIP living units are licensed at the Intermediate-Care-Facility (ICF) level of care.

2. MIP individuals suffer from severe and persistent mental illnesses usually affecting both thought and mood. Individuals often present with co-occurring challenges involving severe disorders of personality, chronic abuse of substances, and limited achievement in academic education or career development. Most Individuals struggle with their severe positive symptoms of schizophrenia or schizoaffective disorder, their reliance on psychotropic medications, their abilities to cope with thoughts of suicide or self-harm, their relations with others, their management of assaultive urges or behaviors, and their general level of adaptive skills that are necessary for successful return to prison and eventual placement in the community.

3. Most MIP Individuals require assistance with their psychiatric disorders, through the use of psychopharmacology, skill-building groups, and counseling related to coping and managing behavior.

4. Psychosocial rehabilitation and recovery-oriented services are provided on the living units or in nearby Mall-service areas. Also, included are supervised access to courtyards and access to other hospital activity and service areas for both personal enrichment and skill development.

5. All Individuals participate in a wellness and recovery planning conference within 7 to 14 days of admission to the unit. A comprehensive integrated assessment is compiled, with contributions from all members of the Individual's team and other medical professionals. A personal Wellness and Recovery Plan is developed based on this assessment, in which the Individual and other team members collaborate in identifying specific goals and interventions designed to assist the person in his progress toward greater independence and self-reliance.

6. The MIP Program operates a performance improvement team comprised of clinicians, management, and nursing staff, which serves to review and enhance service development and delivery. This team oversees program activities and makes recommendations to the Mall Director and Program management for additions and modifications to unit and Mall-based services. Services encompass skill building, enrichment, and rehabilitation activities. Included are such groups as the following:

    a. Orientation to Recovery Services

    b. Medication Self-Management

    c. Substance Abuse Recovery Group

    d. Criminal Thinking Errors

    e. Symptom Self-Management

    f. Anger and Emotion Self-Management

    g. Depression and Crisis Management

    h. Community Re-entry Skills

    i. Community Living Skills

    j. Prison Living Skills

    k. Recreation and Leisure Skills

    l. Work Activity and Experience

    m. Physical Health and Wellness

    n. Spiritual Wellness

    o. Relaxation and Meditation

7. Units are allocated a complement of staff, which includes: a Unit Supervisor, one or two Psychiatrists, two Psychiatric Social Workers, two Rehabilitation Therapists, two Psychologists, and 27-30 Psychiatric Technicians & Registered Nurses (spread over the 24/7 workweek).

B. Sexually Violent Predator (SVP):

1. These Individuals have a diagnosable mental disorder and, in addition to problems of sexual deviance, demonstrate antisocial behavior, poor judgment, anger management deficits, poor impulse control, a lack of social skills, educational deficits and vocational deficits. SVPs are committed to CSH by the Superior Court of the county from which they were sentenced to prison. After a jury determines beyond a reasonable doubt that the person is a SVP, he is committed for appropriate treatment under the Welfare & Institute Code Section 6604. The SVP living units are either designated as a licensed Intermediate-Care-Facility (ICF) level of care, a licensed Acute Care (AC), or as a non licensed Residential Recovery Unit (RRU).

2. The Sex Offender Commitment Program (SOCP) is founded in the relapse prevention and cognitive-behavioral approaches to therapy. This program is structured into five phases, which correspond to the stages of change model developed by James Prochaska and Carlo DiClemente.

   a. Treatment Readiness:

      Facilitates the participants' transition from the prison culture to the treatment environment; prepares participants to take an active role in their therapy; uses didactic methods to educate participants on such topics as hospital attitudes; interpersonal skills, anger management, mental disorders, victim awareness, cognitive distortions, and relapse prevention. It is focused on those who are in a precontemplative and contemplative stage.

   b. Skills Acquisition:

      Shifts participants' focus from education and preparation to personal therapy; teaches coping strategies, behavioral skills, pro-social thinking, and emotional awareness, to increase self-control; requires that the participants acknowledge and discuss past sexual offenses; express a desire to reduce their risk of re-offending; agree to participate in required assessment procedures; be willing and able to conduct themselves appropriately in a group setting. This phase is intended for those who are at a preparation and action stage.

c. Skills Application:

Integrates the skills participants learned during Phase II into their daily lives; broadens and deepens their skills in relapse prevention, coping with cognitive distortions, and developing victim awareness; causes participants to examine their daily experience in unit life and to practice their behavioral interventions through extensive use of journals and logs; requires that participants; accept responsibility for past sexual offenses; articulate a commitment to abstinence, that is reflected in current behavior; understand the trauma resulting from their sexual crimes; are able to correct deviant thoughts; demonstrate ability to manage deviant sexual urges and impulses; show good ability to cope with high risk factors for re-offending; cooperate with institutional supervision; display skills necessary for self-regulation; demonstrate ability to maintain appropriate relations with female staff; display skills necessary to avoid emotional identification with children. This phase is for those at an action stage of change.

