

5150/5585 Involuntary Detention Manual



San Francisco Health Network
Behavioral Health Services

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IMPORTANT PHONE NUMBERS

Adult Protective Services	415-557-5230 1-800-814-0009
Animal Care Control	415-554-9400
Ambulance Services -possible transport American Medical Response King-American Pro Transport St. Joseph's Baysshore	415-931-3900 415-931-1400 1-800-650-4003 415-921-0707 1-650-525-9700
Behavioral Health Access Center -provides authorization and referral for county NON-EMERGENCY behavioral health services	415-255-3737 1-888-246-3333
Child Protective Services	415-558-2650 1-800-856-5553
Comprehensive Crisis Services Children's Unit -provides psychiatric crisis evaluations for individuals <u>under</u> 18 years of age 24 hours per day, 7 days per week Mobile Crisis Treatment Team -provides psychiatric crisis evaluations for individuals age 18 or older Monday through Friday 8:30 AM – 11 PM (last visit 10 PM) Saturday and Holidays 12 PM – 8 PM (last visit 7 PM) Phone triage provided 24 hours per day, 7 days per week	415-970-3800 415-970-4000
Dore Urgent Care Clinic -provides psychiatric crisis care for adults not needing hospitalization	415-553-3100
Edgewood Crisis Stabilization Unit -provides crisis care for minors	415-682-3278
EMERGENCY	911
Friendship Line for the Elderly -24 hour crisis line	1-800-971-0016
Golden Gate Bridge Sergeant -to report people threatening to jump	415-923-2220
HIV Crisis - provides psychiatric crisis services for HIV+ individuals	415-476-3902
Poison Control	1-800-222-1222
Psychiatric Emergency Services, Zuckerberg San Francisco General (PES)	415-206-8125
San Francisco Mental Health Clients' Rights Advocates	415-552-8100 1-800-729-7727
San Francisco Police Department, Psychiatric Liaison Unit Sergeant Kelly Kruger (<i>formerly Dunn</i>)	415-206-8099 415-553-4961
Suicide Prevention -24 hour crisis line	415-781-0500
Westside Community Crisis & Outpatient Clinic -provides walk-in services 245 11 th Street (between Howard & Folsom Streets)	415-355-0311

INTRODUCTION

Attendance at the 5150/5585 Involuntary Detention Training and obtaining a passing score of at least 80% on the post-test is mandatory for any eligible staff seeking authorization. Note that interns and peer support staff are not eligible for certification.

The following individuals are eligible for certification:

- Licensed, license-waivered, or non-licensed professionals who work in an authorized mental health facility;
- Licensed mental health professionals who work in an authorized non-mental health facility (e.g., substance use services, primary care); and
- Licensed physicians who work in a hospital medical emergency department.

Individuals must be re-certified on a regular basis.

- Re-certification is required at least **every five years** for licensed physicians who work in a hospital medical emergency department and for licensed mental health professionals.
- Re-certification is required at least **every three years** for license-waivered and non-licensed professionals who work in authorized mental health facilities.

Authorization does not mean that an individual will receive a card. Programs receive a facility certificate with authorized staff names. Individual cards are issued to all crisis staff and can be issued to other staff whose primary work is in the field (e.g., outreach or work in client's homes). Certified staff has the authority to institute and detain individuals on a hold ***while they are employed and on duty*** for the program for which they are certified. If an individual is employed by more than one authorized site, one can be certified at these sites and does NOT need additional training. When a staff member leaves and moves to another employer that has a facility certificate, that employee may transfer their certification to the new program without re-training as long as it is within the certification period.

Note that San Francisco County has designated Child Crisis Services as having primary responsibility for conducting the 5585 evaluation of any minor in San Francisco County and sole responsibility for authorizing inpatient psychiatric admissions for all publicly funded children and youth. This includes minors who are uninsured or are San Francisco Medi-Cal beneficiaries (see BHS policy 3.03-1).

LANTERMAN – PETRIS – SHORT ACT (LPS ACT):

AN OVERVIEW

People with psychiatric disabilities who are hospitalized involuntarily- - and are often in need of mental health care, medical treatment, and other services- - face a significant curtailment of their basic human rights. Consequently, in the California cases evaluating the potential for rights deprivations, the courts have repeatedly affirmed the Legislature's intent that the rights of involuntarily detained persons with psychiatric disabilities be protected by the LPS Act (e.g., *Keyea v. Rushen* 178 Cal. App. 3d at p. 534, 228 Cal. Rpt 746). The LPS Act expressly guarantees a number of legal and civil rights and provides that individuals who are involuntarily detained retain all rights not specifically denied under the statutory scheme (W&C Sections 5325.1 & 5327).

PRE-LPS

The LPS Act repealed the previously existing indeterminate civil commitment scheme. It also removed legal liabilities previously imposed upon those adjudicated to be mentally ill. To illustrate, prior to LPS, once the judge determined the person to be “mentally disordered” or “insane” through a hearing that frequently took 2-3 minutes, the person was automatically and indeterminately stripped of any meaningful decision-making authority over one's life.

The blanket imposition of these legal liabilities not only deprived one of the rights to make any treatment decisions, but also resulted in deprivations such as the automatic loss of the right to manage one's own money, to vote, marry, or have any control over one's reproductive choice. Forced sterilization of people with psychiatric disabilities was not uncommon. Lobotomies were performed for reasons such as repeatedly assaultive behavior or to treat “mental disorders” such as homosexuality.

REVISIONS TO THE LPS ACT

Senate Bill 364 (SB 364) represents the first significant modernization of the involuntary detention procedures since LPS was enacted in 1967. The changes took effect on January 1, 2014. Highlights of these changes include:

- Eliminates outdated staffing requirements for designated facilities.
- Expands the types of designated facilities such as 23-hour crisis stabilization units and psychiatric health facilities.
- Requires all designated facilities be mental health treatment facilities licensed by the state.
- Provides procedures for assessment and evaluation of detained persons not taken directly to a designated facility (e.g., discharging individuals from custody who no longer need involuntary treatment without first being transported to a designated facility, 72 hour detention period begins at the time of being taken into custody).
- Emphasizes that services be provided on a voluntary basis if appropriate.
- Removes obsolete and stigmatizing language (e.g., changes *mental disorder* to *mental health disorder*).
- Strengthens the protection of rights of people subject to detention.
- Requires a completed 5150/5585 application stating *probable cause* be required by all admitting designated facilities.

- Adds language to the 5150/5585 detainment advisement (e.g., *turning off appliances and water* , providing a written advisement if the individual cannot understand the oral advisement).
- Adds language to the admitting designated facility's advisement (e.g., informing individuals of their treatment options, their right to contact a patients' rights advocate, to receive the admission advisement in a language or modality that they can understand).

Assembly Bill 1194 (AB 1194) was signed into law and went into effect on January 1, 2016. Highlights of these changes include:

- The individual determining if probable cause exists pursuant to W&C Section 5150 shall not be limited to consideration of the danger of imminent harm.
- The determination shall include relevant information about the historical course of the person's mental health disorder if the information has a reasonable bearing on the determination of probable cause and, if so, to be recorded as such on the 5150/5585 application.

The following two amendments to the LPS Act were signed into law and became effective on January 1, 2019:

- Assembly Bill 2099 (AB 2099) clarifies that a completed and signed copy of the 5150/5585 application must be honored as an original.
- Assembly Bill 2983 (AB 2983) establishes that a general acute care hospital or an acute psychiatric hospital cannot insist that a patient voluntarily seeking mental health care be first placed on a 5150/5585 involuntary hold as a condition of admission.

Assembly Bill 1968 (AB 1968) went into effect January 1, 2020 and establishes a lifetime prohibition on gun ownership for those persons involuntarily admitted on a 72-hour hold for danger to self or others more than once during a 12-month period.

HOW TO INTERPRET THE LPS ACT

According to Welfare and Institutions Code Section 5001 (W&I Section 5001), all provisions of the LPS Act are to be interpreted to promote the following legislative purposes:

- To end the inappropriate, indefinite and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, and to eliminate legal disabilities.
- To provide prompt evaluation and treatment of persons with mental health disorders or impaired by chronic alcoholism.
- To guarantee and protect public safety.
- To safeguard individual rights through judicial review.
- To provide individualized treatment, supervision and placement services by a conservatorship program for persons who are gravely disabled.
- To encourage the full use of all existing agencies, professional personnel, and public funds to accomplish these objectives and to prevent duplication of services and unnecessary expenditures.
- To protect persons with mental health disorders and developmental disabilities from criminal acts.
- To provide consistent standards for protection of the personal rights of persons receiving services under this part and under Part 1.5 (commencing with Section 5585).

- i. To provide services in the least restrictive setting appropriate to the needs of each person receiving services under this part and under Part 1.5 (commencing with Section 5585).

OVERVIEW OF LPS PATIENTS' RIGHTS

The LPS Act specifically requires that treatment, rehabilitation and recovery services be provided in the least restrictive manner possible. The LPS Act also specifically mandates that persons with mental health disorders have a right to treatment services which promote the potential of the person to function independently and to safeguard the personal liberty of the individual (W&I Section 5325.1(a)). Therefore, LPS permits involuntary hospitalization only of those persons with mental health disorders for whom such confinement is necessary and appropriate.

The more fundamental the right, the more stringent the due process standards for protection of that right under the LPS Act. So strong is the statutory protection of certain rights that a number of rights under the LPS Act cannot be denied under any circumstances. An example of these "undeniable rights" is codified in Welfare and Institutions Code Section 5325.1 and includes:

- A right to dignity, privacy, and humane care.
- A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program.
- A right to prompt medical care and treatment.
- A right to participate in appropriate programs of publicly supported education.
- A right to social interaction and participation in community activities.
- A right to physical exercise and recreational opportunities.
- A right to be free from hazardous procedures.

Note that physical restraint used for punishment or for other improper purposes or periods of time beyond which the time it was ordered constitutes abuse and must be reported to protective service agencies (W&I Section 15610.63(f)(1)(2)(3)). In some circumstances, such abuses can subject professionals to criminal sanctions.

GOOD CAUSE FOR DENIAL OF RIGHTS

Except for the right to see a patients' rights advocate or to refuse convulsive treatment, insulin coma treatment, or psychosurgery, the rights listed under Welfare and Institutions Code Section 5325 may be denied by the professional person in charge of the facility, or his or her designee, for good cause (W&I Sections 5325 & 5326).

Good cause exists when the professional person in charge of the facility has good reason to believe that:

- the exercise of the specific right would be injurious to the patient **OR**
- there is evidence that the specific right, if exercised would seriously infringe on the rights of others **OR**
- the institution or facility would suffer serious damage if the specific right is not denied **AND**
- there is no less restrictive way of protecting against these occurrences.

The reason used to justify the denial of a right to a patient must be related to the specific right denied. A right shall not be withheld or denied as a punitive measure, nor shall a right be considered a privilege to be earned.

Denial of rights based on the good cause standard is the least stringent criteria for denying a right, and generally apply to rights such as the right to wear one's own clothing, have access to private storage space, and to see visitors each day. That the good cause requirement is not more stringent should not be misinterpreted as diminishing the importance of these personal rights. These rights must be protected in every designated facility in which voluntary and involuntary mental health services are being provided, and are subject to documentation and reporting requirements.

DOCUMENTATION REQUIREMENTS

Because of the importance of the denial of these patients' rights, each denial of rights must be documented in the patient's record. Such documentation must include:

- Date and time the right was denied.
- Specific right denied.
- Good cause for denial of right.
- Date of review if denial was extended beyond 30 days.
- Signature of professional person in charge of the facility or designee authorizing denial of right.

It should be noted that loss of personal property complaints and those involving punitive denials of access to one's own storage space are not uncommon and among the more distressing complaints filed by patients with San Francisco Mental Health Clients' Rights Advocates (SFMHCRA).

In addition, admitting facilities are required to prominently post patients' rights in the predominant languages of the community and to explain in a language or modality accessible to the patient. Upon admission, each patient is to receive a copy of a State Department of Health Care Services prepared patients' rights handbook.

RIGHT TO EXERCISE INFORMED CONSENT TO MEDICATION

A patient with a psychiatric disability must be provided with all essential information required to make an informed decision whether or not to accept a treatment recommended by a physician (W&I Section 5152). Under LPS, an individual must be given written and oral information about medications they are being prescribed as a result of their mental health disorder and this information must include:

- the probable effects and possible side effects of medications;
- the nature of the mental illness, or behavior, that is the reason the medication is being given or recommended;
- the likelihood of improving or not improving without the medication;
- reasonable alternative treatments available;
- the name and type, frequency, amount, and method of dispensing the medications, and the probable length of time that the medications will be taken; and
- the fact that the above information has or has not been given shall be indicated in the patient's record.

RIGHT TO REFUSE MEDICATION

Antipsychotic medication may be administered if the patient does not refuse the medication following disclosure of the right to refuse medication as well as the information outlined above (W&I Section 5332). Antipsychotic medication refers to any drug customarily used for the treatment of symptoms of psychosis and other severe mental and emotional disorders. If any patient orally refuses or gives other indication of refusal of treatment with that medication, the medication shall only be administered as follows:

- upon a determination of that person's incapacity to refuse the treatment in a hearing held for that purpose; or
- in case of an emergency defined as a situation in which action to impose treatment over the person's objection is immediately necessary for preservation of life or the prevention of serious bodily harm to the person or to others and it is impracticable to first gain consent (W&I Section 5008(m)). In the event of an emergency, only medication required to treat the emergency may be administered and the medication shall be provided in the manner least restrictive to the personal liberty of the individual.

RIESE HEARING

In 1991, the California legislature enacted Senate Bill 665 (SB 665), mandating informed consent and capacity hearing procedures to implement Riese v St. Mary's Hospital and Medical Center. Riese was the 1987 judicial decision recognizing that persons detained pursuant to LPS have a right to give or refuse consent to medication prescribed for treatment. At the core of the Riese decision is the recognition that mental health patients may not be presumed to be incompetent solely because of their involuntary hospitalization (W&I Sections 5326.5 & 5331).

The reason why the prescriber/petitioner bears the burden of proving the patient's incapacity to refuse medications by clear and convincing evidence in a statutorily defined hearing for that purpose is the intrusiveness and fundamental nature of the right at stake. The court observed that treatment with antipsychotic drugs not only affects the patient's bodily integrity, but also the patient's mind, the "quintessential zone of privacy." To assess capacity, the Riese court stated the decision maker should focus on whether the patient is:

- aware of his or her situation (e.g., diagnosis/condition);
- able to understand the benefits and risks of, and alternatives to, the medication; and
- able to understand and evaluate the medication information and participate in the treatment decision through a rational thought process.

The court stated that it should be assumed that a patient is using rational thought processes unless a clear connection can be shown between the patient's delusional or hallucinatory perceptions and the patient's decision. In addition, the court held that even where there were irrational fears about the treatment, the presence of some rational reasons for refusal of the treatment was enough to surmise that the patient had capacity to make treatment decisions. The court concluded that the evidence showed a disagreement between the physician and the patient, but such a disagreement did not show that the patient lacked capacity (Conservatorship of Waltz 180 Cal. App. 3d 722,227 Cal. Rptr. 436, 1986).

