Riverside University HEALTH SYSTEM Behavioral Health

LPS 5150 Training Manual

For general inquiries regarding 5150 authorization and non-placement 5150 issues, please contact RUHS-BH, LPS 5150 Certification & Oversight at 951-358-6391.

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INTRODUCTION

On behalf of Riverside University Health System- Behavioral Health (RUHS-BH), we welcome you to the Welfare and Institutions Code 5150 training course. This course is a requirement to be authorized by RUHS-BH to write 5150s. A 5150 is an application to detain a person who is deemed to be a Danger to Self, or a Danger to Others, or Gravely Disabled, as a result of a mental disorder, for psychiatric evaluation, assessment, and/or treatment.

The core objectives of the course are to teach you how to evaluate to determine if a person with a mental disorder meets the legal criteria to be placed on a 5150 hold for Danger to Self, Danger to Others, and/or Grave Disability. You will learn the legal and clinical criteria for evaluating both adults and minors.

We will briefly discuss what medical clearance means and what it does not mean. You will learn how to recognize when the mentally ill person is potentially dangerous and learn tips to protect yourself while you are evaluating a dangerous person for a 5150 hold.

You will learn how to complete the 5150 form accurately and where to send the copy of the hold. We will cover Tarasoff responsibilities and procedures for mental health professionals.

You will also learn pertinent RUHS-BH policies and procedures relating to 5150 issues such as authorization, interruption of a hold, etc.

Lastly, following the training, you will be given a test with a series of questions. You are required to score a minimum of 80% correct to successfully pass. If you pass the test, you will be authorized for two years during which time you must write at least one accurate 5150. Please see Policy 142- 5150 Authorization for Professional Persons for more info. Please note, your 5150 authorization will be limited to the work site stated on your application.

HISTORICAL FRAMEWORK: WELFARE & INSTITUTION CODE 5150

THE LANTERMAN-PETRIS-SHORT ACT. The Lanterman–Petris–Short (LPS) Act is California legislature pertaining to the involuntary civil commitment of persons to a mental health institution in the State of California. The LPS Act set the precedent for modern mental health commitment procedures in the United States. The LPS Act was named after three politicians who co-authored the legislation, Frank D. Lanterman, Nicholas C. Petris and Alan Short. This LPS Act was signed into law in 1967. This groundbreaking legislature was designed:

- To end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons;
- To provide prompt evaluation and treatment of persons with serious mental disorders;
- To promote public safety;
- To safeguard individual rights of mentally ill patients through judicial review;
- To provide individualized treatment, supervision, and placement services by a conservatorship program for Gravely Disabled persons;
- To encourage the full use of all existing agencies, professional personnel and public funds to accomplish these objectives and to prevent duplication of services and unnecessary expenditures;
- To protect mentally ill persons from criminal acts and help them receive psychiatric evaluation and treatment to improve their mental health

The LPS Act was one of the most significant portions of mental health legislation at that time. It revised the practice of civil commitment of the mentally ill, as it increased the legal rights for mentally ill patients while balancing those rights with the need for civil commitment of dangerous mentally ill persons.

The LPS Act states that persons with mental disorder have the same legal rights and responsibilities that are guaranteed to all other persons by the Federal Constitution and federal laws as well as the Constitution and laws of the State of California.

The Act states that the mentally ill shall not be excluded from participation in, or denied the benefits, or be subjected to discrimination, under any program or activity, which receives public funds. (Section 5325.1)

LPS allows a peace officer, or an authorized professional at a 5150 designated facility, or other professional persons designated by the County, to, upon probable cause, write an application for an involuntary psychiatric assessment, known as a 5150, and have a person who is deemed a Danger to Self, or Danger to Others, or Gravely Disabled and therefore, is unable to obtain or utilize food, shelter or clothing.

LPS also clarifies "If, in the judgment of the professional person in charge of the facility designated by the County for evaluation and treatment, member of the attending staff, or professional person designated by the County, the person can be properly served without being detained, he or she shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis."

The peace officer or other authorized persons writing the 5150 application may also base probable cause on the statements of other reliable persons, such as family members or significant others. Any person providing a false statement can be liable in a civil action against them.

The Act states that a person placed on a 5150 has the right to be assessed by a mental health professional and offered treatment at a 5150 designated facility within 72 hours after being taken into civil protective custody. **The 72 hours starts when the 5150 application is written.**

A minor, who as a result of a mental health disorder, is a Danger to Self, or Danger to Others or is Gravely Disabled, can also upon probable cause be taken into custody by a peace officer or other authorized professionals and taken to a facility designated by the County and approved by the State Department of Health Care Services for 72 hours for evaluation and treatment. Every effort must be made to notify the minor's parent or legal guardian as soon as possible after the minor is detained. (Section 5585.50) However, the minor can also be detained over the objection of the parents or legal guardians.

CALIFORNIA WELFARE & INSTITUTIONS CODE: 5150 & 5585

5150. (a) When a person, as a result of a mental health disorder, is a Danger to Others, or to himself or herself, or Gravely Disabled, a peace officer, professional person in charge of a facility designated by the County for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the County for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the County may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the County for evaluation and treatment and approved by the State Department of Health Care Services.

(b) When determining if a person should be taken into custody pursuant to subdivision (a), the individual making that determination shall apply the provisions of Section 5150.05, and shall not be limited to consideration of the danger of imminent harm.

(c) The professional person in charge of a facility designated by the County for evaluation and treatment, member of the attending staff, or professional person designated by the County shall assess the person to determine whether he or she can be properly served without being detained. If, in the judgment of the professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, or professional person designated by the county, the person can be properly served without being detained, he or she shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis.

(d) Whenever a person is evaluated by a professional person in charge of a facility designated by the county for evaluation or treatment, member of the attending staff, or professional person designated by the county and is found to be in need of mental health services, but is not admitted to the facility, all available alternative services provided pursuant to subdivision (c) shall be offered as determined by the county mental health director.

(e) If, in the judgment of the professional person in charge of the facility designated by the County for evaluation and treatment, member of the attending staff, or the professional person designated by the County, the person cannot be properly served without being detained, the admitting facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the peace officer, professional person in charge of the facility designated by the County for evaluation and treatment, member of the attending staff, or professional person designated by the County, and stating that the peace officer, professional person in charge of the facility designated by the County for evaluation and treatment, member of the attending staff, or professional person designated by the County has probable cause to believe that the person is, as a result of a mental health disorder, a Danger to Others, or to himself or herself, or Gravely Disabled. The application shall also record whether the historical course of the person's mental disorder was considered in the determination, pursuant to Section 5150.05.

If the probable cause is based on the statement of a person other than the peace officer, professional person in charge of the facility designated by the County for evaluation and treatment, member of the attending staff, or professional person designated by the County, the person shall be liable in a civil action for intentionally giving a statement that he or she knows to be false.

(f) At the time a person is taken into custody for evaluation, or within a reasonable time thereafter, unless a responsible relative or the guardian or conservator of the person is in possession of the person's personal property, the person taking him or her into custody shall take reasonable precautions to preserve and safeguard the personal property in the possession of or on the premises occupied by the person.

5150.05. (a) When determining if probable cause exists to take a person into custody, or cause a person to be taken into custody, pursuant to Section 5150, any person who is authorized to take that person, or cause that person to be taken, into custody pursuant to that section shall consider available relevant information about the historical course of the person's mental disorder if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a Danger to Others, or to himself or herself, or is Gravely Disabled as a result of the mental disorder.

(b) For purposes of this section, "information about the historical course of the person's mental disorder" includes evidence presented by the person who has provided or is providing mental health or related support services to the person subject to a determination described in subdivision (a), evidence presented by one or more members of the family of that person, and evidence presented by the person subject to a determination described in subdivision (a) or anyone designated by that person.

(c) If the probable cause in subdivision (a) is based on the statement of a person other than the one authorized to take the person into custody pursuant to Section 5150, a member of the attending staff, or a professional person, the person making the statement shall be liable in a civil action for intentionally giving any statement that he or she knows to be false.

5585.50. (a) When any minor, as a result of mental disorder, is a Danger to Others, or to himself or herself, or Gravely Disabled and authorization for voluntary treatment is not available, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the County, or other professional person designated by the County may, upon probable cause, take, or cause to be taken, the minor into custody and place him or her in a facility designated by the County and approved by the State Department of Health Care Services as a facility for 72-hour treatment and evaluation of minors. The facility shall make every effort to notify the minor's parent or legal guardian as soon as possible after the minor is detained.

(b) The facility shall require an application in writing stating the circumstances under which the minor's condition was called to the attention of the officer, member of the attending staff, or professional person, and stating that the officer, member of the attending staff, or professional person has probable cause to believe that the minor is, as a result of mental disorder, a Danger to Others, or to himself or herself, or Gravely Disabled and authorization for voluntary treatment is not available. If the probable cause is based on the statement of a person other than the officer, member of the attending staff, or professional person, the person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false.

*Note: A minor can be detained over the objection of the guardian or parent.

CALIFORNIA PENAL CODE: 4011.6

4011.6. In any case in which it appears to the person in charge of a county jail, city jail, or juvenile detention facility, or to any judge of a court in the county in which the jail or juvenile detention facility is located, that a person in custody in that jail or juvenile detention facility may be mentally disordered, he or she may cause the prisoner to be taken to a facility for 72-hour treatment and evaluation pursuant to Section 5150 of the Welfare and Institutions Code and he or she shall inform the facility in writing, which shall be confidential, of the reasons that the person is being taken to the facility. The local mental health director or his or her designee may examine the prisoner prior to transfer to a facility for treatment and evaluation.

Where the court causes the prisoner to be transferred to a 72-hour facility, the court shall forthwith notify the local mental health director or his or her designee, the prosecuting attorney, and counsel for the prisoner in the criminal or juvenile proceedings about that transfer. Where the person in charge of the jail or juvenile detention facility causes the transfer of the prisoner to a 72-hour facility the person shall immediately notify the local mental health director or his or her designee and each court within the county where the prisoner has a pending proceeding about the transfer. Upon notification by the person in charge of the jail or juvenile detention facility the court shall forthwith notify counsel for the prisoner and the prosecuting attorney in the criminal or juvenile proceedings about that transfer.

