IMPORTANT INFORMATION FOR FAMILY MEMBERS

Family Information and Authorization for Verbal Release of Information

On October 4, 2001, Assembly Bill 1424 (Thomson) was signed by the Governor and chaptered into law (Welfare & Institutions Code Section 5150.05) (See reverse). The law became effective January 1, 2002. AB-1424 modifies the LPS (Lanterman-Petris-Short) Act, which governs involuntary treatment for people with mental illness in California.

As per AB-1424, input from family members shall be considered in the determination of whether involuntary treatment is appropriate. Family members are often able to provide valuable information to treatment providers. (Family members who knowingly give false information may be liable to their mentally ill family member in a civil action). Family members should be aware that AB-1424 does not affect existing confidentiality statutes which prohibit treatment professionals from providing information to family members without the written consent of the mentally ill family member (Form “Notification of Patient’s Admission/Release of Verbal Information”). However, it is never a violation of confidentiality statutes for treatment providers to receive information from family members. (See RUHSBH brochure “Confidentiality Guidelines for Caregivers: Family Members and Significant Others”).

To facilitate implementation of AB-1424, Riverside University Health System – Behavioral Health has developed the forms to assist family members in their provision of information to treatment providers. They are:

- “Information Provided by Family Member”
- “Information Provided by Family Member - History of Mentally Ill Person’s Crisis Episodes”

It is not required that family members use RUHSBH forms when providing information to treatment providers. Written and/or verbal information from family members is always acceptable.

Please note: The Family Advocate Program would be interested in hearing from you regarding any suggestions you may have for improving these forms and/or any problems or successes you may have in obtaining care for your relative. Additional copies may be obtained at this facility or by contacting the Family Advocate Program at the address and/or number listed above.
On October 4, 2001, Assembly Bill 1424 (Thomson-Yolo D) was signed by the Governor and chaptered into law. The law became effective January 1, 2002. AB-1424 modifies the LPS (Lanterman-Petris-Short) Act, which governs involuntary treatment for people with mental illness in California. Quoting the legislative intent of the bill:

“The Legislature finds and declares all of the following: Many families of persons with serious mental illness find the Lanterman-Petris-Short Act system difficult to access and not supportive of family information regarding history and symptoms. Persons with mental illness are best served in a system of care that supports and acknowledges the role of the family, including parents, children, spouses, significant others, and consumer-identified natural resource systems. It is the intent of the Legislature that the Lanterman-Petris-Short Act system procedures be clarified to ensure that families are a part of the system response, subject to the rules of evidence and court procedures.”

More specifically, AB-1424 requires:

- That the historical course of the person’s mental illness be considered when it has a direct bearing on the determination of whether the person is a danger to self/others or gravely disabled;

- That relevant evidence in available medical records or presented by family members, treatment providers, or anyone designated by the patient be considered by the court in determining the historical course;

- That facilities make every reasonable effort to make information provided by the family available to the court; and

- That the person (a law enforcement officer or designated mental health professional) authorized to place a person in emergency custody (5150 hold) consider information provided by the family or a treating professional regarding historical course when deciding whether there is a probable cause for hospitalization.

Upon the signing of AB-1424, W&I Code 5150.05 was added to the 5150 code. It reads:

When determining if probable cause exists to take a person into custody, or cause a person to be taken into custody, pursuant to Section 5150, any person who is authorized to take that person, or cause that person to be taken into custody pursuant to that section shall consider available relevant information about the historical course of the person’s mental disorder if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a danger to others, or to himself or herself, or is gravely disabled as a result of the mental disorder.
This **TWO-PAGE** form was developed to provide a means for family members to communicate about their relatives mental health history pursuant to AB-1424, which requires all individuals making decisions about involuntary treatment to consider information supplied by family members. Mental Health staff will place this form in the consumer’s mental health chart. Under California and Federal Law, consumers have the right to view their chart.