USE OF SECLUSION OR RESTRAINTS

It is widely recognized that the use of seclusion or restraint is always intrusive and potentially dangerous to both patients and staff. Increasing awareness of the potential for serious psychological and lethal harm to patients subjected to this intervention has led to the

promulgation of standards to ensure proper monitoring and to severely limit its use. To date, prone restraint resulting in positional asphyxia has proven to be the most significant and underreported lethal restraint – related hazard.

The Centers for Medicare and Medicaid Services (CMS), as well as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), promulgated significant changes in their standards governing patients' rights as they pertain to seclusion and restraint. These include the right to be free from any type that is not medically necessary or is used as a means of coercion, discipline, convenience, or retaliation by staff, and preserving individual safety and dignity when restraint or seclusion is used. The standards require an initial assessment for risk factors such as pre-existing conditions or any physical disabilities and limitations that would place the patient at risk during use of restraint. The standards address the need for clinical justification whereby the use of restraint is not based on an individual's restraint history or solely on a history of dangerous behavior, and is limited to emergencies in which there is an imminent risk of an individual physically harming oneself, staff, or others, and less restrictive measures would be ineffective. Non-physical techniques are considered the preferred intervention (e.g., redirecting the individual's focus, employing verbal de-escalation). The standards defined who could authorize the use of restraint or seclusion, and defined time limits regarding both written and oral orders.

The enacted Senate Bill 130 augmented and strengthened former state law as well as JCAHO and CMS protections (commencing with Section 1180 of the Health & Safety Code). Selected provisions include:

Declares that the use of seclusion or restraint:

- is not treatment
- does not alleviate human suffering or positively change behavior

Allows restraint in behavioral emergencies ONLY:

- when a person presents an immediate danger of serious harm to self or others

Emphasizes reducing use of seclusion or restraint through:

- good milieu programs, interesting activities, and attention to every person's need for sufficient space
- changing the culture of facilities through the commitment of manager/staff to reducing seclusion or restraint
- state utilization of best practices developed in other states
- using the most efficient modern resources to accomplish these goals, including computerized data collection and analysis, public access to this info via Internet, strategies for organizational change, staff training, debriefing models, and recovery-based treatment models

PROHIBITS: Prone mechanical restraint on a person at risk for positional asphyxiation as a result of one of the following risk factors that are known to the provider:

- obesity
- pregnancy
- agitated delirium or excited delirium syndromes
- cocaine, methamphetamine, or alcohol intoxication
- exposure to pepper spray
- preexisting heart disease, including, but not limited to, an enlarged heart or other cardiovascular disorders
- respiratory conditions, including emphysema, bronchitis, or asthma

EXCEPT when written authorization has been provided by a physician, made to accommodate a person's stated preference for the prone position or because the physician judges other clinical risks to take precedence. The written authorization may not be a standing order and shall be evaluated on a case-by-case basis by the physician.

REQUIRES FACILITIES to avoid the deliberate use of prone containment techniques whenever possible, utilizing the best practices in early intervention techniques, such as de-escalation, and to utilize quality reviews and debriefings following seclusion or restraint episodes. If prone containment techniques are used in an emergency situation, a staff member shall observe the person for any signs of physical duress throughout the use of prone containment. Whenever possible, the staff member monitoring the person shall not be involved in restraining the person.

ALSO PROHIBITS placing a person in a facedown position with the person's hands held or restrained behind the person's back; or physical restraint or containment as an extended procedure.

ALSO PROVIDES the right to be free from the use of a drug used in order to control behavior or to restrict the person's freedom of movement, if that drug is not a standard treatment for the person's medical or psychiatric condition.

INVOLUNTARY DETENTION UNDER THE LPS ACT

Procedures for involuntary commitment of an individual for mental health treatment is governed by the Lanterman-Petris-Short (LPS) Act of 1967, codified in the California Welfare and Institutions Code (W&I Sections 5000 et. seq.). The LPS Act provides specific guidelines for the commitment of individuals with mental health disorders and provides protection for the legal rights of such individuals. The authority for initially detaining an individual for involuntary mental health evaluation and treatment is found in the Welfare and Institutions Code Sections 5150-5155 and Sections commencing with 5585.

PURPOSE OF DETENTION

The purpose of a 72-hour hold is for evaluation and treatment. The person detained must be evaluated as soon as possible after admission to a designated facility. The person may be released at any time during the 72-hour period if a determination is made by the professional person in charge of the facility that the detained person no longer requires evaluation and treatment.

GROUND FOR DETENTION

The grounds for detention are specified in Welfare and Institutions Code Sections 5150 and 5585.50. Under these statutes, an individual may be detained when, as the result of a mental health disorder, the individual is a danger to others or to self, or is gravely disabled. Grave disability means a condition in which a person, as a result of a mental health disorder, is unable to provide for one's basic personal needs or food, clothing and shelter (W&I Section 5008(h)). The person acting to involuntarily detain an individual must be a peace officer or professional designated by the county.

PROBABLE CAUSE

The authorized person must have probable cause to detain an individual. Probable cause is defined as facts known to the authorized person that would lead a person of ordinary care and prudence to believe, or to entertain a strong suspicion, that the person detained is, as the result of a mental health disorder, a danger to others or to self, or is gravely disabled (W&I Section 5150.05).

LIABILITY FOR FALSE STATEMENT

Any person who intentionally gives a false statement for purposes of detaining an individual shall be liable in a civil action.

DETAINMENT ADVISEMENT

Each person, at the time he or she is first detained or taken into custody under W&I Sections 5150 and 5585.50, shall be provided, by the authorized person who takes the person into custody, an oral advisement. Note that the oral advisement must be given in a language or modality accessible to the person. If the person cannot understand an oral advisement, the information shall be provided in writing. The oral advisement includes the following information (W&I Section 5150(g)):

My name is _____ . I am a (peace officer, mental health professional) with (name of agency). You are not under criminal arrest, but I am taking you for an examination by mental health professionals at (name of facility). You will be told your rights by the mental health staff.

If taken into custody at his or her residence, the person shall also be told the following information: **You may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken.**

It is the responsibility of the person taking someone into custody to take reasonable precautions to preserve and safeguard the personal property in the possession of that person or on the premises occupied by that person (W&I Section 5150(f)). If a responsible relative, guardian or conservator is willing to secure the property, the report should give the name of this person(s) holding it secure. Residential providers should have a method to safeguard the possessions of persons placed on detention.

The authorized person must complete and provide a written application to the designated facility stating the circumstances under which the individual's condition was called to the attention of the authorized person, and the facts or statements relied upon to have probable cause to believe the person is a danger to self, or is a danger to others, or is gravely disabled.

For each patient evaluated, the designated facility shall keep a record of the advisement which includes all of the following: the name of the person detained for evaluation, the name and position of the peace officer or mental health professional taking the person into custody, the date the advisement was completed, whether the advisement was completed, the language or

modality used to give the advisement, and, if the advisement was not completed, a statement of good cause (W&I Section 5150(g)).

TRANSPORT TO DESIGNATED FACILITY

“Designated facility” or “facility designated by the county for evaluation and treatment” means a facility that is licensed or certified as a mental health treatment facility or a hospital, as defined in Health & Safety Code commencing with Section 1250, by the State Department of Public Health, and may include, but is not limited to, a licensed psychiatric hospital, a licensed psychiatric health facility, and a certified crisis stabilization unit. If it is determined that the person can be properly served without being detained, the person shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis. If it is determined that the person cannot be properly served on a voluntary basis, the individual must be taken to a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services.

ADMISSION ADVISEMENT

Upon admission to a facility, the detained person shall be given the following information orally and in writing, and in a language or modality accessible to the person by the admission staff of the facility. The written information shall be available to the person in English and in the person’s primary language. Accommodations for other disabilities that may affect communication shall also be provided.

My name is _____. My position here is _____. You are being placed into this psychiatric facility because it is our professional opinion that, as a result of a mental health disorder, you are likely to:

- A. harm yourself**
- B. harm someone else**
- C. be unable to take care of your own food, clothing and housing needs**

We believe this is true because (list of the facts upon which the allegation of dangerous or gravely disabled due to mental health disorder is based, including pertinent facts arising from the admission interview).

You will be held for a period of up to 72 hours. This does/does not include weekends or holidays. Your 72-hour period begins at (time) on (date).

You will be held for a period up to 72 hours. During the 72 hours you may also be transferred to another facility. You may request to be evaluated or treated at a facility of your choice. You may request to be evaluated or treated by a mental health professional of your choice. We cannot guarantee the facility or mental health professional you choose will be available, but we will honor your choice if we can.

During these 72 hours you will be evaluated by the facility staff, and you may be given treatment, including medications. It is possible for you to be released before the end of the 72 hours. But if the staff decides that you need continued treatment you can be held for a longer period of time. If you

are held longer than 72 hours, you have the right to a lawyer and a qualified interpreter and a hearing before a judge. If you are unable to pay for the lawyer, then one will be provided to you free of charge.

If you have questions about your legal rights, you may contact the county Patients' Rights Advocate at 415-552-8100.

If the notice is given in a county where weekends and holidays are excluded from the 72 hour period, the patient shall be informed of this fact.

For each patient admitted for evaluation and treatment, the designated facility shall document in the medical record the name of the person performing the advisement, date of the advisement, whether the advisement was completed, the language or modality used to communicate the advisement, and a statement of good cause if the advisement is not completed.

Prior to admitting a person to a designated facility, the professional person in charge of the facility or designee shall assess the person to determine the appropriateness of the involuntary detention (W&I Sections 5150 and 5585.52).

Each person admitted to a designated facility for up to 72 hours for evaluation and treatment shall receive an evaluation as soon as possible after being admitted and shall receive whatever treatment and care the individuals' condition requires for the full period of the hold (W&I Section 5152(a)).

RELEASE FROM DETENTION

The person shall be released prior to 72 hours if it is determined that the person no longer requires evaluation and treatment (W&I Section 5152(a)).

At the end of the 72-hour period, the detained person must be evaluated to determine whether further care and treatment is required. If the person no longer requires evaluation and treatment, the person shall be released (W&I Sections 5152 & 5172).

If further care and treatment is required, the notice of certification should indicate that the person was advised of the need for continued treatment and that the person was unable or unwilling to accept treatment on a voluntary basis or to accept referral to services. As unwillingness to accept treatment on a voluntary basis is a pre-condition to involuntary detention, the failure to adequately address the issue of voluntariness may serve as a basis for release.

If the person continues to be a danger to self, or a danger to others, or is gravely disabled, the person may be certified for intensive treatment and detained for up to 14 additional days (W&I Section 5250).

INVOLUNTARY DETENTION OF MINORS

The civil commitment of minors is governed by Welfare and Institutions Code commencing with Section 5585. For purposes of the LPS Act, a minor is anyone under the age of 18 who is not married, or a member of the armed forces, or declared emancipated by a court of law. Minors have the same legal rights as adults with respect to involuntary holds, and must also meet the

same criteria. However, there are some differences which must be observed. Minors may only be taken into custody under W&I Section 5585.50 when authorization for voluntary inpatient treatment is not available. This would include situations when the parent, guardian or other person authorized to provide consent is not available, or refuses to authorize voluntary treatment, or agrees to authorize voluntary treatment but factors suggest that the minor would not obtain the necessary voluntary treatment. The definition of a gravely disabled minor has been somewhat modified to state that the minor, as a result of a mental health disorder, must be "unable to use the elements of life which are essential to health, safety and development, including food, clothing, shelter, even though provided to the minor by others. Intellectual disability, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder (W&I Section 5585.25)."

As a rule, a minor's voluntary admission to acute inpatient psychiatric care can only be executed by the person entitled to the minor's custody. The right to contest voluntary admission is not available to minors under age 14; however, certain rights may be invoked (e.g., request for independent clinical review, Roger S procedure, advice by counsel) by minors age 14 to 17 which are subject to specific criteria (private vs. public/county facility, wards and dependents of the court).

CIVIL COMMITMENT LAWS & PROCEDURES

Voluntary Status

Legal standard for voluntary patient status

All civil committed involuntary patients must be advised of the ability to receive mental health treatment on a voluntary basis (W&I Section 5250(c)). Therefore, it is necessary that the facility make a determination of whether the patient is willing or able to accept treatment on a voluntary basis.

The legal standard for voluntary treatment of a patient is that the patient is "willing or able to accept treatment on a voluntary basis." Patients may be voluntary because 1) they are not dangerous to themselves, dangerous to others, or gravely disabled and they request treatment or, 2) they are dangerous to themselves or others or gravely disabled, but they are willing and able to accept treatment. In both cases, the patient fails to meet the criteria for involuntary commitment, but for different reasons.

Legal rights of voluntary patients

a. The right to discharge themselves from a facility at any time.

The significance of a voluntary patient's right to leave any time is emphasized by the fact that is specifically stated in four separate sections of the LPS Act (W&I Sections 6000(e), 6002(c), 6005, and 6006) and again in the implementing regulations of the California Code of Regulations, Title 9, Section 865. This section states that a facility has an affirmative obligation to inform a voluntary patient of the right to be discharged at any time. This information must be given at the time of admission.

b. The right to refuse anti-psychotic medication.

Voluntary patients have an explicit right to accept or refuse anti-psychotic medication after being fully informed of the risks and benefits of such treatment. California Code of Regulations, Title 9, Sections 850-856 describe the specific criteria which must be met in order for facilities to meet their duty to properly inform voluntary patients of the risks and benefits of a proposed treatment plan.

c. The right not to be placed in seclusion and/or restraint in a non-emergency situation.

The law intends that voluntary patients not be subject to seclusion and restraint. Any use of seclusion and restraint must meet the legal criteria for emergency and be accompanied by an evaluation of appropriate legal status.

Involuntary Status

Legal standard for involuntary detention (the 72-hour hold)

The person who takes an individual into custody can be a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, a member of the attending staff of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county (W&I Section 5150).

a. Probable Cause

A person may be involuntarily detained only if there is probable cause to believe that, as a result of a mental health disorder, the person is a danger to self, or a danger to others, or is gravely disabled (W&I Section 5150). Such persons may be detained involuntarily for psychiatric evaluation and treatment. "Probable cause" is a legal standard used to determine whether the person meets criteria for a hold. An appellate court has defined "probable cause" pursuant to W&I Section 5150 as follows:

"To constitute probable cause to detain a person pursuant to section 5150, a state of facts must be known to the peace officer (or other authorized person) that would lead a person of ordinary care and prudence to believe, or to entertain a strong suspicion, that the person detained is mentally disordered and is a danger to himself or herself, or to others, or is gravely disabled. In justifying a particular intrusion, the officer must be able to point to specific and articulable facts which, taken together with rational inferences from those facts, reasonably warrant his belief or suspicion...each case must be decided on the facts and circumstances presented to the officer at the time of the detention...and the officer is justified in taking into account the past conduct, character, and reputation of the detainee..." *People v. Triplett (1983), 144 Cal.App.3d 283.*

For people completing a 5150/5585 application, the most important phrase in the above definition is "specific articulable facts." What is required is information about the person or statements the person makes, that indicate a mental health disorder which impedes the ability to provide food, clothing, and shelter or which indicates dangerousness to self or others.

b. Mental Health Disorder

An equally important concept in commitment law is the link between mental condition and behavior. In order to be detained under the Welfare and Institutions Code Section 5150, the person must be, "as a result of a mental health disorder," a danger to self or others or gravely disabled. Danger to self or others without a mental health disorder does not meet the standard. Likewise, inability to provide food, clothing and shelter without a mental health disorder is not enough. Further, there must be an articulable connection between the mental health disorder and dangerousness or the inability to provide for oneself. For example, a person may find one's self unable to provide for food, clothing and shelter for reasons unrelated to a mental health disorder, such as the loss of a job, recent divorce, etc. Note that mental health disorder is not defined by law, and that the person placing a hold is not required to make a psychiatric diagnosis of mental disorder; however, must be able to articulate the behavioral symptoms of a mental health disorder.

c. Danger to Self

This criteria may be either a deliberate intention to injure oneself (e.g., overdose) or a disregard of personal safety to the point where injury is likely (e.g., wandering about in heavy traffic). The danger must be present, substantial, physical, and demonstrable.

d. Danger to Others

Danger to others should be based on words or actions that indicate the person in question either intends to cause harm to a particular individual or intends to engage in dangerous acts with gross disregard for the safety of others.

e. Grave Disability

The Welfare & Institutions Code defines gravely disabled as "a condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing or shelter."