If a prisoner is detained in, or remanded to, a facility pursuant to those articles of the Welfare and Institutions Code, the facility shall transmit a report, which shall be confidential, to the person in charge of the jail or juvenile detention facility or judge of the court who caused the prisoner to be taken to the facility and to the local mental health director or his or her designee, concerning the condition of the prisoner. A new report shall be transmitted at the end of each period of confinement provided for in those articles, upon conversion to voluntary status, and upon filing of temporary letters of conservatorship.

A prisoner who has been transferred to an inpatient facility pursuant to this section may convert to voluntary inpatient status without obtaining the consent of the court, the person in charge of the jail or juvenile detention facility, or the local mental health director. At the beginning of that conversion to voluntary status, the person in charge of the facility shall transmit a report to the person in charge of the jail or juvenile detention facility or judge of the court who caused the prisoner to be taken to the facility, counsel for the prisoner, prosecuting attorney, and local mental health director or his or her designee.

If the prisoner is detained in, or remanded to, a facility pursuant to those articles of the Welfare and Institutions Code, the time passed in the facility shall count as part of the prisoner's sentence. When the prisoner is detained in, or remanded to, the facility, the person in charge of the jail or juvenile detention facility shall advise the professional person in charge of the facility of the expiration date of the prisoner's sentence. If the prisoner is to be released from the facility before the expiration date, the professional person in charge shall notify the local mental health director or his or her designee, counsel for the prisoner, the prosecuting attorney, and the person in charge of the jail or juvenile detention facility,

who shall send for, take, and receive the prisoner back into the jail or juvenile detention facility.

A defendant, either charged with or convicted of a criminal offense, or a minor alleged to be within the jurisdiction of the juvenile court, may be concurrently subject to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

If a prisoner is detained in a facility pursuant to those articles of the Welfare and Institutions Code and if the person in charge of the facility determines that arraignment or trial would be detrimental to the well-being of the prisoner, the time spent in the facility shall not be computed in any statutory time requirements for arraignment or trial in any pending criminal or juvenile proceedings. Otherwise, this section shall not affect any statutory time requirements for arraignment or trial in any pending criminal or juvenile proceedings.

For purposes of this section, the term juvenile detention facility includes any state, county, or private home or institution in which wards or dependent children of the juvenile court or persons awaiting a hearing before the juvenile court are detained.

CALIFORNIA WELFARE & INSTITUTIONS CODE: PATIENTS' RIGHTS

5325.1. Persons with mental disorder have the same legal rights and responsibilities guaranteed all other persons by the Federal Constitution and laws, and the Constitution and laws of the State of California, unless specifically limited by Federal or State law or regulations.

No otherwise qualified person by reason of having been involuntarily detained for evaluation or treatment under provisions of this part or having been admitted as a voluntary patient to any health facility, as defined in Section 1250 of the Health and Safety Code, in which psychiatric evaluation or treatment is offered shall be excluded from participation in, be denied the benefits, or be subjected to discrimination under any program or activity, which receives public funds.

It is the intent of the legislature that persons with a mental disorder shall have rights including, but not limited to, the following:

a. A right to treatment services which promotes the potential of the person to function independently. Treatment should be provided in ways that are least restrictive of the personal liberty of the individual.

b. A right to dignity, privacy, and humane care.

c. A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program.

d. A right to prompt medical care and treatment.

e. A right to religious freedom and practice.

f. A right to participate in appropriate programs of publicly supported education.

g. A right to social interaction and participation in community activities.

h. A right to physical exercise and recreational opportunities.

i. A right to be free from hazardous procedures.

Persons who are involuntarily detained have an absolute right to refuse any or all medical treatment in the absence of a life or death medical situation.

5150 OVERVIEW

What is a 5150?

A 5150 is an application for an involuntary psychiatric evaluation and/or treatment when a person is deemed, a result of a mental disorder, a Danger to Self, or Danger to Others, or Gravely Disabled. When a person meets these legal criteria to be placed on a 5150 hold, the person is transported to a designated psychiatric inpatient facility for evaluation and treatment for up to 72-hours against their will. If the attending physician believes that further treatment is necessary, the person can be held involuntarily for an additional 14 days after a judicial hearing. The person can be held for additional days beyond this additional 14 days after judicial review. It should be noted that **the 5150 form is an application for psychiatric evaluation—it does not necessarily mean the person will be admitted into an inpatient psychiatric facility.** As Welfare Institutions Code 5151 indicates *"the professional person in charge of the facility or his or her designee shall assess the individual in person to determine the appropriateness of the involuntary detention" (face to face assessment).*

5150s are for when Voluntary Treatment is Refused or Not a Viable Option

If, in the professional's judgment, the person can be **properly served** (W & I Code 5151) without being detained; then he or she shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis.

Advisement

When persons are taken into custody on a 72-hour hold, they must be told (WIC 5157):

(a) The name, position, and agency of the person initiating the custody;
(b) The name of the facility where they will be evaluated;
(c) That they are not under criminal arrest, but are being detained for evaluation by mental health professionals; and
(d) That they will be told their rights by the staff at the facility.

If taken into custody at their residence, they must also be advised that:

(a) They may bring a few approved personal items with them; and
(b) They may make a phone call and/or leave a note to tell friends or family where they have been taken.

An inability to complete the verbal advisement is allowed for **good cause only which must be indicated on the 5150 application form.**

DANGER TO SELF (DTS)

Definition: As a result of mental disorder, the person must be suicidal (or expresses significant harm to self) or engage in behavior that puts him/her at serious Danger to Self; dangerous behavior can be intentional or unintentional.

Listed below are examples of behaviors which, when they are a result of a mental disorder, often indicate that a person meets 5150 criteria for "Danger to Self" and is appropriate for involuntary commitment at a designated facility for psychiatric evaluation and treatment:

- The person has indicated by words or actions he/she is having thoughts to commit suicide or inflict bodily harm on self.
- The person's statements or actions indicate a specific plan, intent, and/or means by which to commit suicide or inflict harm to self and these means are within the ability of the person to carry out (person has access to the means).
- The person refuses to accept, or is unwilling or unable to obtain, psychiatric evaluation and treatment on a voluntary basis.

****Per AB1424, evidence of being a Danger to Self does not have to be personally observed by the evaluator and may be observations reported to the evaluator by a reliable witness, which includes family members and/or significant others.**

Evaluator Questions to Assist with Determination

- Does the person have intent to harm himself/herself? Ask the person or a reliable witness who can report on current symptoms and behaviors that describe the intent.
- How does the person intend to harm himself/herself? What is the plan? Look for weapons, pills, or evidence of a plan – gas left on, jumping off a ledge, etc.
- Has the subject ever done anything to try to harm himself/herself in the past? Past suicide attempts or dangerous behavior.
- If the person did attempt to harm himself/herself in the past, what did he/she do? Were prior attempts serious and/or lethal in nature?

DANGER TO OTHERS (DTO)

Definition: As a result of a mental disorder, the person expresses harm to others or demonstrates behavior that puts the safety of others at risk of serious harm; dangerous behavior can be intentional or unintentional.

Listed below are examples of behaviors which, when they are a result of a mental disorder, often indicate that a person meets 5150 criteria for "Danger to Others" and is appropriate for involuntary commitment at a designated facility for psychiatric evaluation and treatment:

- A person has indicated by words or actions that he/she is having thoughts to cause bodily harm to another person.
- The person's threats or intentions are specific as to the particular person(s) he/she would do harm to. (*If there is a specific person/target, this requires a Tarasoff consultation for possible reporting.)
- The person identifies the plan, intent, and/or means by which he/she would do harm to another person, and these means are within the ability of the person to carry out (person has access to the means).
- The person is engaging in or intends to engage in behavior that is irrational, impulsive, or reckless nature, such as destruction of property or misuse of a vehicle as to put others directly in danger or harm.
- The person's behaviors or words regarding intent to cause harm to another person are based on, or caused by, the person's mental state, which indicates the need for psychiatric evaluation and treatment.
- The person refuses to accept, or is unwilling or unable to obtain, psychiatric evaluation and treatment.

****Per AB1424, evidence of being a Danger to Others does not have to be personally observed by the evaluator and may be observations reported to the evaluator by a reliable witness, which includes family members and/or significant others.**

Evaluator Questions to Assist with Determination

- Is the person actively or passively engaged in violent or dangerous behavior?
- Does the person state he/she is going to carry out violent or dangerous behavior?
- Does the person have a plan to follow through with statements of harm to others?
- Does the person have the means and access to the means to follow through with plan?
- Does the person have a background of violence or dangerous behavior? Has the person acted on plans of violent behavior in the past?

GRAVELY DISABLED (ADULTS) (GD)

Definition: As a result of a mental disorder, the person is not able to provide or utilize food, clothing, or shelter.

Evidence of the inability to provide/utilize food, clothing, or shelter may include the following examples, which should be verified by personal observations of the evaluator or by observations reported to the evaluator by reliable witnesses.

Listed below are examples of behaviors which, when they are a result of a mental disorder, often indicate that a person meets 5150 criteria for "Gravely Disabled" and is appropriate for involuntary commitment at a designated facility for psychiatric evaluation and treatment:

- FOOD: The person is malnourished and dehydrated; little or no food in house and person is unable to establish where or how he/she obtains meals; person has no realistic plan for obtaining meals; person has repeatedly stated he/she no longer intends to eat; person has been losing substantial weight without reasonable explanation; person repeatedly eats items not ordinarily considered fit for human consumption; refusal to leave jail cell for multiple days and refusing food/water due to depression resulting in dehydration

- CLOTHING: person regularly fails to wear clothing; person not wearing appropriate level of clothing necessary to ensure safety during prevailing climatic conditions; person has no realistic plan for obtaining clothing.

- SHELTER: person has no realistic plan for obtaining shelter; person has a room but refuses to use it and instead sleeps outside in the backyard; person sleeps in dangerous conditions like roof or other dangerous/unfit places that put the person at risk of harm; breaks into buildings or homes for shelter.

