5150 Training Manual

Riverside County

Department of Mental Health

January 2012

Riverside County Department of Mental Health

5150 TRAINING

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INTRODUCTION

On behalf of Jerry Wengerd, the Director of Riverside County Department of Mental Health (RCDMH), we welcome you to the Welfare and Institutions Code 5150 training class. This class is required to be authorized by the RCDMH to write a 5150 application for a person with a mental disorder so that they may be placed in civil protective custody and taken to a designated facility for assessment and treatment.

The objectives of the class are to teach you how to evaluate to determine if a person with a mental illness meets the legal criteria to be placed on a 5150 hold for danger to self, danger to others, 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 tips to protect yourself while you are evaluating a dangerous person for a 5150 hold.

You will learn how to complete the 5150 document accurately and who to give copies to.

We will cover Tarasoff responsibilities and procedures for mental health professionals.

You will learn what your obligations are to the Riverside County Department of Mental Health once you pass the test. We will go over the pertinent RCDMH policies that you will be required to follow.

And finally, you will be given a test with approximately 27 questions. You are allowed to miss six (6) questions and still pass the test. If you pass the test, you will be authorized for two years during which time you must write at least one accurate 5150. If you fail to write a 5150 during the two years you will be required to repeat the class.

Your 5150 authorization will be limited to the work site stated on your application.

Riverside County Designated Facilities							
Name of Facility	5150 Designated	Serves Adults	Serves Minor	Contracted Facility			Other Facilities
				Medi-Cal	Medi-Cal Freestanding Facilities Only	Indigent	
Riverside County Regional Medical Center ETS 9990 County Farm road, #4 Riverside, CA 92503 Phone: 951-358-4881	Yes	Yes	Adolescent	Yes	No	Yes	N/A
Oasis Rehabilitation Center Psychiatric Health Facility (adults) 47-915 Oasis Street Indio, CA 92201 Phone: 760-863-8632	Yes	Adult Desert Residents Only	No	Yes	No	Yes	N/A
Alhambra Hospital Behavioral Health Care Ph: 626-286-1191 4619 N. Rosemead Rosemead, CA 91770 Phone: 800-235-5570 Point of Contact: Intake Dept X268	Yes	Yes	Adolescent and Children	Yes	No	No	N/A
Aurora Charter Oak Hospital 1161 East Covina Blvd. Covina. CA 91724 Phone: 626-859-5275, 800-654-2673 Point of Contact: Needs Assessment Unit	Yes	Yes	Adolescent	See Freestanding	Serves ages up thru 21 and 65 or older.	Yes	N/A
Canyon Ridge Hospital 5353 "G" Street Chino. CA 91710 Phone: 909-590-3700 Point of Contact: Psych. Intake Unit	Yes	Yes	Adolescent	See Freestanding	Serves ages up thru 21 and 65 or older.	Yes	N/A
College Hospital of Cerritos 10802 College Place Cerritos. Ca 90703 Main Phone: 1-562-924-9581 Point of Contact: Intake Dept. 800-352-3301	Yes	Yes	No	No	No	No	Serves ages up thru 21 and 65 or older with Medi-Cal
College Hospital of Costa Mesa 301 Victoria Street Costa Mesa, CA 92627 Phone: 800-773-8001 Point of Contact: Access/Intake Department	Yes	Yes	Adolescent	Yes	No	Yes	N/A
Loma Linda Behavioral Medical Center 1710 Barton Road Redlands, Ca 92373 Phone: 909-558-9275 Point of Contact: Psych. Intake Unit	Yes	Yes	Adolescents and Children	No	No	No	Serves ages up thru 21 and 65 or older with Medi-Cal

Riverside County Designated Facilities							
Name of Facility	5150 Designated	Serves Adults	Serves Minor	Contracted Facility			Other Facilities
				Medi-Cal	Medi-Cal Freestanding Facilities Only	Indigent	
Redlands Community Hospital 350 Terracina Blvd. Redlands, CA 92373 Phone: 909-335-5500, ext. 5655 Point of Contact: Psych. Intake Unit	Yes	Yes	No	Yes	No	Yes	N/A
San Bernardino Community Hospital 1805 Medical Center Drive San Bernardino, CA 92411 Phone: 909-887-6333, press #4 Point of Contact: Behavioral Health Charge/Intake Nurse	Yes	Yes	No	No	No	No	Adult Medi-Cal
Western Medical Anaheim 1025 S. Anaheim Blvd. Anaheim, CA 92805 Main Phone: 714-533-6220 Point of Contact: Intake Department : 888-428-7828	Yes	Yes	No	Yes	No	Yes	N/A
Silver Lake Medical Center - 2 Campuses Ingleside Campus 7500 E. Hellman Avenue Rosemead, CA 91770 Main Phone: 626-288-1160 Point of Contact: Both Campuses Intake Department: 888-819-9888 Silver Lake Medical Center Downtown Campus 1711 W. Temple Street Los Angeles, CA 90026 Main Phone: 213-989-6100	Yes	Yes	No	No	No	No	Adult Medi-Cal
Aurora Las Encinas Hospital 2900 East Del Mar Blvd Pasadena. CA 91107 Main Phone: 626-795-9901 (800) 792-2345 Point of Contact: Main phone, transfer to Intake	Yes	Yes	No	See Freestanding	Serves ages up thru 21 and 65 or older.	No	N/A

**Disclaimer: All information contained herein is subject to change without notice.*

Revised: October 2011

Involuntary Holds and Psychiatric Hospitalizations Guidelines

1. Individuals who are on involuntary holds and have private healthcare insurance:

    a. County residents who have private health insurance may be transferred to any Riverside County 5150 designated facility for which their private insurance will authorize payment.

    b. Individuals who require psychiatric hospitalization should generally be admitted to a facility that is closest to their homes. However, RCRMC Inpatient Treatment Facility (ITF) in Riverside and Oasis Rehabilitation Center 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 a county designated facility that has been approved by the insurance company for admission.

2. Individuals being placed on involuntary holds by professionals who are not authorized to do so:

    a. This is a reminder that individuals who are not currently authorized by RCDMH to write holds can not legally write them.

    b. If a hospital allows unauthorized persons to write involuntary holds, the hospital places itself at risk of termination of RCDMH authorization. Whenever it is found that a hospital has allowed unauthorized use, the hospital will be notified and will be expected to immediately correct the situation.

3. Sending patients on an involuntary hold to hospitals <u>not</u> designated by Riverside County is illegal. Attached is an updated list of designated facilities that are to be utilized.

4. Requiring willing, voluntary patients to have a 5150 for admission is also illegal.

WELFARE AND INSTITUTIONS CODES 5150
THE LANTERMAN-PETRIS-SHORT ACT

The Lanterman-Petris-Short Act, named after three politicians, became effective in the state of California on July 1, 1969. This was one of the most significant pieces of mental health legislation to that time. It revised the practice of civil commitment of the mentally ill, because it increased the legal rights for mental patients while balancing those rights with the need for civil commitment of dangerously mentally ill persons.

The Act states that persons with mental illness 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. 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)

This Act 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 a psychiatric assessment, known as a 5150, and have a person who due to a mental disorder is demonstrating dangerous behavior towards self or others, or gravely disabled and therefore, is unable to obtain or utilize food, shelter or clothing, be taken into civil protective custody.

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 in the field where the application is written.

A minor, who as a result of a mental disorder is a danger to self or 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 Dept. of Mental Health for 72 hours for evaluation and treatment. The minor has a right to have his parents or guardians notified. However, the minor can also be detained over the objection of the parents or legal guardians.

