



5150

**Involuntary
Detention
Training Manual**

**Community Behavioral Health Services
San Francisco Department of Public Health**

April, 2010

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IMPORTANT PHONE NUMBERS

EMERGENCY

From your cell phone in SF

911
553-8090

Access to Community Behavioral Health Services

255-3737

To get authorized for county NON-EMERGENCY mental health services

Adult Protective Services

557-5230

Child Crisis (individuals under 18 years of age)

970-3800

Child Protective Services

558-2650

Community Behavioral Health Services

255-3481

Christine Davenport 5150 Procedure oversite

Dore Urgent Care Clinic

553-3100

Golden Gate Bridge Sergeant (people threatening to jump)

923-2220

HIV Crisis (for people HIV + AIDS)

476-3902

MAP Mobile Assistance Patrol-transportation for homeless people seeking drug and/or medical treatment

431-7400

Mobile Crisis Treatment Team=psychiatric evaluations

355-8300

Monday thru Friday 11 AM-11PM (last visit 10PM)

Weekends and Holidays 12 N-8PM (last visit 7PM)

Officer Kelly Dunn, San Francisco Police Department Psychiatric Liaison Unit

255-3727

Poison Control

1-800-523-2222

Psychiatric Emergency Services (SFGH PES)

206-8125

Karen Backowski R.N. Clinical Director

206-3794

San Francisco Mental Health Clients' Rights Advocates

552-8100

1-800-729-7727

Suicide Prevention (Phone Crisis Services)

781-0500

Transportation for 5150: (ambulance services)

St. Joseph

415-460-6020

Pro Transport

510-812-5200

King America

415-931-3000

AMR

415-922-9400

Westside Crisis Walk-in at 245 11thStreet (betw Folsom and Howard)

355-0311

INTRODUCTION

Attendance at the 5150 Involuntary Detention Training is mandatory for any authorized person in adult/older adult services at least once every five years.

Attendance does not mean that an individual will receive a 5150 card. Facilities/programs receive a facility certificate with authorized staff names. For staff whose primary work is in the field, e.g. outreach or work in client's homes, individual 5150 cards will be issued.

Only **licensed** mental health staffs who work **outside** of mental health programs, e.g., substance abuse, social services or primary care are eligible for 5150 authorization.

Program specific staff authorization lists are sent out for updating purposes on a regular basis.

Your comments on the training evaluation form are meaningful and important. Please take the time to let us know how this training can be improved. Please let us know if you have any specific case examples to share and / or if you have encountered any problems with the 5150 procedures, police, transportation etc.

Questions about the manual or the 5150 procedure please contact Christine Davenport 415/255-3481. Questions about patients' rights issues should be directed to Robert Marquez or Fancher Larson at 415/552-8100.

LANTERMAN – PETRIS – SHORT ACT (LPS): AN OVERVIEW

People with psychiatric disabilities who are hospitalized involuntarily- - and are often in dire need of mental health care, medical treatment and other services- - face a massive curtailment of their basic human rights. These rights deprivations include everything from not being allowed to wear one's own clothes to being physically restrained, forcibly medicated. Consequently, in the California cases evaluating the potential for such rights deprivations, the courts have repeatedly affirmed the Legislature's unmistakable intent that the rights of involuntarily detained persons with psychiatric disabilities be "scrupulously" protected by the LPS Act. See, 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 involuntarily detained mental health clients retain all rights not specifically denied under the statutory scheme. (See Welfare & Institution Code Secs. 5325.1 and 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", (in a hearing that frequently took 2-3 minutes), the person was automatically and indeterminately stripped of any meaningful decision-making authority over her 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. Today, providers, mental health clients and family members are sometimes surprised to learn that psychosurgery, which is also referred to as lobotomy, remains a legal treatment option in the State of California. See Welfare & Institutions Code Sec. 5325(g).

HOW TO INTERPRET THE LPS ACT

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

- (a.) To end the inappropriate, indefinite and involuntary commitment of mentally disordered persons, developmentally disabled persons, and persons impaired by chronic alcoholism, and to eliminate legal disabilities;
- (b.) To provide prompt evaluation and treatment of persons with serious mental disorders or impaired by chronic alcoholism;
- (c.) To guarantee and protect public safety;

- (d.) To safeguard individual rights through judicial review;
- (e.) To provide individualized treatment, supervision and placement services by a conservatorship program for gravely disabled persons;
- (f.) 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;
- (g.) To protect mentally disordered persons and developmentally disabled persons from criminal acts.

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 illness have a right to treatment services, which promote the potential of the person to function independently, safeguard the personal liberty of the individual. See Welfare & Institutions Code, Sec. 5325.1(a). Therefore, LPS permits involuntary hospitalization only of those mentally disabled persons for whom such confinement with its accompanying severe deprivation of liberty, is necessary and appropriate.

PATIENTS' RIGHTS

CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5325.1

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

- 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, of 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.

Noteworthy is the fact 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. Welfare and Institutions Code Sec. 15610.63(f)(1)(2)(3). In some circumstances, such abuse can subject a clinical professional to criminal sanctions.

GOOD CAUSE FOR DENIAL OF RIGHTS

The rights listed under Welfare and Institutions Code Sec. 5325 (except the right to refuse convulsive or insulin coma treatment, psychosurgery and the right to see an advocate) may be denied by the professional person in charge of the facility, or his or her designee, for good cause. See Welfare and Institutions Code Sec. 5325 and 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/resident OR
That there is evidence that the specific right, if exercised would seriously infringe on the rights of others; OR

That the institution or facility would suffer serious damage if the specific right is not denied;
AND

That there is no less restrictive way of protecting the interests specified in (1), (2), or (3).

- 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 or be denied as a part of a treatment modality.

Denials 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 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 his or her treatment record. Such documentation must include:

- (1.) Date and time the right was denied.
- (2.) Specific right denied.
- (3.) Good cause for denial of right
- (4.) Date of review if denial was extended beyond 30 days
- (5.) Signature of professional person in charge of the facility or his or her 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 clients with San Francisco Mental Health Clients' Rights Advocates (SFMHCRA).

In addition, each patient must be given notification to the patient of other constitutional and statutory rights in a language or modality accessible which are found in the State Department of Mental Health prepared handbook which must be given to each patient upon admission.

RIGHT TO EXERCISE INFORMED CONSENT TO MEDICATION

INFORMATION REQUIRED FOR INFORMED CONSENT UNDER WELFARE AND INSTITUTIONS CODE SECTION 5152

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.

Under LPS, an individual must be given written and oral information about medications they are being prescribed as a result of their mental illness 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;
- the fact that the above information has or has not been given shall be indicated in the individual's record.

RIGHT TO REFUSE

UNDER CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5332

- Medication may be administered if that person does not refuse that medication following disclosure of the right to refuse medication as well as the information outlined above.
- If any person orally refuses or gives other indication of refusal of treatment with that medication, the medication shall only be administered ...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 (California Welfare & Institutions Code 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.

Consequently, the administration of long-acting medications under emergency circumstances is prohibited.

RIESE HEARING (CAPACITY)

In 1991, the California legislature enacted SB 665, mandating informed consent, and capacity hearings procedures to implement Riese v St. Mary's Hospital and Medical Center ("Riese"). 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 with psychiatric medications.

At the core of Riese is the recognition that mental health patients may not be presumed to be incompetent solely, because of their involuntary hospitalization. See Welfare and Institution Code Sec. 5326.5 and 5331.

The reason why the prescriber/petitioner bears the burden of proving the refuser'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 right at stake. The Court observed that treatment with antipsychotic drugs, not only affects the patient's bodily integrity, but 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:

- 1) is aware of his or her situation (e.g. diagnosis/condition);
- 2) is able to understand the benefits and risks of, and alternatives to, the medication; and,
- 3) is 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 between the patient's delusional or hallucinatory perceptions and the patient's decision can be shown. 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 require the conclusion that the patient had capacity to make treatment decisions. The court concluded that the evidence showed a disagreement between the doctor 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 RESTRAINTS

It is widely recognized that the use of seclusion or restraint is always intrusive and potentially dangerous to both mental health clients 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.

HCFA, now referred to as CMS (The Centers for Medicare and Medicaid Services) as well as JCAHO promulgated significant changes in their standards governing patients' rights as they pertain to restraint, (Restraint also refers to seclusion, unless otherwise noted).

What follows are selected significant changes concerning Patient Rights and seclusion and restraint under JCAHO and CMS standards:

JCAHO - Definition Patient Rights: TX 7.1: Intent statement addresses preserving the individual safety and dignity when restraint or seclusion is used.

CMS – Definition of Patient Rights: Sec. 482.13 Patient has the right to be free from restraint of any form that are not medically necessary or used as a means of coercion, discipline, convenience, or retaliation by staff.

ASSESSMENT FOR RISK FACTORS

JCAHO – TX 7.1.3: Initial assessment of individual at admission/intake. Pre-existing medical conditions or any physical disabilities and limitations that would place patient at risk during use of restraint (e.g. for prone restraint, obesity, respiratory or heart problems, pregnancy).

CLINICAL JUSTIFICATION

JCAHO – TX 7.14-TX.7.1.4.1 Intent: Restraint use is limited to emergencies in which there is an imminent risk of an individual physically harming himself or herself, staff, or others, and non-physical intervention would not be effective.

Non-physical techniques are always considered as the preferred intervention. Such intervention may include redirecting the individual's focus or employing verbal de-escalation

The use of restraint is not based on an individual's restraint history or solely on a history of dangerous behavior.

CMS – Section 482.13(f)(2): Restraint can be used only in emergency situation if needed to ensure the patients safety and less restrictive measures have been ineffective.

Notification of Licensed Independent Practitioner

JCAHO – TX.7.1.5 Intent: Must be within one hour if a non-Licensed Independent Practitioner (LIP) initiates use and continued use depends on authorization by an LIP.