All such examples must be shown to be the result of a mental disorder and not merely the result of a lifestyle or attitude choice. It must also be established that the person is either unwilling or unable to voluntarily accept needed treatment.

It should also be noted that the mere presence or possession of food, clothing, or shelter does not, in itself, invalidate the condition of "Grave Disability." The deciding factor is often the inability to utilize food, clothing, or shelter. For example, a person whom repeatedly eating garbage because he/she feels the food in his/her house has been poisoned is Gravely Disabled despite the presence of food. A 5150 is then appropriate because, as a result of a mental disorder, this person is unable to utilize normal edible products that he/she possesses.

When determining who is Gravely Disabled for the purposes of a 14-day certification or a determination of conservatorship, the following definitions shall apply to Sections 5250 and 5350 WIC, as amended by Statutes of 1989, Chapter 999.

- A person is not Gravely Disabled if that person can survive safely without involuntary detention with the help of a responsible family, friends, or others who are both willing and able to help provide for the person's basic personal needs for food, clothing, and shelter.

- Family, friends, or others shall not be considered willing or able to provide help unless they specifically indicate their willingness and ability to help provide the person's basic personal needs for food, clothing, and shelter.

Evaluator Questions to Assist with Determination

- When has the person last eaten something? What did he/she eat? If the person hasn't eaten today, do they plan to eat today? What did he/she eat yesterday?
- If the person has not been eating is it due to dieting or religious ritual?
- Is the person refusing to eat due to paranoia that someone is trying to poison his/her food?
- Does the person eat certain foods that would be dangerous to his/her health?
- Does the person refuse to wear clothes? Did the person, due to a mental disorder, remove clothing in a public setting?
- Is the person dressed in a manner, which endangers his/her health or safety?
- Is the person refusing to use shelter available to them, as a result of a mental disorder, and instead living in dangerous or unfit conditions?
- Is the person experiencing medical problems as a result of neglecting basic needs of food, shelter, and/or clothing that put him/her at significant risk of self harm?

Your assessment should substantiate that specific factors exist which the person displays to indicate serious faults in comprehension or judgment. These serious faults make the person unable to use the means at his/her disposal or unable to provide for his/her basic personal needs. You must also determine if the person can or cannot accept help or does he/she need someone else to make the decision for him/her to accept help.

You will need to question the person and check his/her answers. Is there food in the refrigerator and/or cupboards? Is the house a fire hazard? Is his/her residence so dirty as to be a health hazard? Does he/she expose himself/herself to "inadvertent" nudity or exhibitionism? Do have consent to speak with a relative or friend to obtain more information?

Guideline Examples for Determination of Grave Disability

These guideline examples are for making recommendations as to whether individual persons are Gravely Disabled or not Gravely Disabled. The following statement, issued by the Attorney General's Office, will provide an overall framework for this determination:

"In determining whether an individual is 'Gravely Disabled' within the meaning of Welfare and Institutions Code Section 5008. (h), the following facts shall be considered:

1. The display of such serious faults in comprehension or judgment as to make him/her unable to use the means at his/her disposal to provide for his/her basic personal needs;
2. His/her inability to request assistance voluntarily to meet these needs."

The 1989 Statute amendments to WIC Sections 5150 and 5350 for determination of who is Gravely Disabled: "An individual 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."

Family, friends, or others shall not be considered willing and able to provide help unless they

specifically indicate their willingness and ability to help provide the person's basic personal needs for food, clothing, or shelter.

Here are additional examples:

	NOT GRAVELY DISABLED	GRAVELY DISABLED
Food:	Has adequate knowledge of his/her nutritional needs. If on special diet (diabetic, etc.) and can follow it with routine medical supervision. Is able to shop for food, prepare simple meals, and/or order from a menu.	Cannot distinguish between food and non-food. Endangers health by gross negligence in necessary diet. Demonstrates excessive and consistent food preferences or aversions which endanger health (except for religious reasons).
Clothing:	Dresses appropriately: buttons buttoned; zippers Zipped; appropriate to season and situation. Can shop for clothing; make arrangements for laundry and/or cleaning. Can make or arrange for minor repairs. Knows to sort out the useful and wearable from the useless, worn out, etc.	Public nudity or "inadvertent" exhibitionism. Bizarre style of dress that would be apt to get patient into trouble (does not include unconventional dress that is used by any social group, class or clan).
Shelter:	Can locate housing. Can negotiate with landlord. Understands payment of rent or mortgage and taxes. Can maintain his/ her own housing, house-keeping etc. Knows how to arrange for utilities, telephone, etc.	Tends to repeatedly misuse parks and bus stations for sleeping. Does not know how to locate housing or communicate with landlords, etc. and/or cannot request or utilize help in doing these housing tasks. Manages household in a way that is a clear danger to health (fire hazard, filth, etc.)

"DANGER-TO-SELF" & "DANGER-TO-OTHERS"

Both Danger-to-Self and Danger-to-Others are essentially the same as for adults in that the following four criteria must be met and must be due to a mental disorder:

MAUI

- **M**eans-Do they have the means to follow through with threats or behavior?
- **A**bility-Do they have the ability (mentally and/or physically) to follow through with risk behavior?
- **U**nwilling/Unable-Are they unwilling or unable to follow through with voluntary treatment?
- **I**ntent-Do they intend to harm themselves or others ***OR*** do they intend to start/continue risky behavior?

When considering these criteria in minors it is also important to **consider the minor's current developmental stage**. For example, what a child has access to or should have access to will vary with age (access to firearms, medications, adult supervision, etc.), and these factors must be considered, especially related to the "means" criteria. Lastly, can the parents/caregivers adequately keep the child from engaging in harm? Can they keep the child from harming other children?

"GRAVE DISABILITY"

Welfare and Institutions Code Section 5008 (1) states:

"A Gravely Disabled minor is a minor who, as a result of a mental disorder, is unable to use the elements of life which are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others."

The definition differs significantly from the adult definition of "Grave Disability". Any determination of "Grave Disability" must still be due to a mental disorder but the evaluation is of the minor's **inability to properly utilize the elements of life, rather than of the minor's inability to provide them**.

- Health- may be evaluated by considering the minor's ability to utilize those elements of the environment which lead to the maintenance, recovery, or development of a state of physical well-being, sufficient to allow the minor to grow and function within the normal demands of the setting where the minor lives. These elements will normally be provided by parents, surrogate parents, health practitioners, and other responsible adults.

- Safety- may be evaluated by considering the minor's ability to assess and cope with the environment, to the degree expected of that age, to the extent that the individual is able to exclude significant threat to self. This threat may be from routine stresses and/or dangers from the environment, or from self-initiated action.

- Development- may be evaluated by analysis of whether or not the minor is able to function and thrive as would usually be expected of a child of that age. Deficiencies in comprehension, judgment, control, and/or learning should be considered.
    - When development is used as the basis for establishing "Grave Disability", it is particularly important to determine a pattern of developmental deficiency, based on

frequency, severity, and/or number of areas of deficiency.

Welfare and Institutions Code Section 5585.25 further states:

"Intellectual disability, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder."

HEALTH

- Examples of graved disability related to health:

    - Neglects nutrition to the extent it becomes life endangering.
    - Consistently remains out of assigned shelter exposing oneself to heat exhaustion
    - Taking bites of clothes in attempt to eat clothing or destroy clothing causing lack of protection from climate conditions.
    - Consistently refuses to maintain standards of personal hygiene to the extent that health is endangered (e.g. risk of infection).
    - Refuses to take medications to address serious medical conditions causing risk of serious injury and/or death.

SAFETY

- Examples of graved disability related to safety:

    - Repeatedly places food in body orifices, other than the mouth, e.g. beans in ears, nose, etc.
    - Eats non-food materials, e.g. razor blades, feces, trash, etc.
    - Repeatedly seeks shelter in dangerous environments, e.g. condemned buildings, areas subject to flooding, fires, or infections, etc.
    - Is dangerously destructive to assigned living quarters, e.g. fire setting, window breaking, etc.
    - Uses shelter to injure self, e.g. head banging, wall hitting, etc.
    - Lights clothing on fire.
    - Injures self or others with clothing.
    - Frequently uses dangerous items inappropriately.
    - Exposes self to dangerous activities due to inability to differentiate reality from fantasy, e.g. attempting to tackle cars on the freeway, attempting to fly without benefit of airplane, etc.
    - Displays impaired judgment in terms of seeking inappropriate social situations, thereby repeatedly and unnecessarily exposing self to social situations likely to result in personal danger.

DEVELOPMENT

- Examples of graved disability related to development:

    - Social skills are vastly impaired (e.g. runs around pushing other kids for no reason) which puts minor at serious risk of injury and/or fights.
    - Smears or throws food, or otherwise handles food in an age inappropriate manner.
    - Begs, steals, or gives away food outside the range of age normal behavior.

- Is consistently unmanageable in assigned living quarters outside the range of age normal behavior.
- Frequently seeks shelter in socially destructive environments, e.g. places of criminal activity, substantial substance abuse, etc.
- Repeatedly refuses to use any assigned and appropriate shelter and instead prefers less desirable shelter (e.g. wants to sleep in the backyard versus bedroom).
- Destroys own or other's clothing inappropriately.
- Persistently defecates in clothing significantly beyond expected age.
- Engages in public nudity beyond age expectancy.
- Habitually gives away or loses clothing beyond age expectancy.
- Is so withdrawn that person cannot obtain the environmental experiences or stimulation necessary for normal development.

PRINCIPLES & GUIDELINES FOR ASSESSING CHILDREN: KEY TERMS

- ***"in loco parentis"-*** This means that you, as the one assessing for 5150, have limited rights, duties and responsibilities to provide for reasonable care for the minor in place of the parent. The ongoing safety of the minor is the primary concern and under ***in loco parentis*** the responsibility for this is transferred from the parent/guardian to you as a designated 5150 evaluator. Additionally, this means that you may, when appropriate, place a child on a hold over the objections of the parent or caregiver.