The person must be unable to provide for basic personal needs as a result of a mental health disorder. Mere inability to provide for needs is not sufficient. Nor is refusal of treatment evidence of grave disability. Note also that, regardless of the person's past, the question is whether they are presently gravely disabled. Furthermore, a person is not "gravely disabled" if that person can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to help provide for the person's basic personal needs for food, clothing, or shelter. However, unless they specifically indicate in writing their willingness and ability to help, family, friends, or others shall not be considered willing or able to provide this help.

Legal standard for involuntary detention (intensive treatment)

If the designated facility determines that the person is in need of additional treatment beyond the 72-hours, it may certify the person for up to an additional 14 days of treatment, but only if the person has first been offered voluntary treatment and has refused it (W&I Section 5250(c)). The requirement that the person be given the option of voluntary treatment continues through all later stages of the commitment process (W&I Section 5260).

a. Timing of Certifications

The client may be certified on or before the expiration of the 72-hour hold (W&I Section 5250). The 72-hour hold is computed in terms of hours rather than days. The client may also be certified during an intervening period of voluntariness that occurs after the 72-hour hold.

b. Certification Form

For a person to be certified, the notice of certification must be signed by two people. The first person must be the professional person, or his/her designee, in charge of the facility providing evaluation services. The designee must be a physician or licensed psychologist who has a doctoral degree in psychology and at least five years postgraduate experience in the diagnosis and treatment of emotional and mental disorders. The second person must be a physician or psychologist who participated in the patient's evaluation. If the first person who signed also performed the evaluation, then the second person may be another physician or psychologist. If the professional person in charge, or his or her designee, is the physician who performed the medical evaluation or a psychologist, the second person to sign may be another physician or psychologist unless one is not available, in which case a licensed clinical social worker, licensed marriage and family counselor, licensed professional clinical counselor, or a registered nurse who participated in the evaluation can sign the notice of certification (W&I Section 5251).

The hearing officer at the certification review hearing cannot be an employee of the county mental health program or a facility designated for 72-hour holds (W&I Section 5256.1). The patient has the right to be present at the hearing, to be represented by counsel, and to present evidence. In addition, the patient has the right to cross-examine witnesses, to make reasonable requests that the staff members be present as witnesses, to have the hearing officer informed of the fact that the patient is receiving medication and the possible effect of the medication on one's behavior at the hearing, and to have family members or friends notified (or, if the patient prefers, not notified) of the hearing (W&I Section 5256.4)

c. Habeas Corpus/Judicial Review

A patient has legal recourse during the detention to contest confinement by means of a "habeas corpus" or writ hearing. There is a constitutional right to habeas corpus during each period of detention (U.S. Constitution, Article 1, Section 9; California Constitution, Article 6, Section 10; Penal Code 1473), as well as statutory right when detained under W&I Sections 5250, 5260 or 5270.10 (W&I Section 5275).

At any time during the first 14-day certification period, the patient may request release by presenting their request to any member of the staff or to the person who delivered the notice of certification (W&I Section 5275). The staff member must then forward the request for release to the director of the facility or his/her designee, who in turn must then "as soon as possible" inform the superior court for the county in which the facility is located of the request for release. Intentional failure to do so is a misdemeanor (W&I Section 5275). If a patient asks to file a petition for a writ of habeas corpus, hospital staff must assist the patient and may not deny the right to file it on the grounds that a certification review hearing is pending.

A state superior court judge must hold a hearing within two judicial days of filing of the habeas corpus petition. The judge must decide whether there is probable cause to believe that the patient is gravely disabled, or a danger to self or others. The patient has the right to be represented by an attorney. If the patient cannot afford an attorney, the public defender will provide representation without cost. While judicial review is pending, the patient may not be transferred out of the county (W&I Section 5276).

Longer-term Holds

a. Additional intensive treatment of gravely disabled persons.

A limited number of counties, by resolution of their board of supervisors, have adopted an additional commitment status for use following the 14-day certification. Upon completion of the 14-day period of intensive treatment, a patient may be certified for an additional period of not more than 30 days of intensive treatment if the patient remains gravely disabled and remains unwilling or unable to accept treatment voluntarily (W&I Section 5270.15). The second certification is initiated in a manner consistent with 5250 procedures whereby the patient is entitled to a second certification review hearing and/or judicial review of the additional certification.

The patient's condition shall be analyzed at intervals, not to exceed ten days to determine if the patient continues to meet criteria for certification. If the patient does not meet the criteria, the patient must be released.

b. Additional intensive treatment of suicidal persons.

If the patient continues to be a danger to self, the patient can be held for a second 14-day period, but no longer. Thus, a patient judged a danger to self can be held for a 72-hour hold, followed by 14 days of certification and 14 more days of re-certification – 31 days in all. After that, the patient must be released unless the patient is reclassified as a danger to others or is gravely disabled (W&I Section 5264).

Re-certification requires a second notice of certification (W&I Section 5261). Danger to self is carefully defined for purposes of re-certification: the patient must have "threatened or attempted to take his own life" either during the present detention or as part of the events bringing about the detention. The patient must continue to "present an imminent threat of taking his/her own life." Again, the patient must have been advised of, but not accepted, voluntary treatment (W&I Section 5260).

c. Post-certification of imminently dangerous persons.

At the expiration of the 14-day period of intensive treatment, a patient may be confined for further treatment for an additional period, not to exceed 180 days if one of the following exists (W&I Section 5300):

- The patient has attempted, inflicted, or made a serious threat of substantial physical harm upon the person of another after having been taken into custody, and while in custody, for evaluation and treatment, and who, as a result of mental disorder or mental defect, presents a demonstrated danger of inflicting substantial physical harm upon others.

- The patient had attempted, or inflicted physical harm upon the person of another, that act having resulted in his or her being taken into custody and who presents, as a result of mental disorder or mental defect, a demonstrated danger of inflicting substantial physical harm upon others.
- The patient had made a serious threat of substantial physical harm upon the person of another within seven days of being taken into custody, that threat having at least in part resulted in his or her being taken into custody, and the patient presents, as a result of mental disorder or mental defect, a demonstrated danger of inflicting substantial physical harm upon others.

Thus, a patient judged a danger to others can be held for the initial 72-hour hold, followed by 14 days of certification, followed by 180-day renewable periods of post-certification.

The decision to commit a person for post-certification treatment must be made by a court with the assistance of a court-appointed psychiatrist or psychologist with forensic skills (W&I Section 5303.1). The patient has a right to be represented by an attorney and to demand a trial by jury. If the patient cannot afford an attorney, an attorney will be appointed (W&I Section 5302). The court hearing must take place within four judicial days after the petition is filed or within ten judicial days if a jury trial is requested, unless the patient's attorney requests a continuance. In order to certify the patient, the jury verdict must be unanimous. If no decision is made within 30 days of the filing of the petition, not including extensions of time requested by the patient's attorney, the patient must be released.

Conservatorship

An LPS conservatorship is a legal relationship in which a person is appointed by the court to serve as a conservator and who acts in the interests of a "gravely disabled" individual to ensure that the basic needs for food, clothing and shelter are met, and if authorized, that the individual receive adequate medical and psychiatric care and treatment.

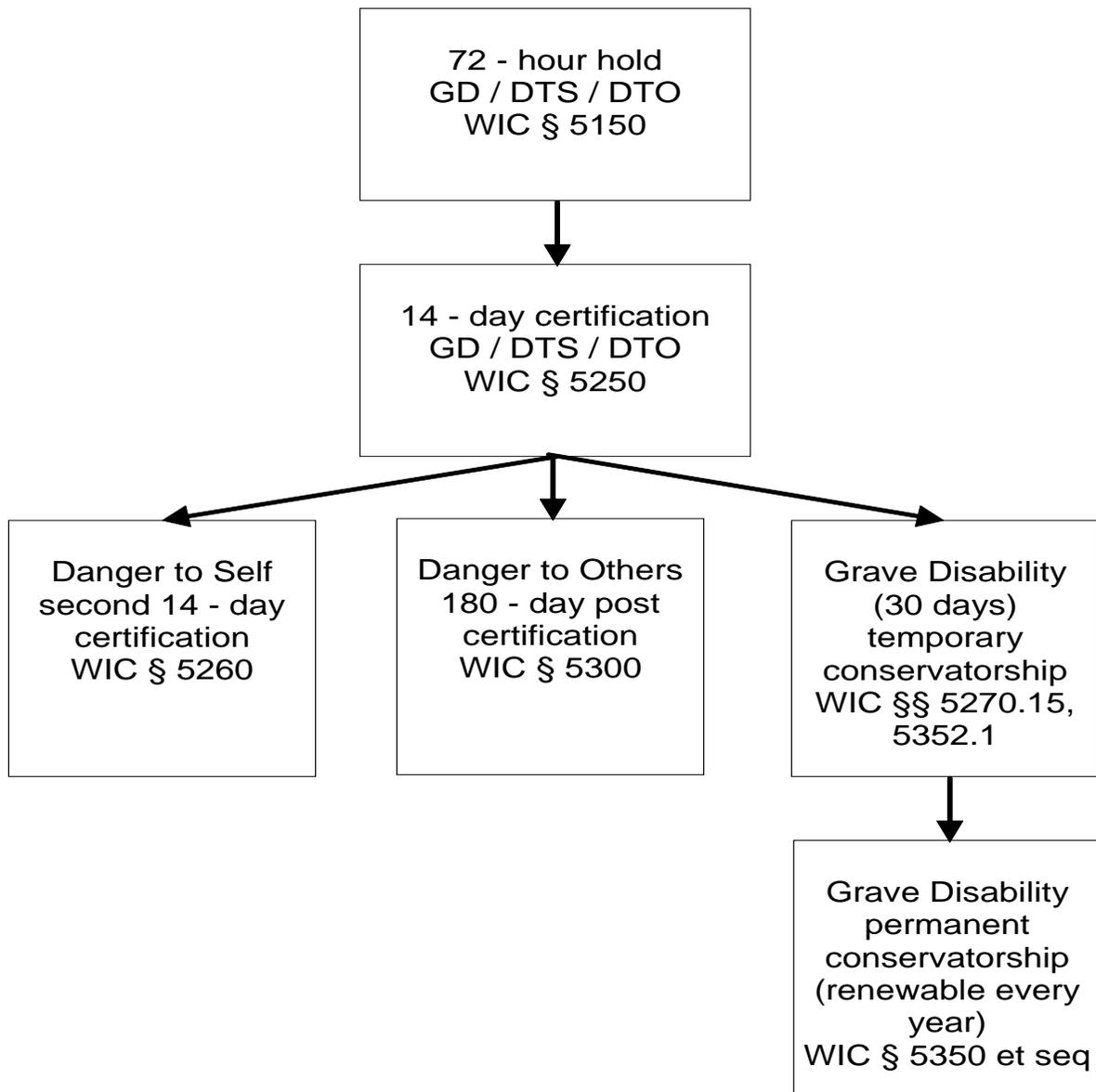
If the individual is "gravely disabled," the person can be placed on a temporary conservatorship for 30 days (W&I Section 5352.1), followed by a permanent conservatorship for renewable one-year periods (W&I Section 5361).

Legal standard:

- An adult may be referred for conservatorship if, due to a mental disorder or chronic alcoholism, the individual cannot provide for basic personal needs such as food, clothing or shelter (W&I Section 5350).
- A minor may also be referred for conservatorship, if, as a result of mental disorder, the minor is unable to use the elements of life that are essential to health, safety, and development, including food, clothing and shelter, even though provided to the minor by others (W&I Sections 5350 & 5585.25).

A conservatorship of the estate (probate) may also be appointed by the court. Often the same person is appointed as conservator to the person and of the estate. The conservator of the estate is empowered by the court to handle the conservatee's property and income, pay bills, etc. If a conservator of the estate is not appointed, then the conservatee retains the full rights regarding property and income management.

OVERVIEW OF THE CIVIL COMMITMENT PROCESS



CONDUCTING THE 5150/5585 EVALUATION

The assessment needs to be conducted face-to-face and in a location that is as safe and conducive to an evaluation as possible. The primary goals of the assessment are to determine that:

- *the person is at risk of danger to self and/or to others and/or is gravely disabled; and*
- *the danger to self and/or others and/or grave disability is the result of a mental health disorder either temporary or prolonged; and*
- *the person is unable or unwilling to voluntarily receive psychiatric treatment or otherwise commit to a safety plan.*

Determining Grave Disability

A person is not considered gravely disabled if the person can survive safely with the help of others who are willing and able to provide for the person's basic needs. Possible **warning signs** of grave disability may include:

- Signs of malnourishment or dehydration.
- Unwillingness to eat when food is provided.
- Inability to articulate a plan for obtaining food.
- Irrational beliefs about food that is available (e.g., it's poisoned, inedible, etc.)
- Destruction or giving away of clothing to the point where the person cannot clothe self or unwillingness to clothe self when clothing is provided.
- Inability to formulate a reasonable plan to obtain shelter or unable to utilize shelter when shelter is provided.
- Inability to engage in personal hygiene when appropriate facilities are provided.

Determining Risk of Danger to Self or to Others

Possible **warning signs** may include:

- Words or actions threatening suicide or homicide, or expressing a strong wish to die or harm others including threats against public locations
- Words or actions indicating gross disregard for personal safety or the safety of others
- Signs of mood disturbance including low mood, anxiety, guilt, purposelessness, hopelessness, worthlessness, rage or anger, agitation, sleep or appetite changes, withdrawal and isolation, impulsivity or behaving recklessly
- Words or actions indicating a specific plan such as giving away possessions, or obtaining means of harming self or others such as purchasing a weapon, rope, poisons, or medications
- Increased use of alcohol or drugs

Risk factors include:

- Previous threats or attempts at harming self or others
- Mental health disorders particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Alcohol and other substance use disorders
- Impulsive or aggressive tendencies
- Family history of self-harm or violence against others
- History of trauma or abuse including prostitution and sexual exploitation

- Physical illnesses or injury
- Major loss (real or anticipated) such as financial, academic, relational, home, or death
- Significant stressors such as unexpected pregnancy, family conflict, legal problems, relocation, failing school, sexual or gender identity conflicts, gang/peer pressures, subjected to bullying
- Access to lethal means
- Lack of social supports and isolation from activities and others that were once pleasurable, cultural isolation
- Barriers to accessing care, or changes in care such as discharge from a psychiatric hospital, or treatment unresponsiveness
- Exposure to the media, community, or others who have died by suicide or committed violence
- Certain cultural and religious beliefs

When evaluating for risk of danger to self or others, assess for:

- **Ideation** – does the person have thoughts about harming self and/or others (i.e., frequency, intensity, and duration of thoughts)?
- **Intent** – does the person intend to harm or kill self and/or others (i.e., extent to which the person expects to carry out the plan and believes the plan to be lethal vs. injurious)?
- **Lethality** – how lethal is the means for harming self and/or others?
- **Plan** – does the person have a plan for harming self and/or others (i.e., timing, location, specificity, lethality, availability, rehearsals, and preparatory acts)?
- **Means** – does the person have the means and opportunity to carry out the plan to harm self and/or others (e.g., stockpiled medications, possession of a gun, rope, ability to get to bridge)?