CALIFORNIA WELFARE AND INSTITUTIONS CODE

Sc 5150. Dangerous or gravely disabled person; taking into custody; application; basis of probable cause; liability

When any person, as a result of a mental disorder, is a danger to others, or to himself/herself, or gravely disabled, a peace officer, a member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional persons designated by the county may, upon probable cause, take, or cause to be taken, the person into custody* and place him/her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation.

Such facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer, a member of the attending staff, or a professional person, and stating that the officer, a member of the attending staff, or a professional person has probable cause to believe that the person is, as a result of a mental disorder, a danger to others, or to himself/herself, or gravely disabled. If the probable cause is based on the statement of a person other than the officer, a member of the attending staff, or a professional person, such person shall be liable in a civil action for intentionally giving a statement, which he or she knows to be false.

Sc 5170. Dangerous or gravely disabled person; taking into civil protective custody

When any person is a danger to others, or to himself/herself, or gravely disabled as a result of inebriation, a peace officer, a member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, or other person designated by the county may, upon reasonable cause, take, or cause to be taken, the person into civil protective custody and place him/her in a facility designated by the county and approved by the State Department of Alcohol and Drug Abuse as a facility for 72-hour treatment and evaluation of inebriates.

CALIFORNIA WELFARE AND INSTITUTIONS CODE

Sc 5585.50 Custody and placement of minor in facility; notice to parent or legal guardian; probable cause application; civil liability for intentional false statement.

When any minor, as a result of a mental disorder, is a danger to others, or to himself/herself, or gravely disabled and authorization for voluntary treatment is not available, a peace officer, a member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional persons designated by the county may, upon probable cause, take, or cause to be taken, the minor into custody and place him/her in a facility designated by the county and approved by the State Department of Mental Health 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.

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, a member of the attending staff, or a professional person, and stating that the officer, a member of the attending staff, or a professional person has probable cause to believe that the minor is, as a result of a mental disorder, a danger to others, or to himself/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, a 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.
(added by Stats.1988, c. 1202Sc2.)

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

CALIFORNIA WELFARE AND INSTITUTIONS CODE
PATIENT'S RIGHTS

5325.1 Persons with mental illness 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 illness 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.

RIVERSIDE COUNTY

DEPARTMENT OF MENTAL HEALTH POLICY

POLICY NO:	**142**
SUBJECT:	**5150 AUTHORIZATION FOR PROFESSIONAL PERSONS**
REFERENCES:	Community Mental Health Services Act, Division 5, Welfare & Institutions Code; Title 9, California Administrative Code; Policy Nos. 140, 141 and 143, Riverside County Department of Mental Health; State Department of Mental Health, Memorandum of 2-8-83, Patients' Rights Office.
FORM:	Application for Authorization of Staff: 5150 Authority (Revised February 2003)
EFFECTIVE DATE:	June 26, 1990
REVISED DATE:	March 26, 2003

POLICY:

Riverside County Department of Mental Health (RCDMH) provides a system of comprehensive services to meet the mental health needs of County residents. At times it becomes necessary to detain against their will certain persons with serious mental disorders for psychiatric evaluation and treatment. The Welfare and Institutions Code (WIC), Division 5, Section 5150, specifies the circumstances under which a person may be detained and the procedures required to initiate detention.

In accordance with WIC, it is the policy of the Department to establish standards and procedures to formally authorize professionals to initiate the process of involuntary detention of mentally disordered persons. Peace officers are authorized by law to sign the 5150 documents to detain persons who are a danger to themselves or others, or gravely disabled. Mental health professionals must be specifically authorized by the county as to the scope of their authority to act in this capacity. The requirement for formal authorization to do this applies to both county-employed professionals and to those employed by private mental health facilities.

PURPOSE:

The purpose of this policy is to identify the professional persons who may be authorized by Riverside County to initiate 5150 detentions; to specify the criteria qualifying such persons to be granted this authority; and to enumerate the procedures involved in the authorization process. It is the intent of this policy that 5150 detention for 72-hour emergency treatment and evaluation under the Lanterman-Petris-Short (LPS) Act should be utilized only when voluntary evaluation and treatment is not a viable option. Whenever possible, the least restrictive mode of treatment should be utilized and voluntary status encouraged.

A. 5150 Authorization of Personnel

Section 5150 (et seq.), WIC, authorizes the following classes of persons, upon probable cause, to take into custody, or cause to be taken, individuals who are gravely disabled or a danger to themselves or others as a result of mental illness:

1. Peace Officers,

2. Members of attending staff of a County-designated 5150 evaluation facility, and

3. Certain other professional persons authorized by the County.

   NOTE: Section 823, Title 9, CAC, defines "attending staff" as: "...any person having responsibility for the care and treatment of the patient, as authorized by the Local Mental Health Director, on the staff of an evaluation facility designated by the county. [a RCDMH 5150 designated facility]"

A professional staff person who is granted authority to initiate 5150 detentions may exercise this authority only within that specific facility, unless such authority is specifically extended to other locations by the local Mental Health Director. It is important to note that when a 5150 is initiated by an authorized designee the decision to actually admit and detain the person for evaluation and treatment on involuntary inpatient status is made by the designated facility's authorized professional.

RCDMH employees authorized by the local Mental Health Director to have 5150 authority under the category of "other professional persons" retain this authority throughout the County, when they are operating as a RCDMH employee. Such authority does not extend to other employment, unless specifically approved by the local Mental Health Director, or his designee.

5150 authority is granted by the local Mental Health Director; therefore, that authority does not extend into other counties unless specifically provided for by contract or authorization by that other county, or with approval of the RCDMH Mental Health Director.

B. Criteria for Authorization of Personnel

Only persons meeting the licensing, discipline and training requirements delineated below will be eligible to apply for authority to initiate 5150 detainments within Riverside County:

Licensed) psychiatrists;
Licensed (or license-waivered) psychologists;
Licensed (or licensed-waivered) clinical social workers;
Licensed (or licensed-waivered) marriage &family therapists
Registered nurses.

Professional persons who are eligible for authorization include:

1. Professional persons as specified above, who are attending staff of a, LPS designated hospital or facility, for evaluations at that facility only.

2. Other professionals, as listed above, including emergency room medical physicians, of non-designated hospitals;

3. Employees of County contracted providers of mental health services, who meet LPS training requirements and whose employing facility enters into a specific agreement with the local Mental Health Director to provide LPS functions;

4. RCDMH Employees, who need this authority to conduct their assigned job tasks.

All authorized professional staff will have provided a minimum of two years of clinical experience providing treatment to mentally ill clients.

C. Exception of RCDMH Employees only

Generally, only licensed staff with the required experience will be authorized to initiate involuntary detentions. However, in program areas within the RCDMH where such personnel are not available, exceptions may be authorized on a case-by-case basis by the Director or designee. In all cases, staff so authorized will receive regular training, and supervision for this function.

D. Application for Authorization

Application for authorization of staff shall include a completed and signed application form and a copy of the current professional license (or verification of "Board-eligible" status, or license waiver pending attainment of all requirements). The application must be co-signed by the applicant's supervisor or Medical Director.

All authorized staff must complete 5150 training (as described below, under "TRAINING") receive a passing score on the written examination provided by RCDMH.