CMS – Section 482.13(f)(3)(ii)(B): Must be followed by consultation with the patient’s treating physician, as soon as possible if restraint is not ordered by the patient’s treating physician.

ORDER BY LIP

JCAHO – TX.7.1.5 Intent: Must be verbal or written within one hour (after initiation by a qualified staff member) by LIP. Includes the role of the LIP in ordering the restraint.

CMS – Section 482.13(f)(3)(ii): Must be ordered by a physician or other LIP permitted by the State and the hospital to order restraint.

TIME LIMITED ORDERS

JCAHO – TX 7.1.7: Verbal and written orders are limited to:

- Four (4) hours for adults;
- Two (2) hours for ages 9-17;
- One (1) hour for under age 9.
- The original order can be used to reapply the restraint if the individual is at risk of harming self or others, but a new order must be obtained from the LIP.
- A new order must also be obtained from the LIP if restraint or seclusion needs to continue beyond the expiration of the time-limited order

CMS – Section 482.13(f)(3)(ii)(D): Written orders are limited to:

- Four (4) hours for adults;
- Two (2) hours for ages 9-17;
- One (1) hour for under age 9.
- The original order may only be renewed in accordance with these limits for up to a total of 24 hours.
- If restraints are discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating seclusion or restraint, and the requirements restart.

NEW RESTRAINT REQUIREMENTS

Now, recently enacted Senate Bill No.130 (adds division 1.5 commencing with section 1180 to the Health and Safety Code both augments and strengthens former state law as well as JCAHO and CMHS protections. Selected provisions include:

SB 130 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 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 managers/staff to reducing S/R;
- State utilization of best practices developed in other states, and
- 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:

- (A) Obesity.
- (B) Pregnancy.
- (C) Agitated delirium or excited delirium syndromes.
- (D) Cocaine, methamphetamine, or alcohol intoxication.
- (E) Exposure to pepper spray.
- (F) Preexisting heart disease, including, but not limited to, an enlarged heart or other cardiovascular disorders.
- (G) 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. 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 help or restrained behind the person's back.

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 LANTERMAN- PERTIS-SHORT ACT

INTRODUCTION

Procedures for involuntary commitment of an individual for mental health treatment is governed by the Lanterman-Pertis-Short (LPS) Act of 1967, codified in California Welfare and Institutions Code (WIC sections 5000 et. seq.). The LPS Act provides specific guidelines for the commitment of mentally disordered individuals, 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 WIC Sec.5150-5173.

THE PURPOSE OF DETENTION

The purpose of a 72-hour hold is for evaluation and treatment. WIC Sec.5151. 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 WIC Sec.5152.

RIGHT TO EVALUATION

Evaluation consist of multidisciplinary analyses of a person's medical, psychological, social, financial and legal conditions as may appear to constitute a problem...(Addressing patients legal conditions that appear to constitute a problem may be an appropriate client referral or call to SFMHCRA on client's/patient's behalf.)

GROUNDS FOR DETENTION

The grounds for detention are specified in WIC Sec.5150. Under the statute, an individual may be detained when, **as the result of a mental disorder**, the individual is a danger to others, or to himself or herself, or is gravely disabled. Grave disability means a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs or food, clothing and shelter (WIC Sec.5008). The person acting to involuntarily detain an individual must be 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 mentally disordered and is a danger to himself or herself, or others, is gravely disabled. *People v. Triplett* (1983)144Cal.App.3d 283

LIABILITY FOR FALSE STATEMENT

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

TRANSPORT TO DESIGNATED FACILITY

The individual must be taken to a facility designated by the county and approved by the State Department of Mental Health as a facility or 72-hour treatment and evaluation. The authorized person must complete a written form 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 himself or herself, is a danger to others, or is gravely disabled.

ADVISEMENT

Upon being detained under the *California Welfare & Institutions Code*, Div.5, Chap.2, Sec.5150, an oral advisement must be given to the person being detained which includes the following information:

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

You may bring a few personal times with you, which I will have to approve. You can make a phone call and/or leave a note to tell your friends and/or family where you have been taken.

It is the responsibility of the person taking someone into custody on WIC 5150 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. If family, friends or landlord are willing to secure the property, the report should give the name of these person(s) holding it secure. Residential providers should have a method to safeguard the possessions of persons placed on detention.

The professional detaining the person shall make a record of the advisement, the name and position of the person who gave the advisement and whether the advisement was completed. If the advisement is not given, the mental health professional at the facility shall give the advisement and document same in the chart.

Upon admission to a facility the detained person shall be given the following advisement orally and in writing in a language or modality accessible to the person. The written information shall be provided in the person's native language or the language, which is the person's principal means of communication.

My name is _____. My position here is _____. You are being detained on this psychiatric unit because it is our professional opinion that as a result of a mental disorder you are likely to:

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

We feel this is true because (reason). You will be held on the unit for a period up to 72-hours, beginning (time/date) and ending (time/date).

During these 72-hours, you will be evaluated by the hospital staff and you may be released before the end of the 72-hours. If the mental health professionals here decide that you need continued treatment, you may be held for a longer period of time. If you are held longer than 72-hours, you have the right to a lawyer, a qualified interpreter and a hearing before a judge. If you are unable to pay for a lawyer, one will be provided free. This advisement must be documented in the person's medical record.

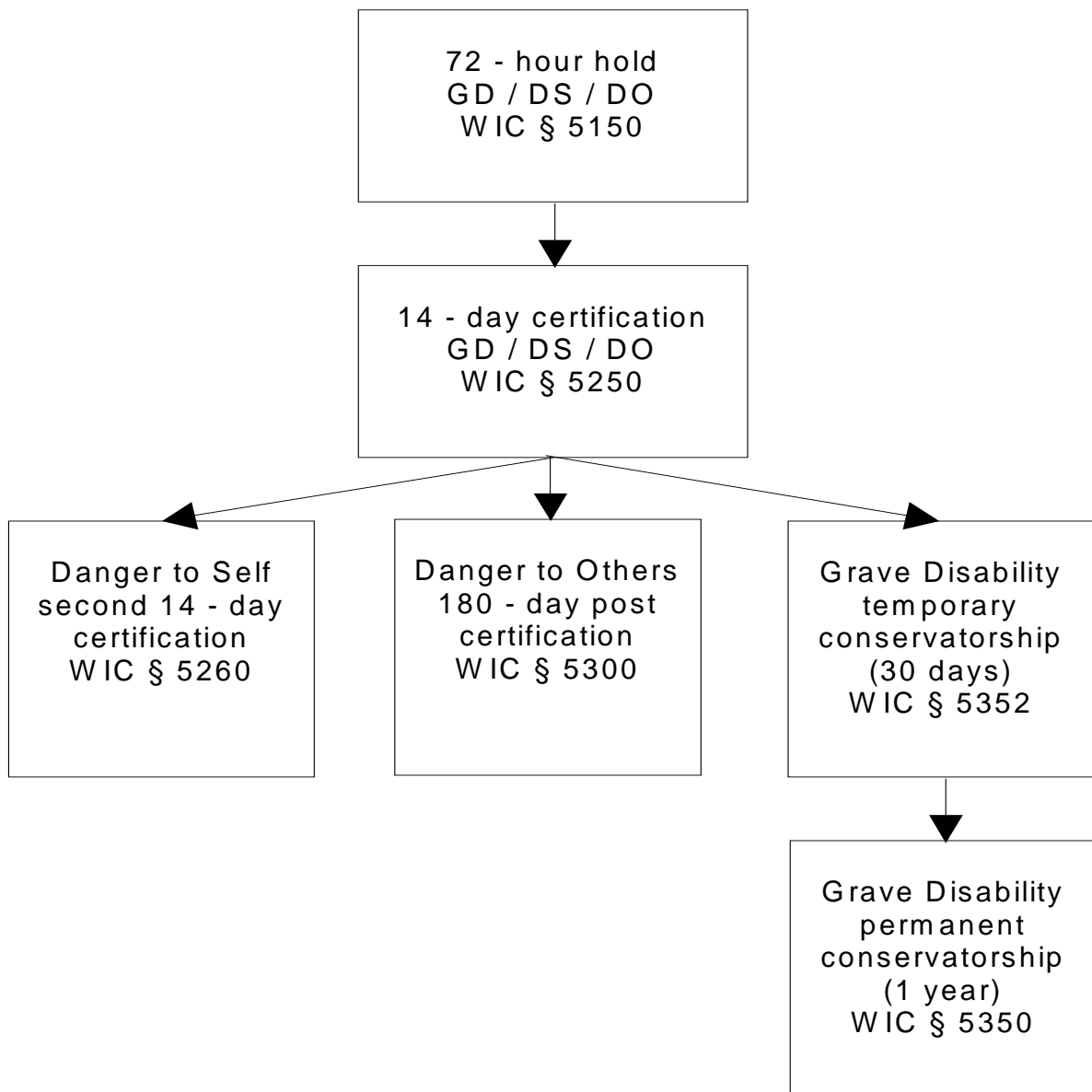
RELEASE FROM DETENTION

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. *WIC.Div.5, Art.1.5, Sec.5172.*

If further care and treatment is required, the person must be informed of the evaluation, and the advice of the need for, but has not been able or willing to accept treatment, or to accept referral to services which must be described on the certification application. As willingness 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 or voluntariness ordered by the decision maker.

If the person continues to be a danger to himself or herself, or others, or is gravely disabled, the person may be certified for intensive treatment and detained for up to 14 additional days. *WIC, Sec.5250.*

CIVIL COMMITMENT LAWS & PROCEDURES



LEGAL STATUS

A. Voluntary Patients

1. 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." (W&I Section 5250 [c]) Patient 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. (W&I Section 5250 [c]) In both cases, the patient fails to meet the criteria for involuntary commitment, but for different reasons.