Consider the presence of **protective factors** in your overall assessment of risk as these can help mitigate the level of risk. Protective factors include, but are not limited to, the following examples:

- restricted access to lethal means
- effective clinical care
- easy access to supports
- strong family and community supports
- responsibility to children or beloved pets
- support through on-going health care relationships
- interpersonal skill in problem solving and conflict resolution
- ability to cope with stress
- adequate frustration tolerance
- cultural and religious beliefs that discourage self-harm and violence

The person's strengths, potential barriers to safety, and consultation with colleagues provides the context for assessing level of risk, addressing immediate safety issues, determining probable cause, and identifying the appropriate course of action (e.g., the need for immediate containment via a 5150/5585 hold, refer to Dore Urgent Care Clinic or crisis stabilization unit).

A **safety plan** is developed with the person and the involvement of others as needed (e.g., other providers, parent/legal guardian, family members, significant others, school personnel) to reduce risk, stabilize the crisis, and to coordinate care. The components of a safety plan generally include:

- Provision for emergency contact and intensification of services
- Anticipation of destabilizing events and plans to deal with them

- Containment and added support as required
- Continuous monitoring of risk factors and reassessment as the person or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY/HOMICIDALITY	POSSIBLE INTERVENTIONS
High	Mental health disorder with severe symptoms, or acute precipitating event; protective factors not relevant.	Potentially lethal attempt or persistent ideation with strong intent or rehearsal.	Admission generally indicated unless a significant change reduces risk. Suicide/homicide precautions.
Moderate	Multiple risk factors, few protective factors.	Ideation with plan, but no intent or behavior.	Admission may be necessary depending on risk factors. Develop safety plan. Give emergency/crisis numbers.
Low	Modifiable risk factors, strong protective factors.	Ideation, but with no plan, intent or behavior.	Outpatient referral, symptom reduction. Develop safety plan. Give emergency/crisis numbers.

* This chart is intended to represent a range of risk levels and interventions, not actual determinations.

COMPLETING THE 5150/5585 APPLICATION

Once it is determined that the criteria are met, the *Application for up to 72-Hour Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment* needs to be thoroughly and accurately completed. *Do not use unsubstantiated information with the intention of making sure the person is hospitalized. It is a legal document.* A copy of this document must be provided to the receiving facility.

In general, this application must adequately address the following:

- Circumstances by which the person came to the attention of the writer.
- Sufficiently detailed information or specific facts that support *probable cause* or the belief that the person is, as a result of mental health disorder, a danger to others, a danger to self, or gravely disabled.
- Consideration of the historical course of the person's mental health disorder.
- That notice of advisement was/was not complete and to include a *good cause* or reason why it was not possible to provide an advisement.
- Include the time and date of initiating the hold.

Detainment Advisement:

When a hold occurs, the detained person shall be provided the *detainment advisement* information orally (and in writing if the person cannot understand the oral advisement). This information is located on the application form (upper right hand corner) and should be read to the person. The advisement includes:

- your name, role, and agency
- why he/she is being detained
- assurances that this is not a criminal arrest
- being taken for an examination by mental health professionals
- name of receiving facility
- assurances that the receiving facility will inform of rights
- if the evaluation is at the person's residence, you must also tell the person that he/she can bring necessary personal items, that he/she can leave word for friends and/or family, and that he/she can request assistance in turning off any appliance or water

“Complete Advisement” or “Incomplete Advisement” should be checked. If the advisement is not completed, document why (“good cause”) where indicated. Indicate the name and position of who provided/attempted the advisement and note the date. Include the language or modality used to convey the advisement.

Application is Made To/For:

Document the name of the designated facility where the person will be transported. Include the address and telephone number if known. Be as specific as possible in order to inform those who are transporting the person of the location of the receiving facility.

When indicating the name of the person in the “Application is hereby made for” section, use the person’s complete name and indicate the date of birth as this will increase the likelihood that the receiving facility can correctly identify the individual. Completing the “residing at” section is critical. The address should be complete with zip code and phone number if possible. As the receiving facility may have only the 5150/5585 application form as identifying information, it is important that the personal data be as complete as possible.

The section below “residing at” requires that you check the responsible party if the person is a minor or conserved and authorization for voluntary treatment is not available and to provide pertinent contact information in regard to the person, such as parent, legal guardian(s), and conservator. This section also ask that you indicate if the minor is under the jurisdiction of the juvenile court. Hospital discharge planning often depends on the accuracy of this information.

Detained Person’s Condition was called to my Attention:

This section identifies how the person came to your attention. If applicable, it should include who initially contacted you, a short description of why the caller wanted assistance, or what the person was doing to require an emergency assessment.

All descriptions should be behavioral and not diagnostic. Some examples of behavioral descriptions are:

- “accompanied by a friend who reports that the person threatened a neighbor”
- “called by school principal to assess student who expressed suicidal thoughts to school counselor”
- “the person called me saying he was going to kill himself”

Specific Facts considered as Probable Cause:

Document behavioral descriptions of the person that lead you to believe this individual can be detained based on the criteria for danger to self, danger to others, or grave disability.

Behavioral descriptions refer to what the person DOES and SAYS and do not rely on clinical terms. Examples are:

- “the patient says she is going to kill herself by overdose because her boyfriend left her” instead of “patient has suicidal ideation and intent after failed romance”
- “patient tells me that the TV is speaking to him about things” instead of “patient experiencing thought insertion”
- “the patient reports that her voices are telling her to hang herself” instead of “patient has command hallucinations”

Quotes from the person are desirable. Behavioral descriptions from reliable sources (i.e., collateral information) are helpful. Write enough to justify “probable cause” and your decision to detain the individual.

Historical Course of the Mental Health Disorder:

Per W&I Section 5150.05, you need to consider available relevant information about the historical course of the person’s mental health disorder and decide whether or not the information has a reasonable bearing on the determination of probable cause. Check the box which best describes your determination and provide a response where indicated. If the information is provided by an individual other than you or the person being evaluated, it is optional whether you include their name, address, phone number, and relation.

Criteria, signature, date/time:

Check the box(es) that correctly define the criteria for the detention or hold. Print and sign the application. Include your work phone number, job title, and your program’s name and address. Include the date and time of the hold as this protects the patient’s rights and informs the receiving facility when the patient should be evaluated for release.

In summary, good documentation includes:

- Write or print legibly
- Be specific and descriptive
- Avoid vague terminology, abbreviations, or psychiatric jargon
- Use quotes
- Name sources
- Specify criteria for involuntary detention
- Proofread, ensure all mandatory sections are complete, sign, include the date & time

MANAGING THE CRISIS

Staff members are encouraged to consult and seek support throughout the course of the evaluation as needed. This can include enlisting support from other staff members within your program or from outside agencies such as Child Crisis Services, Mobile Crisis Treatment Team, Edgewood Crisis Stabilization Unit, SFPD Psychiatric Liaison Unit, Westside Community Crisis, and Dore Urgent Care Clinic.

As part of effectively managing the crisis, it is important to:

- consider the safety of others including yourself, other staff and patients, and family
- consider if the person needs an urgent medical evaluation
- have others present as back-up
- request that police be present if the individual is violent and presenting a public safety risk

Staff should stay with the person at all times throughout the evaluation and to monitor while waiting for transport. Continue to assess for safety until transport arrives and provide what the person might need in order to feel safe while waiting (e.g., quiet office, tea). Evaluate the need for police back up and call 911 if there is an immediate risk of harm. Provide the 911 operator a full description of the imminent risk, your name and relationship to the person, description

and location of the person, and a description of yourself if out in the field so that the police can identify you.

Once transport arrives, introduce yourself to the EMT (emergency medical technician) or police and explain the risk and reason for the detainment. Be very specific about what prompted you to write the hold as a person's demeanor can change upon seeing the presence of transport. Give the completed application to the EMT or police to provide to the receiving facility. Contact the receiving facility to provide pertinent information about the individual. Providers of ongoing care for the individual are encouraged to be assertive about calling ZSFG Psychiatric Emergency Services or the inpatient unit for clinical updates and discharge planning.

Reminders:

- Most adults arriving at ZSFG Psychiatric Emergency Services do not get admitted to inpatient psychiatric units
- Individuals will not be detained for the full 72 hours if criteria are not met or can be properly served without being detained
- Individuals may return to baseline rapidly and the hold discontinued

It is critical that you document in the individual's medical record risk factors and how you assessed and addressed these risks. Documentation should include the following where applicable:

- Threats or attempts to harm self or others
- Expressed intention to engage in dangerous activity
- Means available to carry out threats
- Plan to harm self or others
- Indications of grave disability
- Reports by others that they are concerned about the individual
- Collateral contacts with providers and family members if available
- Any safety measures taken including a safety plan to reduce risk and follow up plan with the individual
- Identified protective factors including those that can be enhanced

If you become aware of concerning information during the course of an evaluation, understand that you may also be required by law to file a mandated report (see BHS policies on special situations governing release of information: 3.06-09: *Duty to Warn & Protect*; 3.06-11: *Child Abuse & Neglect Reporting Act*; 3.06-13: *Elder & Dependent Adult Reporting Requirements*). Note that staff may have additional reporting requirements as well (e.g., BHS incident reporting, State licensing).

Programs are advised to consider the needs of staff following a 5150/5585 incident and to provide support, debriefing, and/or case review as indicated.

<p>APPLICATION FOR UP TO 72-HOUR ASSESSMENT, EVALUATION, AND CRISIS INTERVENTION OR PLACEMENT FOR EVALUATION AND TREATMENT</p> <p><i>Confidential Client/Patient Information</i></p>		<p>DETAINMENT ADVISEMENT</p> <p>My name is _____. I am a (peace officer/mental health professional) with (name of agency). You are not under criminal arrest, but I am taking you for examination by mental health professionals at (name of facility).</p> <p>You will be told your rights by the mental health staff.</p> <p>If taken into custody at their residence, the person shall also be told the following information:</p> <p>You may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken.</p>	
<p>Welfare and Institutions Code (W&I Code), section 5150 (g)(1), requires that each person, at the time they are first taken into custody under this section, shall be provided, by the person who takes them into custody, the following information orally in a language or modality accessible to the person. If the person cannot understand an oral advisement, the information shall be provided in writing.</p>			
<p><input type="checkbox"/> Complete Advisement <input type="checkbox"/> Incomplete Advisement</p> <p>Date of Advisement/Attempt: _____</p>			
<p>Good Cause for Incomplete Advisement:</p> <p>_____</p>			
<p>Advisement Completed/Attempted By:</p>	<p>Position:</p>	<p>Language or Modality Used:</p>	
<p>To (name of 5150 designated facility): _____</p> <p>Application is hereby made for the assessment and evaluation of _____, date of birth of _____, and residing at _____, California, for up to 72-hour assessment, evaluation, and crisis intervention, or placement for evaluation and treatment at a designated facility pursuant to Section 5150, et seq. (adult) or Section 5585 et seq. (minor), of the W&I Code.</p> <p>If authorization for voluntary treatment is not available for a minor/conservatee, indicate to the best of your knowledge who has legal authority to make medical decisions on behalf of the minor/conservatee: (name and contact information, if available)</p> <p>(Check one): <input type="checkbox"/> Parent(s) <input type="checkbox"/> Legal Guardian(s) <input type="checkbox"/> Conservator <input type="checkbox"/> Other: _____</p> <p>Indicate to the best of your knowledge whether the minor is under the jurisdiction of the juvenile court:</p> <p>(Check one): <input type="checkbox"/> W&I Code 300 (dependent) <input type="checkbox"/> W&I Code 601, 602 (ward)</p> <p>The detained person's condition was called to my attention under the following circumstances:</p> <p>_____</p> <p>_____</p> <p>Specific facts that I have considered that lead me to believe that this person is, as a result of a mental health disorder, a danger to others, a danger to self or or gravely disabled:</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> I have considered the historical course of the person's mental disorder as follows:</p> <p>_____</p> <p><input type="checkbox"/> No reasonable bearing on determination</p> <p><input type="checkbox"/> No information available because: _____</p>			

**APPLICATION FOR UP TO 72-HOUR ASSESSMENT, EVALUATION, AND CRISIS INTERVENTION
OR PLACEMENT FOR EVALUATION AND TREATMENT (CONTINUED)**

OPTIONAL INFORMATION			
History Provided by (Name)	Address	Phone Number	Relation

Based upon the above information, there is probable cause to believe that said person is, as a result of mental health disorder:

- Danger to Self (DTS)** **Danger to others (DTO)**
 Gravely disabled (as defined in W&I Code section 5008 or 5585.25)

NOTIFICATIONS TO BE PROVIDED PURSUANT TO SECTION 5152.1 AND/OR 8102 OF THE WELFARE AND INSTITUTIONS CODE

Notify behavioral health director/designee: _____ (Name) _____ (Phone)

and peace officer/designee: _____ (Name) _____ (Phone) of

person's release or end of detention if either of the boxes below are checked.

NOTIFICATION OF PERSON'S RELEASE IS REQUESTED BY THE REFERRING PEACE OFFICER BECAUSE:

- The person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.
 Weapon was confiscated pursuant to Section 8102 W&I Code.

Signature, title and badge number of peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, designated members of a mobile crisis team, or professional person designated by the county.

Name:	Title/Badge Number:	Date:	Phone:
Signature: X		Time:	

Name of Law Enforcement Agency or Evaluation Facility/Person:	Address:
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REFERENCES

Welfare and Institutions Code

Sections: 300, 601, 602, 5008, 5150, 5150.05, 5152.1, 5328, 5585.25, 5585.50, 8102

Name of Individual Detained: _____ **DOB:** _____

**INVOLUNTARY PATIENT ADVISEMENT
(TO BE READ AND GIVEN TO THE
PATIENT AT TIME OF ADMISSION)**

Confidential Patient Information

Name of Facility:

Patient's Name:

Admission Date:

Section 5150(i) of the Welfare and Institutions Code requires that each person admitted to a facility designated by the county for evaluation and treatment be given specific information orally and in writing, and in a language or modality accessible to the person and a record of the advisement be kept in the person's medical record.