d. Discharge Readiness:

Develops a detailed Community Safety Plan developed in conjunction with the offender's assigned Conditional Release Program (CONREP); involvement of family members and significant others in the relapse prevention plan; focuses on how the skills in relapse prevention, managing cognitive distortions, victim empathy, and coping strategies will generalize and transfer to the community setting treatment teams must determine that participants; can fully describe the negative impact of abuse on their victims; acknowledge and accept past sexual offenses; articulate commitment to abstinence; correct all cognitive distortions; able to control deviant sexual urges and interests; can describe a complete range of prospective high-risk factors and internal warning signs; cope with risky situations and thinks in ways that reduce his likelihood for re-offending in their daily lives; follow rule and comply with requirements of supervision; display no inappropriate impulsivity or inappropriate emotions; relate well with women and able to avoid emotional identification with children; CONREP in the county of commitment is willing to accept participant into outpatient treatment and supervision. This phase is at the action and maintenance stages of change.

e. Community Outpatient Treatment under CONREP is administered by Liberty Healthcare in the offenders' county of commitment; California Superior Court approves and orders placement into this final phase of treatment; transfers the site of ongoing treatment from CSH to the community setting; provides intensive on-going supervision and monitoring to facilitate early detection of relapse and ensure community safety. This phase is intended for those at the maintenance and evaluation stages of change.

VI. THE CLINICAL-ADMINISTRATIVE MATRIX

A. The Program Director is responsible for the overall management of the Program and utilization of resources toward the outcome of care and treatment. Programs support the development of dispositionally relevant, clinical programming for all Individuals in the hospital. The Program Director is responsible for assigning responsibilities to the clinical staff to deliver appropriate active treatment interventions. The clinical authority and responsibility for the care and active interventions of each Individual is vested in the treatment team. The responsibility for evaluating the effectiveness, quality, and appropriateness of the Individual's care, is delegated to the Medical Staff, who works cooperatively with the Discipline Chiefs of Service to define appropriate Standards of Clinical Practice. The Program Director is the administrative partner within this matrix management system.

B. The Medical Staff Bylaws provide for the Medical Staff structure, credentialing and privileging of staff, and standards of practice for clinical staff. The Bylaws also provide for review of clinical care and treatment, including quality assessment, Individual care monitoring, utilization review, psychotropic medication review, review of high risk Individuals, review of Individual care incidents, and peer review. Significant findings of these committees are forwarded through the Medical Executive Committee to the Executive Director. Action plans are channeled through the appropriate program, department, or service organization.

C. Clinical supervision of each clinician is provided by the relevant discipline service, through the appointed Discipline Chief (i.e., psychiatrists by the Department of Psychiatry, Medical Director; social workers by the Social Work Service through the Chief of Social Work Service, etc.). Annual and ongoing clinical evaluations of the clinician's work and current competence are conducted by the Discipline Services, through the appointed Discipline Chief. The clinician's administrative supervisor incorporates these evaluations into the Annual Performance Appraisal Summary. Clinical and administrative evaluations are based upon an individualized duty statement. Duty statements are based on the discipline services' general expectations of employee performance, the specific privileges granted to the clinician, and are tailored by the clinician's administrative supervisor to the needs of the Individuals in the specific program.

VII. OTHER SERVICES PROVIDED

A. Central Program Services (CPS):

CPS is a clinical intervention program providing specialized day and evening services upon direct referral from the WR Team. CPS intervention services and resources are available to all Individuals. CPS provides rehabilitative, educational, vocational, recreational, and evaluation services which include:

1. Arts Center

2. Gymnasium

3. Barber Shop

4. Resident Policy Advisory Council

5. Education Services

6. Health and Wellness

7. Leisure Referrals

8. Special Events

9. Moss Landing Library

10. Religious Services

11. Substance Abuse Services

12. Vocational Instruction

13. Vocational Services

B. Central Medical Services (CMS):

1. CMS provides definitive medical care and evaluation to all Individuals in the hospital. These services include radiology, public health, laboratory, physical therapy, dentistry, pharmacy, medical clinics, sick call, contractual services inside and outside the hospital, and review of community-based consultations. Services are available to Individuals on referral from general physicians and psychiatrists who have primary responsibility on the units.

2. Urgent Care Room (UCR) – CSH's UCR is located on Unit MA02. Services provided to Individuals and staff is limited to initial exam, evaluation and treatment of an acute or serious injury or illness. In certain cases this may extend to a somewhat prolonged period for initial stabilization of the condition prior to admitting to the Infirmary Unit or transport to an acute medical facility. Treatment of injuries and/or illness must fall within the "Scope of Medical Practice in the UCR," as approved by the Department of Medicine of CSH.