E. Allocation of Authorized Personnel

The local Mental Health Director (or designee) will limit the number of eligible persons authorized to initiate 5150 detentions according to the following guidelines:

1. Within the RCDMH, only professional staff recommended by program supervisors, and deemed essential to the daily operations of LPS-related services/programs by the local Mental Health Director will be authorized such authority.

2. Attending staff of designated facilities and County contracted providers of mental health services must likewise be determined essential to daily operations and recommended by the Medical Director/Clinical Manager of that facility.

3. The local Mental Health Director (or designee) shall review the completed applications. If the request is denied, the Director or designee shall notify the supervisor in writing, and specify reasons for the action. The supervisor will, in turn, notify the applicant. Applicants will be notified of the next 5150 training session.

4. The Director will provide for biennial review of all previously authorized staff, to determine whether the authorization shall

continue or be terminated.

5. The Medical Director or County program supervisor at each facility or clinic shall maintain for inspection by the local Mental Health Director (or designee), records verifying that 5150 designees have met the eligibility, training and testing requirements.

6. The Medical Director or County program supervisor at each facility or clinic shall notify the local Mental Health Director, or designee, of all deletions to the roster of persons authorized to order involuntary detention, at least quarterly.

F. Procedures for Renewal of Authorization

1. Unless specifically indicated to the contrary, all authorizations will be valid for two years.

2. The local Mental Health Director, or designee, will notify the Program supervisors and Medical Directors at least 60 days prior to the expiration of the professional person's authorization.

3. The Medical Directors and County Program Supervisors shall submit new application forms for professional persons with copies of current license, copy of a 5150 written by the applicant in the last two (2) years, and request for reauthorization to the local Mental Health Director, or designee.

4. The local Mental Health Director or designee shall review the request, approve or deny the request, and forward in writing to the Medical Director or Program supervisor, who shall notify the applicant. If the request for authorization is denied, the Director shall specify the reason(s) for this decision in writing.

G. Scope of Authority

It is the intent of this policy that each 5150 authorized professional, with certain exceptions, exercise this authority only at facilities where the professional has admission privileges or maintains employment at the time of authorization The authority to sign 5150 detention documents terminates when the relationship or employment with the facility ceases.

All 5150 designees shall follow the guidelines below:

1. Authority to initiate 5150 applications for detention shall be exercised only while the approved designee is on duty with the facility and/or program, which recommended him/her.

2. Professional persons authorized to initiate involuntary detention must send the person to an authorized Riverside County 5150 facility only.

3. Furthermore, authorized attending staff are authorized to initiate 5150 applications only within the confines of that authorized facility.

4. A professional person serving on the staff of more than one authorized facility must be officially authorized for each specific facility at which he/she intends to use this authority.

5. Designees granted 5150 authority under the category "Other Professionals," shall exercise involuntary detention authority only in accordance with the written agreement established between the designee's employing facility and RCDMH.

6. The County Program supervisor or the Medical Director/Clinical Manager of a facility shall notify the local Mental Health Director within 90 days of any designee's termination of employment or termination of authorization.

7. All 5150 authorized staff, at the direction of the local Mental Health Director, shall make available 5150 documents to the RCDMH for the purposes of monitoring and quality assurance.

H. Revocation or Termination of 5150 Authorization

The RCDMH Medical Director may recommend to the local Mental Health Director revocation and/or termination of the 5150 authorization of any individual under the following circumstances (not inclusive):

1. Consistently inappropriate 5150's as determined by the 5150 Training Committee through review of documentation.

2. Failure to execute 5150 authority during the authorization period (two years).

3. Change of job responsibilities and/or assignment, resulting in an individual's failure to meet the criteria necessary to receive 5150 authority.

4. Abuse of 5150 authority as determined by the RCDMH 5150 Committee. The 5150 Committee consists of:

   a. The Department of Mental Health Medical Director
   b. Program Chief
   c. Patients' Rights Advocate
   d. Quality Assurance Coordinator
   e. Regional Mental Health Services Supervisors

I. Appeal Procedures

1. A person who has been denied 5150 authorization status upon application or renewal, or whose authority has been suspended or revoked by the local Mental Health Director, may appeal that action. The appeal must be made in writing to the local Mental Health Director, through Program supervisors or Medical Director, within ten (10) days of notification of the action.

2. Within ten (10) business days of receipt of the written appeal request, the local Mental Health Director (or designee) shall review the request with the aggrieved party. It shall be within the discretion of the local Mental Health Director as to who shall be involved in such a review. The review may be continued by the Director over a period of time as may be necessary to resolve the matter.

3. At the conclusion of the review, the local Mental Health Director shall, within five (5) business days, affirm, modify or rescind the original recommendation regarding authorization. and shall summarize the reason(s) for such action in writing to the aggrieved individual. The decision of the local Mental Health Director shall be final.

J. Monitoring of 5150 Functions

1. Under the direction of the RCDMH Program Chief, the 5150 Committee will conduct ongoing monitoring of authorized staff to ensure appropriateness of 5150 detentions, and will document such monitoring.

2. Monitoring activities may include, but are not be limited to periodic review of 5150 documents, and on-site visits to review procedural compliance with LPS statutes regarding 5150 detention.

3. Additionally, facilities employing authorized staff shall establish an internal system of supervision and monitoring of these staff to ensure proper implementation of 5150 authority by staff.

4. Facilities that employ these authorized staff will comply with the State of California Department of Mental Health Quality Assurance Standards and Guidelines.

5. The local Mental Health Director shall be notified of any deficiencies in procedural compliance. Depending upon the nature of the severity of the non-compliance, the Mental Health Director may:

   a. Temporarily suspend the authorization for a period of time not to exceed sixty (60) days (for the purposes of corrective action and assurance of future compliance), or

   b. Withdraw the authorization of the professional person(s) involved.

K. Training

All professional persons authorized under the provisions of WIC 5150 to order involuntary detention will complete the following training requirements:

1. Formal training concerning LPS provisions and the detention process

2. Current patients' rights legislation

3. Passing score on an examination administered by the RCDMH.

Failure to pass the examination will result in non-authorization; however, the professional person may attend the next formal training, and retake the examination.

Training and formal testing will be offered on at least a quarterly basis. Special arrangements for training may be made more

frequently , at the discretion of the RCDMH Program Chief or 5150 Committee.

All persons with authority to order involuntary detention may be required to participate in training and retesting at least every two years, or sooner, at the discretion of the Director of Mental Health.

Approved by: John J. Ryan (Signature)
Director of Mental Health

RIVERSIDE COUNTY

DEPARTMENT OF MENTAL HEALTH

POLICY NO.:	**221**
SUBJECT:	**INTERRUPTING 5150 APPLICATIONS IN THE FIELD**
REFERENCES:	State Department of Mental Health Staff Counsel Opinion, dated April 2, 1991
FORMS:	None
EFFECTIVE DATE:	August 1, 1992
REVISED DATE:	December 20, 2010 and December 21, 2009

POLICY:

It is the policy of Riverside County Department of Mental Health (RCDMH) that authorized department employees and authorized employees of non-designated and designated facilities may interrupt the 5150 application for a client to the designated 5150 facility when, in the judgment of the authorized employee, the client no longer meets the 5150 criteria for involuntary treatment or has indicated a willingness and a capacity to participate in any necessary treatment on a voluntary basis. The authorized individual may interrupt such 5150 transfers in order to prevent unnecessary psychiatric hospitalizations, and to ensure that clients receive mental health services in the least restrictive setting possible.