- When assessing a minor **without the parent/guardian present**, every effort should be made to contact the parent/guardian prior to the evaluation. Such efforts must be documented, especially if you have to complete the assessment without contacting them. In these circumstances the responsibilities and duties transferred to you by ***loco parentis*** permit you to complete the assessment.

- As with adults, Danger to Others, Danger to Self and Grave Disability in minors must be the direct result of a mental disorder (i.e. a disorder defined in the DSM). This means that there is a **greater breadth of available diagnoses to document the probable cause in minors**. Some common childhood diagnoses are:

    - Adjustment Disorder
    - Conduct Disorder
    - Oppositional Defiant Disorder
    - Attention Deficit Hyperactivity Disorder

- The concept of "**Least Restrictive Placement**" is an important principle to remember in the evaluation of children as well as adults, and every effort should be made to ensure that a 5150 is the last available choice to keep the minor safe. If the minor can be treated effectively in an outpatient or voluntary basis safety, this should occur, in place of involuntary inpatient commitment.

- **Emancipated Minors** are considered adults with similar rights, but these cases can become complicated quickly. Consultation on these cases when they arise is prudent and recommended – along with corresponding documentation.

RISK ASSESSMENT

When conducting a risk assessment it is important to remember some basic information:

- We are not good at predicting danger or risk. Therefore you are not expected to prevent danger and risk, but instead assess for danger and risk.
- The expectation is to minimize but not eliminate risk
- Broad consideration of the person, the person's circumstances, and available resources are necessary to develop alternatives to a 5150
- In the end, you will be able to document a defendable rationale for your actions based on your assessment
- Allows you to go home and sleep comfortably

Consider Your Safety First

- Make sure there are exit/escape routes for both you and the patient
- Be aware of all exits
- Ask for backup if you have reason to believe it may be dangerous to conduct the assessment alone
- Believe all threats – if the person threatens you, gently ask, "Do I need to be worried for my safety?" Sometimes a person who is agitated does not realize they are being threatening and will deescalate when asked.

FIREARMS PROHIBITION: PROHIBITION TO OWN, POSSESS, OR PURCHASE FIREARMS

Effective 1997, pursuant to Section 8103 W&IC, when any person taken into custody as **a Danger to Self, or Danger to Others**, under W&IC 5150, and is admitted to a mental health facility under W&IC 5250/5260/5270.15, or placed under court supervision under Section 5350 (LPS Conservatorship), is prohibited from owning, purchasing or possessing a fire arm for five (5) years.

The admitting facility is required to file a report with the State Dept. of Justice, identifying these clients on the day of admission. A subsequent, updated report is required when the patient is discharged from the facility.

Any person who communicates a threat to a licensed psychotherapist, against a reasonably identifiable victim, and the psychotherapist reports to law enforcement, is prohibited from owning, or purchasing a firearm for six months. Enforcement of this prohibition is responsibility of law enforcement—not the authorized person.

Evaluating For Medical Clearance

When persons have physical health concerns or potentially complicated medical issues, they may be required to be seen at a medical hospital prior to being accepted at a designed facility. This is determined by the receiving psychiatrist at the designated facility and/or based on clinical judgment of the 5150 authorized person after assessing for medical problems (e.g. dehydrated; dizzy; overdose; etc.)

Once the patient is seen in the emergency room of a medical hospital, the **receiving psychiatrists** at the designated 5150 facilities will make the final determination if the patient is medically cleared for admission to their facilities. The easiest way to define medical clearance for the purpose of admission to a locked psychiatric facility is to ask the following question:

If the patient was **not** on a 5150, could the patient be discharged home with no home health treatment and no follow-up with outpatient doctor's appointment needed for at least 48 hours?

If the answer is yes, the patient may be referred to the designated 5150 facility for admission. However, the **receiving psychiatrist** may ask for additional labs, medical test results etc. or request that the patient be observed longer in the medical hospital prior to being accepted for admission to the psychiatric facility.

Medical clearance may be necessary due to these examples, but not limited to: the person is significantly intoxicated by alcohol; is experiencing a serious medical problem such as dehydration and/or dizziness; attempted suicide via overdose or substantial cutting.

INVOLUNTARY PSYCHIATRIC HOSPITALIZATION GUIDELINES

1. Individuals with private healthcare insurance:

    - County residents, requiring involuntary psychiatric hospitalization, who have private health insurance, may be transferred to any Riverside County 5150 designated facility for which their private insurance will authorize payment.

    - Individuals who require involuntary psychiatric hospitalization should generally be referred to a facility that is closest to their homes. However, Inpatient Treatment Facility (ITF) in Riverside and Psychiatric Health Facility (PHF) in Indio have priority to serve those who are indigent/uninsured or have Medi-Cal insurance coverage. Therefore, all hospitals must determine if individuals who have been placed on a 5150 hold have private insurance coverage, and if so, seek insurance company authorization of payment for hospitalization. If authorized, the individual should then be transferred to the designated facility that has been approved by the insurance company for admission.

2. Sending individuals on an involuntary hold to a facility <u>not</u> designated by Riverside County is illegal.

3. Detaining individuals who are willing and able to accept voluntary psychiatric hospitalization is illegal.

4. Writing 5150 holds without being authorized by Riverside County is illegal. This includes writing 5150s after your authorizations expired.

Suicide Fact Sheet in the United States (CDC, 2015)

Prevalence

- In 2013, suicide was the 10th leading cause of death for all ages.
- In 2013, there were 41,149 suicides, at a rate of 113 suicides each day or one every 13 minutes.
- In 2010, 33.4% of people who died from suicide tested positive for alcohol, 23.8% for antidepressants, and 20.0% for opiates, including heroin and prescription pain killers.
- Societal costs of suicide are an estimated $51billion in medical and work loss costs.

Suicide and Gender

- Males represent 77.9% of all suicides, taking their own lives at nearly 4 times the rate of females.
- Suicide is the 7th leading cause of death for males and the 14th for females.
- Firearms are the most common method used by males (56.9%).
- Poisoning is the most common method used by females (34.8%).
- Females are more likely than males to have suicidal thoughts.

Suicide and Age

- Suicide is the 3rd leading cause of death among persons aged 10 to 14 years, the 2nd among persons aged 15 to 34, the 4th among persons aged 35 to 44, the 5th among persons aged 45 to 54, the 8th among persons aged 55 to 64, and the 17th among persons aged 65 years and older.
- In 2011, middle-aged adults had the highest suicide rate (56%), nearly 30% increase from 1999-2010.
- Full-time college students aged 18 to 22 years were less likely to attempt suicide compared with others in the same age group (0.9 vs. 1.9%).

Suicide and Race/Ethnicities

- Among American Indians/Alaska Natives across all ages, suicide is the 8th leading cause of death.
- Among American Indians/Alaska Natives aged 10 to 34, suicide is the 2nd leading cause of death.
- Among American Indian/Alaska Native adolescents and young adults ages 15 to 34, the suicide rate is 1.5 times higher than the national average for the same age group (19.5 vs. 12.9 per 100,000).
- The percentages of adults aged 18 or older having suicidal thoughts in the past year were 2.9% for blacks, 3.3% for Asians, 3.6% for Hispanics, 4.1% for whites, 4.6% for Native Hawaiians/Other Pacific Islander, 4.8% for American Indians/Alaska Natives, and 7.9% for people reporting two or more races.
- Among Hispanic students in grades 9 to 12, the prevalence of considering suicide attempt were 18.9%, having suicidal plan 15.7%, having suicide attempt 11.3%,

having suicide attempt that resulted in medical attention 4.1% was higher than white and black students.

Suicidal Thoughts and Behavior

Among adults over 18 years during 2013:

- An estimated 9.3 million people (3.9% of the adult population) reported having suicidal thoughts in the past year.
- Among adults aged 18 to 25 had the highest percentage for having serious suicidal thoughts (7.4%), followed by adults aged 26 to 49 (4.0%), then by adults aged 50 or older (2.7%).
- An estimated 2.7 million people (1.1%) reported having suicidal plan in the past year.
- Of the adults who had suicidal plan in the past year, 2.5% were adults aged 18 to 25, 1.35% were adults aged 26 to 49, and 0.6% were those aged 50 or older.
- An estimated 1.3 million adults (0.6%) attempted suicide in the past year. Of the total, 1.1 million reported having suicidal plans while 0.2 million did not have suicidal plans.

Among students in grades 9 to 12 during 2013:

- 17.0% of students had serious thought about suicidal attempt in the past year. Of the total, 22.4% were females and 11.6% were males.
- 13.6% of students had suicidal plans in the past year. Of the total, 16.9% were females and 10.3% were males.
- 8.0% of students attempted suicide in the past year. Of the total, 10.6% were females and 5.4% were males.
- 2.7% of students who attempted suicide required medical attention. Of the total, 3.6% were females and 1.8% were males.

Risk Factors

Several risk factors have consistently been identified to increase the likelihood of persons attempting suicide or dying by suicide.

- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- History of mental health disorder, depression in particular
- History of alcohol and substance abuse
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Cultural and religious beliefs
- Local epidemics of suicide
- Isolation, a feeling of being cut off from other people
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal methods

- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or suicidal thoughts

Protective Factors

While protective factors for suicide have not been studied as extensively as risk factors, they are believed to prevent individuals from having suicidal thoughts and behavior.

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

13 DEFENSIBLE HYPOTHESES CONCERNING VIOLENT BEHAVIOR

By J. Reid Meloy, Ph.D.

1. Violent behavior cannot be predicted with absolute certainty.

2. Probability statements can be made about violent behavior when enough information is known.

3. There is not enough research to know how to accurately predict community violence.

4. Long-term institutional violence, or lack thereof, does not necessarily predict community violence, of lack thereof.

5. Recent clinical research in acute psychiatric settings is more accurate in predicting violence. There also appears to be a correlation between violence in acute psychiatric inpatient settings and community violence.

6. There are individual and situational factors that do correlate with violence.

7. No psychological tests predict violence, but certain psychological test variables appear to correlate with violent behavior.

8. The higher the base rate for violence behavior in a given population, the more accurate the prediction of violence can be.

