Health, Housing & Community Services
Mental Health Commission

To: Mental Health Commissioners
From: Jamie Works-Wright, Commission Secretary
Date: July 11, 2023

Documents Pertaining to 7/20/23 Agenda items:

Agenda Item	Description	Page
2. a	Approval of the July 20, 2023 Meeting Agenda	1
2. b	Approval of the June 15, 2023 Meeting Minutes	3
7.	Mental Health Manager Report – Jeff Buell	
	a. Manager Report	5
	b. Caseload Statics June 2023	7
Email Correspondence	**Memo:** 7/5/23 UCSF 5150/5585 training -- KEEP THIS HANDY	14
	Attachment: CBHS 5150 Detainment Advisement Multi-Language 2017.pdf	16
	Attachment: DHCS-1801-20191106 (5150-5585).pdf	18
	Attachment: Involuntary_Detention_Manual_April2020.pdf	20
	Memo: SCU update	81
	Attachment: BART Crisis specialist.docx	82
	Memo: [FASMI Discussion] Modernization Presentation today /Bee article /Fact sheet	85
	Memo: Follow up to MHC mtg of June 15, 2023	92
	Memo: FASMI Discussion Alameda County Meeting Roundup June 19-June 23: Meetings Related to Serious Mental Illness (SMI) and the Jail	94
	Attachment: BHCIP awards.pdf	104
	Memo: Mental Health Advisory Board Meeting (June 21, 2023)	105
	Attachment: MHAB Main Board Agenda (June 2023).pdf	107
	Attachment: MHAB Unapproved Meeting Minutes (May 2023).pdf	108
	Attachment: Resolution Designating 26M for MH Program and Services Unit.pdf	113
	Attachment: Sen Skinner's Letter re MH Program and Services Unit.pdf	121
	Attachment: MHAB Letter to Board of Supervisors re Jail Expansion Plan.pdf	124
	Attachment: Memo - ACBH Departmental Response to MHAB Annual Report Recommendations.pdf	126
	Attachment: ACBH Departmental Response to MHAB FY2021-2022 Annual Report.pdf	135
	Memo: MHSA act information	154

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Health, Housing & Community Service Department
Mental Health Commission

Berkeley/ Albany Mental Health Commission

Regular Meeting
Thursday, July 20, 2023

Time: 7:00 p.m. - 9:00 p.m.

Location: North Berkeley Senior Center
1901 Hearst Ave. Berkeley, Conference Room A

Teleconference Location
2475 Prince St, Berkeley, CA 94705

AGENDA

1. **Roll Call (1 min)**

2. **Preliminary Matters (5 min)**
   a. Action Item: Approval of the July 20, 2023 agenda
   b. Public Comment (non-agenda items)
   c. Action Item: Approval of the June 15, 2023 minutes

3. **SCU and update – Lisa Warhuus**

4. **Proposal for Early Intervention in Psychosis Program provided by Alice Feller – Andrea Prichett**

5. **Mental Health Commissions role regarding the policy of the city re: police sweeping homeless folks – Judy Appel**

6. **Motion to establish subcommittee concerning the Governor's plan for "Transformation of Behavioral Health Services – Edward Opton**

7. **Mental Health Manager's Report and Caseload Statistics – provided by Jeff Buell**
   a. MHC Manager Report
   b. Caseload Statistic June 2023

8. **Recording Mental Health Commission Meetings and Posting Them – Andrea Prichett**

9. **Subcommittee Reports**
   a. **Youth Subcommittee**
   b. **Membership Subcommittee**
   c. **Evaluation Subcommittee**
      i. **Annual Report**

10. Community Health Records – Margaret Fine

11. Providing a state legislative update on behavioral health particularly as it relates to our work in the City of Berkeley – Margaret Fine

12. Adjournment

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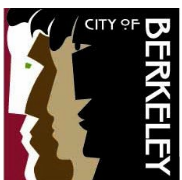
Contact person: Jamie Works-Wright, Mental Health Commission Secretary (510) 981-7721 or Jworks-wright@berkeleyca.gov

Communication Access Information: This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services specialist at 981-6418 (V) or 981-6347 (TDD) at least three business days before the meeting date. ***Please refrain from wearing scented products to this meeting. Attendees at trainings are reminded that other attendees may be sensitive to various scents, whether natural or manufactured, in products and materials. Please help the City respect these needs.*** *Thank you.*

SB 343 Disclaimer

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection in the SB 343 Communications Binder located at the Adult Clinic at 2640 MLK Jr. Way, Berkeley, CA 9470



Department of Health,
Housing & Community Services
Mental Health Commission

Berkeley/Albany Mental Health Commission
Draft Minutes

DRAFT

7:00 pm
North Berkeley SC 1901 Hearst

Regular Meeting
June 15, 2023

Members of the Public Present: Alice Feller, Ann Hawkins, Loretta Smith
Staff Present: Jeff Buell, Karen Klatt, Jamie Works-Wright

1) **Call to Order at 7:09 pm**
Commissioners Present: Judy Appel, Margaret Fine, Edward Opton, Andrea Prichett, Glenn Turner **Absent:** Monica Jones, Kate Harrison, Mary Lee Kimber-Smith

Vote to have a commission member temporary Chair the meeting due to the Chair and Vice Chair being out. Margaret Fine was selected based on a number selection.

2) **Preliminary Matters**
   a) **Approval of the June 15, 2023 agenda**
   M/S/C (Opton, Appel) Motion to approve the agenda
   PASSED
   Ayes: Appel, Fine, Opton, Prichett, Turner **Noes:** None; **Abstentions:** None; **Absent:** Harrison, Jones, Kimber-Smith

   b) **Public Comment-** 4 public comment

   c) **Approval of the May 18, 2023 Minutes**
   M/S/C (Turner, Opton) Motion to approve the minutes
   Make a friendly amendment to modify item #4
   M/S/C (Prichett, Appel) Motion to add that Jeff Buell submitted a written report
   PASSED
   Ayes: Appel, Fine, Opton, Prichett, Turner **Noes:** None; **Abstentions:** None; **Absent:** Harrison, Jones, Kimber-Smith

***Motion to extend the meeting to 9:15**
M/S/C (Prichett, Turner) Motion to extend the meeting to 9:15
PASSED
Ayes: Appel, Fine, Opton, Prichett, Turner **Noes:** None; **Abstentions:** None; **Absent:** Harrison, Jones, Kimber-Smith

3) **MHSA Three Year Plan Public Hearing – Karen Klatt (45 min)** MHSA FY24-26 Three Year Plan
M/S/C (Prichett, Appel) Motion that the MHC write a letter that explains why we are not taking an action and that includes that we didn't have enough time to make a thoughtful and constructive recommendation and there are points which we feel that the policies pursued by the city manager are at odds with the budgeting priorities described in this document. Point 1. They take no recommendation 2. Ran out of time and will revise our time line for reviewing the MHSA report 3. We have concerned that portions of the policies currently being pursued by the City Manager conflict with the priorities expressed in this budget.

PASSED
Ayes: Appel, Prichett, Turner **Noes:** None; **Abstentions:** Fine, Opton; **Absent:** Harrison, Jones, Kimber-Smith

4) **Recording Mental Health Commission Meetings and Posting Them – Andrea Prichett**
Did not get to item

5) **Mental Health Manager's Report and Caseload Statistics – Jeff Buell (15 min)**
   a) MHC Manager Report
   b) Caseload Statistic May 2023
      - No Motion Made

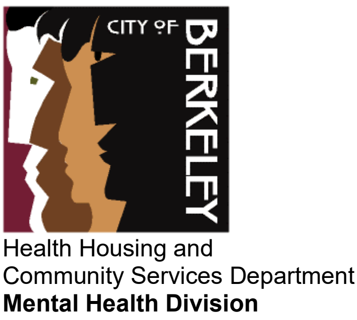
6) **Subcommittee Reports (20 min) -** Did not get to item
   a) Youth Subcommittee
   b) Membership Subcommittee
   c) Evaluation Subcommittee
      i) Annual Report

7) **Community Health Records – Margaret Fine -** Did not get to item

8) **Providing a state legislative update on behavioral health particularly as it relates to our work in the City of Berkeley – Margaret Fine -** Did not get to item

9) **Adjournment – 9:15 PM**

Minutes submitted by: ________________________________
Jamie Works-Wright, Commission Secretary



Health Housing and
Community Services Department
Mental Health Division

MEMORANDUM

To: Mental Health Commission
From: Jeffrey Buell, Mental Health Division Manager
Date: 6/29/2023
Subject: Mental Health Manager Report

Mental Health Services Report

Please find the attached report on Mental Health Services for June 2023.

Of note, this report is being delivered earlier than usual due to the absence of the Mental Health Manager for the July 2023 Meeting.

Information Requested by Mental Health Commission

No questions were submitted by the Mental Health Commission for this month.

Mental Health Division Updates

The Mental Health Division's areas of updates:

A) Hiring of vacant positions continues. New positions currently are required to have explicit permission from the City Manager to ensure that they are necessary.
B) As part of the continued improvements to technology, Alameda County Behavioral Health is rolling out a new client services data system called SmartCare to replace the decades old program (INSYST) that has been running on 50-year-old technology. Berkeley Mental Health, as a contractor of the County, will also start utilizing this system in July 2023. This should support streamlining and productivity improvements to client services. Other CalAIM guided changes continue to be rolled out on the DHCS and County timelines.
C) The Governor released a new set of information regarding his plans to "modernize mental health care." Details are included about the proposed redistribution of the MHSA funds from current allocation levels. The Mental Health Division will work on a more specific overview of how these changes will affect specific programming. It appears at this time that there will be a significant

reduction in funds for prevention and treatment programs that are not full service partnerships (Assertive Community Treatment modeled teams).
https://www.dhcs.ca.gov/services/Pages/Modernizing-our-Behavioral-Health-Initiative.aspx

Berkeley Mental Health Caseload Statistics for June 2023

Adult Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Previous 12 Months	Fiscal Year 2023 (July '22-June '23) Demographics as of June 2023
Adult, Older Adult and TAY Full Service Partnership (AFSP) (Highest level outpatient clinical case management and treatment)	1-10 for clinical staff.	5 Clinicians, 1 Clinical Supervisor	54	$9,021	Clients: 61 API: 1 Black or African-American: 33 Hispanic or Latino: 1 White: 26 American Indian: 0 Other/Unknown: 0 Male: 35 Female: 25 Missing Gender ID: 0 Prefer Not to Answer Gen ID: 1 Multiple Gender ID: 0 Heterosexual: 49 Unknown: 4 Missing Sex Orient: 0 Bisexual: 1 Queer: 1 Prefer Not to Answer Sex Orient: 3 Multiple Sex Orient: 2 Gay: 0 Questioning: 1 Lesbian: 0
Adult FSP Psychiatry (June Stats)	1-100	.5 FTE	44		
AFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)				$2,037,600	
Homeless Full-Service Partnership (HFSP) (Highest level outpatient clinical case management and treatment)	1-8 for clinical staff	5 Clinicians, 1 Clinical Supervisor	39	$7,720	Clients: 41 API: 2 Black or African-American: 24 Hispanic or Latino: 1 Other/Unknown: 0 White: 14 Male: 27

7

Berkeley Mental Health Caseload Statistics for June 2023

					Female: 12 Missing Gender ID: 1 Unknown: 1 Prefer No to Answer: 0 Multiple Gender Identities: 0 Heterosexual: 32 Missing Sex Orient: 1 Bisexual: 3 Unknown: 3 Gay: 1 Questioning: 1 Multiple Sex Orient: 0 Prefer Not to Answer: 0 Lesbian: 0
HFPS Psychiatry (June Stats)	1-100	.0 FTE	27		
HFSP FY22 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			TBD		
Comprehensive Community Treatment (CCT) (High level outpatient clinical case management and treatment)	1-20	7 Clinicians 1 Team Lead 1 Clinical Supervisor	152	$2,989	Clients: 177 American Indian: 2 API: 17 Black or African-American: 68 Hispanic or Latino: 7 Other/Unknown: 4 Pacific Islander: 1 White: 78 Male: 91 Female: 77 Multiple Gender Identities: 2 Missing Gender ID: 1 Non-Conforming Gender ID: 2 Prefer Not to Answer Gender ID: 1 Female to Male: 1 Queer Gender ID: 1 Unknown: 1 Heterosexual Sex Orient: 130 Unknown: 18 Missing Sexual Orient: 2

8

Berkeley Mental Health Caseload Statistics for June 2023

					Bisexual Sex Orient: 3 Lesbian Sex Orient: 5 Gay Sex Orient: 3 Prefer Not to Answer Sex Orient: 10 Multiple Sexual Orient: 1 Queer Sexual Orient: 2 Other Sexual Orient: 3
CCT Psychiatry (June Stats)	1-200	0.75 FTE	122		
CCT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,617,010		
Focus on Independence Team (FIT) (Lower level of care, only for individuals previously on FSP or CCT)	1-20 Team Lead, 1-50 Post Masters Clinical 1-30 Non-Degreed Clinical	1 Licensed Clinician 1 CHW Sp./ Non-Degreed Clinical, 1 Clinical Supervisor	86	$1,603	Clients: 92 API: 7 Black or African American: 33 Hispanic or Latino: 5 Other/Unknown: 0 White: 47 Male: 52 Female: 38 Intersex: 1 Missing Gender ID: 1 Other Gender ID: 0 Heterosexual: 79 Unknown: 6 Missing Sexual Orient: 1 Prefer Not to Answer Sexual Orient: 4 Gay: 1 Multiple Sexual Orient: 1 Questioning: 0
FIT Psychiatry (June Stats)	1-200	.25	87		
FIT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$900,451		