Name of Family Member receiving services (Consumer)________________________________________________________

Date of Birth: ___________ Primary Language: _______________ Religion (Optional): _______________

Address: ___________________________________________ Phone: ____________________________

Medi-Cal: □Yes # ____________________ □No Medicare: □Yes # ____________________ □No

Name Of Insured: ________________________ Name Private Medical Ins: ________________________

Does he/she have Conservator? □Yes □No □Not Sure Yes? Name: ______________________________________

Does consumer receive SSI/SSDI? □Yes □No Name of Payee: ________________________________

□Yes □No Please ask my family member to sign an authorization (RUHSBH) Form “Notifications of Patient’s Admission/Release of Verbal Information”) permitting mental health providers to communicate with me about his/her care.

□Yes □No I wish to be contacted as soon as possible in case of an emergency, transfer, or discharge.

□Yes □No My relative has an Advanced Directive (If yes, and a copy is available, please attach a copy to this form)

Brief History of Mental Illness (age of onset, previous capabilities and interests, dangerous to self or others, consumer’s ability to provide for his/her basic needs such as food, clothing, and shelter). Use back of form for additional information if necessary.

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Treating professionals are prohibited from providing information about the consumer **TO** family members without **WRITTEN** authorization of the consumer. (RUHSBH Form: “Notification of Patient’s Admission/Release of Verbal Information”). **Nothing prevents treatment providers from receiving information **FROM** family members.

(CONTINUED ON REVERSE)
Consumer Diagnosis: ____________________________________________________________

Any substance abuse problems? □ Yes □ No Drug of choice: _________________

**CURRENT STRENGTHS:**

Education: ___________________________ Employment/ Volunteer: _____________________________

Goals: ___________________________ Other: _____________________________

**CURRENT MEDICATIONS (Psychiatric and Medical):**

Name: ___________________________ ___________________________ ___________________________

Name: ___________________________ ___________________________ ___________________________

Name: ___________________________ ___________________________ ___________________________

Medications consumer responded well to: _________________________________________________

Medications that **DID NOT** work for consumer: _______________________________________

Treating Psychiatrist: ___________________________ Phone: _____________________________

Case Manager: ___________________________ Phone: _____________________________

Significant Medical Conditions: _______________________________________________________

Allergies-Medications, Food, Chemicals, Other: _______________________________________

Primary Care Physician: ___________________________ Phone: _____________________________

Current Living Situation: ___________________________________________________________

**INFORMATION SUBMITTED BY:**

Name (print): ___________________________ Relationship to (Consumer) ___________________________

Address: ___________________________ City, State: ___________________________ Zip: ___________

Phone: ___________________________ Signature: ___________________________ Date: ___________

Please use this space to continue answers to questions or to provide any other information that may be useful.

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This **TWO-PAGE** form was developed to provide a means for family members to communicate about their relatives’ mental health history pursuant to AB-1424, which requires all individuals making decisions about involuntary treatment to consider information supplied by family members. Mental Health staff will place this form in the consumer’s mental health chart. Under California and Federal Law, consumers have the right to view their chart.

**Name of Family Member receiving services (Consumer):** __________________________________________

**Date of Birth:** __________    **Primary Language:** __________    **Religion (Optional):** __________

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<tr>
<th>Date</th>
<th>Crisis Behavior/Event (include a description of the crisis and any triggers or precipitants)</th>
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<th>Result Of The Action</th>
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Treating professionals are prohibited from providing information about the consumer TO family members without WRITTEN authorization of the consumer. (RUHSBH Form: “Notification of Patient's Admission/Release of Verbal Information”). **Nothing prevents treatment providers from receiving information FROM family members.**

(CONTINUED ON REVERSE)
What has helped this mentally ill person to deal with these crisis's in the past?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

What has **NOT** been helpful?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Your Name (Print): ________________________ Relationship To Consumer: __________

Address: ________________________________ City/State: _______________ Zip: ________

Phone: _______________ Signature: _______________ Date: _______________

Please use this space to continue answers to questions or to provide any other information you feel may be useful.

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Information Provided by Family Member - History of Mentally Ill Person’s Crisis Episodes

Page 2  Staff to File in “Correspondence” Section of Client Chart  (Revised 7/2016)