9. Violent behavior may be due to biological, psychological, and/or social factors.

10. Violence can be conceptualized as either emotional-laden or predatory.

11. The more primitive the violence, the more involved are the primitive portions of the brain; that is, the limbic system and the reticular formation.

12. Virtually all individuals have the biological structure to be violent, but will usually not express it due to higher cortical functional and structural inhibitions.

13. The four most significant demographic variables that predict violence are:

    a. Male gender
    b. Alcohol and/or drug intoxication
    c. Paranoid ideation
    d. Past history of violent behavior

20 TIPS FOR CONDUCTING ASSESSMENTS IN HIGHLY STRESSFUL OR DANGEROUS SITUATIONS

1. Try to focus on the client's worldview.

2. Focus on behavior and try to avoid speaking for the client.

3. Use simple and concrete terms.

4. Be mindful of your tone, volume and tempo of speech.

5. Do not challenge the abilities of the person in crisis by asking complex questions.

6. When setting limits, make sure they are clear, reasonable and enforceable.

7. Be patient and speak clearly.

8. Avoid predicting future events and making promises.

9. Be genuine and authentic.

10. Make sure to validate the client's emotions even when you cannot validate their behavior.

11. It is vitally important that the patient in crisis feels that he/she is being heard.

12. Don't adopt a defensive posture (arms and feet crossed; chair leaning back; hands in pockets or hidden behind you). Keep hands in view, with a neutral, respectful stance.

13. Be concerned about your own personal safety – ask for additional staff if you feel anxious.

14. Be thoughtful about where you are going to meet with the client, considering safety and well-being of the client and staff. Leave a way open for flight – be aware of exits for both you and the client.

15. Assess present cognitive and affective state.

16. Consult with any other staff or collateral contacts that may have knowledge of current or present stressors, risk factors, or protective factors.

17. Assess role of external and internal factors – restructure the physical setting to decrease stimuli.

18. If at all possible, determine past history of violence.

19. If a client presents with significant anger, acknowledge their anger and ask if staff is in immediate risk. Allow client to take breaks and engage in coping skills as needed. Avoid discussing triggers until the client is de-escalated and it feels safe to do so.

20. Remain issue and problem solving oriented.

HOSPITAL AND COMMUNITY PSYCHIATRY

DIAGNOSING DANGEROUSNESS:

HEDLUND EXPANDS THE LIABILITY OF TARASOFF

by

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(*Please note: The following article was not written by Riverside County, but has been used for many years as the guiding concept in the practical application of Tarasoff duties in Riverside County. Though many of the articles' points are still salient today, because laws and the interpretation of laws change over time, not all lines of reasoning from this article can be applied directly as written. This article is reviewed in conjunction with a live presentation. Application of this material should be applied in the context of the updated information provided during a LPS 5150 authorization training and should not be applied independently. No one should make a Tarasoff decision alone. Please consult with your supervisor and group of your colleagues before determining an appropriate course of action.)

In this article, we briefly review the holdings of Tarasoff (1) against its original background,

explain the holdings of the recently adjudicated Hedlund (2) case, and explore how these holdings extend the liability of clinicians. More important, the article articulates the proper clinical response to situations in which clients threaten harm to third parties and describes a schema that can help therapists make decisions, which are both clinically responsible and legally sound.

When the California Supreme Court's Tarasoff (1) decision burst on the scene in 1974, it was widely predicted that it would radically affect the practice of psychotherapy **by establishing that psychotherapists had a duty "to exercise reasonable care to protect the foreseeable victims of danger" (1) posed by their patients**. In actual fact, however, very few cases were tried in California or elsewhere which used Tarasoff as the basis for a cause of action. This was one of the surprises of the aftermath of Tarasoff. However, the California Supreme Court issued a decision on September 19, 1983, which not only confirmed Tarasoff, but actually extended it in several important ways. The case, Wilson et. al. v. Superior Court of Orange County, usually referred to as the Hedlund case (2), may be very influential, not because it changes Tarasoff in any significant conceptual way, but because the extensions may open the gates to much more frequent use of Tarasoff as precedent.

Tarasoff v. Regents of the University of California (1) was the subject of controversy and misunderstanding from the time it was issued. The case is still commonly- and incorrectly- cited as imposing a duty on psychotherapists to warn intended victims of serious threats of violence made by patients receiving mental health treatment.

To counter what appears to be general confusion about the case and its practical effects, it may be useful to clarify the actual facts and holdings of Tarasoff, and to indicate how those holdings have been affected by subsequent litigation.

<u>The essential facts in Tarasoff v. Regents of the University of California are these:</u>

Prosenjit Poddar, a Berkeley graduate student, was persuaded to seek aid at the Mental Health Department of the student health services on the Berkeley campus because of his obsession with a female student, Tatiana Tarasoff. In the course of his treatment, he confided to his therapist that he intended to harm Tatiana. The therapist took the threat seriously, attempted to dissuade Poddar, and failing to do so, requested the campus police to detain Poddar briefly, but judging him rational, they released him. Two months later, on October 17, 1969 he killed Tatiana Tarasoff. Tatiana's parents sued the therapist, the police involved, and the University of California as their employer, on the grounds that the defendants had failed to confine Poddar, and that they had failed to warn Tatiana that she was in danger. Eventually, the California Supreme Court was called upon to decide whether Tatiana's parents had a cause for action against the defendants. Later, in 1974, the court decided that a cause for action for negligence did exist against both therapist and the police for the "failure to warn" (Tarasoff I). (3) After great outcry from the professions and institutions involved, the Court, in an unusual move, agreed to a rehearing. The Court's definitive decision, issued on July 1, 1976 (Tarasoff II), (1) exempted the police from potential liability, but held that the plaintiff's suit could be amended to provide a cause for action in law against the therapist. The Court also laid down a standard against which the obligations of therapists in such cases could be measured, but it did <u>not</u> establish a duty

to warn.

The change between Tarasoff I and Tarasoff II is undoubtedly the cause of much of the confusion about the practical ramifications of the Tarasoff case. It is important to note that, contrary to some reports of the case, the Court did not find anyone actually liable—it left that question for the lower court to decide. It merely found the therapist potentially liable under the law. Furthermore, since the case was settled out of court, no actual liability was ever found against anyone.

The standard set by the Tarasoff case for therapists reads as follows: "When a therapist determines, or pursuant to the standards of his/her profession should determine, that his/her patient presents a serious danger of violence to another, he/she incurs a serious obligation to use reasonable care to protect the intended victim from such danger" (1). Thus, the Court held that, although there is no relationship between the therapist and the person threatened, the special relationship between the therapist and the therapist's patient is sufficient to impose on the therapist a legal responsibility for assaultive acts committed by the patient under the following conditions: Either the therapist knows that his/her patient poses a serious threat to another person, or the therapist negligently fails to predict the threatened assault (that is, the therapist should have known of the danger), and the therapist fails to take appropriate steps to avert the danger, and the patient actually assaults the person threatened.

The immediate question that arises for a clinician is, "What is meant by the phrase 'reasonable care to protect the intended victim' (Tarasoff II, p 431)." (1) The Court does not set down a rigid standard; it recognizes that what is reasonable in one (1) situation may not be reasonable in another. Also, it does not hold the therapist to a perfect standard as judged by the wisdom of hindsight. **The Court makes it very clear that, in some cases, a warning to the threatened party or some other particular action may be too radical a course to constitute "reasonable" care. In other cases, warning the victim may not be sufficient to fulfill the therapist's obligation. The fact that Tarasoff I does not simply mandate a warning in every case has been repeatedly emphasized here because it has so often been misunderstood to mean exactly that.**

The therapist's legal duty can be better understood if we consider factors that influence the existence of a legal duty in general. The Court in Thompson lists these as "the foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost, and prevalence of insurance for the risk involved." (4)

These are the factors that the California Supreme Court took into consideration when it affirmed the existence of a duty based on the theory that a special relationship exists between the therapist and the patient. A later decision of the New Jersey State Court, Milano (5) has gone even further by saying that the existence of a duty to warn may also be based more broadly on a moral obligation so the welfare of the community analogous to the obligation that a physician has to warn a third person of infectious or contagious disease.

It might, then, be useful to think of Tarasoff as establishing a legal duty that requires therapists to do what a responsible therapist would do anyway, namely, to take necessary measures to protect endangered persons while still maintaining confidentiality to the extent possible.

Several Court decisions have clarified the application of Tarasoff to practical situation. Bellah v. Greenson (1977) (6) involved a young woman who killed herself while under a doctor's care. The doctor had concluded that the young woman was in danger of committing suicide, and he had noted that fact in his records. Two (2) years later, the young woman's parents sued the doctor for failing to warn them of her condition. The Court said that the parents had no cause for action, since threats to self and property were not mentioned in Tarasoff. The Court declined to extend the holdings of Tarasoff to suicide and property damage because confidentiality is the overriding concern in these cases.

In Thompson v. County of Alameda (1980) (4), a juvenile probationer who had threatened to kill an unnamed neighborhood child was nonetheless released on home leave. Immediately, he killed young Thompson, whose parents sued Alameda County for releasing the juvenile probationer at all, for not exercising due care in not warning people in the style of Tarasoff, and for choosing the probationer's mother as custodian. The County was ruled immune from suit both for releasing the juvenile and for the choice of custodian. While the County was not immune from Tarasoff suits, **the court ruled that Tarasoff did not apply to no-specific threats to non-specific persons. Thus, for Tarasoff to apply, the victim must be identifiable, and the peril must be foreseeable.**

Mavrodis v. Superior Court of the County of San Mateo (1980) (7) concerns a couple who, after being beaten by their son, sued to obtain his medical records from various psychiatric institutions to prove that they should have been warned. The Court provided for an in-camera review of the records, then ruled that "if a patient does not pose imminent threat of serious danger to a readily identifiable victim, a disclosure of patient's confidence would not be necessary to avert threatened danger, and therapist would be under no duty to make such disclosure" (p. 725) (7). **Imminence of danger is therefore necessary for the Tarasoff duty to exist.**

The Hedlund case involves suits brought by LaNita Wilson and her minor son, Darryl Wilson, against two (2) licensed psychologists, Bonnie Hedlund and Peter Ebersole. LaNita and Darryl allege that while LaNita and her boyfriend, Stephen Wilson, were receiving mental health services from Drs. Hedlund and Ebersole, Stephen told his therapist that he intended to shoot LaNita. LaNita further claims that, despite Stephen's threat and despite the fact that the psychologists' professional skills ought to have led them to believe this threat to have been serious, Drs. Hedlund and Ebersole did not take reasonable care to protect her safety or that of other foreseeable victims. This could have been done by warning LaNita of the threat, notifying the police, or taking other reasonable preventive actions. But since they did not take any preventative action and Stephen did carry out his threat on April 9, 1979, by shooting LaNita with a shotgun, and in the process also wounding three-year old Darryl, LaNita brought suit on her own behalf and also on Darryl's.