2. 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 Section 6000 [b], 6002, 6005, 6006) and again in the implementing regulations of the Title 9, C.C.R. Section 865.

Title 9, C.C.R. Section 865 states that a facility has an affirmative obligation to inform a voluntary patient of the right to be discharge 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 or such treatment. Title 9, C.C.R. Section 850-856 sets out 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 absents an emergency situation.

The law intends that involuntary 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.

B. Involuntary Patients

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

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

a. Probable Cause

A person may be involuntarily detained only if there is probable cause to believe that, as a result of a mental disorder, the person is a danger to self, danger to others or gravely disabled. (W&I Section 5150). Such persons may be detained involuntarily for psychiatric evaluation and/or treatment.

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 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, 144Cal. App.3d283 (1983)*

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

b. Mental Disorder

An equally important concept in commitment law is the link between mental condition and behavior. In order to be detained under W&I Section 5150, the person must be, "as a result of a mental disorder", a danger to self or others or gravely disabled. Danger to self or others without a mental disorder does not meet the standard. Likewise, inability to provide food, clothing and shelter without a mental disorder is not enough. Further, there must be an articulable connection between the

mental disorder and dangerousness or the inability to provide for oneself. For example, a person may find themselves unable to provide for food, clothing and shelter for reasons unrelated to their mental disorder, such as the loss of a job, recent divorce, etc.

c. Danger to Self

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

Documentation could include some or all of the following:

- Words or actions showing intent to commit suicide or bodily harm.
- Words or actions indicating gross disregard for personal safety.
- Words or actions indicating a specific plan to suicide.
- Means available to carry out suicide plan (i.e. pills, firearms present or available).

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.

Documentation could include some or all of the following:

- Threats against particular individuals.
- Attempts to harm certain individuals.
- Means available to carry out threats or to repeat attempts (i.e. firearms, or other weapons).
- Expressed intention or attempts to engage in dangerous activity.

e. Grave Disability

The W & I Code defines gravely disabled as “a condition in which a person, as a result of a mental 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 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.

Documentation could include some or all of the following:

- Signs of malnourishment or dehydration.
- Inability to articulate a plan for obtaining food.
- No food available in the house or at hand if not in a house.
- Irrational beliefs about food that is available (i.e. it's poisoned, inedible, etc.)
- Destruction or giving away of clothing to the point where the person cannot clothe themselves.
- Inability to formulate a reasonable plan to obtain shelter.

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

If the facility clinicians concluded that the person is in need of additional treatment beyond the 72-hours, they may certify the person for 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, 5300)

a. Timing of Certifications

The client may be certified on or before the expiration of the 72-hour hold. (W&I Section 5172) (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 with psychology doctorate and five years postgraduate experience in mental health. The second person must be 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. In other counties, public defenders, court appointed counsel or private attorneys provide representation.

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 individual has the right to be present at the hearing, to be represented by counsel and to present evidence. In addition, the individual 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 individual is receiving medication and the possible effect of the medication on his/her behavior at the hearing, and to have family members or fiends notified (or, if the client prefers, not notified) of the hearing (W&I Section 5256.4)

c. Habeas Corpus/Judicial Review

A client has recourse to state court at any point during his detention to contest the legality of his confinement by means of a “habeas corpus” or writ hearing. There is both a constitutional right to habeas corpus during each period of detention (U.S. Const., art. 1, section 9; Cal.Const., art 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 person 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 of 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, a danger to self or others. The client has the right to be represented by an attorney. If the client cannot afford an attorney, the public defender will provide representation without cost. While judicial review is pending, the individual may not be transferred out of the county. (W&I Section 5276).

d. Amendment of Certification

If the professional staff of a designated facility has analyzed a certified person’s condition and has found the person is, as a result of mental disorder or impairment by chronic alcoholism, certifiable on one of more additional legal grounds (grave disability and/or a danger to self or others) for which he/she was not originally certified, two professional staff, who meet the same requirements in W&I Section 5251, may amend the certification.

The amended form shall include the amended ground(s), the date of the amendment, dated signatures of the certifying staff members and the starting date of the original certification. In no case shall the 14-day hold endure longer than 14 days from the start date of the original certification.

The patient must be advised of the amendment to the certification and documentation of the advisement entered into the medical record. If the amendment is made before the certification review hearing, the patient and the Patients' Rights Advocate must be notified of this amendment as soon as possible but not later than one hour prior to the certification review hearing.

Longer-term Holds

a. Additional Certification

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 person remains gravely disabled and remains unwilling or unable to accept voluntary treatment voluntarily (W&I Section 5270.15). The second certification is initiated in a manner consistent with 5250 procedures; the patient is entitled to a second certification review hearing and/or judicial review of the additional certification.

The person's condition shall be analyzed at intervals, not to exceed ten days to determine if the person meets criteria for certification. If the person does not meet the criteria, he/she must be released.

b. Additional intensive treatment of suicidal persons.

If the individual is a "danger to himself/herself," he/she can be held for a second 14-day period, but no longer. Thus, a person judged a danger to himself 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, he/she must be released (unless he/she is reclassified as a danger to others or 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 individual 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. He/she must continue to "present an imminent threat of taking his/her own life." Again, the individual must have been advised of, but not accepted, voluntary treatment. (W&I Section 5260).

c. Post-certification

At the expiration of the 14-day period of intensive treatment, a person may be confined for further treatment for an additional period, not to exceed 180 days if one of the following exists:

- The person has attempted, inflicted, or made a serious threat of substantial physical harm upon the person of another 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 person had attempted, or inflicted physical harm upon the person of another, as a result of mental disorder or mental defect, a demonstrated danger of inflicting substantial physical harm upon others.
- The person 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 person presents, as a result of mental disorder or mental defect, a demonstrated danger of inflicting substantial physical harm upon others. (W&I Section 5300)

Thus, a person 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. (W&I Section 5303.1). The patient has a right to be represented by an attorney and to demand a trial by jury. If he/she cannot afford an attorney, the public defender will represent him/her. (W&I Section 5302) The court hearing must take place within four working days after the petition is filed, or within ten days if a jury trial is requested, unless the person's attorney requests a continuance. In order to certify the person, 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 person's attorney, the person must be released.

C. Conservatorship

An LPS conservatorship of the person is a legal relationship in which a person is appointed by the court to serve as conservator 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," she/he can be placed on a temporary conservatorship for 30 days (W&I Section 5352), followed by a permanent conservatorship for renewable one-year periods.

Legal standard:

- An adult may be referred for conservatorship if, due to a mental disorder or chronic alcoholism, he/she cannot provide for basic personal needs such as food, clothing or shelter. (W&I Section 5302)
- A minor may also be referred for conservatorship, if, as a result of mental disorder, he/she is unable to take advantage of those things considered to be essential for health, safety and development, including food, clothing and shelter, even though provided to him/her by others. (W&I Section 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.

HOW TO WRITE A "5150"

APPLICATION FOR 72-HOUR DETENTION FOR EVALUATION AND TREATMENT
Confidential Client/Patient Information
See California W & I Code Section 5328

MH 302 (8/98)

W & I Code, Section 5157, requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

Advisement Complete **Advisement Incomplete**

Good Cause for Incomplete Advisement

Advisement Completed By

Position

Date

To:

Application is hereby make for the admission of _____

Residing at _____, California, for

72-hour treatment and evaluation pursuant to Section 5150, (adult) et seq. or Section 5585 et seq. (minor), of the welfare and Institutions Code. If a minor, to the best of my knowledge, the legally responsible party appears to be/is: (Circle one) Parent; Legal Guardian; Juvenile Court as a WIC 300; Juvenile Court as WIC 601/602: Conservator. If known, provide names, address and telephone number:

The above person's condition was called to my attention under the following circumstances: (See reverse side for definitions)

The following information has been established: (Please give sufficiently detailed information to support the belief that the person for whom evaluation and treatment is sought is in fact a danger to others, a danger to himself/herself and/or gravely disabled.)

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

A danger to himself/herself. **A danger to others.** **Gravely disabled adult.** **Gravely disabled minor.**

Signature title and badge number of peace officer, member of attending staff of evaluation facility or per designated by county.

Date

Phone

Time

Name of Law Enforcement Agency or Evaluation Facility/Person

Address of Law Enforcement Agency or Evaluation Facility/Person

Weapon was confiscated and detained person notified of procedure for return of weapon pursuant to W & I Code Section 8102. (officer/unit & phone #) _____

NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

NOTIFICATION OF PERSON'S RELEASE FROM AN EVALUATION AND TREATMENT FACILITY IS REQUESTED BY THE REFERRING PEACE OFFICER BECAUSE:

Person has been referred under circumstances in which criminal charges might be filed pursuant to W & I Code Sections 5152.1 and 5152.2. Notify (officer/unit & phone #) _____

Weapon was confiscated pursuant to W & I Code Sections 8102.

BASIC EXAMPLE

THE ORIGINAL MUST FOLLOW THE CLIENT

State of California - Health and Welfare Agency

Department of Mental Health

APPLICATION FOR 72-HOUR DETENTION FOR EVALUATION AND TREATMENT

Confidential Client/Patient Information

See California W & I Code Section 5328

MH 302 (8/98)

W & I Code, Section 5157, requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

Advisement Complete **Advisement Incomplete**

Good Cause for Incomplete Advisement

Medical or physical state - be specific

Advisement Completed By

DETAINMENT ADVISEMENT

My name is _____ I am a (Peace Officer, etc.) 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).

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 in substantially the following form:

You may bring a few personal items with you which I will have to approve. You can make a phone call and/or leave a note to tell your friends and/or family where you have been taken.