My name is _____ My position here is _____

You are being placed into this psychiatric facility because it is our professional opinion, that as a result of a mental health disorder, you are likely to: (check applicable)

- Harm yourself Harm someone else Be unable to take care of
your own food clothing or shelter

(List specific facts upon which the allegation of dangerous or gravely disabled due to mental health disorder is based, including pertinent facts arising from the admission interview):

We believe this is true because:

You will be held for a period of up to 72 hours. This (**does**) / (**does not**) include weekends or holidays. Your 72-hour period begins at: _____ on: _____
(Time) (Date)

You will be held for a period up to 72 hours. During the 72 hours you may also be transferred to another facility. You may request to be evaluated or treated at a facility of your choice. You may request to be evaluated or treated by a mental health professional of your choice. We cannot guarantee the facility or mental health professional you choose will be available, but we will honor your choice if we can.

During these 72 hours you will be evaluated by the facility staff, and you may be given treatment, including medications. It is possible for you to be released before the end of the 72 hours. But if the staff decides that you need continued treatment you can be held for a longer period of time. If you are held longer than 72 hours, you have the right to a lawyer and a qualified interpreter and a hearing before a judge. If you are unable to pay for the lawyer, then one will be provided to you free of charge.

If you have questions about your legal rights, you may contact the county Patients' Rights Advocate at _____ (phone number of county Patients' Rights Advocacy Office).

Advisement Completed or Attempted by:	Position:	Language or Modality Used:
Good Cause for Incomplete Advisement:		Date of Advisement:

DETAINMENT ADVISEMENT

My name is _____. I am a _____ with _____ . You are not under criminal arrest, but I am taking you for examination by mental health professionals at _____ .

You will be told your rights by the mental health staff.

If taken into custody at your residence, you may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken.

AVISO DE DETENCIÓN

Mi nombre es _____. Yo soy un _____ con _____. Usted no está bajo arresto criminal, pero le voy a llevar para que lo examinen unos profesionales de la salud mental en _____ .

Se le informará de sus derechos por parte del personal de salud mental.

Si se le pone bajo custodia en su residencia, se le permite llevar algunos artículos personales con usted, los que yo voy a tener que aprobar. Por favor avíseme si usted necesita ayuda para apagar algún aparato o el agua. Usted puede hacer una llamada telefónica y dejar una nota para decirles a sus amigos o familia adónde le han llevado.

羈押通知

我的名字是 _____ 。我是一位有 _____ 的 _____ 。您不是因犯罪被拘捕，但我現在要帶您到 _____ 。

進行專業的心理健康檢查。心裡健康工作人員將會告知您所擁有的權利。

如果您在住所被拘留，您可以隨身帶一些個人物品，但必須經我批准。請告知我若您需幫助關閉任何電源或水源開關。您可以打電話及留張便條告訴您的親友您被帶去的地方。

SỰ BẮT GIỮ SAU KHI ĐÃ NGHỊ ÁN

Tên tôi là _____. Tôi là _____ với _____.
Bạn không bị bắt giữ về hình sự, nhưng tôi phải đưa bạn đi khám bởi các chuyên gia y tế tâm thần tại _____.

Nhân viên y tế tâm thần sẽ cho bạn biết về những quyền của bạn.

Nếu bị bắt giữ tại nơi cư trú, bạn có thể mang theo một vài vật dụng cá nhân với sự đồng ý của tôi. Xin vui lòng cho tôi biết nếu bạn cần được giúp để tắt bất cứ thiết bị nào hoặc để khóa hệ thống nước trong nhà. Bạn có thể gọi điện thoại và để lại thư nhắn tin cho bạn bè hoặc gia đình về nơi bạn được đưa đến.

ЗАЧИТЫВАНИЕ ПРАВ ПРИ ЗАДЕРЖАНИИ

Меня зовут _____. Я _____ из _____.
Вы не арестованы, но я должен задержать вас для осмотра специалистами в области психиатрии в _____.

Ваши права вам разъяснят сотрудники психиатрического отделения.

Если вы подложите задержанию у себя дома, вы можете взять с собой личные вещи, которые я должен буду одобрить. Пожалуйста, сообщите мне, если вам нужна помощь в отключении воды или приборов. Вы можете сделать телефонный звонок и оставить записку, чтобы сообщить вашим друзьям и близким, куда вас забрали.

TAGUBILIN NG PAGPIPIGIL (DETAINMENT ADVISEMENT)

Ang pangalan ko ay _____. Ako ay mula sa _____.
Hindi kayo sumasailalim ng pag-arestong kriminal, ngunit dadalhin ko kayo para suriin ng mga propesyonal ng kalusugang pangkaisipan sa _____. Sasabihan kayo ng inyong mga karapatan ng kawani ng kalusugang pangkaisipan.

Kung kukunin kayo sa pag-iingat sa inyong tirahan, maaari kayong magdala ng ilang personal na mga gamit kasama ninyo, na dapat kong aprubahan. Mangyari lamang na ipaalam sa akin kung kailangan ninyo ng tulong sa pagsasara ng anumang kagamitan o tubig. Maaari kayong tumawag sa telepono at mag-iwan ng mensahe para sabihin sa inyong mga kaibigan o pamilya kung saan kayo dadalhin.

TARASOFF v. THE REGENTS OF THE UNIVERSITY OF CALIFORNIA

Supreme Court of California, 1976

Facts: Prosenjit Poddar, an Indian graduate student studying naval architecture at the University of California, Berkeley, started to date a fellow student named Tatiana Tarasoff. He kissed her a few times and felt he had a special relationship with her. He was totally unfamiliar with American mores and had never had a date before. He felt betrayed when Tatiana flaunted her relationships with other men. Because of his depression he went to a psychologist, Dr. Moore, at the University Health Service. He revealed his intention to get a gun and shoot Tatiana Tarasoff. Dr. Moore sent a letter to the campus police requesting them to take Poddar to a psychiatric hospital. The campus police interviewed Mr. Poddar, but he convinced them that he was not dangerous. They released him on the promise that he would stay away from Ms. Tarasoff. When the Health Service psychiatrist in charge returned from vacation, he directed that the letter to the police be destroyed and no further action taken.

Mr. Poddar moved in with Tatiana's brother over the summer while Tatiana was visiting her aunt in Brazil. When Tatiana returned, Mr. Poddar stalked her and stabbed her to death.

The parents of Tatiana sued the campus police, Health Service employees, and Regents of the University of California for failing to warn them that their daughter was in danger. The trial court dismissed the case because it said there was no cause of action. Before Tarasoff, a doctor had a duty to a patient, but not to a third party. The Appeals Court supported the dismissal. An appeal was taken to the California Supreme Court.

In 1974, the California Supreme Court reversed the appellate decision. The Court held that a therapist bears a duty to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from a patient's condition. This is known as the Tarasoff I decision.

The Tarasoff I decision meant that the trial court was instructed to hear the lawsuit against the police and various employees of the University of California. Due to great uproar among psychiatrists and policemen, the California Supreme Court took the very unusual step of rehearing the same case in 1976. The decision came to be known as Tarasoff II.

Holding: "When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps. Thus, it may call for him to warn the intended victim, to notify the police, or to take whatever steps are reasonably necessary under the circumstances."

Reasoning: The Court quoted as precedent that doctors have been held liable for negligent failure to diagnose a contagious disease or failing to warn family members of it.

The defendants contended through amice briefs, including an IPA brief, that psychiatrists were unable to accurately predict violence. The Court replied that they did not require therapists to render a perfect performance, "but only to exercise that reasonable degree of skilled care ordinarily possessed by members of their profession under similar circumstances." Proof, aided

by hindsight, is insufficient to establish negligence. In the Tarasoff case itself, the therapist did accurately predict Poddar's danger of violence.

The ultimate question of resolving the tension between the conflicting interests of patient and potential victim is one of social policy, not professional expertise. The risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that may be saved. One of the famous alliterative quotes from this case is, "The protective privilege ends where the public peril begins."

Dissent: Concern was expressed that the majority decision may result in an increase in violence because patients might not seek treatment. There was also concern that psychiatrists may over commit patients to avoid the risk of civil liability.

Commentary: The majority of state supreme courts that have addressed the issue have concurred with the Tarasoff decision. At least 17 states have now passed Tarasoff limiting statutes, which usually require an explicit threat, and state that the therapist's Tarasoff duty will be discharged if he does one of a number of things, such as notify the intended victim, and/or law enforcement authorities.

The most common error about Tarasoff today is the misconception that it is a duty to warn rather than a duty to protect. This is due to the publicity given to the 1974 Tarasoff I case, which was superseded by Tarasoff II in 1976.

The case was settled out of court for a significant amount of money and never went to trial. Mr. Poddar served four years of a five-year prison sentence for manslaughter. His conviction was overturned due to faulty jury instructions on diminished capacity. A second trial was not held on the promise that Mr. Poddar returns to India. He was last heard to be happily married in India.

Predictions that psychotherapy would be drastically altered never came to pass. Research showed that even before the Tarasoff decision, therapists were breaching confidentiality to protect intended victims.

TARASOFF INCIDENTS

The purpose of this order is to set procedures for investigating and reporting threats communicated to a psychotherapist, commonly referred to as Tarasoff incidents.

I. GUIDELINES

A. DEFINITION OF A TARASOFF INCIDENT. A Tarasoff incident is one in which a person has communicated to a psychotherapist a serious threat of physical violence against a reasonable identifiable victim.

B. RELEVANT CODES

1. **PSYCHOTHERAPIST DEFINED.** Section 1010 of the Evidence Code defines a psychotherapist as:
 - a. A psychiatrist, or a person whom the patient reasonably believes to be a psychiatrist.
 - b. A licensed psychologist.
 - c. A licensed clinical social worker.
 - d. A licensed school psychologist, holding state credentials to provide such services in schools.
 - e. A licensed marriage, family, or child counselor.
 - f. Registered associates, assistants, interns and trainees working under the supervision of licensed psychiatrists, licensed psychologists, licensed clinical social workers, or under the supervision of licensed marriage, family and child counselors.
2. **CIVIL LIABILITY.** Section 43.92 of the Civil Code exempts psychotherapist from civil liability if they do the following:
 - a. Make reasonable efforts to notify the victim or victims, and
 - b. Make a police report, relating complete information regarding the threats and the success or failure of efforts to notify the victim(s).
3. **POSSESSION OF FIREARM OR DEADLY WEAPON.** Section 8100 (b) (1) of the Welfare and institutions Code prohibits persons, who have communicated a third-party threat to a psychotherapist, from purchasing, possessing, or having access to any firearm or other deadly weapons for six months after the date of the threat.

Section 8105 (c) of the Welfare and institutions Code requires that a licensed psychotherapist immediately report the identity of persons subject to this prohibition.

II. POLICY

It is the policy of the San Francisco Police Department that in incidents involving third-party threats communicated by a person to a psychotherapist, officers shall prepare an incident report.

III. PROCEDURES

- A. **ASSIGNMENT.** Communications shall assign calls of Tarasoff incidents to a patrol unit for the initial investigation and completion of an incident report. In special circumstances, the Communications may notify the Department's Psychiatric Liaison Unit which will then be responsible for completing the incident report.
- B. **INCIDENT REPORT.** When preparing the report, follow these procedures:
 1. **TITLE.** Title the report "Tarasoff Threats."
 2. **WITNESSES, REPORTEES, ETC.** Include the names of reporteers, witnesses, and intended victims. Describe the circumstances of the threat along with efforts by the psychotherapist to notify the intended victim. Indicate whether the intended victim was notified of the threat.
 3. **SUSPECT INFORMATION.** In order for the Psychiatric Liaison Unit to make the required notifications to the Department of Justice – which is required in 8105 (c) of the Welfare and Institutions Code – include the suspect's name (including any alias), sex, race, DOB or approximate age, height, weight, hair and eye color, Social Security number, driver license number. Also include the suspect's mailing address and date the threat was reported.
 4. **ASSIGNMENT.** Assign the report to 5G200 (General Work Section) with copies to the Psychiatric Liaison Unit.
- C. **QUESTIONS.** If you have any questions, call officers at the Psychiatric Liaison Unit (PLU), at 206-8099 (Monday – Friday 0900-1700 hrs.). During non-business hours, contact the PLU through the Operations Center.

References

Section 1010 Evidence Code
Section 43.92 Civil Code
Welfare & Institution Code Sections 8100 (b) (1), 8105 (c), 8102
Welfare & Institution Code Sections 5150
DGO 6.14, Psychological Evaluation of Adults
DGO 7.02, Psychological Evaluation of Juveniles
DGO 3.05, Department Weapon Return Panel

BHS Policies and Procedures

 <p>City and County of San Francisco Department of Public Health San Francisco Health Network BEHAVIORAL HEALTH SERVICES</p>	1380 Howard Street, 5th Floor San Francisco, CA 94103 415.255-3400 FAX 415.255-3567
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**POLICY/PROCEDURE REGARDING: Special Situations Governing the Release of Information:
Duty to Warn and Protect Third Parties in Response to a Client Threat**

Issued By: Kavoo Ghane Bassiri, LMFT, LPCC <i>KBlin</i> Director of Behavioral Health Services	Manual Number: 3.06-09
Effective Date: September 24, 2018	References: <i>Tarasoff v. Regents of the University of California</i> , 17 Cal.3d 425 (Cal. 1976); <i>Ewing v. Goldstein</i> , 120 Cal. App. 4th 807 (2004); <i>Ewing v. Northridge Hospital Medical Center</i> , 120 Cal. App. 4th 1289 (2004); Civil Code §43.92; Evidence Code §§1010 & 1024; and Welfare & Institutions Code §5328(18).

Substantive Revision. Replaces Policy 3.06-09 dated September 13, 2013.

Purpose:

The purpose of this policy is to provide guidance to staff of San Francisco Behavioral Health Services (BHS) regarding the psychotherapist’s duty to warn and to protect a reasonably identifiable victim(s) of a BHS client’s serious threat of physical violence communicated by a client or the client’s family member to the psychotherapist (formerly referenced as “*Tarasoff Decision*”), to ensure that those BHS staff who meet the definition of “psychotherapist” as defined in Evidence Code §1010 understand and meet their reporting requirements, and to advise BHS staff who are not psychotherapists about their responsibilities to report to management information that they may receive about a client’s serious physical threats communicated by the client or their family members.

Background:

In review of the case of *Tarasoff v. Regents of the University of California* in 1974, the California Supreme Court established the duty to warn when deciding that a psychotherapist bears a duty to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from a patient’s condition. In the 1976 rehearing of the *Tarasoff* case, the California Supreme Court established that “the protective privilege ends where the public peril begins” and held that the psychotherapist incurs an obligation to use reasonable care to protect the intended victim against such danger. In review of *Ewing v. Goldstein* in 2004, the California Court of Appeals further expanded the criteria for triggering the duty to warn and protect when deciding that the psychotherapist’s obligation also applies to those instances when a member of the patient’s family advises the psychotherapist, for

purposes of advancing the patient’s treatment, that the patient has communicated a serious threat of physical violence against a reasonable identifiable victim or victims. The appellate court decision thus determined that a “communication from a patient’s family member to the patient’s therapist” which conveys a credible threat of physical violence against an identifiable victim “is a ‘patient communication’ within the meaning of section 43.92” and therefore imposes a duty to warn upon the psychotherapist. This ruling expanded the interpretation of Civil Code §43.92 to "include family members as persons covered within the statute who, upon communication to a therapist of a serious threat of physical violence against a reasonably identifiable victim, would trigger a duty to warn."