The psychologists, for their part, sought to have the Wilson suits dismissed on the grounds that LaNita's claim was filed after the expiration of the one-year statute of limitations for

personal injury, and that Darryl's suit failed to state a cause for action. However, the Orange County Superior Court overruled the demurrer (objection) of the psychologists, so they petitioned the California Supreme Court to reinstate their demurrer and dismiss the action against them.

The issue in LaNita's case that the California Supreme Court was called upon to decide was whether a negligent failure to comply with the duty recognized in Tarasoff constituted "professional negligence" (which carried a three-year statute of limitations) or simply a personal injury (with the one-year statute of limitations). The psychologists argued that "professional negligence" applies only to those things in the course of diagnosis and treatment resulting in injury to the patient and that any injury occurring to a third party as a result of a "failure to warn" is ordinary negligence to which the one-year statute of limitations applies.

The Court agreed, however, with LaNita's contention that the statutory definition of professional negligence is not limited to injuries which happen to a "patient." It also supported her argument that the essence of Tarasoff duty is derived from the professional skill of the therapist to diagnose or recognize the danger posed by a patient. The duty to warn or take other appropriate action flows from this professional diagnostic skill and is, in the Supreme Court's opinion, inextricably interwoven with it. Therefore, the Court upheld the Superior Court's decision that a therapist's failure to fulfill the Tarasoff duty toward third parties constituted professional negligence subject to a three- year statute of limitations and LaNita's cause for action was upheld.

Darryl's stated cause for action was that he suffered serious emotional damages as a bystander to Stephen's attack on LaNita. Darryl claimed that it was foreseeable that Stephen's threats, if carried out, would bring considerable risk to bystanders and especially those, like Darryl, in close relationship to LaNita.

He further argued that the psychologists' duty of reasonable care therefore extended to him and that the duty was breached when they failed to act to protect LaNita and other foreseeable victims.

In reply to these allegations, the psychologists simply argued that because Stephen made no threat against Darryl, and they had no duty to warn him of the threat to LaNita, there is no cause for action in the case.

The question the Court saw was whether a therapist, who fails to fulfill the duty to protect an identifiable potential victim, may be liable not only to the threatened person, but also to persons who may be injured if the threat is carried out. **The Court did not need to decide the question of whether all bystanders are covered because, in this case, it felt that there could be no doubt but that harm coming to Darryl was foreseeable if the threat against LaNita were carried out. Since the Court saw Darryl as a foreseeable and identifiable victim, it is not surprising that it decided to extend recognition of a Tarasoff duty to persons in close relationship to the object of a patient's threat by reasoning that the existence of such possible endangered persons is one of the factors to be considered in evaluating the danger and choosing appropriate**

protective steps. **The Court denied the psychologists' petition on Darryl's cause for action because the possibility of injury to Darryl, if Stephen carried out his threat to LaNita was, in its view, foreseeable and, therefore, any negligent failure to diagnose or warn LaNita of the danger posed by Stephen constitutes a cause for action for Darryl.**

What are the practical implications of Hedlund for psychotherapists? It could be argued that Hedlund changes nothing in the way that therapists should act to fulfill their Tarasoff obligations; it only heightens their liability if they do not act in that way: (1) **by extending the length of time that they are able to be sued after an injury from one year to three; and (2) by expanding the persons who may have a cause for action against them from the victim of a patient's attack to also include foreseeable bystanders of such an attack**. In this view, clinicians should follow the same procedures as after Tarasoff, but there is now an increased likelihood that they will incur liability by not following a guide for action such as the one below.

A GUIDE FOR ACTION

The critical issues and options facing clinicians as a result of Tarasoff as expanded by Hedlund can be identified in the decision chart (See Figure 1). The clinician can use the chart to organize his/her thinking by following the chart from Step A to Step G. The issues depicted in the chart arise when a client who comes under the protection of confidentiality poses a threat of serious harm to a third party. **Note that threats of suicide or threats of destruction of property do not warrant consideration under Tarasoff, because, in these cases, the client's right to confidentiality is presumed to outweigh the potential danger.**

STEP A

Here, the (decision) chart calls for the therapist to distinguish between clear threats of harm and vague threats of harm. A vague threat is something like: "If this keeps up, I might do something bad to my mother." In such cases, the clinician must make reasonable inquiry to clarify the client's meaning, but need not conduct an interrogation. A degree of clinical skill and common sense is called for at this point, because the clinician can be held liable for making "a reasonable decision according to the standards of the profession" (Tarasoff II, p. 431) about whether the threat was, in fact, clear.

STEP B

If the threat is seen as clear, the clinician proceeds to Step B. Clinical judgment again comes into play, since the mental health professional must decide whether the threat already determined to be clearly expressed presents only marginal danger (for example, because the threat itself is frivolous or because of the person making the threat), or whether it presents a serious and actual danger. If the therapist determines that serious danger exists and the therapist works in an agency, the appropriate clinical supervisor must be contacted, and the treatment plan must be reviewed according to standard agency procedures. A therapist in private practice should seek consultation from a colleague and establish ample

documentation to buttress (support) his/her legal position. **Clinicians need to remember that they will be judged against "the standards of the profession" (Tarasoff II, p. 431) (1) if it has to be determined whether they ought to have uncovered the existence of a serious danger. This Step is particularly important after Hedlund because of that case's heavy emphasis on the diagnostic responsibility of clinicians to recognize danger.**

STEP C

Now, the clinician considers whether there is an identifiable potential victim of the serious danger threatened. If the clinician cannot identify a specific victim as seriously threatened, the clinician is under obligation to make a reasonable inquiry. **When a specific victim has been named – or when the specific victim is able to be discovered, "upon a moment's reflection" (Tarasoff II, p. 439)–the clinician proceeds to Step D. But, if after inquiry, there is still no identifiable victim, the therapist, as Thompson makes clear, has no Tarasoff obligations. Careful treatment should continue. However, prudence requires the clinician to document his/her reasons for deciding that the victim is not identifiable.**

STEP D

The decision involved in Step D concerns the imminence of the serious danger to an identifiable person. **If the threat of danger is serious but not imminent, the reasons why not imminent danger is seen must be documented in the client's record. The treatment plan can be aimed at reducing the client's potential for violence, and it can be reviewed for progress by a clinical supervisor or colleague.** If the clinician determines after consultation that the danger is imminent, he/she proceeds with the documentation and treatment, but also continues on to Step E.

STEP E

Here, the person threatened is distinguished as a member of one of three different groups: family members or significant others; public officials; and all other persons. **If a public official is threatened seriously and imminently with harm, there are no further decisions to be made. The police must be contacted immediately.** If a family member is threatened, then the clinician proceeds to STEP F. If the threat is to any other person, then the clinician skips STEP F and proceeds to STEP G.

STEP F

In this step, **the therapist determines whether the client and the familial victim are amenable to treatment within the context of family therapy.** If the case is amenable to family therapy, then the potential for violence (and also the warning to the threatened person) can be dealt with in the framework of the system that presumably evokes the violent response. Wexler (9) makes a strong case for the utility of this approach. The therapist should also carefully consider the danger which may foreseeably exist for other family members should the threat be carried out. However, if the clear, serious threat of imminent harm is made not to a public official or a family member, but to some other

specific person, or if the threat to the family member occurs in a case that is not amenable to family therapy, the clinician proceeds to STEP G.

STEP G

This Step provides several options. **The therapist can have the client involuntarily committed to a mental institution as "dangerous to others" if the proper criteria are met. The clinician can warn the victim, warn the relatives of the victim, and call the police - in any combination. Indeed, the clinician may be obligated to do one or all of these things, depending on what seems to provide reasonable care for the safety of the person threatened.** The clinician can also take any other actions that seem reasonable, separately or in combination with the options already mentioned. In any case, care must be taken to document the actions that are taken, including the rationale for the choices made. The rationale is important, because therapists are held to a standard of reasonable care, not a standard of successful performance whatever choice the therapist makes in STEP G, it is important for the therapist to follow-up on the results of the choice, both for the client and for the potential victim.

It could also be argued, however, as the dissent in the case eloquently does argue, that by so heavily and unnecessarily relying on the supposed predictive powers of therapists, the Supreme Court has placed an unnatural and unreasonable burden on psychotherapists to predict the unpredictable and prevent the unpreventable. It is possible that Hedlund decision could unleash some of the dire consequences predicted after Tarasoff. Time will tell. In the meantime, clinicians must go on caring for their client in a way that pays prudent regard to the safety of third parties.

CITATIONS

Tarasoff V. Regents of the University of California, 17 Cal. 3rd, 425, 551 P. 2nd. 334, 131 Cal. Rptr. 14 b(1976) (Tarasoff II), vacating 13 Cal. 3rd. 117, 529 P. 2nd, 553, 118 Cal. Rptr. 129 (1974) (Tarasoff I).

Hedlund et. al. V. Superior Court of Orange County Wilson et. al. (Real Parties in Interest) LA 31676 (1983)

Tarasoff V. Regents of the University of California, 13 Cal. 3rd. 117, 529 P. 2nd. 553, 118 Cal. Rptr. 129 (1974) (Tarasoff I) vacated by Tarasoff V. Regents of the University of California, 17 Cal. 3rd. 425, 551 P. 2nd, 334, 131 Cal. Rptr. 14 (1976) (Tarasoff II).