Position

Date

*

*

To: Name of Facility Designated to Receive Person on 5150

Application is hereby make for the admission of Name AKA (Birthdate & Social Security Number Optional)

Residing at _____, California, for

72-hour treatment and evaluation pursuant to Section 5150, (adult) et seq. or Section 5585 et seq. (minor), of the welfare and Institutions Code. If a minor, to the best of my knowledge, the legally responsible party appears to be/is: (Circle one) Parent; Legal Guardian; Juvenile Court as a WIC 300; Juvenile Court as WIC 601/602: Conservator. If known, provide names, address and telephone number:

The above person's condition was called to my attention under the following circumstances: (See reverse side for definitions) (Your facility) was called by (residential care, case manager, etc. include telephone #) (if significant other get #) - report the following -- use quotes, be specific, avoid abbreviations, short summation of treatment history that logically leads up to this moment in time. (3rd 5150 in 3 months)

The following information has been established: (Please give sufficiently detailed information to support the belief that the person for whom evaluation and treatment is sought is in fact a danger to others, a danger to himself/herself and/or gravely disabled.)

Upon arrival at Facility -- Staff member noted the following. Note specific behaviors, quotes from client, use professional nomenclature if you are labeling a behavior e.g. auditory hallucinations -- client states he hears dead mother's voice calling him to join her in heaven.

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

A danger to himself/herself. **A danger to others.** **Gravely disabled adult.** **Gravely disabled minor.**

Signature title and badge number of peace officer, member of attending staff of evaluation facility or per designated by county. *

Date *

Phone

Time *

*

Name of Law Enforcement Agency or Evaluation Facility/Person *

Address of Law Enforcement Agency or Evaluation Facility/Person

*

Weapon was confiscated and detained person notified of procedure for return of weapon pursuant to W & I Code Section 8102. (officer/unit & phone #) _____

NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

NOTIFICATION OF PERSON'S RELEASE FROM AN EVALUATION AND TREATMENT FACILITY IS REQUESTED BY THE REFERRING PEACE OFFICER BECAUSE:

Person has been referred under circumstances in which criminal charges might be filed pursuant to W & I Code Sections 5152.1 and 5152.2. Notify (officer/unit & phone #) _____

Weapon was confiscated pursuant to W & I Code Sections 8102.

BAD EXAMPLE #1

State of California - Health and Welfare Agency

Department of Mental Health

APPLICATION FOR 72-HOUR DETENTION FOR EVALUATION AND TREATMENT

Confidential Client/Patient Information

See California W & I Code Section 5328

MH 302 (8/98)

W & I Code, Section 5157, requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

DETAINMENT ADVISEMENT

My name is _____
I am a (Peace Officer, etc.) 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).

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 in substantially the following form:

You may bring a few personal items with you which I will have to approve. You can make a phone call and/or leave a note to tell your friends and/or family where you have been taken.

Advisement Complete **Advisement Incomplete**

Good Cause for Incomplete Advisement

Advisement Completed By

Position

Date

8/18/2001

To: SFGH-PES

Application is hereby make for the admission of _____

Residing at _____, California, for

72-hour treatment and evaluation pursuant to Section 5150, (adult) et seq. or Section 5585 et seq. (minor), of the welfare and Institutions Code. If a minor, to the best of my knowledge, the legally responsible party appears to be/is: (Circle one) Parent; Legal Guardian; Juvenile Court as a WIC 300; Juvenile Court as WIC 601/602: Conservator. If known, provide names, address and telephone number:

The above person's condition was called to my attention under the following circumstances: (See reverse side for definitions)

**BIB amb under influence heroin & cocaine.
Been here 3x in 3 mos.**

The following information has been established: (Please give sufficiently detailed information to support the belief that the person for whom evaluation and treatment is sought is in fact a danger to others, a danger to himself/herself and/or gravely disabled.)

Suicidal

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

A danger to himself/herself. **A danger to others.** **Gravely disabled adult.** **Gravely disabled minor.**

Signature title and badge number of peace officer, member of attending staff of evaluation facility or per designated by county.

Date 7/18/2001

Phone

Time 6P

415-555-3366

Name of Law Enforcement Agency or Evaluation Facility/Person

Address of Law Enforcement Agency or Evaluation Facility/Person

Weapon was confiscated and detained person notified of procedure for return of weapon pursuant to W & I Code Section 8102.

(officer/unit & phone #) _____

NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

NOTIFICATION OF PERSON'S RELEASE FROM AN EVALUATION AND TREATMENT FACILITY IS REQUESTED BY THE REFERRING PEACE OFFICER BECAUSE:

Person has been referred under circumstances in which criminal charges might be filed pursuant to W & I Code Sections 5152.1 and 5152.2.

Notify (officer/unit & phone #) _____

Weapon was confiscated pursuant to W & I Code Sections 8102.

GOOD EXAMPLE #2

State of California - Health and Welfare Agency

Department of Mental Health

APPLICATION FOR 72-HOUR DETENTION FOR EVALUATION AND TREATMENT

Confidential Client/Patient Information

See California W & I Code Section 5328

MH 302 (8/98)

W & I Code, Section 5157, requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

DETAINMENT ADVISEMENT

My name is _____ I am a (Peace Officer, etc.) 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).

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 in substantially the following form:

You may bring a few personal items with you which I will have to approve. You can make a phone call and/or leave a note to tell your friends and/or family where you have been taken.

Advisement Complete **Advisement Incomplete**

Good Cause for Incomplete Advisement		
Advisement Completed By	Position ER Physician	Date 7/18/2001

To: SFGH-PES

Application is hereby make for the admission of _____
Residing at _____, California, for 72-hour treatment and evaluation pursuant to Section 5150, (adult) et seq. or Section 5585 et seq. (minor), of the welfare and Institutions Code. If a minor, to the best of my knowledge, the legally responsible party appears to be/is: (Circle one) Parent; Legal Guardian; Juvenile Court as a WIC 300; Juvenile Court as WIC 601/602: Conservator. If known, provide names, address and telephone number:

The above person's condition was called to my attention under the following circumstances: (See reverse side for definitions)
Brought in ambulance at request of SFPD. Found in alley unconscious and requiring emergency care. Has had 3 similar ER visits at St. Mary's in last 3 months.

The following information has been established: (Please give sufficiently detailed information to support the belief that the person for whom evaluation and treatment is sought is in fact a danger to others, a danger to himself/herself and/or gravely disabled.)
Toxicology +/-or heroin and cocaine. Client's name admits he attempted to overdose to end his life. Hears voices telling him to run into traffic. States he will "use as much as it takes" next time he overdoses.

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

A danger to himself/herself. **A danger to others.** **Gravely disabled adult.** **Gravely disabled minor.**

Signature title and badge number of peace officer, member of attending staff of evaluation facility or per designated by county.	Date	7/18/2001	Phone
	Time	6P	415-555-3366
Name of Law Enforcement Agency or Evaluation Facility/Person		Address of Law Enforcement Agency or Evaluation Facility/Person	

Weapon was confiscated and detained person notified of procedure for return of weapon pursuant to W & I Code Section 8102.
(officer/unit & phone #) _____

NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

NOTIFICATION OF PERSON'S RELEASE FROM AN EVALUATION AND TREATMENT FACILITY IS REQUESTED BY THE REFERRING PEACE OFFICER BECAUSE:

- Person has been referred under circumstances in which criminal charges might be filed pursuant to W & I Code Sections 5152.1 and 5152.2.
Notify (officer/unit & phone #) _____
- Weapon was confiscated pursuant to W & I Code Sections 8102.

BAD EXAMPLE #3

State of California - Health and Welfare Agency

Department of Mental Health

APPLICATION FOR 72-HOUR DETENTION FOR EVALUATION AND TREATMENT
Confidential Client/Patient Information
See California W & I Code Section 5328

MH 302 (8/98)

W & I Code, Section 5157, requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

DETAINMENT ADVISEMENT

My name is _____
I am a (Peace Officer, etc.) 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).

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 in substantially the following form:

Advisement Complete **Advisement Incomplete**

You may bring a few personal items with you which I will have to approve. You can make a phone call and/or leave a note to tell your friends and/or family where you have been taken.

Good Cause for Incomplete Advisement		
Advisement Completed By	Position	Date
		9/1/2000

To: _____ Whom this may concern
Application is hereby make for the admission of _____
Residing at _____, California, for

72-hour treatment and evaluation pursuant to Section 5150, (adult) et seq. or Section 5585 et seq. (minor), of the welfare and Institutions Code. If a minor, to the best of my knowledge, the legally responsible party appears to be/is: (Circle one) Parent; Legal Guardian; Juvenile Court as a WIC 300; Juvenile Court as WIC 601/602: Conservator. If known, provide names, address and telephone number:

The above person's condition was called to my attention under the following circumstances: (See reverse side for definitions)
c/o unable to care for herself, becomes withdrawn, sometimes unable to speak.

The following information has been established: (Please give sufficiently detailed information to support the belief that the person for whom evaluation and treatment is sought is in fact a danger to others, a danger to himself/herself and/or gravely disabled.)

h/o possible schizophrenia. Recent admission but stopped taking meds.

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

A danger to himself/herself. **A danger to others.** **Gravely disabled adult.** **Gravely disabled minor.**

Signature title and badge number of peace officer, member of attending staff of evaluation facility or per designated by county.	Date	7/18/2001	Phone
	Time	6P	415-555-3366

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

Weapon was confiscated and detained person notified of procedure for return of weapon pursuant to W & I Code Section 8102.
(officer/unit & phone #) _____

NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

NOTIFICATION OF PERSON'S RELEASE FROM AN EVALUATION AND TREATMENT FACILITY IS REQUESTED BY THE REFERRING PEACE OFFICER BECAUSE:

Person has been referred under circumstances in which criminal charges might be filed pursuant to W & I Code Sections 5152.1 and 5152.2.
Notify (officer/unit & phone #) _____

Weapon was confiscated pursuant to W & I Code Sections 8102.