Family, Youth and Children's Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Last 12 months	Fiscal Year 2023 (July '22-June '23) Demographics as of June 2023
Children's Full-Service Partnership (CFSP)	1-8	1 Senior Behavioral Health Clinician	9	$7,890	Clients: 12 American Indian: 0 API: 0 Black or African-American: 6 Hispanic or Latino: 6 Other/Unknown: 0 White: 0 Female: 4 Male: 6 Missing Gender ID: 1 Unknown: 1 Non-Conforming Gender ID: 0 Heterosexual: 6 Missing Sexual Orient: 1 Unknown: 4 Gay: 1 Other Sexual Orient: 0 Questioning Sexual Orient: 0
CFSP Psychiatry (June Stats)	1-100	0	5		
CFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$489,235		
Early and Periodic Screening, Diagnostic and Treatment Prevention (EPSDT) /Educationally Related Mental Health Services (ERMHS)	1-20	3 Clinicians, 1 Clinical Supervisor	51	$2,298	Clients: 67 American Indian: 6 API: 4 Black or African-American: 27 Hispanic or Latino: 13 Other/Unknown: 2 White: 15 Female: 28 Male: 23 Missing Gender ID: 5 Unknown: 6 Multiple Gender ID: 3 Non-Conforming Gender ID: 2

					Female to Male: 0 Other Gender ID: 0 Heterosexual: 28 Unknown: 22 Missing Sexual Orient: 5 Gay: 4 Multiple Sexual Orient: 3 Bisexual: 2 Lesbian: 1 Prefer Not to Answer: 1 Other Sexual Orient: 0 Queer Sexual Orient: 0 Questioning Sexual Orient: 1
ERMHS/EPSDT Psychiatry (June Stats)	1-100	0	11		
EPSDT/ERMHS FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$1,062,409		
High School Health Center and Berkeley Technological Academy (HSHC)	1-6 Clinician (majority of time spent on crisis counseling)	4 Clinicians, 0 Clinical Supervisor	Drop-in: 14 Externally referred: 12 Ongoing tx:81 Groups: 12 Offered/ 10 Conducted		N/A
HSHC FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$396,106		

11

Crisis and ACCESS Services	Staff Ratio	Clinical Staff Positions Filled	Total # of Clients/Incidents	MCT Incidents Detail	Calendar Year 2023 (Jan '23- Dec '23) Demographics – From Mobile Crisis Incident Log (through June 2023)
Mobile Crisis (MCT)	N/A	2 Clinicians filled at this time	• 84 - Incidents • 20- 5150 Evals • 4 - 5150 Evals leading to involuntary transport	• 74 - Incidents: Location - Phone • 23 - Incidents: Location - Field • 0 - Incidents: Location - Home	Clients: 311 API: 10 Black or African-American: 44 White: 84 Hispanic or Latino: 7 Other/Unknown: 166 Female: 128 Male: 151 Transgender: 0 Unknown: 32
MCT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$771,623		
Transitional Outreach Team (TOT)	N/A	.5 Licensed Clinician, (TOT and CAT have been recently merged)	• 3 – Incident(s)	N/A	Clients: 22 API: 1 Black or African-American: 4 White: 11 Hispanic or Latino: 2 Other/Unknown: 4 Female: 12 Male: 8 Transgender: 0 Unknown: 2
TOT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$272,323		
Crisis, Assessment, and Triage (CAT)	N/A	2 Non-Licensed Clinicians, .5 Licensed Clinician, 0 Clinical Supervisor	• 139 - Incidents	N/A	Clients: 279 API: 8 Black or African-American: 52 White: 60 Hispanic or Latino: 6 Other/Unknown: 153 Female: 105 Male: 114 Transgender: 1 Unknown: 59

CAT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)	$735,075

Not reflected in above chart is Early Childhood Consultation, Wellness and Recovery Programming, or Family Support.
In demographics, other/unknown is used both when a client indicates that they are multi-racial and when demographic info is not known.

*Average System Costs come from Yellowfin, and per ACBH include all costs to mental health programs, sub-acute residential programs, hospitals, and jail mental health costs.

Works-Wright, Jamie

From: Edward Opton <eopton1@gmail.com>
Sent: Wednesday, July 5, 2023 4:04 PM
To: Works-Wright, Jamie
Cc: Berkeley/Albany Mental Health Commission
Subject: Fwd: 7/5/23 UCSF 5150/5585 training -- KEEP THIS HANDY
Attachments: CBHS 5150 Detainment Advisement Multi-Language 2017.pdf; DHCS-1801-20191106 (5150-5585).pdf; Involuntary_Detention_Manual_April2020.pdf

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

7.5.23

To: Jamie Works-Wright
From: Edward Opton

Attached below is an e-mail from UCSF Psychiatry, and attached to it, at the very bottom, are three documents. One of the three, the one on the right, is a manual of standards and procedures for involuntary commitment on grounds of psychiatric disability in California.

I don't think we should burden the Mental Health Commissioners and their photocopy machines and filing cabinets with copies of such a lengthy document, but I think it would be a good idea to file a copy of the document in the Commission's records so that it will be available if needed. The process for involuntary commitment is complex, and it may become the subject of considerable controversy this year and next year, as FASMI (Families of the Adult Mentally Ill) currently is making a determined effort to apply the process more widely and/or to amend it.

Begin forwarded message:

From: "Tarpey, Dominic" <Dominic.Tarpey@ucsf.edu>
Subject: 7/5/23 UCSF 5150/5585 training -- KEEP THIS HANDY
Date: July 5, 2023 at 12:51:54 PM PDT
Cc: "Tarpey, Dominic" <Dominic.Tarpey@ucsf.edu>

For participants in the Wed, 2-4pm 7/5/23 training —please keep this email handy and note the following:

- The passcode to the post-test will be given out at the end of the training.
- Zoom link below
- Today's training is for UCSF faculty, staff, and trainees only

POST-TEST:
https://ucsf.co1.qualtrics.com/jfe/form/SV_4Zr8a9yntI56y5E

ZOOM:
Meeting ID: 917 9963 4882
Password: 364197

Join from a PC, Mac, Linux, iOS or Android device:
https://ucsf.zoom.us/j/91799634882?pwd=bUNONWxscWNiYTlRL0V0WUkyb2xZQT09

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Pronouns: he, him, his

weill.ucsf.edu | https://psych.ucsf.edu/lpph | ucsfhealth.org

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DETAINMENT ADVISEMENT

My name is ______________________. I am a _________________________with ________________________. You are not under criminal arrest, but I am taking you for examination by mental health professionals at ______________________. You will be told your rights by the mental health staff.

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

AVISO DE DETENCIÓN

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

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

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

羈押通知

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

進行專業的心理健康檢查。心裡健康工作人員將會告知您所擁有的權利。

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

SỰ BẮT GIỮ SAU KHI ĐÃ NGHỊ ÁN

Tên tôi là ________________________. Tôi là ___________________________với _____________________________. Bạn không bị bắt giữ về hình sự, nhưng tôi phải đưa bạn đi khám bởi các chuyên gia y tế tâm thần tại _________________________.
Nhân viên y tế tâm thần sẽ cho bạn biết về những quyền của bạn.
Nếu bị bắt giữ tại nơi cư trú, bạn có thể mang theo một vài vật dụng cá nhân với sự đồng ý của tôi. Xin vui lòng cho tôi biết nếu bạn cần được giúp để tắt bất cứ thiết bị nào hoặc để khóa hệ thống nước trong nhà. Bạn có thể gọi điện thoại và để lại thư nhắn tin cho bạn bè hoặc gia đình về nơi bạn được đưa đến.

ЗАЧИТЫВАНИЕ ПРАВ ПРИ ЗАДЕРЖАНИИ

Меня зовут ____________________________. Я _________________________ из _________________________. Вы не арестованы, но я должен задержать вас для осмотра специалистами в области психиатрии в _______________________.
Ваши права вам разъяснят сотрудники психиатрического отделения.
Если вы подлежите задержанию у себя дома, вы можете взять с собой личные вещи, которые я должен буду одобрить. Пожалуйста, сообщите мне, если вам нужна помощь в отключении воды или приборов. Вы можете сделать телефонный звонок и оставить записку, чтобы сообщить вашим друзьям и близким, куда вас забрали.

TAGUBILIN NG PAGPIPIGIL
(DETAINMENT ADVISEMENT)

Ang pangalan ko ay _________________________. Ako ay mula sa_______________ _____________________________. Hindi kayo sumasailalim ng pag-arestong kriminal, ngunit dadalhin ko kayo para suriin ng mga propesyonal ng kalusugang pangkaisipan sa ___________________________. Sasabihan kayo ng inyong mga karapatan ng kawani ng kalusugang pangkaisipan.
Kung kukunin kayo sa pag-iingat sa inyong tirahan, maaari kayong magdala ng ilang personal na mga gamit kasama ninyo, na dapat kong aprubahan. Mangyari lamang na ipaalam sa akin kung kailangan ninyo ng tulong sa pagsasara ng anumang kagamitan o tubig. Maaari kayong tumawag sa telepono at mag-iwan ng mensahe para sabihin sa inyong mga kaibigan o pamilya kung saan kayo dadalhin.

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

Confidential Client/Patient Information

Welfare and Institutions Code (W&I Code), section 5150 (g)(1), requires that each person, at the time they are first taken into custody under this section, shall be provided, by the person who takes them into custody, the following information orally in a language or modality accessible to the person. If the person cannot understand an oral advisement, the information shall be provided in writing.

☐ **Complete Advisement** ☐ **Incomplete Advisement**

Date of Advisement/Attempt:____________________

Good Cause for Incomplete Advisement:

DETAINMENT ADVISEMENT

My name is ________________________. I am a (peace officer/mental health professional) with (name of agency). You are not under criminal arrest, but I am taking you for examination by mental health professionals at (name of facility).

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

If taken into custody at their residence, the person shall also be told the following information:

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

Advisement Completed/Attempted By:	Position:	Language or Modality Used:

To (*name of 5150 designated facility*):____

Application is hereby made for the assessment and evaluation of ___________________________, date of birth of _____, and residing at ____, California, for up to 72-hour assessment, evaluation, and crisis intervention, or placement for evaluation and treatment at a designated facility pursuant to Section 5150, et seq. (adult) or Section 5585 et seq. (minor), of the W&I Code.

If authorization for voluntary treatment is not available for a minor/conservatee, indicate to the best of your knowledge who has legal authority to make medical decisions on behalf of the minor/conservatee: (name and contact information, if available)

(**Check one**): ☐ **Parent(s)** ☐ **Legal Guardian(s)** ☐ **Conservator** ☐ **Other:**____________________

Indicate to the best of your knowledge whether the minor is under the jurisdiction of the juvenile court:

(Check one): ☐ **W&I Code 300 (dependent)** ☐ **W&I Code 601, 602 (ward)**

The detained person's condition was called to my attention under the following circumstances:

____

____

Specific facts that I have considered that lead me to believe that this person is, as a result of a mental health disorder, a danger to others, a danger to self or or gravely disabled:

____

____

☐ I have considered the historical course of the person's mental disorder as follows:

____

____

☐ No reasonable bearing on determination

☐ No information available because: ____

Please Note: A copy of this application shall be treated as the original.

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

OPTIONAL INFORMATION

History Provided by (Name)	Address	Phone Number	Relation

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

☐ **Danger to Self (DTS)** ☐ **Danger to others (DTO)**

☐ **Gravely disabled (as defined in W&I Code section 5008 or 5585.25)**

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

Notify behavioral health director/designee: ______________________ ____________________
(Name) *(Phone)*

and peace officer/designee: ______________________________ ________________ of
(Name) *(Phone)*

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

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

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

☐ Weapon was confiscated pursuant to Section 8102 W&I Code.

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

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

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

REFERENCES

Welfare and Institutions Code

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

Name of Individual Detained:________________________ **DOB:**________________

Please Note: A copy of this application shall be treated as the original.

5150/5585 Involuntary Detention Manual

April 2020

Table of Contents

Entry	Page
Important Phone Numbers	2
Introduction	3
Lanterman-Petris-Short Act (LPS Act): An Overview	4
Pre-LPS	4
Revisions to the LPS Act	4
How to Interpret the LPS Act	5
Overview of LPS Patients' Rights	6
Good Cause for Denial of Rights	6
Documentation Requirements	7
Right to Exercise Informed Consent to Medication	7
Right to Refuse Medication	8
Riese Hearing	8
Use of Seclusion and Restraints	8
Involuntary Detention Under the LPS Act	10
Purpose of Detention	10
Grounds for Detention	10
Probable Cause	11
Liability for False Statement	11
Detainment Advisement	11
Transport to Designated Facility	12
Admission Advisement	12
Release from Detention	13
Involuntary Detention of Minors	13
Civil Commitment Laws and Procedures	14
Voluntary Status	14
Involuntary Status	15
Longer-term Holds	18
Conservatorship	19
Overview of the Civil Commitment Process	20
Conducting the 5150/5585 Evaluation	21
Determining Grave Disability	21
Determining Risk of Danger to Self or to Others	21
Completing the 5150/5585 Application	23
Detainment Advisement	23
Application is Made To/For	24
Detained Person's Condition was called to my Attention	24
Specific Facts Considered as Probable Cause	24
Historical Course of the Mental Health Disorder	25
Criteria, signature, date/time	25
Managing the Crisis	25
Appendix: 5150/5585 Application	27
Admission Advisement	29
Detainment Advisement in Threshold Languages	30
Tarasoff v. Regents University of California	32
SFPD General Order: Tarasoff Incidents	34
BHS P&P 3.06-09 Duty to Warn & Protect	36
SFPD General Order: Psychological Evaluation of Adults	41
SFPD General Order: Psychological Evaluation of Juveniles	46
BHS P&P 3.07-02: Authority for Involuntary Detention	50
BHS P&P 3.03-1: Involuntary Detention of Minors	54

IMPORTANT PHONE NUMBERS

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

INTRODUCTION

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

The following individuals are eligible for certification:

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

Individuals must be re-certified on a regular basis.