The psychotherapist’s duty to warn and protect is codified in Civil Code §43.92 which states that a “psychotherapist” has a duty to protect any reasonably identifiable victim or victims of a serious threat of physical violence communicated to the psychotherapist by a patient. This section further states that if there exists a responsibility to protect, **the duty shall be discharged by the psychotherapist “by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.”** Under this statute, a psychotherapist is provided immunity if a serious threat has been communicated, in any form, by the patient or family member against a “reasonably identifiable” victim or victims, and the psychotherapist discharges their duty by notifying law enforcement and the victim(s).

The legal privilege for communications between a psychotherapist and a patient is codified in California Evidence Code §§1010-1014. Evidence Code §1024 states that “there is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.”

Section 5328(18) of the Welfare & Institutions Code states that “when the patient, in the opinion of his or her psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies and county child welfare agencies as the psychotherapist determines is needed for the protection of that person or persons.” The protected health information released about the patient should be the minimum necessary to enable the potential victim(s) to recognize the seriousness of the threat and to take the proper precautions for protection.

Scope:

This policy applies to all staff within Behavioral Health Services, including both non-psychotherapists and psychotherapists as defined by Evidence Code §1010. **“Psychotherapist”** is defined in California Evidence Code §1010 as:

- (a) A person authorized to practice medicine in any state or nation who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry.
- (b) A person licensed as a psychologist under Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.
- (c) A person licensed as a clinical social worker under Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code, when he or she is engaged in applied psychotherapy of a nonmedical nature.
- (d) A person who is serving as a school psychologist and holds a credential authorizing that service issued by the state.

- (e) A person licensed as a marriage and family therapist under Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.
- (f) A person registered as a psychological assistant who is under the supervision of a licensed psychologist or board certified psychiatrist as required by Section 2913 of the Business and Professions Code, or a person registered as an associate marriage and family therapist who is under the supervision of a licensed marriage and family therapist, a licensed clinical social worker, a licensed psychologist, or a licensed physician and surgeon certified in psychiatry, as specified in Section 4980.44 of the Business and Professions Code.
- (g) A person registered as an associate clinical social worker who is under supervision as specified in Section 4996.23 of the Business and Professions Code.
- (h) A person registered with the Board of Psychology as a registered psychologist who is under the supervision of a licensed psychologist or board certified psychiatrist.
- (i) A psychological intern as defined in Section 2911 of the Business and Professions Code who is under the supervision of a licensed psychologist or board certified psychiatrist.
- (j) A trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, who is fulfilling his or her supervised practicum required by subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 of, or subdivision (c) of Section 4980.37 of, the Business and Professions Code and is supervised by a licensed psychologist, a board certified psychiatrist, a licensed clinical social worker, a licensed marriage and family therapist, or a licensed professional clinical counselor.
- (k) A person licensed as a registered nurse pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, who possesses a master's degree in psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing.
- (l) An advanced practice registered nurse who is certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code and who participates in expert clinical practice in the specialty of psychiatric-mental health nursing.
- (m) A person rendering mental health treatment or counseling services as authorized pursuant to Section 6924 of the Family Code.
- (n) A person licensed as a professional clinical counselor under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code.
- (o) A person registered as an associate professional clinical counselor who is under the supervision of a licensed professional clinical counselor, a licensed marriage and family therapist, a licensed clinical social worker, a licensed psychologist, or a licensed physician and surgeon certified in psychiatry, as specified in Sections 4999.42 to 4999.46, inclusive, of the Business and Professions Code.
- (p) A clinical counselor trainee, as defined in subdivision (g) of Section 4999.12 of the Business and Professions Code, who is fulfilling his or her supervised practicum required by paragraph (3) of subdivision (c) of Section 4999.32 of, or paragraph (3) of subdivision (c) of Section 4999.33 of, the Business and Professions Code, and is supervised by a licensed psychologist, a board-certified psychiatrist, a licensed clinical social worker, a licensed marriage and family therapist, or a licensed professional clinical counselor.

Policy:

Behavioral Health Services must take action to protect reasonably identifiable potential victims from BHS clients consistent with applicable law, including provisions of the Welfare & Institutions Code, the Civil Code, the Evidence Code, and the requirements of the *Tarasoff* decision and subsequent case law. When a BHS client or their family member communicates to any staff of a BHS program that the

client has made a serious threat of physical violence against a reasonably identifiable victim or victims, then actions pursuant to applicable law must be implemented in order to protect the third party. Staff are encouraged to consult with the clinical supervisor or Program Director throughout this process. If questions remain, such as whether the communication made triggers a duty to warn, who is considered a “family member,” or if the victim is “reasonably identifiable,” BHS providers are encouraged to consult with their System of Care Program Manager, the BHS Risk Manager, or the agency’s legal counsel. Decisions made as to how the situation will be handled should be carefully documented in the medical record. At minimum, documentation should address each of the conditions which serve as the basis for the duty to warn and protect: that the client communicated to the psychotherapist a threat of serious physical violence or the psychotherapist obtains information of such a threat having been made by the client from a credible family member; that the threat of physical violence was a serious one; and that the victim or victims were reasonably identifiable.

The steps indicated below are applicable to all BHS staff when a client or the client’s family member communicates to staff a client’s serious threat of physical violence against a reasonably identifiable victim or victims.

- BHS staff, including non-clinical staff, must immediately report any such communication to a clinical supervisor or Program Director to determine the most appropriate action.
- Clinical staff, bearing in mind the potential urgency of the danger, shall review the available history and treatment of the client to determine level of risk, and discuss the information with the clinical supervisor or Program Director to decide whether or not the client presents a serious danger to a reasonably identifiable victim or victims.
- If the communication is received from a family member, staff shall determine the nature of the relationship to verify the individual meets the definition of a family member, determine whether the family member made the communication in furtherance of the client’s treatment, and determine whether the communication conveys a credible serious threat of violence.
- If it is decided that the client does not present a serious danger to a reasonably identifiable victim or victims, then this fact must be documented in the medical record, including the rationale. In such instances where the client does not meet the threshold for issuing a warning, staff should continue monitoring the level of dangerousness through ongoing risk assessment and safety planning, and identify and implement interventions that may decrease the risk.
- If it is decided that the client does present a serious danger to a reasonably identifiable victim, the following three actions shall be taken as soon as is practically possible:

1. Initiate an evaluation for involuntary detention if the client’s dangerousness to other(s) appears to be the result of a mental health disorder and the client can be located. If the client cannot be located, notify local law enforcement for assistance. The receiving LPS-designated facility shall be informed by the staff initiating the involuntary detention of the efforts to notify law enforcement and to warn a potential victim. Document all efforts in the client’s medical record.

2. Make reasonable efforts to notify the intended victim or victims whether or not the client is hospitalized. Involuntary hospitalization of the client does not discharge the duty to warn and protect the potential victim or victims. Contact may be made through whatever means is indicated, such as by telephone, in writing, or visitation. Documentation in the client’s medical record is required and should include specific efforts to contact the potential victim, times and dates of these attempts, and copies of any written correspondence.

Only the minimum amount of information necessary to protect the intended victim or victims shall be released. This exception to client confidentiality must be carried out with care and consideration with the maintenance of the public safety and therapeutic relationship as objectives. When issuing warnings, Substance Use Disorder service providers are encouraged to consult with their program management as to how to best safeguard the confidentiality of clients receiving Substance Use Disorder services.

A verbal or written warning to the potential victim(s) should include the following information: that you have a professional relationship with the client, that this client has communicated a serious threat of physical violence to the intended victim(s), that you are required by law to warn the victim(s), a description of the threat, and that the victim(s) should take steps to ensure one's own protection.

3. Contact the local law enforcement agency having jurisdiction where the potential victim resides. Involuntary hospitalization of the client does not discharge the duty to notify law enforcement. Enter in the medical record the name of the person to whom the report was made with the date, time, and information released.

A Quality of Care (QOC) report must be completed and submitted when a duty to warn and protect has taken place. The QOC report should include the name of the staff member issuing the warning, the names of any other persons involved in the decision, law enforcement and victim notification information, and any relevant circumstances surrounding the warning.

Contact Person:

Risk Manager, Behavioral Health Services, 415-255-3400

Distribution:

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PSYCHOLOGICAL EVALUATION OF ADULTS

This order outlines policies and procedures for dealing with psychologically distressed adults, including abatement, detainment and arrest. It includes procedures for admission to facilities, medical treatment, weapons confiscation, and preparation of incident reports.

I. GUIDELINES

- A. CRITERIA FOR INVOLUNTARY DETENTIONS. Officers may detain an individual for psychiatric evaluation pursuant to Section 5150 of the Welfare and Institutions Code only when the officer believes that, as a result of mental illness, an individual is:
1. A danger to himself/herself, or
 2. A danger to others, or
 3. Gravely disabled, meaning the individual is unable to care for himself/herself and has no reliable source of food, shelter or clothing.

II. POLICY

- A. It is the policy of the San Francisco Police Department that in incidents involving psychologically distressed adults, officers shall:
1. ABATE. If the individual has not committed a crime and is not, as a result of a mental disorder, a danger to himself/herself, a danger to others, or gravely disabled, abate the incident and recommend that the individual contact a mental health professional.
 2. DETAIN. If an individual has not committed a crime but is, as a result of a mental disorder, a danger to himself/herself, a danger to others, or gravely disabled, detain the individual for psychiatric evaluation and treatment.
 3. ARREST. If an individual has committed a crime, arrest the individual and book or cite according to Department policies and procedures. Cited individuals who are, as a result of mental disorder, a danger to themselves, a danger to others, or are gravely disabled shall also be detained for psychiatric evaluation.
- B. ASSISTANCE TO OUTSIDE AGENCIES
1. STAFF MEMBER IS PRESENT. It is the intention of the Department that police assistance to clinicians will be restricted to cases where the person to be detained for psychiatric evaluation (5150 W & I) is currently violent and presenting a public safety risk.

2. STAFF MEMBER IS NOT PRESENT. When an emergency evaluation is requested by a clinician who is not at the scene, the officer shall make his/her own independent evaluation and take appropriate action consistent with that evaluation.
3. APPLICATION FOR EVALUATION. Except in an emergency situation as determined by the officer, a clinician must prepare the "Application for 72-Hour Detention for Evaluation and Treatment" and make arrangements with Psychiatric Emergency Services (PES) prior to requesting assistance.
4. STAFF IDENTIFICATION. Clinicians who are certified to initiate involuntary detentions must carry an identification card issued by the County Director of Mental Health. If the clinician cannot show his/her card, the decision to detain will be the responsibility of the officer at the scene.
5. TRANSPORTATION. If all criteria are met for a psychiatric detention, take the person and the clinician's paperwork to PES at SFGH only. If the person is currently not demonstrating a public safety risk, do not transport. Advise the clinician to consult with his/her supervisor regarding appropriate transportation.

III. PROCEDURES

- B. ABATEMENT. When abating a situation involving a mentally disturbed individual, follow these procedures:
 1. INCIDENT REPORT. If the individual needs psychiatric evaluation but does not meet 5150 W & I criteria, prepare an incident report entitled "Aided Case/Request Evaluation" and list the individual as "D" (detained).
 2. COPIES. Forward a copy of the report to the Psychiatric Liaison Unit, which will be responsible for appropriate follow up.
- C. DETENTION. When detaining an individual for psychiatric evaluation and treatment, follow these procedures:
 1. TRANSPORTATION. Take the individual to Psychiatric Emergency Services (SFGH) only and complete an "Application for 72-Hour Detention for Evaluation and Treatment."
 2. REPORT. Prepare an incident report and title it "Aided Case/5150 W & I." List the individual as "D" (detained).
 - a. DESCRIPTION. Include a detailed physical description of the individual and an accurate residence address. Also include his/her date of birth, SF number, driver license number, Social Security number, and any other identification numbers.
 - b. FIREARMS/WEAPONS. List any confiscated firearms or deadly weapons in the incident report.
 - c. PROPERTY. Describe how the person's property was safeguarded or placed in police custody.
 - d. CRITERIA. Describe the circumstances that formed the reasonable and probable cause to believe that one or more of the criteria listed under Section I.A. above were present.

D. **ARRESTS.** After arresting a mentally disturbed individual for a criminal offense, cite or book according to Department policy (see DGO 5.06, Citation Release). Also follow these procedures:

1. **CITATION.** If an individual is eligible for citation release, but as a result of a mental disorder is a danger to himself/herself, a danger to others, or is gravely disabled, cite the individual and take him/her to PES at SFGH. Indicate on the "Application for 72-Hour Detention for Evaluation and Treatment" that the person has been cited for an offense.
2. **BOOKING.** If an individual cannot be cited pursuant to Department policy, book him/her and request on the booking form that Jail Psychiatric Services evaluate the individual in the jail.
3. **INCIDENT REPORT.** In either of the above cases, prepare an incident report and forward a copy to the Psychiatric Liaison Unit. Title the report by the offense and indicate that you have either cited and detained the individual for psychiatric evaluation or booked the individual and made a referral to Jail Psychiatric Services.

Example: Battery/Fists/Cited & 5150'd

E. **FACILITIES.** Currently, adults are evaluated at Psychiatric Emergency Services (PES) at SFGH. Due to policy and budget considerations, facilities may change along with the hours of operation. Any changes will be announced in Department Bulletins.

F. **VOLUNTARY ADMISSIONS.** There is no such thing as a "voluntary 5150." The fact that an individual is willing to accompany you to a psychiatric facility does not make the evaluation voluntary. If you believe that psychiatric evaluation is necessary, complete an "Application for 72-Hour Detention for Evaluation and Treatment" even though the individual willingly accompanies you to PES.

G. **COORDINATING PSYCHIATRIC DETENTION WITH EMERGENCY MEDICAL TREATMENT.** If an individual is injured or ill, you must have him/her medically treated before requesting a psychiatric evaluation. The following procedures apply when an individual is not under arrest.

1. **SAN FRANCISCO GENERAL HOSPITAL.** If an individual is being treated at San Francisco General Hospital, Emergency Department, go to the Psychiatric Emergency Services (PES) and complete the "Application for 72-Hour Detention for Evaluation and Treatment." Leave the original at PES and take a copy to the emergency room attending physician. Your responsibility ends here. Any security services will be provided by SFGH Institutional Police.
2. **OTHER MEDICAL FACILITIES.** When an individual is being treated at any other hospital emergency room, complete the "Application for 72-Hour Detention for Evaluation and Treatment" and present it to the attending physician. The physician is responsible for arranging for transportation of the patient to PES at San Francisco General Hospital. Any security required will be provided by the hospital's security staff. Your responsibility ends here.
3. **INCIDENT REPORT/EVALUATION FORM.** In either of the cases above, prepare an incident report, title it "Aided Case/5150 Detention," and attach a copy of the

“Application for 72-Hour Detention for Evaluation and Treatment” to it. List the individual as “D” detained and include the circumstances of the incident, the name of the medical facility, and the attending physician.

H. JUVENILES. See DGO 7.02, Psychological Evaluation of Juveniles.

I. FIREARMS AND DEADLY WEAPONS. Welfare and Institutions Code Section 8102 requires law enforcement officers to seize firearms and other deadly weapons from individuals detained or apprehended for examination of a mental condition pursuant to Section 5150 W & I. When seizing a firearm or deadly weapon, advise the individual to contact the SFPD Legal Division concerning its return. Also fax a copy of your incident report to the Department’s Legal Division.