BAD EXAMPLE #4

State of California - Health and Welfare Agency

Department of Mental Health

APPLICATION FOR 72-HOUR DETENTION FOR EVALUATION AND TREATMENT

Confidential Client/Patient Information

See California W & I Code Section 5328

MH 302 (8/98)

W & I Code, Section 5157, requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

DETAINMENT ADVISEMENT

My name is _____
I am a (Peace Officer, etc.) 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).

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 in substantially the following form:

You may bring a few personal items with you which I will have to approve. You can make a phone call and/or leave a note to tell your friends and/or family where you have been taken.

Advisement Complete **Advisement Incomplete**

Good Cause for Incomplete Advisement
Advisement Completed By

Position	Date
	11/28/2002

To: Whom this may concern

Application is hereby make for the admission of _____
Residing at _____, California, for _____

72-hour treatment and evaluation pursuant to Section 5150, (adult) et seq. or Section 5585 et seq. (minor), of the welfare and Institutions Code. If a minor, to the best of my knowledge, the legally responsible party appears to be/is: (Circle one) Parent; Legal Guardian; Juvenile Court as a WIC 300; Juvenile Court as WIC 601/602: Conservator. If known, provide names, address and telephone number:

The above person's condition was called to my attention under the following circumstances: (See reverse side for definitions)
Came with family. Crying constantly x 4 days. Little sleep, no appetite.

The following information has been established: (Please give sufficiently detailed information to support the belief that the person for whom evaluation and treatment is sought is in fact a danger to others, a danger to himself/herself and/or gravely disabled.)

On Celexa, Lorazepam. Formerly on Prozac. She is abusing Soma tabs for unexplained reason.

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

A danger to himself/herself. **A danger to others.** **Gravely disabled adult.** **Gravely disabled minor.**

Signature title and badge number of peace officer, member of attending staff of evaluation facility or per designated by county.	Date	7/18/2001	Phone
	Time	9:00 AM	641-6625
Name of Law Enforcement Agency or Evaluation Facility/Person	Address of Law Enforcement Agency or Evaluation Facility/Person St. Luke's Hospital - ER 3555 Cesar Chavez Street S.F. CA 94110		

Weapon was confiscated and detained person notified of procedure for return of weapon pursuant to W & I Code Section 8102.
(officer/unit & phone #) _____

NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

NOTIFICATION OF PERSON'S RELEASE FROM AN EVALUATION AND TREATMENT FACILITY IS REQUESTED BY THE REFERRING PEACE OFFICER BECAUSE:

Person has been referred under circumstances in which criminal charges might be filed pursuant to W & I Code Sections 5152.1 and 5152.2.

Notify (officer/unit & phone #) _____

Weapon was confiscated pursuant to W & I Code Sections 8102.

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

MH 303 E/S (3/87)

Name of Facility

Patient's Name	Admission Date
----------------	----------------

Section 5157 © and (d) of the Welfare and Institutions Code (W&I) requires that each person admitted for 72-hour evaluation be given specific information orally and in writing, and a record of the advisement be kept in the patient's medical record.

My name is _____

My position here is _____

You are being placed in this psychiatric facility because it is the opinion of the professional staff, that as a result of a mental disorder, you are: (check applicable)

Dangerous to yourself _____

Dangerous to others _____

Gravely Disabled (unable to provide for your own food. Clothing or shelter) _____

(Document specific evidence which substantiates reason for hold):

We feel this is true because _____

You will be held for a period of up to 72 hours. This (does not) (does) include weekends or holidays.

Your 72-hour period will begin: _____ .
(time and date)

Your 72-hour evaluation and treatment period will end at: _____ .
(time and date)

During these 72 hours, you will be evaluated by the hospital staff, and the treatment you receive may include medications. It is possible for you to be released before the end of the 72 hours, but if the professional staff decide 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 free.

State law presumes you to be competent regardless of whether you have been evaluated or treated for mental disorder as a voluntary or involuntary patient.

Good Cause for Incomplete Advisement	Date	
Advisement Completed By	Position	Date

cc: Original to the Patient
Carbon to Patient's Record

MENTAL STATUS Exam

- a. Appearance. Describe patient's appearance, For example: Neat, sloppy, casual, eccentric, odorous, seductive, unkempt, and disheveled. Include Consciousness, which ranges from alert through inattentive, lethargic, clouded, obtunded, and stuporous, to comatose. Also include quality of eye contact.
- b. Attitude and Interview Behavior. Describe what you see. Attitude may be friendly, cooperative, compliant, passive, ingratiating, hostile, etc. Behavior could be inappropriate, bizarre, angry, irritable, pathetic, withdrawn, dependent, etc.
- c. Motor Activity. Examples: Calm, restless, fidgety, accelerated, agitated, retarded, etc. include mannerisms, tics, jerks, spasms, tongue darting, "pill rolling," etc..
- d. Speech. Consider quality of speech [e.g., tone, inflection, loudness, pronunciation (slurring, lisp, etc.), pace (slow, rapid, halting), etc.]: quantity (e.g., excessive / pressure of speech, poverty of speech, etc.); organization (e.g., coherent, logical, relevant, disorganized, flight of ideas, loss of place, over abstraction, overly concrete, vague, etc.); use of words (e.g., difficulty in word finding, relationship of appropriateness to context, etc.).
- e. Affect and Mood. Affect might be appropriate (i.e., full range and appropriate to circumstances.), euthymic, flat, blunted, restricted, muted, etc. Mood could be depressed, dysphonic, anxious, elevated, euphoric, hostile, irritable, clam, fearful, indifferent, etc. Does mood or effect change during course of interview?
- f. Thought Process and Content. Thought Process includes tangential, circumstantial, loose associations, "word salad," preservation, thought blocking, incoherent, clang associations, etc. Thought Content includes hallucinations, delusions, illusions, and ideation. Please specify within each group [e.g., "grandiose delusion of five years duration, including ideas of reference (i.e., people/radio taking about him/her/and thought broadcasting" (i.e., people/radio talking about him/her) and thought broadcasting" (i.e., believing that others can read his/her mind).]
- g. Memory and Orientation. Is immediate, short-term, recent, or remote memory, or fund of information impaired? Is patient oriented to person, time, place and situation?
- h. Insight and Judgment. Insight refers to an understanding of the condition one is experiencing. Judgment has to do with social judgment, and can often be determined by behavior leading to the need for our intervention. If in doubt, a "What would you do if . ." question might be instructive.

Note: Whenever possible, illustrate with direct quote from patient.

MENTAL STATUS EXAM INDICATORS

APPEARANCE:

- Appropriate to situation
- Unkempt
- Disheveled
- Unusual physical characteristics

BEHAVIOR:

- Apathetic
- Rigid, tense
- angry, aggressive
- Other

FACIAL EXPRESSION SUGGESTS:

- Anxiety, fear, apprehension
- Irritability
- Anger
- Decreased variability of expression
- Bizarreness
- Depression, sadness
- Other

GENERAL BODY MOVEMENTS:

- Accelerated
- Decreased, slowed
- Atypical, peculiar
- Restless or chaotic
- Repetitive Movements
- Other (e.g. abnormal movements associated with medications)

AMPLITUDE AND QUALITY OF SPEECH:

- Pressured, unremitting, difficult to stop
- Slowed
- Atypical, slurring, stammering
- Other (Mute, aphasia, etc)

MOOD (Client's subjective report or as inferred by observer):

- Cheerful
- Elated
- Euphoric
- Worried, anxious
- Sarcastic
- Annoyed
- angry, aggressive
- Other: fear, apprehension, etc.

AFFECT (Affect is the process of emotional expression and is graded by range, intensity, modulation and appropriateness):

- Full range
- Constricted
- Intense
- Blunted
- Flat
- Affect does not fit with the content being expressed
- Other

PERCEPTION:

- Distortions

HALLUCINATIONS:

- Auditory
- Visual
- Tactile
- Gustatory

ORIENTATION:

- Disoriented to person
- Disoriented to place
- Disoriented to time+/- or situation

THINKING:

Level of Consciousness

- awake, alert
- other

Attention Span:

- remembers after 3 minutes
- remembers after 5 minutes

Calculation Ability

INSIGHT INTO PSYCHOLOGICAL PROBLEMS:

- Inability to acknowledge problems
- Blames others or circumstances

JUDGMENT:

- Impaired ability to manage daily living
- Impaired ability to make reasonable decisions

MEMORY:

- Immediate recall impaired
- Recent memory impaired
- Remote memory impaired

THOUGHT CONTENT:

- Obsessions or compulsions
- Phobias
- Derealization or depersonalization
- Suicidal ideation
- Homicidal ideation
- Delusions
- Overvalued ideas
- Ideas of reference
- Ideas of influence

STREAM OF THOUGHT:

- Goal directed
- Circumstantial (rambling, eventually gets to the point)
- Tangential (doesn't get to the point)
- Loose associations
- Preservation
- Blocking

WARNING SIGNS OF SUICIDAL PERSON

City and County of San Francisco
Mobile Crisis Treatment Team
355-8300

What is Happening Now?

- Look depressed
- Talks about suicide
- Preoccupation with death
- Overwhelming sense of hopelessness and helplessness. Has a fixed belief that there is no hope, nothing will ever change. Seems paralyzed by despair and locked into this thought pattern.
- Has command hallucinations to harm self
- Has a discrete plan and there is a probability that person can carry out plan (e.g. has pills, gun, rope, etc.)
- An expressed terror of “losing it”
- Currently under the influence of drugs/alcohol
- Has had a recent loss-death or break-up with partner, loss of job, pet, series of broken promises, etc.
- Recent diagnosis of life-threatening illness
- Recent change in personality (e.g. sad to anxious)
- Made arrangements for care of pets (particularly if pets are prominent part of support system)
- Has a recently made out a will

What about Past?