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

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

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

LANTERMAN – PETRIS – SHORT ACT (LPS ACT):

AN OVERVIEW

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

PRE-LPS

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

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

REVISIONS TO THE LPS ACT

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

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

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

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

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

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

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

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

HOW TO INTERPRET THE LPS ACT

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

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

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

OVERVIEW OF LPS PATIENTS' RIGHTS

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

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

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

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

GOOD CAUSE FOR DENIAL OF RIGHTS

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

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

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

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

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

DOCUMENTATION REQUIREMENTS

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

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

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

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

RIGHT TO EXERCISE INFORMED CONSENT TO MEDICATION

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

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

RIGHT TO REFUSE MEDICATION

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

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

RIESE HEARING

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

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

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

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

USE OF SECLUSION OR RESTRAINTS

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

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

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

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

Declares that the use of seclusion or restraint:

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

Allows restraint in behavioral emergencies ONLY:

- when a person presents an <u>immediate</u> danger of serious harm to self or others

Emphasizes reducing use of seclusion or restraint through:

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

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

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

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

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

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

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

INVOLUNTARY DETENTION UNDER THE LPS ACT

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

PURPOSE OF DETENTION

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

GROUNDS FOR DETENTION

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

PROBABLE CAUSE

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

LIABILITY FOR FALSE STATEMENT

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

DETAINMENT ADVISEMENT

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

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

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

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

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

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

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

TRANSPORT TO DESIGNATED FACILITY

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

ADMISSION ADVISEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

RELEASE FROM DETENTION

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

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

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

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

INVOLUNTARY DETENTION OF MINORS

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

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

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

CIVIL COMMITMENT LAWS & PROCEDURES

Voluntary Status

Legal standard for voluntary patient status

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

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

Legal rights of voluntary patients

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

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

b. The right to refuse anti-psychotic medication.

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

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

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

Involuntary Status

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

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

a. Probable Cause

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

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

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

b. Mental Health Disorder

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

c. Danger to Self

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

d. Danger to Others

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

e. Grave Disability

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

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

Legal standard for involuntary detention (intensive treatment)

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

a. Timing of Certifications

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

b. Certification Form

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

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

c. Habeas Corpus/Judicial Review

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

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

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

Longer-term Holds

a. Additional intensive treatment of gravely disabled persons.

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

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

b. Additional intensive treatment of suicidal persons.

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

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

c. Post-certification of imminently dangerous persons.

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

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

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

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

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

Conservatorship

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

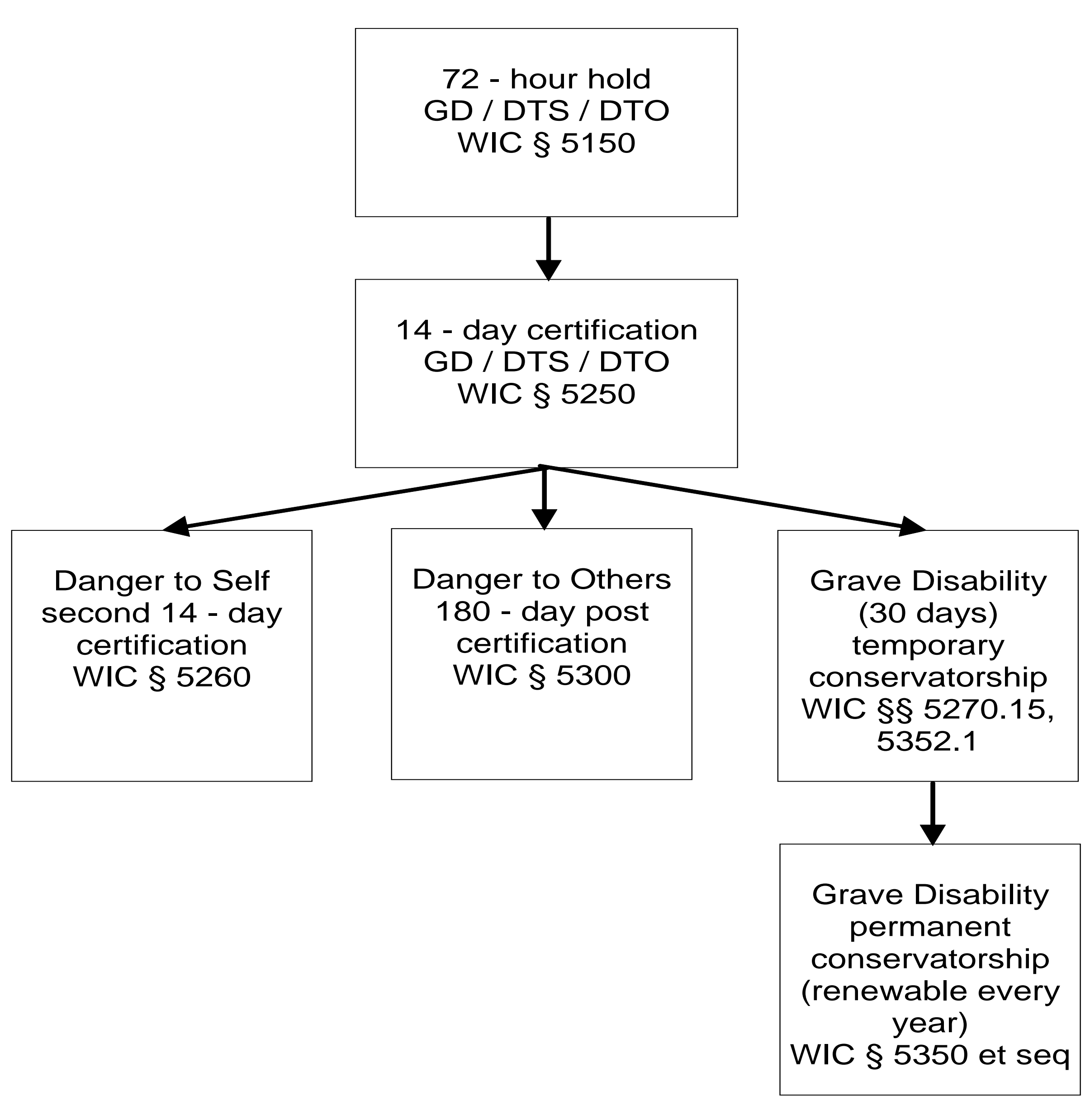
If the individual is "gravely disabled," the person can be placed on a temporary conservatorship for 30 days (W&I Section 5352.1), followed by a permanent conservatorship for renewable one-year periods (W&I Section 5361).

Legal standard:

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

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

OVERVIEW OF THE CIVIL COMMITMENT PROCESS



CONDUCTING THE 5150/5585 EVALUATION

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

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

Determining Grave Disability

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

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

Determining Risk of Danger to Self or to Others

Possible **warning signs** may include:

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

Risk factors include:

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

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

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

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

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

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

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

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

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

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

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

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

COMPLETING THE 5150/5585 APPLICATION

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

In general, this application must adequately address the following:

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

Detainment Advisement:

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

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

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

Application is Made To/For:

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

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

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

Detained Person's Condition was called to my Attention:

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

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

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

Specific Facts considered as Probable Cause:

Document behavioral descriptions of the person that lead you to believe this individual can be detained based on the criteria for danger to self, danger to others, or grave disability. Behavioral descriptions refer to what the person DOES and SAYS and do not rely on clinical terms. Examples are:

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

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

Historical Course of the Mental Health Disorder:

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

Criteria, signature, date/time:

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

In summary, good documentation includes:

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

MANAGING THE CRISIS

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

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

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

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

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

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

Reminders:

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

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

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

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

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

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

Confidential Client/Patient Information

Welfare and Institutions Code (W&I Code), section 5150 (g)(1), requires that each person, at the time they are first taken into custody under this section, shall be provided, by the person who takes them into custody, the following information orally in a language or modality accessible to the person. If the person cannot understand an oral advisement, the information shall be provided in writing.

☐ **Complete Advisement** ☐ **Incomplete Advisement**

Date of Advisement/Attempt:____________________

Good Cause for Incomplete Advisement:

DETAINMENT ADVISEMENT

My name is ________________________. I am a (peace officer/mental health professional) with (name of agency). You are not under criminal arrest, but I am taking you for examination by mental health professionals at (name of facility).

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

If taken into custody at their residence, the person shall also be told the following information:

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

Advisement Completed/Attempted By:	Position:	Language or Modality Used:

To (*name of 5150 designated facility*):____

Application is hereby made for the assessment and evaluation of __________________________,
date of birth of _____, and residing at ____,
California, for up to 72-hour assessment, evaluation, and crisis intervention, or placement for evaluation and treatment at a designated facility pursuant to Section 5150, et seq. (adult) or Section 5585 et seq. (minor), of the W&I Code.

If authorization for voluntary treatment is not available for a minor/conservatee, indicate to the best of your knowledge who has legal authority to make medical decisions on behalf of the minor/conservatee: (name and contact information, if available)

(**Check one**): ☐ **Parent(s)** ☐ **Legal Guardian(s)** ☐ **Conservator** ☐ **Other:**__________________

Indicate to the best of your knowledge whether the minor is under the jurisdiction of the juvenile court:

(Check one): ☐ W&I Code 300 (dependent) ☐ W&I Code 601, 602 (ward)

The detained person's condition was called to my attention under the following circumstances:

Specific facts that I have considered that lead me to believe that this person is, as a result of a mental health disorder, a danger to others, a danger to self or or gravely disabled:

☐ I have considered the historical course of the person's mental disorder as follows:

☐ No reasonable bearing on determination

☐ No information available because: ____

Please Note: A copy of this application shall be treated as the original.

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

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

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

☐ **Danger to Self (DTS)** ☐ **Danger to others (DTO)**

☐ **Gravely disabled (as defined in W&I Code section 5008 or 5585.25)**

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

Notify behavioral health director/designee: ______________________ ______________________
(Name) *(Phone)*

and peace officer/designee: ______________________ ______________________ of
(Name) *(Phone)*

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

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

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

☐ Weapon was confiscated pursuant to Section 8102 W&I Code.

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

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

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

REFERENCES

Welfare and Institutions Code

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

Name of Individual Detained:______________________ **DOB:**______________

Please Note: A copy of this application shall be treated as the original.

State of California
Health and Human Services Agency

Department of Health Care Services

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

Confidential Patient Information

Name of Facility:

Patient's Name:	**Admission Date:**

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

My name is ______________________ My position here is ______________________

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

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

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

We believe this is true because:

____

____

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

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

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

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

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

DHCS 1802 (Revised 12/2019) cc: Original to the Patient/Copy to the Patient's Record

DETAINMENT ADVISEMENT

My name is ________________________. I am a __________________________ with __________________________. You are not under criminal arrest, but I am taking you for examination by mental health professionals at ________________________. You will be told your rights by the mental health staff.

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

AVISO DE DETENCIÓN

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

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

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

羈押通知

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

進行專業的心理健康檢查。心裡健康工作人員將會告知您所擁有的權利。

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

SỰ BẮT GIỮ SAU KHI ĐÃ NGHỊ ÁN

Tên tôi là ________________________. Tôi là __________________________với __________________________. Bạn không bị bắt giữ về hình sự, nhưng tôi phải đưa bạn đi khám bởi các chuyên gia y tế tâm thần tại ________________________.
Nhân viên y tế tâm thần sẽ cho bạn biết về những quyền của bạn.
Nếu bị bắt giữ tại nơi cư trú, bạn có thể mang theo một vài vật dụng cá nhân với sự đồng ý của tôi. Xin vui lòng cho tôi biết nếu bạn cần được giúp để tắt bất cứ thiết bị nào hoặc để khóa hệ thống nước trong nhà. Bạn có thể gọi điện thoại và để lại thư nhắn tin cho bạn bè hoặc gia đình về nơi bạn được đưa đến.

ЗАЧИТЫВАНИЕ ПРАВ ПРИ ЗАДЕРЖАНИИ

Меня зовут __________________________. Я ________________________ из ________________________. Вы не арестованы, но я должен задержать вас для осмотра специалистами в области психиатрии в ______________________.
Ваши права вам разъяснят сотрудники психиатрического отделения.
Если вы подлежите задержанию у себя дома, вы можете взять с собой личные вещи, которые я должен буду одобрить. Пожалуйста, сообщите мне, если вам нужна помощь в отключении воды или приборов. Вы можете сделать телефонный звонок и оставить записку, чтобы сообщить вашим друзьям и близким, куда вас забрали.

TAGUBILIN NG PAGPIPIGIL
(DETAINMENT ADVISEMENT)

Ang pangalan ko ay ________________________. Ako ay mula sa______________ __________________________. Hindi kayo sumasailalim ng pag-arestong kriminal, ngunit dadalhin ko kayo para suriin ng mga propesyonal ng kalusugang pangkaisipan sa ________________________. Sasabihan kayo ng inyong mga karapatan ng kawani ng kalusugang pangkaisipan.
Kung kukunin kayo sa pag-iingat sa inyong tirahan, maaari kayong magdala ng ilang personal na mga gamit kasama ninyo, na dapat kong aprubahan. Mangyari lamang na ipaalam sa akin kung kailangan ninyo ng tulong sa pagsasara ng anumang kagamitan o tubig. Maaari kayong tumawag sa telepono at mag-iwan ng mensahe para sabihin sa inyong mga kaibigan o pamilya kung saan kayo dadalhin.