PROCEDURES:

A. Riverside County Department of Mental Health Authorized Staff

RCDMH provides psychiatric emergency assessment and intervention services, including conducting 5150 assessments. 5150 authorized department employees may be asked to re-assess a client who has been placed on a 5150 application, and has not yet been transported to the designated 5150 facility for evaluation and possible involuntary admission.

1. If, as a result of the department employee's face-to-face and clinical reassessment, the client is found to no longer meet 5150 criteria for involuntary evaluation and treatment, the authorized employee may interrupt the transfer of the client and provide other voluntary mental health and crisis intervention services. The authorized employee will either consults with, and/or have the approval of, a Mental Health Services Supervisor (or Program/Regional Manager) prior to interrupting the 5150 transfer.

2. Following the interruption of a 5150 transfer, it is the responsibility of the authorized employee to facilitate whatever voluntary crisis intervention services may be needed, including, but not limited to:

   a. Voluntary psychiatric hospitalization;

   b. Admission to a crisis residential facility, or lower level of care;

   c. Referral for psychiatric evaluation;

   d. Referral to Mentally Ill/Homeless Program for emergency housing and food, or other local resources for homeless/transient individuals;

   e. Referral to relevant community resources, such as Domestic Violence Program, non-profit counseling services, medical services, etc.;

   f. Referral to drug/alcohol counseling and substance abuse residential treatment facilities;

   g. Giving timely appointments for County Mental Health Outpatient Services;

3. It is the responsibility of the authorized employee to adequately document the results of the clinical reassessment; the multiple consultations; the client's current mental status; the specific reasons the client did not meet 5150 criteria; and the alternative crisis intervention that occurred.

B. Non-Designated 5150 Facility Authorized Staff:

A licensed mental health professional, employed by a non-designated facility and authorized by RCDMH to write 5150s, may discontinue a 5150 based on a face-to-face re-evaluation. The rationale for discontinuing the 5150 must be clearly documented and faxed, along with a copy of the original 5150 application form, to RCDMH Inpatient, Attention: Quality Improvement.

Approved by: _____ Date: 12-28-10
Director of Mental Health

EVALUATING FOR MEDICAL CLEARANCE

A patient evaluated in an outpatient setting, and placed on a 5150, could be required to be medically cleared at a medical hospital prior to being accepted at a designated 5150. You would need to call the facility to determine their admission criteria.

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.

For additional information refer to Medical Criteria Guidelines in your training 5150 training manual.

DANGER TO SELF (DTS)

Definition: As a result of mental disorder, the person must be suicidal or expresses significant harm to him or herself.

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.

A. An individual has indicated by words or actions an intent to commit suicide or inflict bodily harm on self.

B. The individual's statements or actions indicate a specific plan or means by which to commit suicide or inflict harm on self.

C. The individual's plans or means are available or within his/her ability to carry out.

D. The individual refuses to accept, or is unwilling or unable to obtain, psychiatric evaluation and treatment.

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

Evaluator Questions to Assist with Determination

1. Does the subject intend to kill himself/herself?
   Ask the subject or someone involved with him/her.
2. How does the subject intend to kill himself/herself?
   (Look for weapons, pills, or evidence of a plan – gas left on, jumping off a ledge, etc.)
3. Has the subject ever done anything to try to kill himself/herself in the past?
4. If he/she did attempt to kill himself/herself in the past, what did he/she do?

DANGER TO OTHERS (DTO)

Definition: As a result of a mental disorder, the person expresses harm to others or demonstrates a reckless disregard for the safety of others.

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. An individual has indicated by words or actions and intent to cause bodily harm to another person.

B. The individual's threats or intentions are specific as to the particular person (s) he/she would do harm to.

C. The individual identifies the means by which he/she would do harm to another person, and these means are within the ability of the individual to carry out.

D. The individual is engaging in or intends to engage in acts or behavior of such an irrational, impulsive, or reckless nature, such as destruction of property or misuse of a vehicle as to put others directly in danger or harm.

E. The individual's acts or words regarding an intent to cause harm to another person are based on, or caused by, the individual's mental state, which indicates the need for psychiatric evaluation and treatment.

F. The individual refuses to accept, or is unwilling or unable to obtain, psychiatric evaluation and treatment.

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.

Evaluator Questions to Assist with Determination

1. Is the subject actively or passively engaged in violent or dangerous behavior?
2. Does the subject state he/she is going to carry out violent or dangerous behavior?
3. Does the subject have a plan to follow through with this behavior?
4. Does the subject have the means to follow through with this plan?
5. Does the subject have a background of violence or dangerous behavior?
6. Has the subject acted on plans of violent behavior in the past?

Answers to the above questions can be obtained from an interview with either the subject or relatives of the subject. Be SPECIFIC as to what he/she has done, what he/she has said, and who or what he/she has done it to.

GRAVELY DISABLED (ADULTS) (GD)

Definition: As a result of a mental disorder, the person is not able to provide for his basic needs of food, clothing, or shelter, or to voluntarily utilize such provisions when they are offered.

Evidence of inability to provide for 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.

Considering the context of risk. examples may include:

FOOD: 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 frequently obtains food from garbage cans or similar sources; person has been losing substantial weight without reasonable explanation; person repeatedly eats items not ordinarily considered fit for human consumption; person repeatedly steals food.

CLOTHING: Person repeatedly destroys his/her clothing; person regularly fails to wear clothing in keeping with prevailing climatic conditions; clothing repeatedly grossly torn or dirty; person has no realistic plan for obtaining needed clothing.

SHELTER: Person is observed to frequently sleep in abandoned buildings, doorways of buildings, near public thoroughfares, in prohibited areas, or in other than ordinary shelter; person is repeatedly ejected from living quarters by landlords; person has no realistic plan for obtaining 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 patient either is 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 avail oneself of food, clothing, or shelter. For example, a person noted to repeatedly eat 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 avail himself/herself of 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. An individual 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.

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

* "Writing" means any one (1) or combination of the following: handwriting; typewriting; printing; photostatting; photographing; and every other means of recording upon any tangible thing; any words, pictures, sounds, or symbols.
(See Section 250 of the Evidence Code)

Evaluator Questions to Assist with Determination

1. Does the subject have funds?
2. If he/she does have funds, does he/she know where they are, and how to make use of them?
3. Is the subject under medical care?
4. If the subject is under medical care, does he/she follow the doctor's instructions regarding medications?
5. Is the subject maintaining a proper diet? (Check the refrigerator and/or cupboards)
6. Does the subject eat only certain foods that would be dangerous to his/her health?
7. Is the subject's environment maintained to such a degree, as would be a danger?
8. Is the subject dressed in a manner, which endangers his/her health or safety?

Your interview and subsequent investigation should substantiate that specific factors exist which the subject displays to indicate serious faults in comprehension or judgment. These serious faults make the subject unable to use the means at his/her disposal to provide for his/her basic personal needs. You must also determine the subject can 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 subject 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? Is there a relative or friend you can call to obtain more information?

GUIDELINE EXAMPLES FOR DETERMINATION OF GRAVE DISABILITY

The guideline examples are for making recommendations as to whether individual patients 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."