- History of depression or other mental disorder (particularly schizophrenia or bipolar disorder), increased risk when depression starts to lift (it takes energy to go ahead with a plan)
- History of previous attempts—how lethal was previous attempts?
- History of suicide in first degree relative
- Has tried to injure self before
- Withdrawn from family and friends over time
- Gives away belongings or money, particularly previously prized times
- Engages in risky behaviors—sex, drugs, etc.
- Increased use of alcohol and drugs over time
- Change in appearance—unkempt, not caring about personal hygiene in a person who used to be conscious of this, weight loss or gain
- Anniversary of a death/loss
- Change in sleep patterns
- Low self-esteem as manifested by statements like—“My children will be better off without me.”
- Loss of previously held religious beliefs.

P.L.A.I.D. P.A.L.S

San Francisco Suicide Prevention

Plan	Is there one?
Lethality	Is it lethal? Can they die?
Availability	Is there a means to carry out the plan?
Illness	Is a mental or physical illness present?
Depression	Is it present or is there is history?
Previous Attempts	How many? How recent?
Alone	Is the person alone now? Is there a support system?
Loss	Recent death, loss of relationship or job
Substance Abuse	Drugs, alcohol, medicines? Current/Chronic

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 (this case) 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 amicus 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 misperception 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:
 1. A psychiatrist, or a person whom the patient reasonably believes to be a psychiatrist.
 2. A licensed psychologist.
 3. A licensed clinical social worker.
 4. A licensed school psychologist, holding state credentials to provide such services in schools.
 5. A licensed marriage, family, or child counselor.
 6. 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 be 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

CBHS Policies and Procedures



City and County of San Francisco
 Department of Public Health
 POPULATION HEALTH AND
 PREVENTION
 COMMUNITY BEHAVIORAL HEALTH

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

SERVICES

**POLICY/PROCEDURE REGARDING: Special Situation Governing Release of Information
 DUTY TO WARN (Tarasoff Decision)**

Issued By: Robert Cabaj, MD

Manual Number: 3.06-09

Deputy Director Designee of Health for Mental Health

Reference: Tarasoff vs. Regents of
 University of California - Case Law; Civil
 Code §43.92(b), W& I Code §5328(r)

Date: February 1, 2006

(Technical Revision. Replaces memo 3.06-09 of August 7, 2002)

The Tarasoff decision deals with responsibility of the psychotherapist to warn victims of potential violence by clients. Simply stated, this means that the psychotherapist-patient privilege is overshadowed by the therapist's responsibility to warn an intended victim.

A. The general legal requirements for CBHS staff in regard to Tarasoff warnings follow:

1. The psychotherapist's duty does not arise only where the psychotherapist has actual knowledge of danger. It arises whenever the therapist determines, or pursuant to standards of the profession should determine, that the patient presents a serious danger to another. If a patient threatens physical violence against someone, ***or the psychotherapist obtains information of such a threat having been made by the patient from another source including the patient's family***, the threat must be a serious one and the victim or victims must be reasonably identifiable. Some examples of when a victim is "reasonably identifiable" include: a) the victim is specifically named by patient (ex. Bob Smith of 123 Sesame Street); b) the victim is easily identifiable by their relationship to the patient (ex: my mother, brother, employer, colleague, competitor, etc.); or c) other easily recognizable trait (ex.: the Mayor, my congressman, the anchor for the Channel 22 5 p.m. news hour). In order to discharge the duty to warn, the psychotherapist must make reasonable efforts to communicate the threat to the victim or victims and must notify a law enforcement agency.
2. Persons to be notified in a Tarasoff situation must include the intended victim, and the police. The therapist must take all necessary steps to warn the victim of the circumstances such as attempting to contact the potential victim by telephone and/or letter. This may include telling other persons who are in a position to warn the victim. It is reasonable to provide the name and address of the client making the threats and the nature of the violence that the client has threatened. It is not

permissible to provide the police or the victim access to confidential patient records without a valid court order, however.

- B. Serious consideration should be given to initiating a 72-hour involuntary evaluation hold pursuant to Welfare & Institutions Code 5150 on the patient.
- C. Once a decision has been made as to how the situation will be handled clinically, this should be carefully charted. The therapist needs to chart what information was disclosed, to whom, when and why.
- D. The name and location of the law enforcement agency contacted and the name and badge number of the officer must also be included in the chart.
- E. A written incident Quality of Care report or a copy of the Tarasoff report must always be completed by clinical staff and distributed through appropriate Quality Improvement channels when a Tarasoff warning has taken place. This report would include the name of the staff member issuing the warning, the name of the supervisor and any other persons involved in the decision, as well as the circumstances surrounding the warning. In addition, the report must indicate:
 - 1. The patient communicated to the psychotherapist a threat of physical violence *or the psychotherapist obtains information of such a threat having been made by the patient from another source including the patient's family.*
 - 2. That this threat was a serious one.
 - 3. The reasons why the victim or victims were reasonably identifiable. The report must be received at 1380 Howard Street within one week of the incident as soon as possible.

If a therapist makes a Tarasoff warning by making reasonable efforts to communicate the threat to the victim/s and to a law enforcement agency, the therapist is immune from suit by the victim/s even if the victim is subsequently injured. Civil Code §43.92(b). Moreover, such disclosures are authorized by law, Welfare & Institutions code 5328 (r) and do not breach client/therapist confidentiality rules.

Contact Person: Kevin McGirr, RN.MS, MPH 255-3481

Distribution List

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CBHS policies and procedures are distributed by the Quality Management Section, Lucy Arellano, 415-255-3687, Coordinator

DO NOT COPY

REPORT OF WARNING

DO NOT COPY

To identified/Identifiable Victim of Potential Violence

This form is for the exclusive use of Quality Management

PRIVILEGED AND CONFIDENTIAL [cf., EC #1157.6, WIC #4070; #4071, #5328]

Client Name:		BIS #:	
Address:	DOB:	Sex:	Phone #:
Identified/Identifiable Victim:			
Address:	Home Phone #:	Work Phone #:	
Information/observations which lead you to the conclusion that warning needs to be initiated:			
History of other documented assaults or threats of assault by this client:			
Warning Made by (signature): _____		Date and Time of Warning: _____	
Therapist Name (print): _____		Telephone: _____	
Clinic Program:			
Form and Content of Warning:			
Form: In person/phone/written (specify): _____			
Content of Warning:			
Notification to Local Policy/Sheriff's Department:			
Date and Time: _____			
Officer Contacted: _____		Badge No. _____	
In person/phone/written: _____		Police Case # (if applicable): _____	
Follow-up activity/interventions with client (include planned interventions):			
Other staff with whom you consulted on this matter:			
_____	_____	_____	
Name	Clinic/Program	Telephone	
_____	_____	_____	
Name	Clinic/Program	Telephone	
_____	_____	_____	
Name	Clinic/Program	Telephone	

**Policy/Procedure #3.01-2:
MT transportation, updated 9-2005**

Website link:

<http://www.dph.sf.ca.us/MentlHlth/CBHSPolProcMnl/3.01-02TransportPol.pdf>

To be updated soon

See page 1 for ambulance transport telephone numbers

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To be updated soon

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(Policy/Procedure #3.01-2: MT transportation, updated 9-2005)

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.

1. 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.

2. 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 recommended 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.

3. PROCEDURES

- A. 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.
- B. DETENTIONS. 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.
- C. 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 cop to the Psychiatric Liaison Unit. Title the report by the individual for psychiatric evaluation or booked the individual and made a referral to Jail Psychiatric Services.
- Example: Battery/Fists/Cited & 55150'd
- D. 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.
- E. 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 "Appraisal for 72-Hour Detention for Evaluation and Treatment" even though the individual willingly accompanies you to PES.
- F. 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, 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.

G. JUVENILE. See DGO 7.02, Psychological evaluation of Juveniles.

H. 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 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 database 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 eh DOJ Firearms Clearance Section (916) 227-3703

I. 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).

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

Video Scenarios

Introduction

Correct application of the Welfare and Institutions Code Section 5150 involves complex considerations. It is obviously important not to restrict the civil liberties of a person unless there is very good reason to do so. Remember that the behavior evaluated must be the result of a mental disorder in order to initiate a 5150. Many clients are challenged not only with a major mental disorder, but also with substance abuse and/or complex medical issues. In the State of California all persons have the right to refuse medical treatment, including medications, as long as there are no court mandated restrictions. The video portion of this presentation demonstrates some of the clear and the gray areas surrounding the need for application of a 5150. Some of the vignettes are purposely vague so that participants can have the opportunity to test their knowledge of the law. These situations are intended to challenge participants to focus on alternatives to hospitalization that may be more useful in de-escalating the crisis while providing safe containment for clients and their support systems. During the training, participants will have the opportunity to actually write an Application for 72-hour Detention for Evaluation and Treatment.

This workbook and the video portions would not have been possible without the support of many individuals. I want to thank the clients who have shared painful critical moments of their lives with the Mobile Crisis Treatment Team. Clients and their families have taught us so much about crisis intervention. They have shown us that even when challenged with serious mental disorders, the person at the heart of the crisis does have ideas about what is helpful and what is not. With proper response from mental health workers, clients have the ability to articulate what kind of support would be helpful. I want to thank all the people who participated in the videos, particularly Kate Walker, San Francisco Mental Health Board, who kept us realistic. All staff of the Mobile Crisis Treatment Team contributed to the mechanics of the scenarios and in particular I want to thank Mary Bailey, Chris Brazis, LPT, Michael Carroll, BA, David Frankel, Ph.D., Maureen King, Ph.D., Bella Yu and Singkin Yue, Ph.D. I also want to thank Linda Wang, LCSW Director of Adult Services and Edwin Batongbacal, LCSW Assistant Director of Adult Services for San Francisco Community Behavioral Health Services. Through their support this project became a reality. I also want to thank Officer Mike Cowhig, Psychiatric Liaison Unit, of the San Francisco Police Department for clarifying SFPD policy and helping clinicians work more effectively with law enforcement. And finally, none of this would have been possible without Mike Fleming of West Coast Video Productions. He was able to understand my somewhat clumsy articulation of my intent and transform my ideas into thought-provoking scenarios.