TARASOFF v. THE REGENTS OF THE UNIVERSITY OF CALIFORNIA

Supreme Court of California, 1976

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TARASOFF INCIDENTS

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

I. GUIDELINES

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

B. RELEVANT CODES

1. PSYCHOTHERAPIST DEFINED. Section 1010 of the Evidence Code defines a psychotherapist as:

a. A psychiatrist, or a person whom the patient reasonably believes to be a psychiatrist.

b. A licensed psychologist.

c. A licensed clinical social worker.

d. A licensed school psychologist, holding state credentials to provide such services in schools.

e. A licensed marriage, family, or child counselor.

f. Registered associates, assistants, interns and trainees working under the supervision of licensed psychiatrists, licensed psychologists, licensed clinical social workers, or under the supervision of licensed marriage, family and child counselors.

2. CIVIL LIABILITY. Section 43.92 of the Civil Code exempts psychotherapist from civil liability if they do the following:

a. Make reasonable efforts to notify the victim or victims, and

b. Make a police report, relating complete information regarding the threats and the success or failure of efforts to notify the victim(s).

3. POSSESSION OF FIREARM OR DEADLY WEAPON. Section 8100 (b) (1) of the Welfare and institutions Code prohibits persons, who have communicated a third-party threat to a psychotherapist, from purchasing, possessing, or having access to any firearm or other deadly weapons for six months after the date of the threat.

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

II. POLICY

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

III. PROCEDURES

A. ASSIGNMENT. Communications shall assign calls of Tarasoff incidents to a patrol unit for the initial investigation and completion of an incident report. In special circumstances, the Communications may notify the Department's Psychiatric Liaison Unit which will then be responsible for completing the incident report.

B. INCIDENT REPORT. When preparing the report, follow these procedures:

1. TITLE. Title the report "Tarasoff Threats."

2. WITNESSES, REPORTEES, ETC. Include the names of reportees, witnesses, and intended victims. Describe the circumstances of the threat along with efforts by the psychotherapist to notify the intended victim. Indicate whether the intended victim was notified of the threat.

3. SUSPECT INFORMATION. In order for the Psychiatric Liaison Unit to make the required notifications to the Department of Justice – which is required in 8105 (c) of the Welfare and Institutions Code – include the suspect's name (including any alias), sex, race, DOB or approximate age, height, weight, hair and eye color, Social Security number, driver license number. Also include the suspect's mailing address and date the threat was reported.

4. ASSIGNMENT. Assign the report to 5G200 (General Work Section) with copies to the Psychiatric Liaison Unit.

C. QUESTIONS. If you have any questions, call officers at the Psychiatric Liaison Unit (PLU), at 206-8099 (Monday – Friday 0900-1700 hrs.). During non-business hours, contact the PLU through the Operations Center.

References

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

BHS Policies and Procedures

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

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

POLICY/PROCEDURE REGARDING: **Special Situations Governing the Release of Information: Duty to Warn and Protect Third Parties in Response to a Client Threat**

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

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

Purpose:

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

Background:

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

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

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

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

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

Scope:

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

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

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

Policy:

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

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

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

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

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

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

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

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

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

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

Contact Person:
Risk Manager, Behavioral Health Services, 415-255-3400

Distribution:
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Administrative Manual Holders
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BOCC Program Managers
CDTA Program Managers

PSYCHOLOGICAL EVALUATION OF ADULTS

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

I. GUIDELINES

A. CRITERIA FOR INVOLUNTARY DETENTIONS. Officers may detain an individual for psychiatric evaluation pursuant to Section 5150 of the Welfare and Institutions Code only when the officer believes that, as a result of mental illness, an individual is:

1. A danger to himself/herself, or

2. A danger to others, or

3. Gravely disabled, meaning the individual is unable to care for himself/herself and has no reliable source of food, shelter or clothing.

II. POLICY

A. It is the policy of the San Francisco Police Department that in incidents involving psychologically distressed adults, officers shall:

1. ABATE. If the individual has not committed a crime and is not, as a result of a mental disorder, a danger to himself/herself, a danger to others, or gravely disabled, abate the incident and recommend that the individual contact a mental health professional.

2. DETAIN. If an individual has not committed a crime but is, as a result of a mental disorder, a danger to himself/herself, a danger to others, or gravely disabled, detain the individual for psychiatric evaluation and treatment.

3. ARREST. If an individual has committed a crime, arrest the individual and book or cite according to Department policies and procedures. Cited individuals who are, as a result of mental disorder, a danger to themselves, a danger to others, or are gravely disabled shall also be detained for psychiatric evaluation.

B. ASSISTANCE TO OUTSIDE AGENCIES

1. STAFF MEMBER IS PRESENT. It is the intention of the Department that police assistance to clinicians will be restricted to cases where the person to be detained for psychiatric evaluation (5150 W & I) is currently violent and presenting a public safety risk.

2. STAFF MEMER IS NOT PRESENT. When an emergency evaluation is requested by a clinician who is not at the scene, the officer shall make his/her own independent evaluation and take appropriate action consistent with that evaluation.
3. APPLICATION FOR EVALUATION. Except in an emergency situation as determined by the officer, a clinician must prepare the "Application for 72-Hour Detention for Evaluation and Treatment" and make arrangements with Psychiatric Emergency Services (PES) prior to requesting assistance.

4. STAFF IDENTIFICATION. Clinicians who are certified to initiate involuntary detentions must carry an identification card issued by the County Director of Mental Health. If the clinician cannot show his/her card, the decision to detain will be the responsibility of the officer at the scene.

5. TRANSPORTATION. If all criteria are met for a psychiatric detention, take the person and the clinician's paperwork to PES at SFGH only. If the person is currently not demonstrating a public safety risk, do not transport. Advise the clinician to consult with his/her supervisor regarding appropriate transportation.

III. PROCEDURES

B. ABATEMENT. When abating a situation involving a mentally disturbed individual, follow these procedures:

   1. INCIDENT REPORT. If the individual needs psychiatric evaluation but does not meet 5150 W & I criteria, prepare an incident report entitled "Aided Case/Request Evaluation" and list the individual as "D" (detained).

   2. COPIES. Forward a copy of the report to the Psychiatric Liaison Unit, which will be responsible for appropriate follow up.

C. DETENTION. When detaining an individual for psychiatric evaluation and treatment, follow these procedures:

   1. TRANSPORTATION. Take the individual to Psychiatric Emergency Services (SFGH) only and complete an "Application for 72-Hour Detention for Evaluation and Treatment."
   2. REPORT. Prepare an incident report and title it "Aided Case/5150 W & I." List the individual as "D" (detained).

      a. DESCRIPTION. Include a detailed physical description of the individual and an accurate residence address. Also include his/her date of birth, SF number, driver license number, Social Security number, and any other identification numbers.
      b. FIREARMS/WEAPONS. List any confiscated firearms or deadly weapons in the incident report.
      c. PROPERTY. Describe how the person's property was safeguarded or placed in police custody.
      d. CRITERIA. Describe the circumstances that formed the reasonable and probable cause to believe that one or more of the criteria listed under Section I.A. above were present.

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

1. CITATION. If an individual is eligible for citation release, but as a result of a mental disorder is a danger to himself/herself, a danger to others, or is gravely disabled, cite the individual and take him/her to PES at SFGH. Indicate on the "Application for 72-Hour Detention for Evaluation and Treatment" that the person has been cited for an offense.

2. BOOKING. If an individual cannot be cited pursuant to Department policy, book him/her and request on the booking form that Jail Psychiatric Services evaluate the individual in the jail.

3. INCIDENT REPORT. In either of the above cases, prepare an incident report and forward a copy to the Psychiatric Liaison Unit. Title the report by the offense and indicate that you have either cited and detained the individual for psychiatric evaluation or booked the individual and made a referral to Jail Psychiatric Services.

   Example: Battery/Fists/Cited & 5150'd

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

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

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

1. SAN FRANCISCO GENERAL HOSPITAL. If an individual is being treated at San Francisco General Hospital, Emergency Department, go to the Psychiatric Emergency Services (PES) and complete the "Application for 72-Hour Detention for Evaluation and Treatment." Leave the original at PES and take a copy to the emergency room attending physician. Your responsibility ends here. Any security services will be provided by SFGH Institutional Police.

2. OTHER MEDICAL FACILITIES. When an individual is being treated at any other hospital emergency room, complete the "Application for 72-Hour Detention for Evaluation and Treatment" and present it to the attending physician. The physician is responsible for arranging for transportation of the patient to PES at San Francisco General Hospital. Any security required will be provided by the hospital's security staff. Your responsibility ends here.

3. INCIDENT REPORT/EVALUATION FORM. In either of the cases above, prepare an incident report, title it "Aided Case/5150 Detention," and attach a copy of the

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

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

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

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

a. Using RF/

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

b. Using the HELP system

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

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

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

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

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

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

References

DGO 7.02, Psychological Evaluation of Juveniles
DGO 3.23, Department Weapon Return Panel
5150 W & I Code
8102 W & I Code

PSYCHOLOGICAL EVALUATION OF JUVENILES

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

I. INFORMATION AND GUIDELINES

A. PSYCHOLOGICAL DISTRESS. Occasionally, officers may come into contact with a juvenile who appears to be in acute psychological distress. In addition to many other symptoms, this distress may be characterized by severe depression, suicidal behavior, or threats of violence constituting a danger to the juvenile or to others.

B. COMPREHENSIVE CHILD CRISIS SERVICE (CCCS). CCCS is a program of the City and County of San Francisco/San Francisco Department of Public Health/Community Behavioral Health Services. It is the City and County of San Francisco's designated agency responsible for psychiatric evaluation of persons under 18 years who may require urgent psychiatric services. CCCS is a 24-hour mobile response unit that has a response time of approximately 30 minutes. The telephone number for CCCS is (415) 970-3800. To obtain an emergency evaluation, call CCCS and request services.

C. PSYCHIATRIC EMERGENCY SERVICES (PES). PES is a holding facility for adults at San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA. (415)206-8125. If juveniles need to be assessed in a secure setting, CCCS will determine if the juvenile should go to PES. If CCCS determines that an evaluation should occur at PES, a CCCS team will meet the juvenile and responsible adult at PES. If an adult does not accompany the juvenile to PES, the officer will be required to stay throughout the evaluation. Do not transfer a juvenile to PES without first consulting with CCCS.

II. POLICY

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

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

III. PROCEDURES

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

1. NOTIFICATION. Notify CCCS. CCCS will consult with you and decide where an assessment team will meet with you to conduct the evaluation.

2. SUPERVISION. If a responsible adult (parent, legal guardian, or school staff) does not accompany the juvenile, the officer shall remain until the evaluation is complete.

B. CCCS ASSESSMENT WITH PENDING CRIMINAL CHARGES. When requesting an assessment of a juvenile in custody for a criminal offense, follow these procedures:

1. CITATION PROCEDURES. When it is appropriate to issue a criminal citation (see DGO 5.06, Citation Release), telephone CCCS and arrange to have an assessment team meet with you to conduct an evaluation. Members must remain with the juvenile during the evaluation. If the juvenile is not placed on a hold per 5150 W & I, the officer, prior to citing the juvenile, shall contact the authorized receiving facility during their operating hours. A probation officer from the authorized receiving facility, after consulting with the member, will determine whether the arrested juvenile should be brought to his/her facility.

2. BOOKING PROCEDURE. When booking is required, follow these procedures:

   a. Prior to transporting a juvenile, contact CCCS as soon as practical and arrange to have the assessment team meet with you. A member of the assessment team will consult with you and determine where the evaluation should take place. (CCCS may join the officer(s) in the field and evaluate the juvenile at home, school, CCCS office, PES or other locations appropriate for the situation.)

   b. Stay with the juvenile. If the assessment team decides not to request a psychiatric evaluation (5150 W & I), the arresting officers, prior to booking the juvenile, shall contact the authorized receiving facility during its operating hours. A probation officer from the authorized receiving facility, after consulting with the member, will determine whether the arresting juvenile should be brought to his/her location.

   c. If the assessment team decides to psychiatrically hospitalize the juvenile for psychiatric evaluation, CCCS staff will make arrangements to secure an inpatient psychiatric bed and transportation to that bed.

   d. Put a "police hold" on the juvenile by filling out the lower portion of "Application for 72-hour Detention for Evaluation and Treatment," under the section labeled "Notifications to be provided to Law Enforcement Agency." Notify the staff that you will book the juvenile into Youth Guidance Center in absentia. Leave the juvenile in CCCS custody, complete the admissions form and deliver it to the Youth Guidance Center.

C. NOTIFICATION AND TELEPHONE CALLS.

1. NOTIFICATION. Take reasonable and immediate steps to notify the juvenile's parent, guardian or responsible relative that the juvenile is in custody and is being detained for assessment. Inform the parent or guardian that they may be present during the assessment or should be accessible by phone to talk with CCCS during the evaluation.

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

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

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

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

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

2. CITATION. If appropriate (see DGO 5.06, Citation Release), cite the juvenile. Prior to releasing the juvenile, arresting officers shall contact the authorized receiving facility during its operating hours. A probation officer from the authorized receiving facility, after consulting with the officer, will determine whether the arrested juvenile should be brought to his/her location.

3. BOOKING. If the juvenile must be admitted to the hospital, and booking is required, place a "police hold" on the juvenile with the emergency room staff by following these procedures:

   a. Complete the lower portion of the "Application for 72-hour Detention for Evaluation and Treatment" under the section "Notifications to be provided to Law Enforcement Agency."

   b. Complete a YGC Admission Form and deliver it along with a copy of the completed "Application for 72-hour Detention for Evaluation and Treatment" to the Youth Guidance Center. The absentia booking process is complete. The officer shall remain at the hospital until a probation officer from YGC arrives to relieve him/her of responsibility for the juvenile.