1. MENTAL HEALTH FIREARMS PROHIBITION SYSTEM. The Department of Justice, Bureau of Criminal Identification and Information, has developed a database for the Mental Health Firearms Prohibition System (MHFPS). If you are conducting a criminal investigation that involves the acquisition, carrying or possession of a firearm, the CLETS data base will include a message that the person you are investigating may be subject to a mental health firearms prohibition pursuant to Sections 8100/8103 of the Welfare and Institutions Code. This message is provided in addition to the person’s name, personal description, available identifying numbers, such as driver’s license, Social Security, California Identification, Military Identification, or other miscellaneous identification numbers. You can use any CABLE terminal that has CLETS inquiry capability to access this database using one of two ways:

a. Using RF/

- RF/CJIS/FQA Name inquiry
- RF/CJIS/FQN Number inquiry
- RF/CJIS/FQP Record number inquiry

b. Using the HELP system

You can access the three inquires listed above using the HELP system by first selecting the Firearms category (E), then the MHFPS category (E7), finally entering the respective category for name inquiry (E7A), number inquiry (E7B), or record number inquiry (E7C).

If you need the reason a person has been prohibited from owning firearms, contact the DOJ Firearms Clearance Section.

J. PROPERTY. When detaining an individual per 5150 W & I, take reasonable precautions to secure his/her premises and private property. Document this in your incident report. Any personal property that cannot be properly secured must be booked as Property for Safekeeping (see DGO 6.15, Property Processing).

K. MEDICATION. Any medication seized goes with the individual either to jail or the hospital.

L. QUESTIONS. For consultation or information, call officers at the SFPD Psychiatric Liaison Unit (PLU) at 206-8099 (Monday – Friday 0900-1700 hrs.). During non-business hours, contact the PLU through the Operations Center.

M. TARASOFF INCIDENTS. See DGO 6.21, Tarasoff Incidents.

References

DGO 7.02, Psychological Evaluation of Juveniles

DGO 3.23, Department Weapon Return Panel

5150 W & I Code

8102 W & I Code

PSYCHOLOGICAL EVALUATION OF JUVENILES

This order presents guidelines for arrangement of emergency psychological assessment of persons under the age of eighteen, including coordination, emergency medical treatment and filing of criminal charges.

I. INFORMATION AND GUIDELINES

- A. **PSYCHOLOGICAL DISTRESS.** Occasionally, officers may come into contact with a juvenile who appears to be in acute psychological distress. In addition to many other symptoms, this distress may be characterized by severe depression, suicidal behavior, or threats of violence constituting a danger to the juvenile or to others.
- B. **COMPREHENSIVE CHILD CRISIS SERVICE (CCCS).** CCCS is a program of the City and County of San Francisco/San Francisco Department of Public Health/Community Behavioral Health Services. It is the City and County of San Francisco's designated agency responsible for psychiatric evaluation of persons under 18 years who may require urgent psychiatric services. CCCS is a 24-hour mobile response unit that has a response time of approximately 30 minutes. The telephone number for CCCS is (415) 970-3800. To obtain an emergency evaluation, call CCCS and request services.
- C. **PSYCHIATRIC EMERGENCY SERVICES (PES).** PES is a holding facility for adults at San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA. (415)206-8125. If juveniles need to be assessed in a secure setting, CCCS will determine if the juvenile should go to PES. If CCCS determines that an evaluation should occur at PES, a CCCS team will meet the juvenile and responsible adult at PES. If an adult does not accompany the juvenile to PES, the officer will be required to stay throughout the evaluation. Do not transfer a juvenile to PES without first consulting with CCCS.

II. POLICY

- A. It is the policy of the San Francisco Police Department that officers respond in a helpful manner to juveniles whom they believe to be in acute psychological distress. Pursuant to section 5585.50 of the Welfare and Institutions Code, an officer may take a minor for psychiatric evaluation when the minor, as a result of mental disorder, is a danger to others, is a danger to himself/herself, or is gravely disabled, and authorization for voluntary treatment is not available. These are the same criteria that apply to adults under section 5150 W & I Code.

Members are required to provide a Miranda Advisement only in instances described in the Welfare and Institution Code section 625(c).

III. PROCEDURES

- A. **CCCS ASSESSMENT WITHOUT PENDING CRIMINAL CHARGES.** When requesting an assessment, follow these procedures:

1. NOTIFICATION. Notify CCCS. CCCS will consult with you and decide where an assessment team will meet with you to conduct the evaluation.
 2. SUPERVISION. If a responsible adult (parent, legal guardian, or school staff) does not accompany the juvenile, the officer shall remain until the evaluation is complete.
- B. CCCS ASSESSMENT WITH PENDING CRIMINAL CHARGES. When requesting an assessment of a juvenile in custody for a criminal offense, follow these procedures:
1. CITATION PROCEDURES. When it is appropriate to issue a criminal citation (see DGO 5.06, Citation Release), telephone CCCS and arrange to have an assessment team meet with you to conduct an evaluation. Members must remain with the juvenile during the evaluation. If the juvenile is not placed on a hold per 5150 W & I, the officer, prior to citing the juvenile, shall contact the authorized receiving facility during their operating hours. A probation officer from the authorized receiving facility, after consulting with the member, will determine whether the arrested juvenile should be brought to his/her facility.
 2. BOOKING PROCEDURE. When booking is required, follow these procedures:
 - a. Prior to transporting a juvenile, contact CCCS as soon as practical and arrange to have the assessment team meet with you. A member of the assessment team will consult with you and determine where the evaluation should take place. (CCCS may join the officer(s) in the field and evaluate the juvenile at home, school, CCCS office, PES or other locations appropriate for the situation.)
 - b. Stay with the juvenile. If the assessment team decides not to request a psychiatric evaluation (5150 W & I), the arresting officers, prior to booking the juvenile, shall contact the authorized receiving facility during its operating hours. A probation officer from the authorized receiving facility, after consulting with the member, will determine whether the arresting juvenile should be brought to his/her location.
 - c. If the assessment team decides to psychiatrically hospitalize the juvenile for psychiatric evaluation, CCCS staff will make arrangements to secure an inpatient psychiatric bed and transportation to that bed.
 - d. Put a "police hold" on the juvenile by filling out the lower portion of "Application for 72-hour Detention for Evaluation and Treatment," under the section labeled "Notifications to be provided to Law Enforcement Agency." Notify the staff that you will book the juvenile into Youth Guidance Center in absentia. Leave the juvenile in CCCS custody, complete the admissions form and deliver it to the Youth Guidance Center.
- C. NOTIFICATION AND TELEPHONE CALLS.
1. NOTIFICATION. Take reasonable and immediate steps to notify the juvenile's parent, guardian or responsible relative that the juvenile is in custody and is being detained for assessment. Inform the parent or guardian that they may be present during the assessment or should be accessible by phone to talk with CCCS during the evaluation.

2. TELEPHONE CALLS. Advise the juvenile that he/she has a right to make at least (2) completed phone calls: (1) to a parent, guardian, responsible relative or employer, and (2) to an attorney.

D. COORDINATION OF CCCS ASSESSMENT WITH EMERGENCY MEDICAL TREATMENT. When requesting an assessment of a juvenile receiving emergency medical treatment, follow this procedure:

1. NOTIFICATION. Telephone CCCS from the emergency room. CCCS will consult with you regarding coordination of its psychological assessment with the emergency medical treatment. CCCS will respond to the emergency room when the juvenile is medically cleared.

E. COORDINATION OF CCCS ASSESSMENT WITH EMERGENCY MEDICAL TREATMENT OF A JUVENILE IN CUSTODY FOR CRIMINAL OFFENSE. When requesting an assessment of a juvenile who is in custody for a criminal offense and is receiving emergency medical treatment, follow these procedures:

1. NOTIFICATION. Telephone CCCS from the emergency room. CCCS will consult with you regarding coordination of its psychological assessment with the emergency medical treatment. CCCS will respond to the emergency room when the juvenile is medically cleared.
2. CITATION. If appropriate (see DGO 5.06, Citation Release), cite the juvenile. Prior to releasing the juvenile, arresting officers shall contact the authorized receiving facility during its operating hours. A probation officer from the authorized receiving facility, after consulting with the officer, will determine whether the arrested juvenile should be brought to his/her location.
3. BOOKING. If the juvenile must be admitted to the hospital, and booking is required, place a "police hold" on the juvenile with the emergency room staff by following these procedures:
 - a. Complete the lower portion of the "Application for 72-hour Detention for Evaluation and Treatment" under the section "Notifications to be provided to Law Enforcement Agency."
 - b. Complete a YGC Admission Form and deliver it along with a copy of the completed "Application for 72-hour Detention for Evaluation and Treatment" to the Youth Guidance Center. The absentia booking process is complete. The officer shall remain at the hospital until a probation officer from YGC arrives to relieve him/her of responsibility for the juvenile.

F. INCIDENT REPORT

1. NO PENDING CRIMINAL CHARGES. Write an incident report, title it "Aided Case/5150 Evaluation/CCCS."
2. PENDING CRIMINAL CHARGES. If criminal charges are involved, write an incident report and title it by the primary offense, e.g., Battery/Fists/Aided Case/5150 Evaluation/CCCS.

G. QUESTIONS. For consultations or further information, call the Juvenile Division at (415) 558-5500, Monday – Friday, 0900-1700 hours. During non-business hours, contact the Operations Center.

Reference

DGO 5.06, Citation Release

DGO 7.01, Juvenile Policies and Procedures

BHS Policies and Procedures



City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

1380 Howard Street, 5th Floor
San Francisco, CA 94103
415.255-3400
FAX 415.255-3567

POLICY/PROCEDURE REGARDING: **Authority for Involuntary Detention for 72-Hour Evaluation and Treatment**

Issued By: Jo Robinson, MFT
Director of Behavioral Health Services

Date: January 15, 2015

A handwritten signature in blue ink that reads "Jo Robinson".

Manual Number: 3.07-02

References: California Welfare and Institutions Code, Sections 5000-5121, 5150-5155, 5585-5585.25, 5585.50-5585.89; California Code of Regulations, Title 9, Sections 663, 821; and Health and Safety Code, Section 1250.

Technical Revision. Replaces Manual Number 3.07-02 of November 9, 2010

PURPOSE: The intention of this policy is to provide guidelines for establishing authority for involuntary detention for 72 hour evaluation and treatment and to ensure compliance with state law, regulations, and county procedures (Welfare and Institutions Code, Section 5121).

SCOPE: This policy is issued by Behavioral Health Services (BHS) and applies to all designated facilities and individuals in the City and County of San Francisco who have or seek authorization to initiate and sign applications for 72 hour evaluation and treatment pursuant to Section 5150, et seq. or Section 5585, et seq. of the Welfare and Institutions Code. **Note** that for all minors requiring an evaluation for involuntary detention, BHS Child Crisis Services must be contacted. See BHS policy 3.03-1 for specific requirements about the evaluation and inpatient admission of minors.

POLICY:

I. DEFINITIONS

A. DESIGNATED FACILITY is a facility that is licensed or certified as a mental health treatment facility or hospital to evaluate and treat involuntary psychiatric patients (Health and Safety Code, Section 1250 and CCR, Title 9, Sections 663, 821), has a written agreement with BHS to detain individuals in order to provide psychiatric evaluation and treatment for up to 72 hours as described in Welfare and Institutions Code commencing with Section 5000, is designated by ordinance of the San Francisco Board of Supervisors as such a facility (Welfare and Institutions Code, Section 5008(n), and is approved by the Mental Health Licensing section within the California Department of Health Care Services.

B. FACILITY AUTHORIZATION CERTIFICATE is a document issued by BHS to facilities or programs in which qualified staff is certified by BHS to initiate and sign an *Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment* (Form DHCS 1801-04/2014). The certificate is accompanied by a list of those staff within the program or facility designated by the City & County of San Francisco to perform functions commencing with Section 5000 of the Welfare and Institutions Code. Programs are encouraged to have several staff with authorization privileges.

C. AUTHORIZATION CARD is a small, wallet-sized card issued by BHS, which identifies the holder, or individual staff member of an authorized facility, as having the authority to initiate and sign an *Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment* pursuant to Section 5150, et seq. or Section 5585, et seq. of the Welfare and Institutions Code. Staff members who have been issued an authorization card are also reflected on the list of certified staff accompanying the Facility Authorization Certificate. Individual authorization cards are issued to individual staff members of authorized facilities when the preponderance of their work occur offsite of the authorized facility (e.g., outreach, intensive case management). The individual card serves the same objective as the Facility Authorization Certificate described in B above.

D. DESIGNATED STAFF refers to an eligible individual who has completed the required certification training and has successfully passed the examination. Staff certified as designated by the City and County of San Francisco have the authority to initiate and sign an *Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment* for an individual who is a danger to self or others, or is gravely disabled, as a result of a mental health disorder and is unable or unwilling to accept treatment voluntarily.

II. ELIGIBILITY

The following persons are authorized to initiate and sign an *Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment*:

- Individual Peace Officers as defined by Sections 830-832.17 of the California Penal Code.

The following persons who have had direct or delegated training on involuntary psychiatric detention within the last 5 years and have successfully passed the examination are designated by the City & County of San Francisco as authorized to initiate and sign an *Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment*:

- Licensed mental health professionals who work in a designated facility.
- Licensed physicians who work in a hospital medical emergency department.
- Licensed mental health professionals who work in authorized mental health facilities.
- Licensed mental health professionals who work in authorized non-mental health facilities (e.g., primary care, substance abuse).

The following persons who have had direct or delegated training on involuntary psychiatric detention within the last 3 years and have successfully passed the examination are designated by

the City & County of San Francisco as authorized to initiate and sign an *Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment*:

- License waived or non-licensed professionals who work in authorized mental health facilities.

III. TRAINING AND CERTIFICATION PROCESS

The Program Director or designated lead contact person of the authorized facility shall ensure that only staff eligible for initial certification or re-certification as required in the performance of their job duties will attend the required training. Please note that student interns are not eligible for certification. In order to be certified for authorization, staff must attend the required training and successfully pass the examination. Continued certification requires re-training and testing on a regular basis (i.e., 3 or 5 year increments) as described above in section II.

Training related to authorization must be provided by or delegated by BHS. Some programs have been delegated to provide their own training to their staff. Delegated trainings must be approved by the Certification Coordinator for BHS. Delegated trainers must be currently certified. The delegated trainer is to use training materials and components including the post test approved by the Certification Coordinator, and must report those staff to be added to or removed from the facility list to the Program Director or designated lead contact person.

Programs that are authorized and have certified staff to initiate and sign the *Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment* are issued a Facility Authorization Certificate. Once staff are trained and obtain a passing score of at least 80% on the post test, they are added to the facility list. The certification period starts on the day of successful passing of the examination. It is the responsibility of the facility's Program Director or designated lead contact person to help monitor the facility list. The Program Director or designee is to submit needed revisions to the Certification Coordinator for BHS as needed. The official updated facility list is then sent to the Program Director or designee. The facility list is maintained and issued by BHS.