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

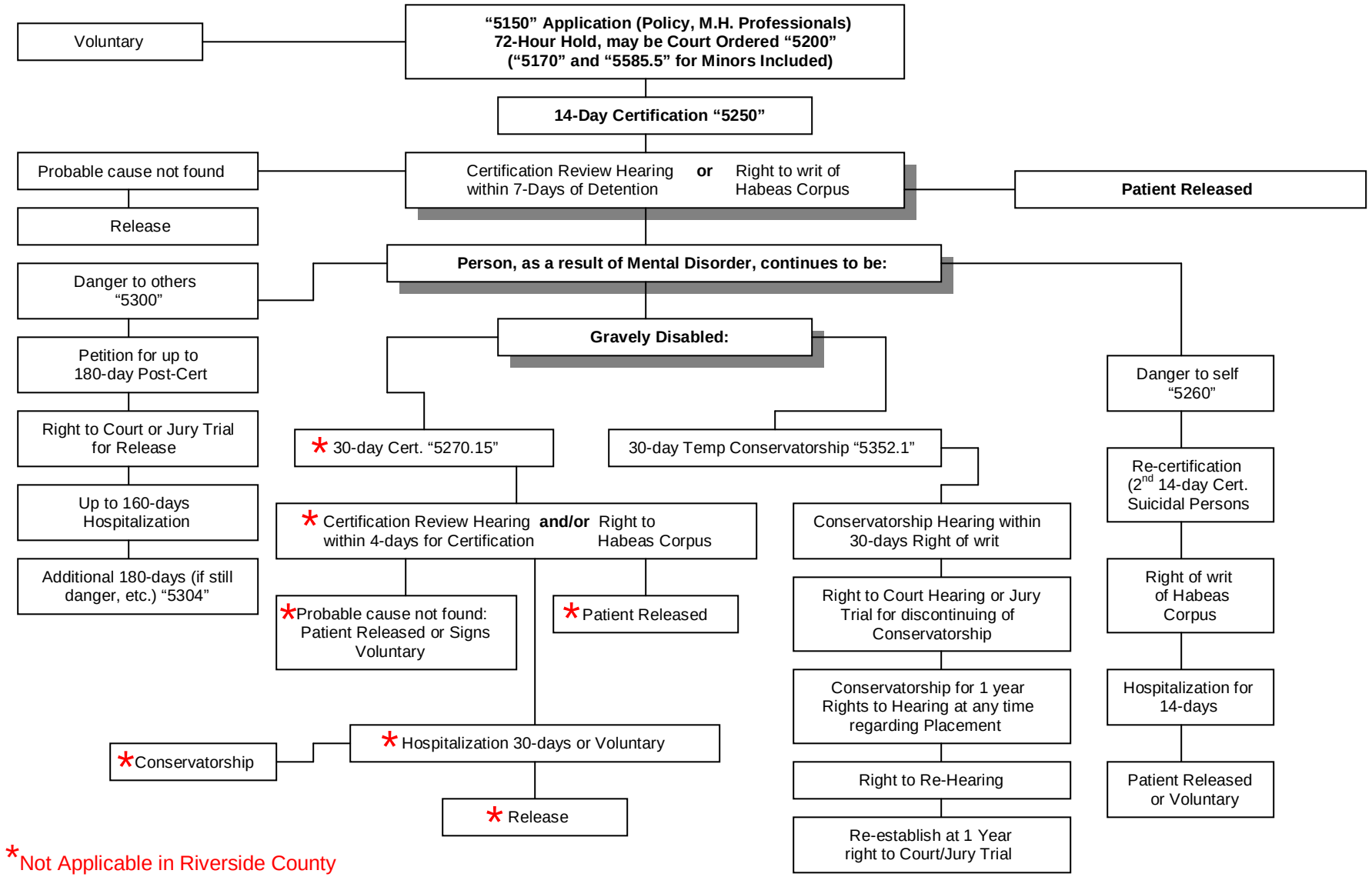
	NOT DISABLED	GRAVE DISABLED
Money:	Knows where his/her money comes from. Knows how much he/she has. If he/she doesn't have any, understands that he/she doesn't. Understands how to pay bills. If he/she has $$ in bank, uses if for his/her and/or family's needs. Has a plan for how he/she will be supported.	Has funds but does not know or understand location and/or extent of them. Miserly to the extent of endangering one's personal health and/or safety. Has no funds, does not see a problem. Grossly inappropriate expenditure of funds needed for basic needs. Refuses to accept means of obtaining necessary funds. (i.e. declines public assistance or opportunities for employment). Needs assistance in money management and cannot accept such help.
Health:	Can and does follow medical doctor's instructions	As a result of a mental disorder, cannot or does

GUIDELINE EXAMPLES FOR DETERMINATION OF GRAVE DISABILITY

	NOT DISABLED	GRAVE DISABLED
	regarding medications which, in the medical doctor's opinion, are essential to normal functioning. There is a religious exception.	not follow doctor's instructions which, in the medical doctor's opinion, are necessary for the individual's survival. Does not include persons who are refusing antipsychotic medications.
Food:	Has adequate knowledge of his/her nutritional needs. If on special diet (diabetic, etc.), 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 needed 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, negotiate with landlords, etc., and cannot ask for or accept help in doing so. Manages his household in such a way as to be a clear danger to to health (fire hazard, filth, etc.)

Special area in the overall determination of grave disability is: Can the patient accept help voluntarily; does he/she know his/her limits; does he/she need someone else to make the decisions for him/her?

LANTERMAN-PETRIS-SHORT ACT CIVIL COMMITMENT FLOW CHART
Welfare & Institution Code, Section 5000 et seq.



*Not Applicable in Riverside County

PRINCIPLES AND GUIDELINES FOR EVALUATING CHILDREN AND ADOLESCENTS

"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:

- Intent
- Plan
- Means
- Unwilling/unable to accept voluntary treatment

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.

"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 find it as a result of a mental disorder, and the gravely disabled behavior must be directly attributable to such a 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**.

A. 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.

B. 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.

C. 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.

D. 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.

Examples:

A. HEALTH

1. Food

   a. Has food fetishes, eating certain foods to the exclusion of others, thereby seriously endangering health.
   b. Eats copiously, causing unusual weight gain.
   c. Does not eat properly, resulting in significant weight loss or documented malnutrition.
   d. Neglects nutrition to the extent it becomes life endangering.

2. Shelter

   a. Consistently remains out of assigned shelter, exposed to the elements.
   b. Consistently seeks or creates un-hygienic conditions in living quarters.
   c. Consistently seeks inappropriate shelter.

3. Clothing

   a. Chews or swallows clothing.
   b. Will not maintain adequate level of clothing to provide protection from the elements.
   c. Consistently refuses to maintain hygienic conditions of clothing.

4. Other

   a. Mutilates self.
   b. Will not maintain necessary health care activities, e.g. cardiac medication, diabetic diets and regimen, anti-convulsive medication.
   c. Consistently refuses to maintain standards of personal hygiene to the extent that health is endangered.

B. SAFETY

1. Food

   a. Repeatedly places food in body orifices, other than the mouth, e.g. beans in ears, nose, etc.
   b. Eats non-food materials, e.g. razor blades, feces, etc.

2. Shelter

   a. Repeatedly seeks shelter in dangerous environments, e.g. condemned buildings, areas subject to flooding, etc.
   b. Is dangerously destructive to assigned living quarters, e.g. fire setting, window breaking, etc.
   c. Uses shelter to injure self, e.g. head banging, wall hitting, etc.

3. Clothing

   a. Lights clothing on fire.
   b. Injures self or others with clothing.

4. Other

   a. Frequently uses dangerous items inappropriately.
   b. 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.
   c. 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.

C. DEVELOPMENT

1. Food

   a. Smears or throws food, or otherwise handles food in an age inappropriate manner.
   b. Begs, steals, secretes or gives away food outside the range of age normal behavior.