F. INCIDENT REPORT

1. NO PENDING CRIMINAL CHARGES. Write an incident report, title it "Aided Case/5150 Evaluation/CCCS."

2. PENDING CRIMINAL CHARGES. If criminal charges are involved, write an incident report and title it by the primary offense, e.g., Battery/Fists/Aided Case/5150 Evaluation/CCCS.

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

Reference
DGO 5.06, Citation Release
DGO 7.01, Juvenile Policies and Procedures

BHS Policies and Procedures

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

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

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

Issued By: Jo Robinson, MFT Director of Behavioral Health Services Date: January 15, 2015	Manual Number: 3.07-02 References: California Welfare and Institutions Code, Sections 5000-5121, 5150-5155, 5585-5585.25, 5585.50-5585.89; California Code of Regulations, Title 9, Sections 663, 821; and Health and Safety Code, Section 1250.

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

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

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

POLICY:

I. DEFINITIONS

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

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

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

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

II. ELIGIBILITY

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

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

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

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

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

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

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

III. TRAINING AND CERTIFICATION PROCESS

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

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

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

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

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

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

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

IV. TRANSPORTATION

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

V. DISCONTINUATION OF THE 72 HOUR INVOLUNTARY HOLD

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

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

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

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BHS Policies and Procedures

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

1380 Howard Street, 5th Floor
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415.255-3400
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POLICY/PROCEDURE REGARDING: **Involuntary Psychiatric Detention and Coordination of Care for Minors**

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

Date: April 2, 2020

Manual Number: 3.03-1

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

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

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

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

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

Psychiatric hospitalization can occur as follows:

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

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

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

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

a. A request for a face-to-face crisis assessment of any minor can be made to CCS by calling CCS at 415-970-3800, 24 hours, 7 days a week. Upon receiving the call, CCS staff will obtain relevant information, complete the Alert form, and consult with the Officer of the Day (OD).

b. The caller will be asked to provide the following information:
   - brief clinical history
   - current status
   - financial information, such as name of insurance carrier, policy and/or ID number

c. Minors who present with immediate medical issues (e.g., overdose, physical injury) will be sent to the nearest hospital emergency room (ER) for medical clearance first.

d. If no medical issues are present, or upon medical clearance, CCS will conduct a face-to-face crisis assessment to determine whether or not an involuntary hold is warranted. CCS is a mobile unit and, where possible, responds to the San Francisco location where the minor is present, including schools, emergency rooms, Psychiatric Emergency Services (PES), police stations, outpatient clinics, Human Services Agency (HSA), Juvenile Justice Center (JJC), residential facilities, CCS office, Crisis Stabilization Unit, group homes, and foster homes. The location of the evaluation depends on safety considerations and the clinical presentation of the minor.

e. If the minor meets criteria for an involuntary hold, CCS will call the appropriate hospital to arrange for inpatient admission and ambulance service for transportation to the hospital. CCS does not arrange for hospital beds or ambulance service if the minor is evaluated in a private ER setting. CCS will also notify parents or legal guardian(s), and current providers in the CYF SOC network of pending admissions. For privately insured minors, CCS will contact the insurance carrier and request prior authorization if needed.

f. CCS will complete all the necessary forms for involuntary admissions.

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

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

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

b. All pertinent clinical information of the minor will be forwarded to the inpatient staff. Treatment interventions, medication regimen, and relevant clinical information will be relayed to the outpatient treatment providers who will continue treatment with the minor upon discharge. In addition, the Inpatient Discharge Planner conducts regular post-hospital follow-up contacts for up to 30 days to facilitate linkage to services, ensure continued stabilization, and to prevent re-hospitalization.

c. It is important that the minor's CYF SOC treatment providers be available within the initial 24 working hours for phone contacts and within the initial 72 working hours of admission for hospital and/or telephone conferences to coordinate acute treatment and develop discharge planning recommendations.

d. For a new referral to a CYF SOC outpatient program, the Inpatient Discharge Planner will contact the program as soon as the minor is admitted to an inpatient unit so that the treatment plan and discharge follow-up can be developed early on. Minors and their families referred by the Inpatient Discharge Planner to outpatient programs may need to be seen more intensively during the initial two months of contact by the outpatient program.

e. A face-to-face intake appointment (or a follow up appointment in the case of continuous treatment) should be available by the outpatient provider to the minor and family within 72 working hours after discharge.

f. If the minor is served by a HSA Child Welfare Worker, Probation Officer, and/or the San Francisco Unified School District (SFUSD), the Inpatient Discharge Planner will contact all of these system partners within 72 hours of admission with the tentative inpatient evaluation, course of treatment, recommendations for discharge, and needed communication with family members.

g. All SF BHS providers are encouraged to call and alert CCS 24 hours, 7 days a week about acute mental health symptoms or behaviors of any minor. Every alert is reviewed by the OD for a clinically appropriate disposition.

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

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

A. Protocol for Human Services Agency (HSA)

a. For any crisis evaluation conducted during regular HSA business hours (Monday-Friday, 7am – 5pm), procedures listed under Section I apply.

b. For SF HSA dependent children or youths placed out-of-county, CCS will coordinate with HSA to transport the minor to the HSA office, CCS office, or an emergency room, for a face-to-face evaluation ONLY if it is safe to do so. If appropriate, a dependent minor who is placed out-of-county and needs a crisis assessment can be taken to the crisis center in that county.

c. CCS and HSA have an MOU to provide Intensive Support Services (ISS) to all HSA dependent children and youths up to 30 days in order to stabilize the current crisis. ISS is a collaborative effort between CCS and Seneca to provide one-to-one short-term intensive support and non-traditional mental health services for HSA dependent minors who are engaging in high risk behaviors and/or discharged from a psychiatric inpatient unit.

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

a. For any crisis evaluation request of a child or youth detained in JJC, staff from Special Program for Youths (SPY) may call the SPY Behavioral Health Medical Director or designee, or may call CCS 24 hours, 7 days a week. The involvement of the SPY Behavioral Health Medical Director or designee in such situations will be in coordination with CCS.

b. If the minor needs to be transferred to a hospital emergency room (ER) for medical treatment first, a correctional officer will accompany the minor and CCS will be notified. Following medical clearance, CCS will respond to the ER to conduct a crisis assessment.

c. When a minor needs to be evaluated by CCS at JJC, SPY staff will meet CCS at the front security entrance. If possible, a correctional officer will escort the youth to the Medical Office and remain with the youth throughout the entire course of evaluation.

d. If the minor meets criteria for an involuntary hold, the SPY Behavioral Health Medical Director or designee, or CCS staff will complete all necessary documents for involuntary admission. SPY and CCS will coordinate arrangement of a hospital bed and transportation for the youth.

e. A safety plan will be developed if the minor does not meet criteria for an involuntary hold. The SPY Behavioral Health OD/Charge Nurse will ensure a follow-up with the youth within 24 hours.

f. Once hospitalized, the CCS Hospital Discharge Planner will follow the youth and coordinate discharge plans with SPY if the youth is publicly funded by San Francisco.

g. CCS works closely with SPY during the entire course of crisis assessment, inpatient admission, hospital discharge planning, and coordinates client care with SPY staff and medical team.

C. Protocol for Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG Pediatric Outpatient, Emergency Room, Psychiatric Emergency Services, and Pediatric Inpatient)

C-1. ZSFG Pediatric Outpatient Unit

a. For any crisis evaluation request of a minor in the ZSFG pediatric outpatient unit, procedures under Section I apply.

C-2. ZSFG Emergency Room (ER)

a. For any crisis evaluation request of a minor by the ER, the minor must first be medically cleared.

b. The ER will call CCS for a psychiatric evaluation if needed.

c. If CCS determines that the minor needs to go to psychiatric inpatient for further evaluation and treatment, the minor will remain in the ER until a psychiatric inpatient bed is secured by CCS.

d. In the event that the ER is unable to maintain the minor, the minor may be transferred to PES.

C-3. ZSFG Psychiatric Emergency Services (PES)

a. Minors should remain in the custody of SFPD until a legal guardian arrives. Without the presence of a legal guardian, SFPD must remain with the minor until CCS completes the evaluation and determines an appropriate disposition.

C-4. ZSFG Pediatric Inpatient Unit

a. Any request for a crisis evaluation of a publicly-funded minor in the ZSFG pediatric inpatient unit, procedures under Section I apply **if** the minor is already medically cleared and ready for discharge from the inpatient unit.

b. For publicly-funded minors who are not medically cleared and are hospitalized at ZSFG, CCS will provide the crisis evaluation and place a hold on the minor if he or she meets the criteria for an involuntary hold. From this point forward, ZSFG psychiatric consult will assume responsibility for ongoing evaluation and treatment.

D. Medical Inpatient Units of Private Hospitals

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

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

E-1. SF Medi-Cal Minors Placed Out-of-County and On A Hold
If a minor with SF Medi-Cal is already assessed and detained on a hold at an out-of-county facility, all relevant documentation, including the psychiatric assessment and the *Application for Up to 72-Hour Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment*, shall be faxed to CCS for review and approval. CCS then follows phone approval instructions to complete a crisis consultation form and to ensure that medical necessity criteria are met.

E-2. SF Medi-Cal Children and Youths Placed Out-of-County Needing A Crisis Evaluation
If the minor with SF Medi-Cal is an HSA dependent placed out-of-county needing a crisis evaluation, CCS will coordinate with HSA to transport the minor to the HSA office, CCS office, or an emergency room, for a face-to-face evaluation ONLY if it is safe to transport the minor (See Section III-A: Protocol for HSA).

F. Procedure for All Private Insurances

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

a. Follow procedures under Section I for all privately insured minors who need a crisis evaluation.

b. For all privately or publicly insured minors evaluated in a hospital emergency room other than ZSFG, the medical staff or social worker of the hospital shall arrange for hospital bed and ambulance transport to the hospital.

c. Minors with Kaiser insurance are typically referred to the Kaiser ER for crisis evaluations. Kaiser clients can be evaluated by CCS at other locations if requested.

d. Minors with Kaiser Medi-Cal insurance can also be evaluated by Kaiser ER and, in these instances, CCS will follow the review and approval protocol delineated above in E-1.

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

a. CCS can refer minors who do not meet criteria for an involuntary hold to CSU for crisis stabilization for a period up to 23 hours, 59 minutes.

b. In conjunction with CCS, designated staff at CSU can place a hold on a minor if the criteria are met for an involuntary psychiatric hold. In these situations, CSU is responsible for completing the paperwork and arranging for a hospital bed and transport to the designated inpatient facility.

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

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

Distribution:
BHS Policies and Procedures are distributed by the BHS Compliance Office

Administrative Manual Holders
BHS Programs
SOC Program Managers
BOCC Program Managers
CDTA Program Managers

Works-Wright, Jamie

From: Andrea Prichett <prichett@locrian.com>
Sent: Wednesday, July 5, 2023 10:13 AM
To: Works-Wright, Jamie
Subject: Re: SCU update
Attachments: BART Crisis specialist.docx

Good morning Jamie.

I hope this works better for you.

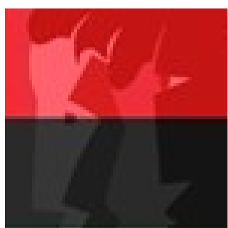
Thanks,

Andrea

On 7/4/23 12:34 PM, Works-Wright, Jamie wrote:

Would you like me to forward the email description below to the commission as well?

Jamie Works-Wright
Consumer Liaison
Jworks-wright@berkeleyca.gov
510-423-8365 cl
510-981-7721 office



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From: Andrea Prichett <prichett@locrian.com>
Sent: Saturday, July 1, 2023 10:03 AM
To: Works-Wright, Jamie <JWorks-Wright@berkeleyca.gov>
Subject: Re: SCU update

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

Sorry! Here is the link to the photos:
https://drive.google.com/drive/folders/1MLXUbWmSw0uuoCe3lryjgFb-yMGoxp_5?usp=sharing

On 7/1/23 9:58 AM, Andrea Prichett wrote:

Dear Jamie,

Can you please include these photos in our packet? They were taken by me on a BART train on Wed June 28th. There was a man who was a bit hard to understand with a bike that was blocking the door to the next train car. These women came and stood around him in a way that was a bit threatening. They had "Crisis Intervention Specialist" written on their backs. I watched and photographed. The man was compliant, but was slow to underdstand what was being asked of him. I could not tell if he had a developmental disability, but he did not appear to be on drugs.

The officer was a bit concerned by my presence. I said that I was with Copwatch and that I also served on the Mental Health Commission and so had an interest in how agencies respond to mental health issues. V. Singleton J-494 explained to me that she is responsible for training officers and others in how to respond to mental health calls. I told her that I thought it might be good to give the person a bit more space so as not to escalate them. She was not especially grateful for my suggestion. (LOL!)

This is a perfect example of what our SCU should NOT be!! The responders looked and acted like cops even though they are not officers. From the walkie talkie to the physical positioning of their bodies relative to the person to the demanding tone of their voices, they are not care providers. They were like unarmed police.

This is just FYI.