August 2004

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An Expansion of the Therapeutic Duty to Warn in a Tarasoff Situation

Recently, the California Appellate Court released a ruling in recent case involving "duty to warn" (Ewing v. Goldstein, 2004). The court ruled that the term "communication" as used in Civil Code 43.92 was not limited to specific communications made by a client to a therapist. Rather, it expanded the use of this term to mean a communication made by a significant family member of the client to a therapist that "leads the therapist to believe or predict that the patient poses a serious risk of grave bodily injury to another." What does this mean to mental health clinicians? As a forensic expert witness, I would like to explain the application in clinical practice of this therapeutic duty.

As of July, 16, 2004, licensed psychotherapists would consider this ruling to be a therapeutic duty. CADCs and CATSs would consider this ruling to be standard of care since they are not recognized by California law nor are these directly applicable to them. However, as reasonable and prudent clinicians, standard of care does apply to these clinicians.

In this case, a psychologist recommended that a client hospitalize himself for observation due to suicidal ideation emanating from a break up with his girlfriend and later began a relationship with a new boyfriend. During the client's hospitalization, the psychologist received a communication from the client's father indicating that his son intended to do serious harm to the boyfriend after he was released from the hospital. The father requested that his son be kept hospitalized for further observation. He was not and upon release, the client murdered the boyfriend and killed himself.

The parents of the murdered boyfriend sued the psychologist for wrongful death due to professional negligence. They contended that the psychologist failed to apply Civil Code 43.92 appropriately and did not warn their son of the serious intention to harm him by the psychologist's client. The Superior Court "threw the case" out of court in a summary judgment because the communication to do serious harm did not come from the client. However, the Appellate Court reversed the summary judgment and agreed that Civil Code 43.92 was interpreted too narrowly. It expanded the meaning of patient communication to include pertinent communications from immediate relatives of the client. It also based its ruling on the inclusion of "communications to psychotherapists by intimate family members" established by a previous Case law (Grosslight v. Superior Court, 1977), which ruled that relevant communications about a client made to a psychotherapist by intimate family members are considered privileged.

Clinical Applications

Mental Health clinicians would consider the following regarding this recent ruling:

1. Apply these changes to their clinical practice immediately.

2. When such a communications regarding a client's "serious threat to harm" is made by an intimate family member, clinicians must consider a communication as part of the contextual reference associated with the client's "mental or emotional disorder, life history, current circumstances and personal or familial relationships."

3. A clinician would ask the following questions: a) is this statement valid? b) Does this statement make sense in light of the client's mental disorder or emotional perturbation? c) In what context did the intimate relative become aware of this information? d) What is the seriousness of the threat to harm?

4. Once these questions have been answered, clinicians would next determine if the communication meets the rest of the Tarasoff standards: a) is this a serious threat to harm? And, b) is there an identifiable victim who is unaware of the threat? If so, clinicians would apply Civil Code 43.92 to make sure they make their legally mandated report appropriately. (CADCs and CATSs use this law as standard of care because they are not legally mandated under this law due to their unlicensed status.

5. In all situations, precise documentation of clinicians' reasoning process of how they determined that a Tarasoff mandate exists or does not exist is required. Clinicians can be sued for "breaching confidentiality" as well as for "failure in their duty to report a serious threat to harm" under Tarasoff. This degree of documentation is a must in such legal actions.

Clinical Examples

Example #1. Anthony was recently fired by his firm due to outsourcing of jobs to another country and has recently become depressed. He has been seeing a therapist for several months due to spousal conflict and to him this is "the last straw." He confides in his sister and tells her the company "is going to pay," however he is not specific about his plans. He refuses to share any more information with her. Worried, his sister calls the therapist and leaves a message on her answering machine telling the therapist what Anthony told her.

As a reasonable and prudent clinician, what recommendations would you make to Anthony's therapist?

A) Follow Civil Code 43.92 immediately and call the police and warn the intended victim.

B) Explore this statement in therapy with Anthony because the therapist does not have a mandate to report under Ewing v. Goldstein.

C) Call the sister and ask her for more information.

B is the best answer. The therapist needs a written Release of Information to speak with the sister. The information provided does not meet the standards set by Tarasoff or Ewing v. Goldstein.

Example #2. John seeks therapy because his lover has decided to leave the relationship and move in with his boss. He can't believe that his ex-lover is involved with a "trashy" person. He tells his mother: "I'm going to put a stop to this foolishness and I am going to teach this trashy person not to steal my lover away from me. I know where he lives and he's going to learn his lesson" His mother is concerned and believes John is serious about hurting the boss, whom she knows. She calls John's therapist and since she has been to see him in conjoint sessions with her son, she leaves a message for the therapist to call her immediately. The therapist calls her and she informs him with great urgency what John has told her.

As a reasonable and prudent clinician, what recommendations would you make to Anthony's therapist?

A) Consider the statement contextually. Is it valid? Does it meet the standards set by Tarasoff and Ewing v. Goldstein? If so, follow Civil Code 43.92 immediately and document his reasoning process carefully and precisely.

B) Wait until the next appointment to bring this issue up with John.

C) Refer John to a psychiatrist for immediate evaluation for medication.

The correct answer is A. Waiting until the next visit places the boss in danger and the therapist could be sued for failure to follow his duty to report a serious threat to harm under Tarasoff. Referring to a psychiatrist does not meet the standard of care. Thus, the clinician must consider the context under which John's mother made the communication and if valid (it meets the standards set by Tarasoff and Ewing v. Goldstein), the clinician must apply Civil Code 43.92 as required by law (for CADCs and CATSs, as required by ethical standards and standard of care).

INSTRUCTIONS TO COMPLETE 5150 FORM

Note: ALWAYS USE THE MOST CURRENT QI 5150 NCR FORM (QI 5150 NCR rev 1/2017)

1. Always use black ink or type.
2. Always write legibly or use the fillable form on the RUHS-BH website.
3. Inform the client who you are and give advisement.
4. Detainment Advisement Section:
    - Fill out section "My name is…" writing the first and last name of the person who provided the advisement
    - Check box indicating if Advisement Complete or Incomplete.
    - If "Advisement Incomplete", indicate reason under "Good Cause for Incomplete Advisement". One sentence is sufficient.
    - Print your first and last name, your professional discipline (i.e. MD, RN, LMFT, LCSW, Psy.D etc.) under "Advisement Completed By" section.
    - Under "Position" write your job title, (i.e. House Supervisor, Nurse Manager, Director, CT I, CT II, BHS III, etc.)
    - Indicate which language or modality the advisement was given.
    - Indicate "Date of Advisement"- this is the date you are writing the document.
5. Under "To (name of 5150 designated facility)" write in the legal name of the Riverside County LPS designated 5150 facility given in this manual where the client is expected to be admitted and evaluated. This is an administrative section that can be altered to update an accepting Riverside County LPS designated facility if needed by crossing out the previous facility name, initialing and adding your badge # or license #.
6. Under "Application is hereby made for the admission of" print client's legal name.
7. Write in Date of Birth or age if known.
8. In "Residing at" section, write the client's address if known. If you are provided with a DMV License/ID always verify if the address on the card is the correct and current address. If homeless, write in "homeless" and the city that they are homeless in.
9. Ask if the client has a legal guardian or conservator. Circle one choice when appropriate. Even if the parent is with the child he/she may not be the legal guardian.
10. Write the name, address and phone number of legal guardian or conservator or family member identified by client. (A payee is not the same as a conservator).
11. Under first narrative section, state briefly how the situation was called to your attention.
12. Skip to the criteria boxes. Formulate your conclusion as to why this person meets the criteria for Danger to Self, Danger to Others and/or Gravely Disabled adult or Gravely Disabled minor. Check all that apply.
13. Return to narrative section and provide enough information to support the criteria for the boxes that you checked. Use applicable quotations. Do not write "unable to contract for safety."
14. In the "Signature" section, **sign your name** and write your professional discipline after your name (i.e., MD, RN, LCSW, LMFT, etc.)
15. Write the name of your agency or facility where you work including the address.
16. Under "Date" write the date you are writing this hold. This date starts the 72-hour clock.
17. Under "Time" write the time that starts the 72-hour clock using military time or A.M. or P.M. **You <u>MUST</u> write the time. Writing a hold without a date/time is invalid and illegal.**
18. Under "Phone", write a contact number of your facility where you can be reached if there are further questions.
19. Always send the original copy with the transportation company transporting the client.

25. **STOP! Do not fill out section, "Notifications to be provided to Law Enforcement Agency", unless you are law enforcement.**
26. If a hold is discontinued due to the client requiring an admission to the medical floor, a re-assessment of the client's **<u>CURRENT</u>** mental status must be conducted after the client has been medically stabilized and cleared by the attending physician.
27. **Fax a copy of the 5150 to LPS 5150 Certification & Oversight at (951) 351-8027 within 1-3 business days. Failure to do so may result in authorization being terminated.**

5150 FORM: BLANK SAMPLE (FRONT SIDE)

Riverside University Health System- Behavioral Health *Only if hold discontinued, Date:_____Time:_____Signature:_____*

APPLICATION FOR ASSESSMENT, EVALUATION, AND CRISIS INTERVENTION OR PLACEMENT FOR EVALUATION AND TREATMENT

Pursuant to W&I Code 5150, 5585 & Penal Code 4011.6

Confidential Client/Patient Information
See California Welfare and Institutions Code (W & I) Code, Section 5328 & HIPAA Privacy Rule 45 C.F.R. § 164.508

Welfare and Institutions Code (W&I Code), Section 5150(f) and (g), 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	Language or Modality Used	Date of Advisement

DETAINMENT ADVISEMENT

My name is _____.
I am a (mental health professional/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:

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

Do not leave blank. Do not write "Any LPS Designated Facility." You are required to specify the facility. You may line through and initial if facility name is changed.

To (name of 5150 designated facility) _____

Application is hereby made for the assessment and evaluation of (name of person) _____
If homeless, indicate city of residence.