2. Shelter

   a. Is consistently unmanageable in assigned living quarters.
   b. Frequently seeks shelter in socially destructive environments, e.g. places of criminal activity, substantial substance abuse, etc.
   c. Repeatedly refuses to use any assigned shelter, which has age

appropriate expectations.

3. Clothing

   a. Destroys own or other's clothing inappropriately.
   b. Persistently excretes in clothing, significantly beyond expected age.
   c. Engages in public nudity beyond age expectancy.
   d. Habitually gives away or loses clothing beyond age expectancy.
   e. Dresses in bizarre manner not appropriate to age group.

4. Other

   a. Lacks ability to adjust to or profit from the educational process - a mental disorder blocks the learning process.
   b. Lacks capacity to meet age appropriate social expectations and/or developmental tasks.
   c. Is so withdrawn that person cannot obtain the environmental experiences or stimulation necessary for normal development.
   d. Does not comprehend the use of money, or the means of obtaining it, as would be expected of age group.

PRINCIPLES AND GUIDELINES FOR EVALUATING CHILDREN AND ADOLESCENTS

PRINCIPLES AND GUIDELINES FOR ASSESSING CHILDREN

A. ***"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.

B. 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.

C. 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**. These diagnoses are located in the DSMIV Chapter "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" and include…
    - Adjustment Disorder
    - Conduct Disorder
    - Oppositional Defiant Disorder
    - Attention Deficit Hyperactivity Disorder

D. 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.

E. **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 these**
- 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 escape routes for both you and the client, or that you are equidistant from the door
- 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 afraid?" – Sometimes a person who is agitated does not realize they are being threatening and will deescalate when asked.

THIRTEEN DEFENSIBLE HYPOTHESES CONCERNING VIOLENT BEHAVIOR

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 accurate necessarily predict community violence, or lack thereof.

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 is multiply determined, and may include, but not necessarily, factors from biological, psychological, and social spheres.

10. Violence can be conceptualized as either affective 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

Helpful Advice for Conducting Assessments In Highly Stressful or Dangerous Situations

1. Avoid the "Royal We" and try to focus on the client's worldview.

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

3. Follow the KISS principle: Keep It Simple.

4. Avoid talking down to the client.

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

6. When setting limits, the therapist must avoid being manipulated.

7. Be patient and speak slowly.

8. Avoid predicting future events and making promises.

9. Praise should be used in moderation, carefully formulated, and expressed with care.

10. Avoid the error of trying to cheer up a depressed patient.

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 f eet crossed; chair leaning back; hands in pockets or hid den behind you). Keep hands in vi ew, with a neutral, respectful stance.

13. Be concerned about yo ur own personal safety – ask for additional sta ff to join you if you feel anxious.

14. Make estimate of present cognitive and affective states.

15. Assess role of external and internal factors – r estructure the physical setting to decrease stimuli.

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

17. Engage the client with open recognition of his/her anger and potential risk – you may ask him/her directly to remain in control. Avoid discussing the content of the rage until the client has control of his/her behavior.

18. Remain issue and problem solving oriented.

19. Assert reality limits – discuss consequence s of losing control and offer alternatives.

20. Leave a way open for flight – be aware of exits for both you and the client.

21. Be aware of exits. Ask for back-up staff if you feel anxious. Believe thr eats of violence.

SUICIDE FACT SHEET

(CDC, 2004)

Occurrence:

- Most popular press articles suggest a link between the winter holidays and suicides (Annenberg Public Policy Center of the University of Pennsylvania 2003). However, this claim is just a myth. In fact, suicide rates in the United States are lowest in the winter and highest in the spring (CDC 1985, McCleary et al. 1991, Warren et al. 1983).
- Suicide took the lives of 30,622 people in 2001 (CDC 2004).
- Suicide rates are generally higher than the national average in the western states and lower in the eastern and midwestern states (CDC 1997).
- In 2002, 132,353 individuals were hospitalized following suicide attempts; 116,639 were treated in emergency departments and released (CDC 2004).
- In 2001, 55% of suicides were committed with a firearm (Anderson and Smith 2003).

Groups At Risk:

Males

- Suicide is the eighth leading cause of death for all U.S. men (Anderson and Smith 2003).
- Males are four times more likely to die from suicide than females (CDC 2004).
- Suicide rates are highest among Whites and second highest among American Indian and Native Alaskan men (CDC 2004).
- Of the 24,672 suicide deaths reported among men in 2001, 60% involved the use of a firearm (Anderson and Smith 2003).

Females

- Women report attempting suicide during their lifetime about three times as often as men (Krug et al. 2002).

Youth

The overall rate of suicide among youth has declined slowly since 1992 (Lubell, Swahn, Crosby, and Kegler 2004). However, rates remain unacceptably high. Adolescents and young adults often experience stress, confusion, and depression from situations occurring in their families, schools, and communities. Such feelings can overwhelm young people and lead them to consider suicide as a “solution.” Few schools and communities have suicide prevention plans that include screening, referral, and crisis intervention programs for youth.

SUICIDE FACT SHEET

(CDC, 2004)

- Suicide is the third leading cause of death among young people ages 15 to 24. In 2001, 3,971 suicides were reported in this group (Anderson and Smith 2003).
- Of the total number of suicides among ages 15 to 24 in 2001, 86% (n=3,409) were male and 14% (n=562) were female (Anderson and Smith 2003).
- American Indian and Alaskan Natives have the highest rate of suicide in the 15 to 24 age group (CDC 2004).
- In 2001, firearms were used in 54% of youth suicides (Anderson and Smith 2003).

The Elderly

Suicide rates increase with age and are very high among those 65 years and older. Most elderly suicide victims are seen by their primary care provider a few weeks prior to their suicide attempt and diagnosed with their first episode of mild to moderate depression (DHHS 1999). Older adults who are suicidal are also more likely to be suffering from physical illnesses and be divorced or widowed (DHHS 1999; Carney et al. 1994; Dorpat et al. 1968).

- In 2001, 5,393 Americans over age 65 committed suicide. Of those, 85% (n=4,589) were men and 15% (n=804) were women (CDC 2004).
- Firearms were used in 73% of suicides committed by adults over the age of 65 in 2001 (CDC 2004).

Risk Factors:

The first step in preventing suicide is to identify and understand the risk factors. A risk factor is anything that increases the likelihood that persons will harm themselves. However, risk factors are not necessarily causes. Research has identified the following risk factors for suicide (DHHS 1999):

- Previous suicide attempt(s)
- History of mental disorders, particularly depression
- History of alcohol and substance abuse
- Family history of suicide
- Family history of child maltreatment
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- 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

- Cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma
- Local epidemics of suicide
- Isolation, a feeling of being cut off from other people

Protective Factors:

Protective factors buffer people from the risks associated with suicide. A number of protective factors have been identified (DHHS 1999):

- 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 handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts

PROHIBITION TO OWN, POSSESS, OR PURCHASE FIREARMS BY THOSE DETAINED AS A DANGER TO SELF OR OTHERS

Effective 1997, pursuant to Section 8103 W&IC, when any person taken into custody as a danger to self, or 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.

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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.