Andrea Prichett

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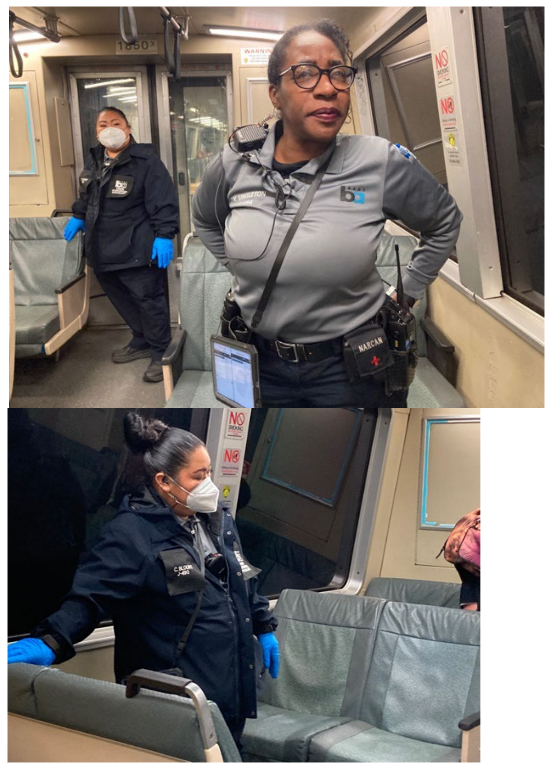
This is a perfect example of what our SCU should NOT be!! The responders looked and acted like cops even though they are not officers. From the walkie talkie to the physical positioning of their bodies relative to the person to the demanding tone of their voices, they are not care providers. They were like unarmed police.

This is just FYI.

Andrea Prichett


NARCAN

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Thursday, June 22, 2023 2:04 PM
To: Works-Wright, Jamie
Subject: FW: [FASMI Discussion] Modernization Presentation today /Bee article /Fact sheet

Internal

Hello Commissioner,

Please see the email from commissioner Edward Opton

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
2640 MLK Jr. Way
Berkeley, CA 94704
JWorks-Wright@berkeleyca.gov
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Edward Opton <eopton1@gmail.com>
Sent: Thursday, June 22, 2023 1:51 PM
To: Works-Wright, Jamie <JWorks-Wright@berkeleyca.gov>
Subject: Fwd: [FASMI Discussion] Modernization Presentation today /Bee article /Fact sheet

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6.22.23

Please distribute the e-mails exchange reproduced below to the Mental Health Commission. I hope you can send the item now rather than wait to include it in the packet distributed in advance of the commission's next meeting. For example, a potentially important webinar is scheduled for 3:30 pm **today**.

Edward Opton

Begin forwarded message:

From: Alison Monroe <amonroe@jps.net>
Subject: [FASMI Discussion] Modernization Presentation today /Bee article /Fact sheet
Date: June 22, 2023 at 11:51:12 AM PDT
To: Mary Ann Bernard <mary_ann_bernard@hotmail.com>
Cc: Lynne Gibbs <gibbslyn2@gmail.com>, Lauren Rettagliata <rettagliata@gmail.com>, Sheila Ganz <sheila.ganz@gmail.com>, "renewed-fasmi-discussion-group@googlegroups.com" <renewed-fasmi-discussion-group@googlegroups.com>, California Advocates <california-advocates@googlegroups.com>

Hello FASMI members,

It looks like FASMI needs to decide whether Governor Newsom's BHSA will be an improvement on MHSA, and whether to support the Modernization bill SB 326 (Eggman).

If anyone can help educate us about this, I'd be delighted.

Besides the Government fact sheet and Bee article below Mary Ann links to below, another source of information is a webiner by the state at 3:30 PM. I doubt they'll take questions, but I plan to watch:

> *DHCS will host a webinar on Thursday, June 22, at 3:30 p.m. (no registration required) to provide additional information and an update on the Governor's proposal to modernize California's behavioral health system.*

Enjoy!

Alison Monroe

> On Jun 21, 2023, at 9:41 AM, Mary Ann Bernard <mary_ann_bernard@hotmail.com> wrote:
>
> I haven't yet read the legislation but everything I see has mentioned treatment beds. It's encouraging that Senator Eggman supports it and wierdly encouraging that REMHDCO doesn't, as they are mostly about mental illness lite and the worried well. (I see from the fact sheet that the Governor's proposal drastically cuts PEI which is where all the waste and scandal has been (and many REHMDCO partners chow down). The big tragedy there is that the PEI provisions always mandated RELAPSE prevention for people with existing severe mental illnesses, but the misnamed Mental Health Services Act Oversight and Accountability Commission and most or all counties have always ignored this mandate, found at Welf. & Inst. Code Section 5840(c), last clause. If they had paid attention to this mandate and the one for "medicallly necessary care" since 2004, the severely mentally ill in California would collectively be far better off now.
>
> In other words, the original MHSA was a good law that was completely undermined by the people who were supposed to be enforcing it.
>
> Today's Bee contains this article on the subject, for whatever it is worth:
> https://eedition.sacbee.com/html5/reader/production/default.aspx?pnum=7&edid=eaaaf250-d047-4cbb-9d27-fe958fae2ec0&isshared=true

Here is the governor's fact sheet: https://www.gov.ca.gov/wp-content/uploads/2023/06/Fact-Sheet_BHSA-Legislative-Reform.pdf I am sure they tried to be accurate but it may not be complete.

I hope to get at this stuff and read the legislation in the next couple of days. I'll highlight any surprises.

From: california-advocates@googlegroups.com <california-advocates@googlegroups.com> on behalf of Lynne Gibbs <gibbslyn2@gmail.com>
Sent: Wednesday, June 21, 2023 8:24 AM
To: Lauren Rettagliata <rettagliata@gmail.com>
Cc: Sheila Ganz <sheila.ganz@gmail.com>; renewed-fasmi-discussion-group@googlegroups.com <renewed-fasmi-discussion-group@googlegroups.com>; California Advocates <california-advocates@googlegroups.com>
Subject: Re: I Support this REMHDCO doesn't

Once again, state leadership focuses exclusively on "Housing and behavioral health treatment in unlocked, community-based settings." Of course, we need much more of this, but it should be abundantly clear by now that we won't successfully address the crisis until we supplement the stock of acute and subacute beds. What more will it take to successfully convey this?

Lynne

On Wed, Jun 21, 2023 at 8:02 AM Lauren Rettagliata <rettagliata@gmail.com> wrote:

<AU7gkwW0iuJJ39lqPLVliFQokiVZGGiTUCxTOiBLWh0FAiQYtfPkBH5WWXvYa6FTx-5FqJvyV_7S5svqMGAzWT_St2eZoBA5GATod6THue7gGZj_6Ldy41IcLAdr3ThGgMPJXxahpHWAA05Th0fA0FTaYvc8
e1-ft.png>

FOR IMMEDIATE RELEASE

Tuesday, June 20, 2023

Governor's Press Office: (916) 445-4571

Governor Newsom & Legislative Partners Unvei Transformation of California's Mental Health Services Act

Housing with Accountability. Reform with Results.

WHAT YOU NEED TO KNOW: Governor Newsom and Legislative leaders are proposing a $4.68 billion bond and modernization of the Mental Health Services Act (MHSA) for the March 2024 ballot, which together would provide California the resources needed to build 10,000 new beds across community treatment campuses and facilities to help Californians with serious mental illness and substance use disorders get the housing and care they need.

SACRAMENTO – Governor Gavin Newsom, in partnership with Senator Susan Talamantes Eggman (D-Stockton) and Assemblymember Jacqui Irwin (D-Thousand Oaks), today annou a legislative package reflecting the Governor's historic Mental Health Services Act (MHSA) transformation and new bond unveiled earlier this year in San Diego as part of his Tour of th State of California. This transformation will focus on **housing with accountability and reform wi results** to help ensure Californians can access critical behavioral health services, including housing and treatment for substance use disorders – making good on a decades-old promis state leaders.

WHAT GOVERNOR NEWSOM SAID: "We are facing a confluence of crises: mental health, opioi housing, and homelessness – and this transformative effort will ensure California is tackling these head-on in a comprehensive and inclusive way. Over the last few years, California ha the nation in expanding access to affordable and quality mental health services – especially children, teens, and people with untreated mental illness. The historic legislative effort announced today will supercharge these efforts to ensure California continues to lead the wa the decades to come."

The two bills: SB 326 (Eggman) & AB 531 (Irwin) focus on **five solutions** to transform Califor behavioral health system through **housing with accountability and reform with results:**

1. Reforming key behavioral health care funding to provide services to the most serious and to treat substance use disorders
2. Building a workforce to reflect and connect with California's diversity
3. Focusing on outcomes, accountability, and equity
4. Housing and behavioral health treatment in unlocked, community-based settings
5. Housing for veterans with behavioral health challenges

Combined, this legislative package will bring this transformation to all communities, all ages, incomes, and cover mental health and substance use disorders as well as build out the Stat capacity to provide behavioral health care, housing, and good jobs for Californians – with **strengthened accountability for results.**

FACT SHEET

These reforms will complement and build upon California's transformative behavioral health expansion and reform efforts under Governor Newsom's Administration, including the creati CARE Court, to provide a continuum of community care for all - from prevention and early intervention to outpatient, crisis, inpatient, and supportive care.

WHAT COMES NEXT: The two bills will work their way through the California Legislature in the coming months. The behavioral health legislative package will go to the voters for approval i March 2024, after consideration and approval by Legislature and Governor Newsom's signa in 2023.

WHAT KEY CALIFORNIA LEADERS ARE SAYING:

- **Senator Susan Talamantes Eggman (D-Stockton):** "We are facing mental health and substance abuse crises on our streets in communities throughout California. This legislation will help us transform our behavioral health system and provide critically needed support for the most vulnerable among us, many of whom are struggling with homelessness in addition to mental illness. The time to act is now."
- **Assemblymember Jacqui Irwin (D-Thousand Oaks):** "Getting veterans experiencing homelessness off the streets has long been a priority for California, but getting some our most vulnerable veterans into needed treatment for behavioral health challenges be transformative. One of the only groups that has seen a recent significant decline i percent of homelessness are veterans, thanks primarily to the very successful Vetera Housing and Homeless Prevention (VHHP) program. Building upon VHHP, AB 531 a SB 326 will provide housing and treatment services to veterans that focus on serious mental illness and substance use disorders. Funding and expanding this program is t right thing to do, and I look forward to working with the Governor and veterans organizations to put these important advances before the voters."
- **Sacramento Mayor Darrell Steinberg, author of the Mental Health Services Act:** "Nearly 20 years ago, I authored proposition 63, California's Mental Health Services Act. Over tw decades, it saved the public mental health system and helped tens of thousands of people. Twenty years ago, mental health was rarely talked about. There was no pandemic, no children's mental health crisis, and homelessness was not nearly the is it is today. It's time to modernize the Mental Health Services Act. Now 58 counties do their best to use the $4 billion annually without any clear state and societal priorities driving their investments. The Newsom administration's bold modernization proposal ensure that more money is spent helping and housing unsheltered Californians living severe mental illness and substance abuse. Is there any issue more important to the people of California and the thousands living in squalor on our streets? It will ensure t early intervention dollars are spent on the most effective strategies, especially helping teenagers get help before they suffer a first psychotic break. We wrote the MHSA to h address the most serious consequences of untreated mental illness. It has done muc good but can do so much more. Simply put, more of these precious resources need t spent on a uniform set of services and strategies that address the immense suffering

people living with mental Illness who are also homeless, in and out of the criminal jus
system, and having little or no chance of living full and productive lives. I fully support
changes and hope the Legislature acts quickly to place the measure on the 2024 ball

- **HHS Secretary Dr. Mark Ghaly:** "Too many Californians with the most severe behavioral health conditions are living on the streets. Many spend significant time incarcerated. Many cycle in and out of hospitals. At the same time, select counties have demonstra promising approaches to supporting these most vulnerable Californians – successfull able to meet their clinical, social services and housing needs. Today's actions provide clear set of priorities and expectations for outcomes. They provide the kind of focus needed to not only provide better, whole-person focused services, but to ultimately be the arch of the lives of many Californians toward successful community living and independence."
- **CalVet Secretary Lindsey Sin:** "There is an undeniable connection between behavioral health and stable housing - something many of our veterans struggle with every day. reform will help us build more housing for our veterans and provide the services and support they need to remain successfully housed."
- **BCSH Secretary Lourdes Castro Ramirez:** "Housing that is deeply affordable and offers ro support services, especially behavioral and health services, shortens the time people experience homelessness and leads to better life outcomes. These measures will exp access to stable housing and essential services, improve lives and build on our collec progress to comprehensively address homelessness."
- **SEIU Local 721 President David Green:** "SEIU members support the Administration's proposed expansion of critical mental health services. There is no such thing as healt without mental health, and access to mental health services has been a gaping hole i our healthcare system. This proposal moves us in the right direction. The inclusion of substance abuse disorder treatment is of particular importance, and the investments our workforce are also essential."

###

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To view this discussion on the web visit https://groups.google.com/d/msgid/california-advocates/BYAPR05MB50480022FC2191FF0FD02CABC55DA%40BYAPR05MB5048.namprd05.prod.outlook.com.

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To view this discussion on the web visit https://groups.google.com/d/msgid/renewed-fasmi-discussion-group/5DA5849D-8EE1-4490-A821-2221BF132D7D%40jps.net.

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, June 20, 2023 10:37 AM
To: Works-Wright, Jamie
Subject: FW: Follow up to MHC mtg of June 15, 2023

Hello Commissioners,

Please see the message below from Andrea.

Jamie Works-Wright
Consumer Liaison
Jworks-wright@berkeleyca.gov
510-423-8365 cl
510-981-7721 office

Please be aware that e-mail communication can be intercepted in transmission or misdirected. The information contained in this message may be privileged and confidential. If you are NOT the intended recipient, please notify the sender immediately with a copy to HIPAAPrivacy@cityofberkeley.info and destroy this message immediately.

From: Andrea Prichett <prichett@locrian.com>
Sent: Tuesday, June 20, 2023 10:29 AM
To: Works-Wright, Jamie <JWorks-Wright@berkeleyca.gov>
Subject: Re: Follow up to MHC mtg of June 15, 2023

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

Just wanted to make sure you saw this and were able to distribute it to commissioners.