None of the persons depicted in these videos are or have been clients of the Mobile Crisis Treatment Team or Community Behavioral Health Services. The scenarios depicted are composites of many interventions.

The videos and the workbook are the property of the City and County of San Francisco and are to be used for training purposes only.

For more information or consultation, please call Carolyn A. Kaufman RN CNS MFT, Program Director, San Francisco Mobile Crisis Treatment Team at 415-355-8300.

General Information on Suicide

The *National Vital Statistics of the United States, Mortality, 2000* ranks suicide as the 11th cause of death for all Americans (homicide is 14th). In the middle to late 90's, suicide was ranked at #8 or #9 in the causes of death list. More people die from suicide on the west coast as compared to the east coast. Suicide rates are typically higher in urban areas and are associated with poverty, inadequate medical care, unemployment and history of mental disorder. There are approximately 734,000 suicide attempts per year with 3 female attempts for every single male attempt. For Americans there are about 25 attempts for every completed suicide. An average of one person dies from suicide in this country once every 18 minutes. On the average, six people are affected by each suicide. Older Americans make up 12.6% of the 2000 population but represented 18.1% of all suicides. For the older adult, the statistics show that one older adult will kill himself every 39.3 minutes. It is estimated that for every four attempts made by older Americans, one older person will die. European-American men are ten times more at risk for suicide when compared with nonwhite males. White men over 80 are the highest at risk group. Older men tend to use firearms to kill themselves. Other methods are hanging and poisoning. (CDC: National Vital Statistics System)

The American Bar Association notes that the presence of a gun in the house increases the risk of suicide five times.

In the American Family Physician (4-15-2000 issue), the strongest risk factor for suicide was admission to a psychiatric hospital. About half of the people studied committed suicide. The time period of greatest risk was during the hospital admission process and the first week after discharge.

Certain professions are noted for being at higher risk for suicide than the general population. This group includes physicians, nurses, therapists, law enforcement and any profession associated with public service. As a member of a high-risk group, learn to recognize the symptoms of depression in yourself that may require therapy and/or supervision. Take the extra time to check-in with colleagues who seem withdrawn and depressed.

Although statistics can be helpful at determining high-risk groups, any person who makes suicidal statements should be evaluated and a plan of care devised that includes the client and the support system. Other factors to consider are: presence of a plan, history of previous attempts, lethality of intent, history of depression, history of head injury, history of sexual abuse, presence of a mental disorder, substance abuse, social isolation, presence of a medical illness and loss. Remember that loss can apply to many areas—loss of a loved one, pet, or job. It can also come from too many disappointments over a short period of time. Many persons who have committed suicide actually were perceived as doing better prior to the act. The sense of relief that the person feels from making the decision to die is misinterpreted as a step towards recovery or acceptance of disappointments. Always consult with a colleague and/or supervisor when a situation seems ambiguous or you have the “gut feeling” that something is not right with your client.

An alarming situation that has made national attention is the phenomena of “suicide by cop.” In this situation, a person creates a relationship where law enforcement is forced to shoot the individual after the person threatens the officer. In many of these cases alcohol and/or drugs are involved. There may also be a history of domestic violence and other legal issues. In most cases, the individual uses a functioning firearm. In some instances, individuals use replicas of guns to provoke the situation with law enforcement.

For further information on statistics, contact the U.S. Department of Health and Human Services, Centers for Disease Control (CDC) @ <http://www.cdc.gov>

National Institute of Mental Health @ <http://www.nimh.gov>

San Francisco Trauma Foundation @ <http://www.sftf.org>

DEPRESSION AND SUICIDE IN THE OLDER ADULT

- ◆ *Objectives: Clinician will list risk factors of suicide associated with older adults.*

Prolonged clinical depression is not considered a normal part of the aging process. Many older adults have somatic complaints that can be attributed to depression once a physical disorder has been ruled out by a medical examination. These complaints are typically about aches and pains, increase or decrease in weight or change in sleep habits. Mobility restrictions may affect a person's sense of independence. Anxiety may cause the older adult to withdraw and at worst restrict activities only to the home. Many older people are not comfortable talking about feelings and can articulate physical discomfort more easily. The hallmark symptoms of depression in older adults are overall feelings of sadness and an inability to find pleasure in activities that were important at one time. There may be a change in dressing habits and hygiene. The symptoms of depression may be perceived by the support system as irritability, crankiness or constant complaining. The family may feel frustrated having tried numerous tactics to "make" the person happy. The depression can also be coupled with alcohol abuse, be part of a chronic disease process or the result of untoward effects from medications. Danger signs include a preoccupation with death and reminiscing about the death of others. The older person may start to get affairs in order and call friends and family to say goodbye. Friends and family may receive phone calls or letters regarding distribution of property and/or money. Another dangerous sign is stock piling medications and refusing to follow medical advice—i.e. treatments for infections, ignoring diet limitations, etc. Any statements that indicate that the older person has suddenly changed a strongly held belief system and/or religious practice needs to be carefully explored. Consulting with the person's spiritual advisor (with person's consent, of course) may be quite useful. The older person is most at risk when mood becomes strangely calm and person seems happy. Remember that it takes a certain amount of energy to perform the suicidal act.

The incidence of homicide-suicides among older adults is increasing. While depression is a factor, desperation may be the precipitant. There is a constriction of world-view on the part of the husband and no dignified solutions are apparent to him. Usually the man perceives a threat to the relationship e.g. a move from the family home to more restricted care, domestic violence or marital problems. The dependency that couples may develop over time may make the thought of living without the other too threatening. Situations that warrant more clinical investigation include:

1. An older couple withdrawing from social situations with peers or religious groups and isolating from family and friends. Refusal/inability to return phone calls.
2. Both members have multiple medical problems and their perception is that things will slowly and painfully get worse.
3. The family has recently discussed with the parents the need to move to an assisted living situation.
4. The husband is caring for wife who has dementia.
5. The couple has history of marital discord and situation escalates to threats of violence.

The purpose of the vignette is to allow the clinician to see clinical depression in an elderly female who also meets the criteria for a 5150 as danger to self. Mrs. Smith has a plan to hurt herself. She is not changing her clothes although she was previously known to be careful and precise in her attire. It is unclear if she is eating. Her sense of helplessness and hopelessness is quite profound. She is irritated with the clinician's questions and explanations.

The goal in writing a practice 5150 form in this situation is to see if clinicians include all the relevant data to support the 5150 for danger to self.

Suggestions for Discussion:

1. Reviewing symptoms of depression across the life span i.e. recognizing that there are discrete differences between the expressions of depression in children, youth, adults and older adults.
2. Review of cross-cultural considerations in dealing with depressed older adults. How do symptoms of clinical depression vary across cultures?
3. What other techniques could the clinician have used during the assessment?
4. What diagnostic considerations would be made in assessing Dementia/Delirium or Psychosis?

Dementia/Delirium or Psychosis?

◆ *Objectives:*

1. *Clinician will distinguish symptoms likely to be associated with dementia, psychosis or delirium.*
2. *Clinician will give examples of when a person with an organic brain syndrome meets criteria for a 5150.*

One of the more perplexing challenges in working with older people is making the correct clinical diagnosis. Since the diagnosis will determine the most appropriate level of treatment, the clinician must be able to differentiate symptoms of disorders that may have similar symptoms. Psychologists are trained to make the differential and if delirium is suspected or if it cannot be ruled-out, then a referral to a physician for medical procedures would be indicated. An evaluation by a physician is necessary with focus on laboratory tests, diagnostic studies and a thorough history and physical. The medical etiology of dementia has caused the psychiatric community to rigidly define boundaries. In some cases the reasons for this are partially financial as psychiatric services may not be reimbursed with this medical diagnosis. Remember that a person challenged with dementia can be a danger to self/others or gravely disabled depending on the circumstances. The following chart prepared by Dr. Charles P. Windham, Medical Director of Mobile Crisis Treatment Team, helps with the differential diagnosis.

Clinical Feature	Delirium	Dementia	Psychosis
Onset	Sudden	Insidious	Gradual
24-hour course	Fluctuating	Stable	Stable
Consciousness	Reduced	Clear	Clear
Attention	Globally Disordered	Less Disordered	Less Disordered
Cognition	Globally Disordered	Globally Impaired	Selectively Impaired
Hallucinations	Usually visual	Often Absent	Usually Auditory
Delusions	Fleeting and poorly organized	Often Absent	Sustained, systematized
Orientation	Usually Impaired	Often Impaired	May be impaired
Psychomotor	Shifting	Often Normal	Varies
Speech	Incoherent	Coherent but Impaired	Varies
Involuntary Movements	Tremor, asterixis	None	Usually absent, unless side effects
Physical Illness or Substances	Present	Absent in Alzheimer's	Usually absent

This vignette focuses on an older adult woman who has been referred by her daughter. The client has a strong connection with her pastor and this relationship proves to be very helpful during the intervention. It is important to note that in the course of the intervention, Mrs. Smith's attitude vacillates from cooperative and friendly to uncooperative with an over-lay of suspicion. Her facial expression also changes throughout the interview. Her speech is clear but it is obvious that she sometimes confabulates or approximates responses when she does not know an answer. Her mood and affect also change depending on the questions and the closer the situation gets to the possibility of an emergency room visit. She has trouble stating the day of the week, her birthday and other bits of general information. She has a novel use for a pen and with prompting calls it a "writer." She admits to hearing voices and she asks the therapist to tell one of her visual hallucinations to leave. She also forgets who the therapist is and the point of the interview. She discounts factual information: She was found the previous night wandering around and could not tell the police her address. Police were able to phone Mrs. Smith's daughter as there was a paper with daughter's name and number in client's coat pocket. Mrs. Smith has also left burners on her gas stove on and daughter has come into the apartment when it is filled with gas. Her judgment seems impaired in that her ability to make safe daily life decisions is questionable.