INSTRUCTIONS TO COMPLETE 5150 DOCUMENT

Note: ALWAYS USE THE MOST CURRENT MH 302 FORM (revised 08/2004)

1. Always use black ink.
2. Always write legibly.
3. Always send original copy with the client. (Hint: Write "original" or mark the original copy with a yellow highlighter).
4. Print your first and last name under "Detainment Advisement" box.
5. Tell client who you are (you are the etc.) and give advisement.
6. Check one box under Advisement Complete or Incomplete.
7. If "Advisement Incomplete" box is checked, write reason under "Good Cause for Incomplete Advisement". One sentence is sufficient.
8. Print your first and last name, your professional discipline (i.e. MD, RN, LMFT, LCSW, etc.) under "Advisement Completed By" section.
9. Under "Position" write your job title, (i.e. House Supervisor, Nurse Manager, Director, CT I, CT II, BHS III, etc.)
10. Under "Date" write the date you are writing the document.
11. Under "To" write in the legal name of the Riverside County LPS designated 5150 facility listed in this manual where the client is expected to be admitted and evaluated. Client may be stopping for medical clearance along the way. (This is a clerical area and can be crossed out and changed if the plan changes).
12. Under "Application is hereby made for the admission of", print client's legal name. Write in DOB (Date of Birth) or age if known. (The document does not prompt you for DOB or age).
13. Write in client's address if known. If you are provided with a DMV License/ID always verify if the 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.
14. 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.
15. 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).
16. Under first narrative area, state briefly how the situation was called to your attention.
17. Skip to the criteria boxes. Formulate your opinion as to why this person meets the criteria for danger to self, danger to others or gravely disabled adult or gravely disabled minor. Check all that apply.
18. Return to narrative area and provide enough information to support the criteria for the boxes that you checked. Use applicable quotations.
19. Under "Signature" this is where you get to sign your name and write your professional discipline after your name (i.e., MD, RN, LCSW, LMFT, etc.) after your name.
20. Write the name of your agency or facility where you work.
21. Under "Date" write the date that starts the 72-hour clock.
22. Under "Time" write the time that starts the 72-hour clock using military time or A.M. or P.M. **You MUST write the time.**
23. Under "Phone", write a contact number of your facility where you can be reached if there are further questions.
24. Under "Address", write the address of your agency or facility.
25. **STOP! Do not check off weapons box or notification boxes 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 **CURRENT** mental status must be conducted after the client has been medically stabilized and cleared by the attending physician.
27. **Fax a copy to Quality Improvement at (951) 358-5038**

Adult Sample Hold

www.dmh.ca.gov/news/publications/forms

State of California - Health and Human Services Agency — Department of Mental Health

APPLICATION FOR 72 HOUR DETENTION FOR EVALUATION AND TREATMENT
MH 302 (Rev. 08/04) Front

Always Write Legibly

Confidential Client/Patient Information
See California WIC Section 5328 and
HIPAA Privacy Rule 45 C.F.R. § 164.508

Welfare and Institutions Code (WIC), Section 5157, requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

☐ **Advisement Complete** — Check One — ☐ **Advisement Incomplete**

Good Cause for Incomplete Advisement
If Applicable

Advisement Completed By
Print Your Name, License

Position
Job Title

Date
Date

DETAINMENT ADVISEMENT

My name is **Print Your Name**

I am a (Peace Officer, etc.) with (Name of Agency). You are not under criminal arrest, but I am taking you for examination by mental health professionals at (Name of Facility).

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

If taken into custody at his or her residence, the person shall also be told the following information in substantially the following form:

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

To **Name of Riverside County Designated Facility**

Application is hereby made for the admission of **Print Client's Legal Name and DOB**

Residing at **Client's address; If homeless also write City, California**, California, for 72-hour treatment and evaluation pursuant to Section 5150, (adult) et seq. or Section 5585 et seq. (minor), of the WIC. If a minor, to the best of my knowledge, the legally responsible party appears to be / is: (Circle one) Parent; Legal Guardian; Juvenile Court as a WIC 300; Juvenile Court as a WIC 601/602; Conservator. If known, provide names, address and telephone number:

Contact Person(If any) — **Indicate Which Applies**

Phone Number

* * * * * * * * * *

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

1. How the situation was brought to your attention
2. Description of alleged behaviors or situation observed or reported
3. Relevant historical factors

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

1. Observable behaviors or "quotes" of client's statements
2. Diagnosis or symptoms as a result of mental disorder
3. Note if client refuses voluntary treatment and justification of 5150

Based up on the above information it appears that there is probable cause to believe that said person is, as a result of mental disorder: **Check the Appropriate Box(es)**

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

Signature, title and badge number of peace officer, member of attending staff of evaluation facility or person designated by county.
Your Signature, License(i.e. RN, LMFT, LCSW, etc.)

Date
MM/DD/YY

Time
Time **A.M** **P.M.**

Phone
Area Code and Number

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

Address of Law Enforcement Agency or Evaluation Facility/Person
Your Facility's Address

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

NOTIFICATIONS TO BE PROVIDED TO LAW ENFORCEMENT AGENCY

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

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

☐ Weapon was confiscated pursuant to Section 8102 WIC.
Notify (officer/unit & telephone #) _____

SEE REVERSE SIDE FOR INSTRUCTIONS

Minor Sample Hold

www.dmh.ca.gov/news/publications/forms

State of California - Health and Human Services Agency — Department of Mental Health

APPLICATION FOR 72 HOUR DETENTION FOR EVALUATION AND TREATMENT
MH 302 (Rev. 08/04) Front

Always Write Legibly

Confidential Client/Patient Information
See California WIC Section 5328 and
HIPAA Privacy Rule 45 C.F.R. § 164.508

Welfare and Institutions Code (WIC), Section 5157, requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

☐ **Advisement Complete** — Check One — ☐ **Advisement Incomplete**

Good Cause for Incomplete Advisement
If Applicable

Advisement Completed By
Print Your Name, License

Position
Job Title

Date
Date

DETAINMENT ADVISEMENT

My name is **Print Your Name**

I am a (Peace Officer, etc.) with (Name of Agency). You are not under criminal arrest, but I am taking you for examination by mental health professionals at (Name of Facility).

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

If taken into custody at his or her residence, the person shall also be told the following information in substantially the following form:

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

To **Name of Riverside County Designated Facility**

Application is hereby made for the admission of **Print Client's Legal Name and DOB**

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Contact Person(If any) — **Indicate Which Applies**

Phone Number

* * * * * * * * * *

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

1. How the situation was brought to your attention
2. Description of alleged behaviors or situation observed or reported
3. Relevant historical factors

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

1. Observable behaviors or "quotes" of client's statements
2. Diagnosis or symptoms as a result of mental disorder
3. Note if client refuses voluntary treatment and justification of 5150

Based up on the above information it appears that there is probable cause to believe that said person is, as a result of mental disorder: **Check the Appropriate Box(es)**

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

Signature, title and badge number of peace officer, member of attending staff of evaluation facility or person designated by county.
Your Signature, License(i.e. RN, LMFT, LCSW, etc.)

Date
MM/DD/YY

Time
Time **A.M** **P.M.**

Phone
Area Code and Number

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

Address of Law Enforcement Agency or Evaluation Facility/Person
Your Facility's Address

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

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

☐ Weapon was confiscated pursuant to Section 8102 WIC.
Notify (officer/unit & telephone #) _____

SEE REVERSE SIDE FOR INSTRUCTIONS

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FOR EVALUATION AND TREATMENT
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DEFINITIONS

GRAVELY DISABLED

"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) WIC

"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. Mental retardation, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder. SECTION 5585.25 WIC

PEACE OFFICER

"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 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) WIC

INSTRUCTIONS FOR SECTION 5152.1, 5152.2 AND 5585 WIC

Section 5152.1 WIC

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 receipt of notification.