Thanks!

On 6/19/23 11:19 AM, Andrea Prichett wrote:

> Dear Jamie,
>
> I hope you are doing well. I just wanted to follow up on some things from the MHC mtg and I am hoping that you will distribute this message to other commission members as well.
>
> 1. Agenda for next mtg: As is customary in other commissions, I am hopeful that the agenda items that were not able to be discussed at the last meeting will reappear on our July agenda as "Old Business" and that the old business will be agendized before "New Business". This is a common practice and I hope it is

okay to employ in this case.

2. I also believe that we agreed to agendize the Proposal for Early Intervention
in Psychosis Program (Alice Feller) that we received at the meeting. This would be "New Business". 3. We also agreed that a letter needed to be written (Margaret and myself) and sent to Dr. Warhuus, the City Manager and the City Council explaining why we believe
that access to training materials for the SCU are so important and asking for their suport in helping us to gain access to those materials. 4. We agreed that a letter explaining the MHC position should be written and should accompany the MHC recommendation regarding the MHSA funding priorities. I do not recall who was meant to write that letter. Jamie, I am hoping that your notes might clarify exactly who is writing that letter. Thanks much, Andrea Prichett

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, June 20, 2023 7:54 AM
To: Works-Wright, Jamie
Subject: FW: [FASMI Discussion] Alameda County Meeting Roundup June 19-June 23: Meetings Related to Serious Mental Illness (SMI) and the Jail
Attachments: BHCIP awards.pdf

Please see the information below from Commissioner Edward Opton

Jamie Works-Wright
Consumer Liaison
Jworks-wright@berkeleyca.gov
510-423-8365 cl
510-981-7721 office

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From: Edward Opton <eopton1@gmail.com>
Sent: Monday, June 19, 2023 10:52 AM
To: Works-Wright, Jamie <JWorks-Wright@berkeleyca.gov>
Subject: Fwd: [FASMI Discussion] Alameda County Meeting Roundup June 19-June 23: Meetings Related to Serious Mental Illness (SMI) and the Jail

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

6.19.23

To: Jamie Works-Wright
From: Edward Opton

Please forward the pages below the dotted line to the Mental Health Commission and attach copies to the July agenda packet..
———

6.19.23

To: Berkeley Mental Health Commission
From: Edward Opton

The pages that follow deserve our attention..

1. We, the Berkeley Mental Health Commission (MHC), are not alone. Many commissions, agencies, boards, committees, legislators, and administrators, as well as individuals at many levels—city, county, state, federal government, and more—are working in the same arena as our MHC. Much of what they do consists of communicating with one another. This is democracy. It is also chaos. Keeping up with all that's being written, spoken, promulgated and memorialized would be more than a full-time job. If we tried to know all that's happening, would we have any time left for doing? That's democracy. We must make the best of it.

2. The Berkeley MHC has a unique mission: to understand our city's mental health efforts, to urge expansion of the programs that are most effective, and to recommend changes for those that are not.

3. Appraising the effectiveness of mental health programs is as difficult for us as for others, but it is at the heart of the Berkeley MHC's mission.

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Begin forwarded message:

From: "'Brian Bloom' via FASMI Discussion" <renewed-fasmi-discussion-group@googlegroups.com>
Subject: Re: [FASMI Discussion] Re: Alameda County Meeting Roundup June 19-June 23: Meetings Related to Serious Mental Illness (SMI) and the Jail
Date: June 18, 2023 at 8:34:50 PM PDT
To: Alison Monroe <amonroe@jps.net>, Lauren Rettagliata <rettagliata@gmail.com>
Cc: "renewed-fasmi-discussion-group@googlegroups.com" <renewed-fasmi-discussion-group@googlegroups.com>
Reply-To: Brian Bloom <bdbloom@aol.com>

The attached is the best one-page overview of BHCIP awards (rounds 3-5) that I am aware of, but as you'll see, it's dated. The three round 4 grants, which are "submitted" on the graph, have been awarded by now and I don't know which of these have been awarded to the county. The round 5 grants, which are "in development" on the graph, have by now been submitted but I don't know if the state has awarded any round 5 grants.

-Brian

On Sunday, June 18, 2023 at 08:58:59 AM PDT, Lauren Rettagliata <rettagliata@gmail.com> wrote:

Thanks Alison for reminding me that I have to wait until Tuesday with Bauer-Kahan's office.

Hope you or others can share what you learn about CalAIM reform and how Alameda is going to implement.

Alameda County won BHCIP awards and CCE grants. Can you direct me to where I can see what these proposals where that funding was granted? What Providers will now build up infrastructure in Alameda County?

Is there a public meeting where the winning proposals were shared? I am hoping Brian can knows where the BHCIP and CCE funding will be put to work

Thanks— Lauren

On Jun 17, 2023, at 10:25 PM, Alison Monroe <amonroe@jps.net> wrote:

Meetings This Week

Monday, June 19th, is Juneteenth, a County holiday celebrating an 1865 victory over a system of malign neglect; there was a law, but then there was a two-and-a-half-year delay in enforcing it.

On Tuesday, June 20, at 10 AM, the Board of Supervisors will have a special meeting ("work session") at 393 13th St. Agenda: "Discussion and Setting of Board Priorities and Initiatives." Link.

Wednesday, June 21, at noon, is the Assembly Health Committee's deadline for using the Portal to comment on SB-43.

On Wednesday, June 21, at 4 PM, the Mental Health Advisory Board will meet. Agenda. Link. Here is MHAB's argument against spending $26.6 million to build a Mental Health Program and Services Unit at the jail. And here is ACBH's response to the MHAB's ten-point plan of October 2022. The response includes ACBH's argument that opting into the state's IMD waiver proposal may be a waste of effort (if so, the county needs to go after a federal repeal of the IMD Exclusion). The county has funding to buy back only 10 of the 18 beds we've been promised at Villa Fairmont. And 18 beds will not be enough.

On Thursday, June 22, at 10 AM, the Public Protection Committee will meet. Agenda. Link. Three things on the agenda:

1. Update to the Sheriff's list of military equipment, a disquieting shopping list of bigger and better drones, gas canisters, non-lethal bullets, and such things.
2. Presentation by committee advisor Wendy Still about establishing an AB 1185 Sheriff Oversight Board and Inspector General. She presents two alternatives for timing the rollout of the Oversight Board, Inspector General, and Ombudsman: I don't know which alternative is better or what might be missing.
3. Presentation by Wendy Still and health budget expert David Panush on implementing the Cal-AIM reforms to Medi-Cal in the justice system.

On Thursday, June 22, at 1 PM, the County Care First Jails Last Task Force will meet. Look for agenda and handouts here. Link.

On Thursday, June 22, at 5:30 PM, the Family Dialogue Group, hosted by the Office of Family Empowerment of BHCS, will meet. Link. Contractors who advise family members will speak: Bev Bergman of Mental Health America of Alameda County (MHAAC), and people from the Family Education and Resource Center (FERC.

On Friday, June 23, from 9 AM to 1:30 PM, Dr. Lester Love of Pathways to Wellness will lead a training about co-occuring disorders (mental illness plus substance abuse) and the role systemic racism plays in diagnosis and treatment. To register.

Meetings Later

On Tuesday, June 27, from 2 PM to 4 PM, the state Behavioral Health Task Force will discuss the Modernization of the Mental Health Services Act. The public can watch but not speak. To register.

On Tuesday, June 27, the Assembly Health Committee will consider SB-43, the Grave Disability bill. This committee does not take call-in testimony but will probably take brief in-person statements.

Tuesday, June 27, is the next regular meeting of the Board of Supervisors.

On Wednesday, June 28, at 7:30 PM, Francesca Tanenbaum and Sharnice Jones of Patients' Rights will address East Bay NAMI. Link.

On Thursday, June 29, from 4 PM to 6 PM, the state Behavioral Task Force will discuss the Modernization, and this time the public is invited to speak. To register.

On Friday, July 14, the Budget Committee of the Care First Jails Last Task Force should meet. This committee includes Corrine Lee of Probation, Michelle Staratt of the Housing and Community Development Department, Kimberly Graves, and Judge Greg Syren. It meets every second Friday. Expected meeting link (Microsoft Teams).

Monday, July 17, at 1:30, is the next meeting of the Personnel/Legislation/Administration Committee.

Update

The Sacramento County Grand Jury says Sacramento County needs more hospital beds.

A powerful first-page *Chronicle* opinion piece that considers the need for beds. Pasted in below.

Another *Chronicle* opinion piece on SB-43 and drug use.

Another *Chronicle* piece about litigation over the right to sleep in streets.

KTVU and KPIX on the June 13 "Care not Death" rally in front of the Board of Supervisors.

Lisa Fernandez of KTVU writes about Vinetta Martin, a person, apparently with SMI, who died at Santa Rita in April 2021, and who had been left off the running tallies of deaths in the jail. Deputies falsified records about whether they were keeping an eye on her when she committed suicide.

Live State Bills

Much of this information is from the website leginfo.legislature.ca.gov/, Try also Legiscan https://legiscan.com/CA

AB 280, by Assemblymember Holden, limits solitary confinement in prisons and jails. LA Times on this "Mandela bill." Supported by NAMI-CA and co-authored by Mia Bonta and Nancy Skinner. Passed the Assembly Appropriations Committee May 18 as amended 11-4). Passed the Assembly floor May 31 56-16 with 8 abstentions. To be heard by the Senate Public Safety Committee July 11 at 8:30 AM.

AB 360, by Assemblymember Gipson, would prevent a police diagnosis of "excited delirium" from being used in police reports to justify excessive force or killings. This term is not in the list of disorders in the DSM. The bill passed the Assembly (75-0 with 5 abstentions) April 25, passed the Senate Public Safety Committee 5-0, and will be heard in the Senate Judiciary Committee June 27.

*AB 459, by Assemblymember Haney and supported by the Steinberg Institute, establishes a commission to evaluate the outcome of counties' mental health services. It is said to be a step toward a sort of bill of rights for mental health treatment. It passed the Assembly Health Committee 15-0 on April 11. It passed the Assembly floor 79-0 on May 31. To be heard July 12 at 1:30 by the Senate Health Committee.

AB 1437, by Assemblymember Irwin, appears to make it easier to refill a drug prescription for serious mental illness (a refill will be automatically approved for 365 days). It passed the Assembly Health Committee 15-0 on April 11. On May 18 it passed the Assembly Appropriations Committee 15-0. On May 25 it passed the Assembly 75-0 (with 5 abstentions). Will be heard in the Senate Health Committee June 21.

SB 35, by Sen. Umberg, amends last year's CARE Court bill. Fortunately, it removes filing fees for CARE Court petitions; unfortunately, it would allow clients to veto the participation of family members in the court process, or even their being notified about that process. It passed the Senate and has been referred a

second time to the Assembly Health Committee and to the Assembly Judiciary Committee. I don't see a hearing date yet.

SB 43, by Senator Eggman, a bill FASMI endorses, expands the definition of "gravely disabled." It passed the Assembly Judiciary Committee on April 25, 11 to 0. It passed the Senate Appropriations Committee May 8. It passed the Senate Appropriations Committee May 18, without amendments, 7-0. On May 26 it passed the Senate floor 37-0 with three abstentions. On June 8 it was assigned to the Assembly Health and Judiciary Committees. It will be heard in the Assembly Health Committee Tuesday June 27 at 1:30. This committee does not accept phone testimony, only testimony in person. It prefers that advocates send them a letter a week in advance of the hearing through the Legislature's Position Letter Portal.

SB 45, by Sen. Roth, creates a loan fund for building, expanding, or renovating acute psychiatric hospitals. It passed the Senate Health Committee March 23, 7-0. On May 18 it was amended and passed the Senate Appropriations Committee 7-0. It passed the Senate May 30, 40-0, and went to the Assembly. It will be heard in the Assembly Health Committee June 27.

*SB 326, by Eggman, amends the Mental Health Services Act to require counties to request Medi-Cal reimbursement for some services paid for by MHSA money. Passed Health Committee April 27, 11-0. Passed Senate Appropriations Committee 6-0 May 18. Passed the Senate Floor May 24 39-1 with one abstention. It was referred to the Assembly Health Committee. The Governor wants this bill as part of the MHSA "Modernization." Presumably billing Medi-Cal would free up some MHSA money for other uses.

SB 363, by Eggman, would create a database of beds in psych hospitals. Passed Health and Judiciary Committees, placed in Senate Appropriations Committee suspense file April 24, passed May 18 as amended 7-0 (it was amended to move out the compliance date a year further out). Passed the Senate 40-0 on May 24. Passed the Assembly Health Committee 13-0 June 1 and was referred to the consent calendar of the Assembly Committee on Appropriations (not sure what that means). The only group listed as opposing this bill recently is the County Behavioral Health Directors' Association (CHBDA).

SB 717, by Stern, would mandate counties try to reach out for 180 days to people who have been found incompetent to stand trial and who have not been offered court-mandated services. It directs that counties maintain contact with these people and offer them services. The CBHDA opposes this bill, saying the people might be homeless or hard to find. Indeed they might be! It's also true that they might not accept services if offered. I wonder if this bill might be a step to a different paradigm where a County would track its seriously mentally ill individually and resist letting them slip out of the system through homelessness or migration to other counties. SB 717 will be heard Tuesday, June 20th in the Assembly Health Committee.

*Bills that are part of the "Modernization" package

Have a good week!