Suggestions:

1. Discussion on whether or not client meets 5150 criteria.
2. Which behaviors do you see that clearly demonstrate DTO/DTS or GD concerns?
3. Amend the situation to clearly meet 5150 criteria and have clinicians write 5150.

Depression and Substance Abuse

Objectives:

1. *Clinicians will list the symptoms of depression and discuss possible complications when depression and grief are present.*
2. *Clinicians will discuss cultural implications in the loss of a newborn and the effects on the family.*

In this situation, Mary has come to the clinic with her 6-year old daughter. The previous week she gave birth to a stillborn baby who had a major cardiovascular defect. The grief at the loss of a full-term infant is obvious in Mary's demeanor. Her prenatal history is sketchy and she is resistant to letting her daughter go out of the counseling session and will not continue the interview unless the daughter can stay. In addition to a confirmed history of major depression, Mary had been abusing amphetamines during the pregnancy. The screening clinician requested that the Registered Nurse evaluate Mary for medical and danger to self-issues. Mary presents as flat and depressed. She recently left a drug treatment program when she found out that her sister left the 6-year-old daughter alone. The sister is also challenged by amphetamine abuse. The six-year-old does not speak to the RN and is occupied for most of interview with drawings. The daughter's appearance is disheveled and she clings to her mother. Clearly a treatment program that can accept both the mother and daughter is indicated. Mary is also willing to try antidepressant medication and agrees to meet with a psychiatrist.

Questions to consider:

1. What are the symptoms of depression evident in the video?
2. Does the mother meet criteria for a 5150?
3. Should the child be evaluated?
4. Should Child Protective Services be consulted?
5. What treatment options are available to this family?

Substance Abuse as the Primary Focus of Treatment

One of the more challenging situations for clinicians in the field are issues related to substance abuse and determining when a person crosses the line in meeting 5150 criteria. Substance abuse can seem like a slow and steady process that will eventually result in death. Substance abuse, in and of itself, may not be a reason to place an individual on a 5150. Intoxication can cause individuals to behave impulsively, and we cannot use the 5150 criteria to predict behavior that "might" happen. In the first scenario, Rusty is challenged with heroin addiction and chronic medical issues—hypertension, diabetes and hepatitis C. It is obvious that she has an infection due to abscesses on her arms and her foot. She does not seem to mind her chronic homelessness and has a plan of how to take her insulin. She drinks alcohol throughout the interview. She is interested in getting help with her foot and the team starts with that as a focal point to gain more information. In a harm reduction model, starting to build a therapeutic alliance based on the client's stated need opens the door for consideration of other unhealthy practices that the client may want to change. Although Rusty's method of dealing with her diabetes is novel, it apparently works for her—she keeps the insulin at a friend's house. She has a meal plan that consists of a friend waiting in line for her at St. Anthony's. The clinicians are non-judgmental about Rusty's lifestyle and are able to elicit necessary information in order to devise a mutually acceptable treatment plan that starts with response to medical issues. Since Rusty already has her medical needs taken care of at the Tom Waddell Clinic, she is encouraged to continue with this plan. Other harm reduction methods already in place are use of the needle exchange program. There are some allusions to issues of dual diagnosis but the psychiatric component is not evident in the first scenario. There is no indication that Rusty has a plan to precipitously end her life.

Mental Disorder as the Primary Focus of Treatment

In the second scenario, Rusty's psychiatric condition is more pronounced due to the combined use of heroin and amphetamine. She has a belief that Satan is causing her abscesses and that somehow the rising of the sun will

induce the devil to fly out of her foot wound. She is obviously tortured by voices, some of which command her to run out in the street. She is agitated and threatening to the team. Her movements are repetitive and she has a very difficult time taking in information. Repetitive actions and thoughts often cause a constriction of world view where the client feels that only she has a handle on what is happening. Rusty is distrustful of other people's interpretation of what is happening.

The team ignores the obvious threat of the walking stick that could clearly be used as a weapon. Persons under the influence of drugs can impulsively dash out into the street in an effort to get away from anything that could possibly be a threat. Rusty has already split the team into one "good" and one "bad" helper. She thinks the "bad" helper, who happens to be dressed in black, may be part of Satan's scheme. Safety of healthcare workers is paramount and a request for police standby would be indicated in this situation. The clinician needs to be aware of this negative transference and the ramifications. The interview should not continue until any item that can be used as a weapon is out of the client's reach. Rusty has a legal history of arrests for drug related offenses. She has had good and bad relationships with the police, but does have a sense that the police can contain the situation. In this scenario, the clinicians must wrestle with gaining information while balancing the notion that talking about Rusty's fears could make the situation worse and unsafe. While one worker stays with Rusty, the other leaves to call for the police. It is essential that the 911 operators get a full description of the client and some professional estimation of current risk. The voices are telling Rusty to run into traffic. This information must be conveyed so that emergency response will be more immediate. The fact that Rusty has a walking stick that could also be used as weapon (in fact—she has used it to get the psychologist away from her) must be conveyed to the 911 operators. The two dangers—running into traffic and possession of a weapon will make the call a more urgent one. Once the police arrive, one member of the team gives the necessary information to convey that the client is being placed on a 5150 as danger to self and others and that safe transport is not possible because of her erratic behavior. Remember that when police respond to calls, all persons are seen as suspects until the officers have a chance to evaluate the situation.

It is imperative that your identification badge is visible and your role explained to the officers. You will need to reinforce to Rusty that she is not being arrested, but rather detained on a 5150. Hopefully she does not have any outstanding felony warrants that could result in her going to jail. A person with her multiple medical issues should be screened in a medical emergency room before going on to psychiatric emergency services.

1. Does Rusty meet criteria for a 5150 in the first scenario? Why or why not?
2. Does Rusty meet criteria for a 5150 in the second scenario? Have participants fill-out a 5150, then exchange the form with another participant and review the 5150 for clarity and completeness.
3. Are there interventions the team could have done to motivate Rusty in another direction?
4. Review clinic procedure for dealing with agitated and unpredictable clients. What should a clinician do if s/he is alone with a client and the client becomes threatening.
5. Review safety procedures for clinicians who go out in the field. What is the back-up plan should something dangerous or unpredictable emerge during a visit?

Psychotic Agitation in the Community

Case managers often have to contend with complicated situations in the community. The clinician must weigh safety of oneself, the client and the public. The job calls for the ability to make rapid decisions in unfamiliar circumstances. There are times when it would be appropriate to call for more staff or 911 for police back up.

In this video, a client, George Chan, is challenged with delusions and grief. He is found by his case manager attacking property behind the South of Market Clinic. He is thrashing and yelling at plants and throwing chairs around. Although the client is bilingual, during psychotic outbursts he only communicates in Cantonese. He has unresolved grief issues related to the death of his wife ten years ago. He could not go to her funeral because he was too psychotic and hospitalized at the time of the funeral. He thinks he is King George. He has been off his medications for some time. He has a history of requiring police assistance during the 5150 process. The last 5150 required six police officers and the client had to be wrestled to the ground and handcuffed. Upon arrival at PES, he had to be restrained.

The case manager is hoping to avoid a repeat of the last trip to the hospital. She realizes that she needs assistance from Cantonese speaking staff. The case managers decide to go along with George's delusions in order to get him into a car that is safe for patient transport.

1. Have clinicians write a 5150 based on the information in the video and review the 5150s for completeness.
2. What are your concerns about the interaction? Safety?
3. What about the clinicians' decision to go along with the delusions?
4. Are there other clinical/ethical concerns about the interaction?

Cutting Behavior as the Primary Focus of Treatment

In this scenario, the cutting is a major concern. However, many adolescents cut themselves to get relief from stress, not with the intention to kill themselves. Debonay clearly demonstrated to be one of those adolescents. Per her mother's and her report, she appeared to be depressed - she is isolated, cutting school, not motivated to do school work, and sleeping a lot. She also appeared to be mourning for the loss of her close relationship with her mother. Debonay's affect and mood are also congruent with her depressive symptoms: sad, downcast, minimal eye contact, soft, barely audible voice. During the assessment, it is essential for the team to gain Debonay's trust and confidence.

The team universalizes her behavior; they explore her feelings, suicidal ideation, coping skills, self-awareness, insight into her situation and behavior, and last but not least, safety plan.

Initially, Debonay appears to be defensive around the issue of cutting; she actually denies it. Instead of pressuring her, the team continues with the flow of the interview but keeps coming back to the main focus: cutting. Debonay eventually discloses that she cuts when she feels sad and or angry but she makes it clear that her intention is to relieve stress, NOT to kill herself. Debonay also discloses that she does have a weapon in her room which she uses to cut - scissors. This information is very crucial as it pertains to the client's safety plan as well as client's readiness to give up harmful coping skill. Additionally, Debonay has good insight into her problem and behavior. She appears to be motivated to seek help, learning new coping skills, and resolving issues with her mother. In addition to the individual's interview, the team conducts a family session to increase and problem solve issues between Debonay and her mother. During session, safety plan is clearly discussed and agreed upon by all parties such as mother removing weapon from Debonay's room, increasing supervision, Debonay utilizing coping mechanism (writing, listening to music), and follow-up visit with Child Crisis next day as well as starting therapeutic services. Both Debonay and mother are advised to contact Child Crisis immediately should Debonay escalate.

1. Did Debonay meet criteria for a 5150? Why or why not?
2. What happens if Debonay shows the team her arms which are full of fresh cuts? Would that affect her 5150 criteria?
3. What happens if during the course of the interview, Debonay continues to be defensive and non-verbal?