Section 5152.2 WIC

Each law enforcement agency within a county shall arrange with the county mental health director a method for giving prompt notification to peace officer pursuant to Section 5152.1 WIC.

Section 5585 et seq. WIC

Section 300 WIC is a minor who is under the jurisdiction of the Juvenile Court because of abuse (physical or sexual), neglect or exploitation.

Section 601 WIC is a minor who is adjudged a ward of the Juvenile Court because of being out of parental control.

Section 602 WIC is a minor who is adjudged a ward of the Juvenile Court because of crimes committed.

Section 8102 WIC (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 described by Section 8100.

(b) 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 notify the person of the procedure for the return of any firearm or other deadly weapon which has been confiscated.
Where the person is released without judicial commitment, 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.

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.

Practice 5150 Vignette

Use the following vignette to write a practice 5150 on the following page. Write the 5150 as if the person described came to your current work setting. You may need to make up some information to fill in all of the information on the 5150 Form:

At 4:00 p.m., John Smith, 25 year-old African American male, is brought to your facility for treatment by his mother. During the course of treatment John reports, "There are demons thumping in my head," and the demons are telling him to jump in front of a moving car. His mother reports that he has a long history of psychiatric treatment, though he has been off of his medication for over a year. John states he is afraid he is going to hurt himself, but he is unwilling to go to the hospital.

State of California - Health and Human Services Agency | Department of Mental Health

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Confidential Client/Patient Information
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☐ **Advisement Complete** ☐ **Advisement Incomplete**

Good Cause for Incomplete Advisement

Advisement Completed By | Position | Date

DETAINMENT ADVISEMENT

My name is _____

I am a (Peace Officer, etc.) with (Name of Agency). You are not under criminal arrest, but I am taking you for examination by mental health professionals at (Name of Facility).

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

If taken into custody at his or her residence, the person shall also be told the following information in substantially the following form:

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

To _____

Application is hereby made for the admission of _____

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

_____

_____

_____

* * * * * * * * * *

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

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

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

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

Signature, title and badge number of peace officer, member of attending staff of evaluation facility or person designated by county. | Date / Time | Phone

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

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

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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 receipt of notification.

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HOSPITAL AND COMMUNITY PSYCHIATRY

DIAGNOSING DANGEROUSNESS:

HEDLUND EXPANDS THE LIABILITY OF TARASOFF

by

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Tarasoff

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 Riverside County Department of Mental Health 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.

The essential facts in Tarasoff v. Regents of the University of California are these: 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 his "girl friend," 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 (2) months later, on October 17, 1969 he killed Tatiana Tarasoff. Tatiana's parents sued the therapists, 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 therapists. The Court also laid down a standard against which the obligations of therapists in such cases could be measured, but it did not 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 non-specific threats made to non-specified 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 they could have 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 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 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 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 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 (1976) (Tarasoff II), vacating 13 Cal. 3rd. 117, 529 P. 2nd, 553, 118 Cal. Rptr. 129 (1974) (Tarasoff I).

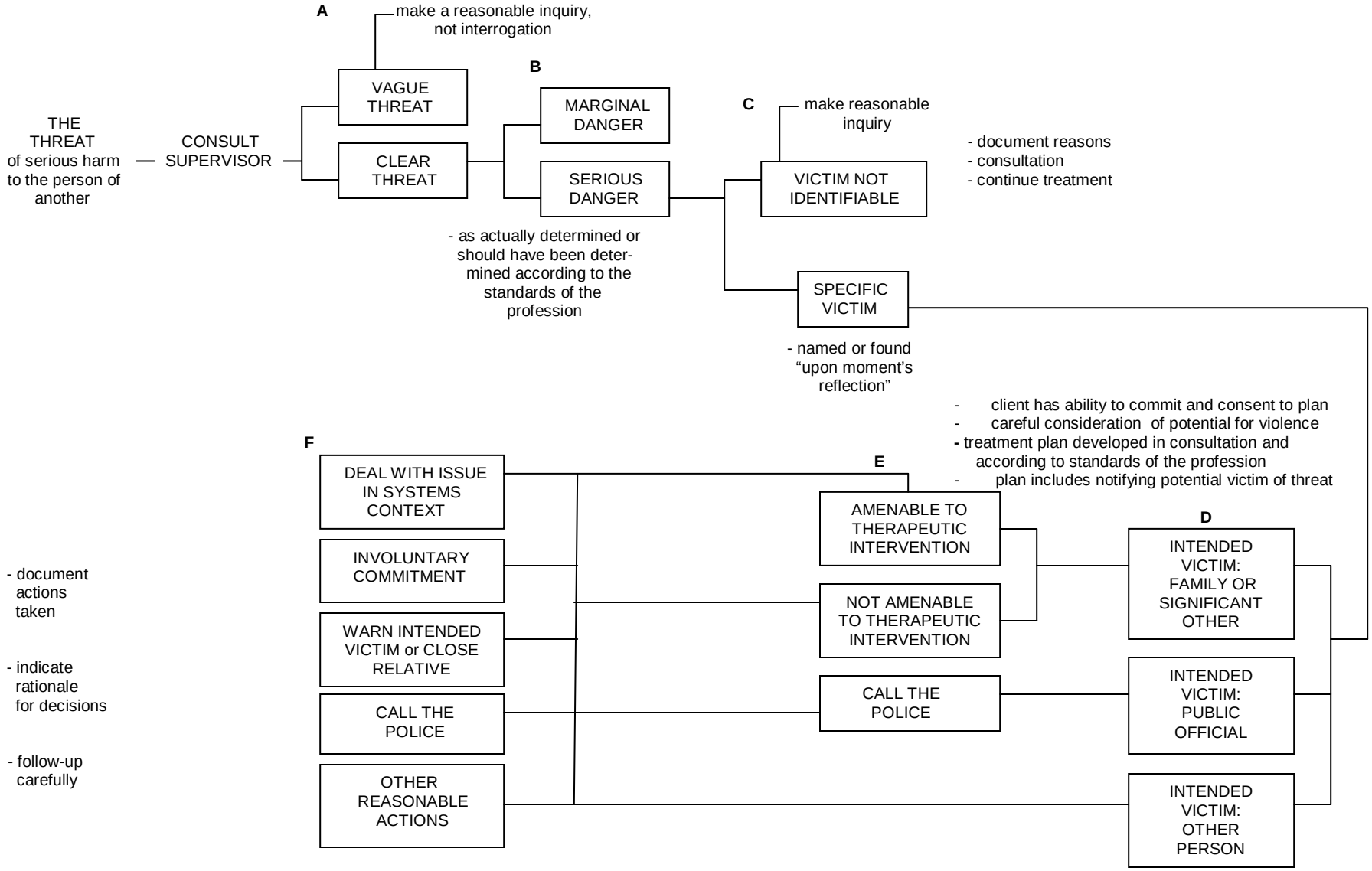
Hedlund et. al. V. Superior Court of Orange County
Wilson et. al. (Real Parties in Interest) LA 31676 (1983)

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).

Figure 1

TARASOFF DECISION CHART



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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 contented 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.

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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) 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).

The author reminds readers that this is not legal advice. Instead, it serves only as an educational illustration of the changing clinical applications of California legal and ethical standard of care. Any legal decision should be made after consultation with an appropriate attorney.

NOTES / COMMENTS

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