Date of Birth _____. Residing at _____, California, for up to 72-hour assessment, evaluation, and crisis intervention or placement for evaluation and treatment at a designated facility pursuant to Section 5150 et seq. (adult), Section 5585 et seq. (minor), of the W&I Code and Penal Code 4011.6 (person in custody). If a minor, authorization for voluntary treatment is not available and to the best of my knowledge, the legally responsible party appears to be/is: (Circle one) Parent; Legal Guardian; Juvenile Court under W&I Code 300; Juvenile Court under W&I Code 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: _____

I have probable cause to believe that the person is, as a result of a mental health disorder, a danger to self, or a danger to others, or gravely disabled because (state specific facts) _____

Do not leave blank. You are required to indicate reason voluntary treatment is not a viable option.

Voluntary treatment is not available/not a viable option due to: _____

Based upon the above information, there is probable cause to believe that said person is, as a result of mental health disorder:
☐ **A danger to self.** ☐ **A danger to others.** ☐ **Gravely disabled adult.** ☐ **Gravely disabled minor.**

Signature, title, and badge number of peace officer, professional person in charge or the facility designated by the county for evaluation and treatment, member of the attending staff, designated members of a mobile crisis team, or professional person designated by the county.	Date:	Phone:
Signature: Position Title:	Time: Military hrs or ☐AM ☐PM	
Print Name:	Agency Name and Address of Law Enforcement Agency/Evaluation Facility/Person:	**Penal Code 4011.6 only** Date and time person no longer in custody:
Badge/Employee #:		Date: Time:

NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

Notify (officer/unit & telephone #) _____

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

☐ The person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.

☐ Weapon was confiscated pursuant to Section 8102 W&I Code. Upon release, facility is required to provide notice to the person regarding the procedure to obtain return of any confiscated firearm pursuant to Section 8102 W&I Code.

SEE REVERSE SIDE FOR REFERENCES AND DEFINITIONS

Original: Accompany Client or 5150/5585 Designated Facility — Copy: 5150/5585/4011.6 Evaluator

5150 FORM: BLANK SAMPLE (BACK SIDE)

APPLICATION FOR ASSESSMENT, EVALUATION, AND CRISIS INTERVENTION OR PLACEMENT FOR EVALUATION AND TREATMENT

REFERENCES AND DEFINITIONS

"Gravely Disabled" 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 for food, clothing and shelter. SECTION 5008(h) W&I Code

"Gravely Disabled Minor" means a minor who, as a result of a mental disorder, is unable to use the elements of life which are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others. Intellectual disability, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder. SECTION 5585.25 W&I Code

"**Peace Officer**" means a duly sworn peace officer as that term is defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code who has completed the basic training course established by the Commission on Peace Officer Standards and Training, or any parole officer or probation officer specified in Section 830.5 of the Penal Code when acting in relation to cases for which he or she has a legally mandated responsibility. SECTION 5008 (i) W&I Code

Section 5152.1 W&I Code

The professional person in charge of the facility providing 72-hour evaluation and treatment, or his or her designee, shall notify the county mental health director or the director's designee and the peace officer who makes the written application pursuant to Section 5150 or a person who is designated by the law enforcement agency that employs the peace officer, when the person has been released after 72-hour detention, when the person is not detained, or when the person is released before the full period of allowable 72-hour detention if all of the conditions apply:

(a) The peace officer requests such notification at the time he or she makes the application and the peace officer certifies at that time in writing that the person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.

(b) The notice is limited to the person's name, address, date of admission for 72-hour evaluation and treatment, and date of release. If a police officer, law enforcement agency, or designee of the law enforcement agency, possesses any record of information obtained pursuant to the notification requirements of this section, the officer, agency, or designee shall destroy that record two years after the receipt of notification.

Section 5152.2 W&I Code

Each law enforcement agency within a county shall arrange with the county mental health director a method for giving prompt notification to peace officers pursuant to Section 5152.1 W&I Code.

Section 5585.50 W&I Code

The facility shall make every effort to notify the minor's parent or legal guardian as soon as possible after the minor is detained. Section 5585.50 W&I Code.

A minor under the jurisdiction of the Juvenile Court under Section 300 W&I Code, is due to abuse, neglect or exploitation.

A minor under the jurisdiction of the Juvenile Court under Section 601 W&I Code is due to being adjudged a ward of the court as a result of being out of parental control.

A minor under the jurisdiction of the Juvenile Court under Section 602 W&I Code is due to being adjudged a ward of the court because of crimes committed.

Section 8102 W&I Code (EXCERPTS FROM)

(a) Whenever a person who has been detained or apprehended for examination of his or her mental condition or who is a person described in Section 8100 or 8103, is found to own, have in his or her possession or under his or her control, any firearm whatsoever, or any other deadly weapon, the firearm or other deadly weapon shall be confiscated by any law enforcement agency or peace officer, who shall retain custody of the firearm or other deadly weapon. "Deadly weapon," as used in this section, has the meaning prescribed by Section 8100.

(b) (1) Upon confiscation of any firearm or other deadly weapon from a person who has been detained or apprehended for examination of his or her mental condition, the peace officer or law enforcement agency shall issue a receipt describing the deadly weapon or any firearm and listing any serial number or other identification on the firearm and shall notify the person of the procedure for the return, sale, transfer, or destruction of any firearm or other deadly weapon which has been confiscated. A peace officer or law enforcement agency that provides the receipt and notification described in Section 33800 of the Penal Code satisfies the receipt and notice requirements.

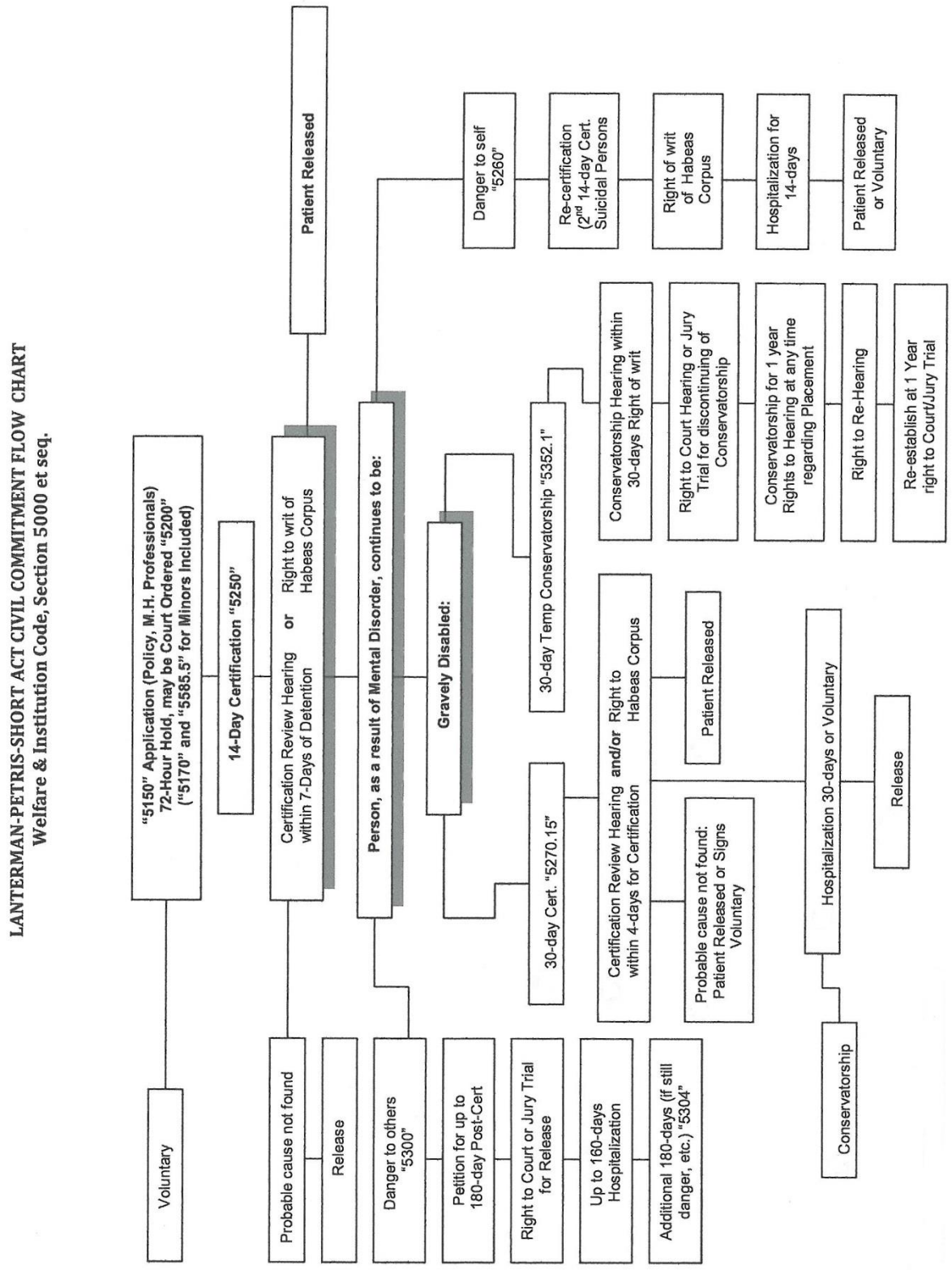
(2) If the person is released, the professional person in charge of the facility, or his or her designee, shall notify the person of the procedure for the return of any firearm or other deadly weapon which may have been confiscated.

(3) Health facility personnel shall notify the confiscating law enforcement agency upon release of the detained person, and shall make a notation to the effect that the facility provided the required notice to the person regarding the procedure to obtain return of any confiscated firearm.

California Penal Code 4011.6

A person in custody at a jail or juvenile detention facility, who has a mental health disorder, may be taken to a facility for 72-hour treatment and evaluation pursuant to Section 5150 of the Welfare and Institutions Code.

FLOWCHART: LANTERMAN-PETRIS-SHORT ACT CIVIL



NOTES


Riverside
University
HEALTH SYSTEM
Behavioral Health