C. Nursing Services:

1. Nursing Services at CSH is committed to delivering quality and appropriate nursing care to Individuals and to maintaining optimal professional nursing conduct and practice of its' members. The mission of Nursing Services is to provide safe, therapeutic, and competent professional service based on individual needs of the population served at CSH.

2. Individuals at CSH will receive nursing care within the framework of the nursing process. Nursing care will be congruent with the overall medical/psychiatric treatment plan formulated by the WR Team and will be delivered by competent practitioners who are a part of that team.

3. Registered Nurse coverage is provided at all times according to identified clinical/nursing needs of the Individuals.

D. Training:

1. The hospital's training program is coordinated through the Training Center. Tracking of training provided and employee compliance with training requirements is accomplished through the hospital's Employee Training Database, maintained by the Training Department. Ensuring compliance with mandated training is the responsibility of the employee and their supervisor.

2. Initial Orientation: Each employee completes an initial orientation program within 60 days of employment, with critical classes being completed within 30 days of employment. (e.g., Preventative Management of Assaultive Behavior, Cardio-Pulmonary Resuscitation. Fire/Life Safety and General Safety, Infection Control, etc.)

VIII. CONTINUUM OF CARE

A. New Individuals are admitted to a Treatment Unit upon arrival. As part of the initial processing, the Individuals will receive an assessment, evaluation, and review of their recovery needs and develop a Wellness and Recovery Plan. Upon completion of their initial process, treatment and rehabilitative services are provided. The WR Team reviews Individuals as required. Changes in program placement are made, as needed, in order to meet the changing needs of the Individual or different kinds of treatment.

B. When the Individual meets the clinical and/or forensic criteria for exit from the facility, a recommendation is made to the court, agency of jurisdiction, or other state hospital.

C. Except for transferring Individuals to other state hospitals, the hospital is not authorized to discharge involuntarily committed Individual without a court order or unless the maximum term of hospitalization defined by the court has been reached. The California Department of Corrections and Rehabilitation (CDCR) retains ultimate jurisdiction over the discharge of their Individuals, except that the hospital can return the Individual to the CDCR or other committing authority.

D. Sexually Violent Predators (SVPs) are eligible for placement in outpatient treatment through the CONREP programs with the approval of the committing courts.

E. Through designated contact persons, the hospital coordinates the after-care planning with county mental health departments, the state-operated CONREP, and other social or mental health agencies. These contact persons also assist in coordinating parole planning for Individuals committed from the CDCR (PC 2684).

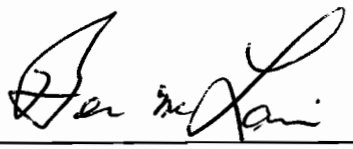
IX. TREATMENT AND REHABILITATION

A. Program Management is responsible to ensure a safe and therapeutic environment through the appropriate management of resources and to ensure the provision of dispositionally relevant, quality treatment specific to their Individual population and program focus.

B. Programs are designed to meet the Wellness and Recovery needs of Individuals. Wellness and Recovery is a system-wide collaborative approach to the Individual's personal recovery which combines medical, psychiatric, psychosocial, and enrichment interventions in assisting the Individual to develop the cognitive, social, and functional skills needed for successful adaptation to his discharge setting, in particular his successful return to the community. Wellness and Recovery is growth-oriented and normalizing. It necessitates the Individual's ownership of the process and emphasizes his strengths over his limitations.

C. Each Individual is directed toward the common goals of recovery and health, adaptive behavior and coping skills, self-esteem and independence, and progressive elimination of maladaptive behaviors, which impede his discharge from hospitalization. These goals are based on the general assumption that positive health is related to one's ability to care for oneself, to form mutually beneficial relationships, to participate in constructive activities for fun and pleasure, and to contribute to the welfare of others.

D. The active treatment intervention offered through the units and Mall in conjunction with CPS, provide a variety of individual, small group, and unit-wide skills-training and rehabilitative services. These interventions are identified through the WR Team process, according to identified goals, needs, interests, and capacities. Intervention activities are designed and provided according to Administrative Directive (A.D.) No. 434 Active Treatment Interventions.



BEN MCLAIN
Executive Director (Acting)

Cross Reference(s):
A.D. No. 130 Facility Declaration
A.D. No. 136 Residential Recovery Units
A.D. No. 138 Performance Improvement Program
A.D. No. 434 Active Treatment Interventions
A.D. No. 518 Nursing Service
A.D. No. 568 Nursing Staff Allocation: Minimum On-Duty Coverage
A.D. No. 946 Training