For those staff eligible for an individual card, the card shall be issued by BHS upon completion of training and passing the examination. Individual cards generally are not issued except to those staff whose work is primarily outside of the authorized facility. The card is mailed to the Program Director or designated lead contact person for distribution. The card is to be surrendered to the facility's Program Director or designee upon the staff's termination from employment at the authorized facility.

Staff authorization to initiate an involuntary psychiatric hold applies only to the facility to which they are issued and only during the authorized staff member's working hours. If one is employed by multiple authorized sites, the individual can request to be listed as being certified at all sites and does not need additional training. When a staff member leaves and moves to another program that has a facility certificate, that employee may request to transfer their certification to the new program without re-training as long as it is within the current certification period (see section II

above). All such requests are to be made through the Program Director or designated lead contact person.

All cards and certifications apply only to the City and County of San Francisco. The list of certified individuals or the individual card shall be made available to the San Francisco Police Department upon request. Revocation of certification status is at the discretion of the Director of Behavioral Health Services or designee.

IV. TRANSPORTATION

Individuals authorized to complete applications will arrange for transportation. Comprehensive Crisis Services, including Mobile Crisis Treatment Team and Child Crisis Services, can be called to do crisis evaluations, but do not provide transportation services for involuntary holds initiated by other certified staff. The San Francisco Police Department is to be called only when a situation might or has resulted in serious bodily harm, or is life-threatening, or a weapon is being used.

V. DISCONTINUATION OF THE 72 HOUR INVOLUNTARY HOLD

Any staff member certified to institute an involuntary psychiatric hold pursuant to Welfare and Institutions Code, Sections 5150 or 5585.50, is also eligible to discontinue the hold. It is required that discontinuation of the hold occurs following a face-to-face evaluation of the client's condition and it is determined that the person no longer meets criteria for danger to self or others, or grave disability as the result of a mental health disorder, and can be appropriately served on a voluntary basis. Upon admission to a designated facility, the facility may discontinue the hold with the authority to release in compliance with Welfare & Institutions Code, Sections 5151 and 5152(a).

Contact Person: Certification Coordinator for BHS, Office of Quality Management, 415-255-3400.

Attachments: *Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment* (form DHCS-04/2014)

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BHS Policies and Procedures



City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

1380 Howard Street, 5th Floor
San Francisco, CA 94103
415.255-3400
FAX 415.255-3567

POLICY/PROCEDURE REGARDING: **Involuntary Psychiatric Detention and Coordination of Care for Minors**

A handwritten signature in blue ink that reads "Marlo Simmons".

Issued By: Marlo Simmons, MPH
Interim Director of Behavioral Health Services

Date: April 2, 2020

Manual Number: 3.03-1

References: California Welfare and Institutions Code, Sections 5150-5155, 5585-5585.25, 5585.50-5585.59, 6000-6008, and 6550-6552.

Technical revision. Replaces Policy 3.03-1 of February 10, 2015

Purpose: The intention of this policy is to define the processes regarding the involuntary psychiatric detention, inpatient admission and discharge, and coordination of care for San Francisco minors.

Scope: This policy is issued by Behavioral Health Services (BHS) and applies to designated facilities and individuals with the City and County of San Francisco who have authorization to initiate and sign applications for 72 hour evaluation and treatment pursuant to Section 5150, et seq., or Section 5585, et seq. of the Welfare and Institutions Code.

Policy: The children's unit within Comprehensive Crisis Services (CCS) is a 24/7 mobile crisis unit that provides acute psychiatric crisis intervention and evaluation for all minors of San Francisco regardless of insurance status. CCS has primary responsibility for the evaluation and sole responsibility for the authorization of all publicly funded inpatient psychiatric admissions of minors (San Francisco Medi-Cal, uninsured), and all requests for admissions must first go through this service. A minor is defined as anyone who is 17 years old and younger and is not emancipated by a court of law, is not married, or is not in the armed forces. Minors who are emancipated are legally considered adults.

Psychiatric hospitalization can occur as follows:

- Involuntary, as a psychiatric emergency when the minor is determined to be a danger to self or others, or is gravely disabled, as a result of a mental health disorder and authorization for voluntary treatment is not available (W&I Code, Sections 5150 & 5585.50). A crisis which requires an evaluation by CCS includes acute mental health symptoms or behaviors such as homicidal, assaultive, suicidal, agitated, out-of-control, psychotic, severe depressive symptoms, or grave disability. In CCS evaluations of minors necessitating involvement of the

San Francisco Police Department (SFPD), the SFPD remains with the minor until the legal guardian arrives or until a completed disposition is made by CCS; or

- Voluntary, through procedures defined in the Welfare and Institutions Code commencing with Sections 6000 and 6552 for minors meeting specific criteria (e.g., admission of a minor within the jurisdiction of the juvenile court, admission to private hospitals).

I. Procedures for Minors Referred for Crisis Services by Programs within the Child, Youth & Family System of Care (CYF SOC):

- a. A request for a face-to-face crisis assessment of any minor can be made to CCS by calling CCS at 415-970-3800, 24 hours, 7 days a week. Upon receiving the call, CCS staff will obtain relevant information, complete the Alert form, and consult with the Officer of the Day (OD).
- b. The caller will be asked to provide the following information:
 - brief clinical history
 - current status
 - financial information, such as name of insurance carrier, policy and/or ID number
- c. Minors who present with immediate medical issues (e.g., overdose, physical injury) will be sent to the nearest hospital emergency room (ER) for medical clearance first.
- d. If no medical issues are present, or upon medical clearance, CCS will conduct a face-to-face crisis assessment to determine whether or not an involuntary hold is warranted. CCS is a mobile unit and, where possible, responds to the San Francisco location where the minor is present, including schools, emergency rooms, Psychiatric Emergency Services (PES), police stations, outpatient clinics, Human Services Agency (HSA), Juvenile Justice Center (JJC), residential facilities, CCS office, Crisis Stabilization Unit, group homes, and foster homes. The location of the evaluation depends on safety considerations and the clinical presentation of the minor.
- e. If the minor meets criteria for an involuntary hold, CCS will call the appropriate hospital to arrange for inpatient admission and ambulance service for transportation to the hospital. CCS does not arrange for hospital beds or ambulance service if the minor is evaluated in a private ER setting. CCS will also notify parents or legal guardian(s), and current providers in the CYF SOC network of pending admissions. For privately insured minors, CCS will contact the insurance carrier and request prior authorization if needed.
- f. CCS will complete all the necessary forms for involuntary admissions.

II. Coordination of Care of the Minor Between CYF SOC Programs and the Inpatient Hospital Discharge Planner During Hospitalization and Discharge

- a. During the period of admission of a minor, an Inpatient Hospital Discharge Planner will be assigned from CCS to follow the minor if publicly funded by San Francisco or uninsured. The Inpatient Discharge Planner works closely with the inpatient staff and

CYF SOC treatment providers, if the minor is in our system of care, to assist in developing a comprehensive discharge plan, and to ensure that needed services and supports are not only in place upon discharge, but also that these services and supports are being utilized.

- b. All pertinent clinical information of the minor will be forwarded to the inpatient staff. Treatment interventions, medication regimen, and relevant clinical information will be relayed to the outpatient treatment providers who will continue treatment with the minor upon discharge. In addition, the Inpatient Discharge Planner conducts regular post-hospital follow-up contacts for up to 30 days to facilitate linkage to services, ensure continued stabilization, and to prevent re-hospitalization.
- c. It is important that the minor's CYF SOC treatment providers be available within the initial 24 working hours for phone contacts and within the initial 72 working hours of admission for hospital and/or telephone conferences to coordinate acute treatment and develop discharge planning recommendations.
- d. For a new referral to a CYF SOC outpatient program, the Inpatient Discharge Planner will contact the program as soon as the minor is admitted to an inpatient unit so that the treatment plan and discharge follow-up can be developed early on. Minors and their families referred by the Inpatient Discharge Planner to outpatient programs may need to be seen more intensively during the initial two months of contact by the outpatient program.
- e. A face-to-face intake appointment (or a follow up appointment in the case of continuous treatment) should be available by the outpatient provider to the minor and family within 72 working hours after discharge.
- f. If the minor is served by a HSA Child Welfare Worker, Probation Officer, and/or the San Francisco Unified School District (SFUSD), the Inpatient Discharge Planner will contact all of these system partners within 72 hours of admission with the tentative inpatient evaluation, course of treatment, recommendations for discharge, and needed communication with family members.
- g. All SF BHS providers are encouraged to call and alert CCS 24 hours, 7 days a week about acute mental health symptoms or behaviors of any minor. Every alert is reviewed by the OD for a clinically appropriate disposition.

III. Procedures for Minors Referred for Crisis Services by Other Children Serving Systems

CCS has current memorandums of understanding (MOU) with various systems serving children and youths to provide a face-to-face evaluation where the minor is located within San Francisco. Typically, the procedures are the same for all these systems as it is for the CYF SOC (Section I, a-f). Additional protocols have been developed pertaining to the target population served by different systems.

A. Protocol for Human Services Agency (HSA)

- a. For any crisis evaluation conducted during regular HSA business hours (Monday-Friday, 7am – 5pm), procedures listed under Section I apply.
- b. For SF HSA dependent children or youths placed out-of-county, CCS will coordinate with HSA to transport the minor to the HSA office, CCS office, or an emergency room, for a face-to-face evaluation ONLY if it is safe to do so. If appropriate, a dependent minor who is placed out-of-county and needs a crisis assessment can be taken to the crisis center in that county.
- c. CCS and HSA have an MOU to provide Intensive Support Services (ISS) to all HSA dependent children and youths up to 30 days in order to stabilize the current crisis. ISS is a collaborative effort between CCS and Seneca to provide one-to-one short-term intensive support and non-traditional mental health services for HSA dependent minors who are engaging in high risk behaviors and/or discharged from a psychiatric inpatient unit.

B. Protocol for Minors in the Juvenile Justice Center (JJC)

- a. For any crisis evaluation request of a child or youth detained in JJC, staff from Special Program for Youths (SPY) may call the SPY Behavioral Health Medical Director or designee, or may call CCS 24 hours, 7 days a week. The involvement of the SPY Behavioral Health Medical Director or designee in such situations will be in coordination with CCS.
- b. If the minor needs to be transferred to a hospital emergency room (ER) for medical treatment first, a correctional officer will accompany the minor and CCS will be notified. Following medical clearance, CCS will respond to the ER to conduct a crisis assessment.
- c. When a minor needs to be evaluated by CCS at JJC, SPY staff will meet CCS at the front security entrance. If possible, a correctional officer will escort the youth to the Medical Office and remain with the youth throughout the entire course of evaluation.
- d. If the minor meets criteria for an involuntary hold, the SPY Behavioral Health Medical Director or designee, or CCS staff will complete all necessary documents for involuntary admission. SPY and CCS will coordinate arrangement of a hospital bed and transportation for the youth.
- e. A safety plan will be developed if the minor does not meet criteria for an involuntary hold. The SPY Behavioral Health OD/Charge Nurse will ensure a follow-up with the youth within 24 hours.
- f. Once hospitalized, the CCS Hospital Discharge Planner will follow the youth and coordinate discharge plans with SPY if the youth is publicly funded by San Francisco.

- g. CCS works closely with SPY during the entire course of crisis assessment, inpatient admission, hospital discharge planning, and coordinates client care with SPY staff and medical team.
- C. Protocol for Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG Pediatric Outpatient, Emergency Room, Psychiatric Emergency Services, and Pediatric Inpatient)
- C-1. ZSFG Pediatric Outpatient Unit
 - a. For any crisis evaluation request of a minor in the ZSFG pediatric outpatient unit, procedures under Section I apply.
 - C-2. ZSFG Emergency Room (ER)
 - a. For any crisis evaluation request of a minor by the ER, the minor must first be medically cleared.
 - b. The ER will call CCS for a psychiatric evaluation if needed.
 - c. If CCS determines that the minor needs to go to psychiatric inpatient for further evaluation and treatment, the minor will remain in the ER until a psychiatric inpatient bed is secured by CCS.
 - d. In the event that the ER is unable to maintain the minor, the minor may be transferred to PES.
 - C-3. ZSFG Psychiatric Emergency Services (PES)
 - a. Minors should remain in the custody of SFPD until a legal guardian arrives. Without the presence of a legal guardian, SFPD must remain with the minor until CCS completes the evaluation and determines an appropriate disposition.
 - C-4. ZSFG Pediatric Inpatient Unit
 - a. Any request for a crisis evaluation of a publicly-funded minor in the ZSFG pediatric inpatient unit, procedures under Section I apply **if** the minor is already medically cleared and ready for discharge from the inpatient unit.
 - b. For publicly-funded minors who are not medically cleared and are hospitalized at ZSFG, CCS will provide the crisis evaluation and place a hold on the minor if he or she meets the criteria for an involuntary hold. From this point forward, ZSFG psychiatric consult will assume responsibility for ongoing evaluation and treatment.

D. Medical Inpatient Units of Private Hospitals

CCS does not provide crisis evaluations of minors that are in a private hospital on a medical inpatient unit. This service is provided by the hospital's psychiatric consultation service.

E. Procedure for Out-of-County Requests for Crisis Evaluation or Inpatient Admission of Minors with SF Medi-Cal

E-1. SF Medi-Cal Minors Placed Out-of-County and On A Hold

If a minor with SF Medi-Cal is already assessed and detained on a hold at an out-of-county facility, all relevant documentation, including the psychiatric assessment and the *Application for Up to 72-Hour Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment*, shall be faxed to CCS for review and approval. CCS then follows phone approval instructions to complete a crisis consultation form and to ensure that medical necessity criteria are met.

E-2. SF Medi-Cal Children and Youths Placed Out-of-County Needing A Crisis Evaluation

If the minor with SF Medi-Cal is an HSA dependent placed out-of-county needing a crisis evaluation, CCS will coordinate with HSA to transport the minor to the HSA office, CCS office, or an emergency room, for a face-to-face evaluation ONLY if it is safe to transport the minor (See Section III-A: Protocol for HSA).

F. Procedure for All Private Insurances

CCS provides crisis intervention and crisis evaluation services to all privately-insured minors of San Francisco upon request.

- a. Follow procedures under Section I for all privately insured minors who need a crisis evaluation.
- b. For all privately or publicly insured minors evaluated in a hospital emergency room other than ZSFG, the medical staff or social worker of the hospital shall arrange for hospital bed and ambulance transport to the hospital.
- c. Minors with Kaiser insurance are typically referred to the Kaiser ER for crisis evaluations. Kaiser clients can be evaluated by CCS at other locations if requested.
- d. Minors with Kaiser Medi-Cal insurance can also be evaluated by Kaiser ER and, in these instances, CCS will follow the review and approval protocol delineated above in E-1.

G. Crisis Stabilization Unit (CSU) at Edgewood Center for Children & Families

- a. CCS can refer minors who do not meet criteria for an involuntary hold to CSU for crisis stabilization for a period up to 23 hours, 59 minutes.
- b. In conjunction with CCS, designated staff at CSU can place a hold on a minor if the criteria are met for an involuntary psychiatric hold. In these situations, CSU is responsible for completing the paperwork and arranging for a hospital bed and transport to the designated inpatient facility.

Contact Person: Comprehensive Crisis Services: Children's Unit (415) 970-3800

Attachment: *Application for Up to 72-Hour Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment* (form DHCS 1801 - revised 12/2019)

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