FASMI's website: https://acfasmi.org/

Thanks to Stephanie Allan for the cut-and-paste below:

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EDITORIAL SAN FRANCISCO CHRONICLE

What state owes S.F. on mental health

California has failed to adequately care for its hardest-to-serve: people with mental illness who have criminal records, including a history of violence

[June 10, 2023]

Napa State Hospital in Martinez is one of the state's few remaining mental hospitals, which began to close in the 1950s.

For years, Bill Gene Hobbs stalked, harassed, kissed and groped women on the streets of San Francisco. Almost immediately recognizable because of his 6-foot-4 frame, "dead eyes" and many tattoos — including the word "E-V-I-L" inked across his knuckles — Hobbs once allegedly followed and grabbed a 15-year-old, calling the young girl an "angel" and his "perfect mate."

On Thursday, a judge sentenced Hobbs to 2½ years in county jail and three years in state prison after a San Francisco jury unanimously found him guilty of battery, sexual battery and assault and felony false imprisonment.

But even as survivors celebrated the ruling, questions remained as to how Hobbs was allowed to terrorize women for so long.

After Hobbs was arrested for grabbing the 15-year-old, he was found mentally incapable of defending himself. The court, however, wasn't able to find a treatment bed for him. And so Hobbs was released from jail after serving his maximum sentence, free to harass once more with no treatment.

Many people in San Francisco no doubt see in Hobbs' case the broader failure of the city to address the behavioral health crisis on its streets. Blame swirls in all directions. Some argue the city's liberal permissiveness and scattershot approach to criminal justice have put the rights of lawbreakers above the safety of the general public. Mayor London Breed blames an overabundance of compassion, and insists it's time for a tougher approach to unruly and dangerous behavior in the streets. Progressive supervisors, meanwhile, say a hyper-focus on policing at the expense of data-driven behavioral health treatment is the culprit.

Amid the local finger-pointing, however, few are meaningfully questioning the role the state of California has played in allowing these crises to grow and fester.

State government is no idle actor in San Francisco's issues. The policies it dictates, the departments it runs and the budget priorities it sets all carry local impacts that cities like San Francisco are in many ways powerless to resolve on their own.

Perhaps nowhere is that more the case than in the realm of mental health.

It's true, San Francisco has consistently failed to react with the urgency required to meet its behavioral health crisis. We have dithered on outreach and infrastructure. We have allowed NIMBYism and PR to interfere with data-driven plans.

But the state bears culpability, too.

In his inability to access mental health treatment, Hobbs was no outlier — California has an extreme shortage of mental health beds. And it has failed to adequately care for its hardest-to-serve population: people with mental illness who also have a criminal record — including those with a history of violence.

This population disproportionately causes bottlenecks in California's mental health delivery system, impacting care for other vulnerable residents. And governments' consistent refusal to rise to the challenge of meeting this demographic's unique needs is a crucial driver of the chaos on our streets. It's a problem

San Francisco — and many other of California's cities and counties — can't solve alone. Only with serious and sustained state intervention will we see meaningful improvement.

To come to this determination, the Editorial Board reviewed thousands of pages of documents, studies and government reports, and conducted interviews with nearly two dozen experts, including government officials, policy wonks, hospital staff, social workers and mental health activists with lived experience in California's systems of care.

How we got here

Understanding the roots of the behavioral health crisis on city streets requires us to go back to the 1950s, when the federal government — buoyed by the promise of psychiatric medicine to regulate serious mental illnesses — began pushing for patients to be treated in community-based settings instead of restrictive, expensive, large-scale institutions. (With the passage of Medicaid, in 1965, it also stopped reimbursing states for many patients cared for in so-called "institutes for mental disease.") California began shuttering many of its mental hospitals, a practice that accelerated under Republican Gov. Ronald Reagan, who in 1967 signed a law called the Lanterman-Petris-Short Act that significantly restricted the government's ability to detain and treat mentally ill people against their will in conservatorships.

Deinstitutionalization enjoyed broad public support due to a desire to end the horrific abuse and inhumane conditions many patients endured in warehouse-like mental hospitals, such as the one depicted in Ken Kesey's 1962 novel "One Flew Over the Cuckoo's Nest." Unfortunately, those good intentions largely didn't translate into coherent policy alternatives. Adequate federal and state funding for community-based treatment centers never materialized. Meanwhile, starting in the '50s, California began shifting responsibility and financing for many mental health services to its 58 counties — resulting in a decentralized, patchwork system that advocates contend was never adequately funded.

So where did mentally ill people previously housed in state hospitals end up? On the streets — and in jails and prisons, which became and remain our state's primary mental health facilities, albeit ill-equipped to handle that role. A San Jose State study determined that of the 19,000 seriously mentally ill people California incarcerated in 2015, nearly 14,000 were there because state hospitals closed. As of this May, over half of the more than 96,000 inmates incarcerated in state prisons were being treated for varying levels of mental illness, state data shows.

Indeed, many of California's most troubled residents receive care only after entering the criminal justice system: More than 90% of the nearly 7,000 patients in California's five remaining state hospitals were sent there by either the criminal court or prison systems after being accused or convicted of crimes related to their mental illness.

Now, California is in the midst of another wave of deinstitutionalization — this time of its carceral system. Following a 2009 federal court order to reduce the population in its overcrowded prisons, the state in 2011 shifted the responsibility for many non-serious, nonviolent and non-sexual offenders from state prisons to county jails and probation offices. In 2012, voters approved Proposition 36 to reduce prison sentences for certain repeat offenders. In 2016, voters greenlit Props. 47 and 57, which reduced penalties for certain lower-level drug and property offenses and empowered the state prison system to expand credit-earning opportunities for inmates, respectively. As state Democrats continue to pass laws to reduce criminal sentences and prevent incarceration, Gov. Gavin Newsom's administration is working to shutter four prisons and Democrats in the state Assembly want to close five more by 2027. Newsom is also seeking to transform some prisons, including San Quentin, into rehabilitation and education centers to better prepare inmates to return to society.

Innovative strategies to improve California's criminal justice system — which has one of the nation's highest recidivism rates — are sorely needed. But the state is also making the same mistake it made in the '60s: dismantling a system — albeit one that's deeply flawed — without first building out an improved alternative.

Consequently, released jail and prison inmates with profound mental health needs are often left to rely on a behavioral care system that has little room to help them. According to a comprehensive 2021 study of the state's mental health infrastructure by the nonpartisan think tank RAND, California lacks space to

meet demand at all three main levels of care — acute, highly structured, around-the-clock medically monitored inpatient care that aims to stabilize patients who can't care for themselves or risk harming themselves or others; subacute, inpatient care with slightly less intensive monitoring; and community residential, staffed non-hospital facilities that aim to help patients with lower-acuity or longer-term needs achieve interpersonal and independent living skills. Excluding state hospital beds, California is short about 2,000 acute beds and 3,000 beds each at the subacute and community residential levels, RAND estimated — though woefully inaccurate and incomplete data makes it difficult to determine the state's actual bed totals.

This lack of infrastructure has contributed to systemic bottlenecks, leaving some individuals whose condition has improved stuck in high-security facilities where they no longer belong, while others with severe needs end up in lower-level settings where they can hurt themselves or others. This mismatch is exacerbating burnout, trauma and turnover in California's already understaffed mental health workforce. And it's leaving far too many of California's sickest residents with nowhere to go, fueling the homelessness and drug addiction crises on our streets.

A clogged system

Dr. Maria Raven, chief of emergency medicine at UCSF Medical Center, outlined exactly how these bottlenecks create chaos in San Francisco.

When people on 72-hour psychiatric holds are brought into Raven's emergency room for evaluation and stabilization, they're supposed to be placed in locked private rooms. But those often aren't available, forcing some patients to be held in overflow rooms or hallways. Where they go after that is an open question. Many people, especially those who don't have private insurance, spend days or weeks in the emergency department — which is far from a therapeutic environment — waiting for an inpatient bed to open up.

If these individuals were open to possibility of receiving prolonged treatment before entering the hospital, Raven and mental health advocates said, getting stuck in this bottleneck often sours them on that prospect.

One reason inpatient beds are so scarce: Many are clogged for years at a time by people on conservatorships awaiting placement in a state hospital. Because these hospitals are among the few facilities in California that will accept patients regardless of their criminal background or medical condition, there's a massive waiting list to get in. As of January 2021, about 1,600 people deemed mentally incompetent to stand trial were stuck in county jails because they had yet to be placed by the Department of State Hospitals, according to a report from the nonpartisan Legislative Analyst's Office. Meanwhile, as of August 2019, more than 200 people on conservatorships had been waiting an average of about one year to be admitted to a state hospital, a 2020 state auditor report found.

Simultaneously, the lack of facilities willing or able to accept improved patients meant that as of January 2020, 138 conserved people were being treated in state hospitals despite the department's recommendation that they be discharged to lower levels of care, according to the state auditor.

What does that mean for San Francisco? According to longtime city social worker Rachel Berman, because it's untenable to have "people sitting in the psych units waiting six months, a year, two years for conservatorship and placement," many San Franciscans who are gravely disabled or who pose a risk to themselves or others are "often just discharged."

In other words, they end up on the street, or in facilities that aren't prepared to care for their complex needs — contributing to dangerous conditions in city shelters and single-room-occupancy hotels that can prompt homeless people to reject placements there.

California's responsibility

Jason Elliott, Newsom's deputy chief of staff and homelessness czar, said the administration recognizes the need for more treatment bed capacity. He pointed to the governor's proposal to put a 2024 ballot measure before voters that would require counties to redirect some existing tax revenue earmarked for

mental health services into buying, building, renovating or subsidizing housing for vulnerable clients. The proposed measure would also authorize billions of dollars in bond funding to build community residential facilities to serve thousands of mentally ill residents, including those struggling with homelessness and substance abuse. Separately, the Newsom administration has earmarked $3 billion for building homes for people suffering from severe behavioral and physical challenges.

“The whole system is gummed up,” Elliott said. “When you widen the aperture, more people can move through, you create throughput. And that helps solve some of the problem … which is people getting stuck.”

But more infrastructure alone won’t solve the problem. That’s because providers often refuse to accept patients, like Bill Gene Hobbs, with criminal records and/ or a history of violence, even when spaces are available.

The RAND report found that more than two-thirds of California’s community residential facilities can’t place people with criminal records — particularly those with arson or sex offender convictions — typically because of the complexity of their needs, liability and risk concerns and their type or lack of insurance coverage, said Nicole Eberhart, one of the report’s coauthors. This prevents subacute facilities — which had an average occupancy rate of 98% in 2021 — from sending improved patients to community residential facilities. This, in turn, prevents subacute beds from opening up for improved patients transferring out of acute facilities. And it means highly in-demand beds are going unused: Community residential facilities had an average occupancy rate of about 87% in 2021.

Another roadblock: More than 50% of psychiatric facilities at all levels of care can’t place people with serious co-occurring conditions, such as dementia or a traumatic brain injury, largely because of the complexity and specialization of care required, RAND found.

Cities like San Francisco can’t clear these roadblocks on their own; they need the state to meaningfully intervene.

One way California can help is to incentivize facilities to take on challenging clients by increasing reimbursements through Medi-Cal, the state’s low-income health insurer that covers one in three residents. Additional funds would not only help providers offset some of their liability concerns, but also help them recruit and retain highly skilled workers and allow them to better serve patients with complex needs. As UCSF’s Raven put it: “[Existing] reimbursement just is not good enough, clearly, because if it were better, then … these places that have (open) beds would be taking these patients.”

Reimbursements for behavioral health providers are set to go up on July 1 as part of CalAIM, California’s ambitious multi-year effort to radically reform Medi-Cal. Through CalAIM, the state is also rolling out a first-in-the-nation program to allow eligible jail and prison inmates to access coverage up to 90 days before their release so they can be connected to necessary medical and behavioral health care and enrolled in social services without any gaps. It’s covering up to six months of rent or temporary housing for people leaving institutional settings who are at risk of homelessness. And it’s investing in community-based alternatives to state hospitalization for felony offenders found incompetent to stand trial.

Mark Ghaly, secretary of the California Health and Human Services Agency, told the Editorial Board he hopes these changes will be the beginning of California turning the corner on mental health. But, he said, “I’ll remind you this system has been this way for decades. It’s going to take a minute to flip it a bit.”

As big and bold as CalAIM is, however, it doesn’t adequately acknowledge the state’s responsibility to improve care for severely mentally ill people involved in the criminal justice system. Other countries, recognizing the unique challenges posed by this specific population and the higher level of resources and coordination required, have pursued models California should seriously consider implementing.

Australia, for example, has developed a comprehensive data-gathering system that helps policymakers determine when and where to invest in new mental health infrastructure. Using that framework, the state of South Australia realized it needed to increase the supply of psychiatric beds for a few key groups, including those involved in the criminal justice system. A 2018 study reviewing South Australia’s policy concluded that U.S. states should also increase their supply of publicly funded beds — including in state

hospitals — to adequately care for people with severe mental illness, “especially for those caught up within the criminal justice system.”

State Sen. Susan Eggman, D-Stockton, is currently carrying a bill to create an online database of mental health and substance abuse treatment beds. Expanding the state hospital system, however, is likely a no-go in California.

“We really want to make sure that … as the governor is trying to close prisons, we’re not overbuilding a prison complex by another name,” Elliott said, adding that as the state builds more beds at lower levels of care it will “by definition create more capacity” in state hospitals.

That, however, will hold true only if those lower-level facilities agree to accept patients with criminal backgrounds. Given their historic reluctance to do so, California may need to develop facilities specifically designed to treat mentally ill people involved in the criminal justice system.

It’s an approach that has shown promise in Italy, which after closing its state mental hospitals oversaw the development of locked regional community facilities focused on rehabilitating people who had pled not guilty to crimes by reason of insanity. A 2020 study found that 65% of the 1,580 patients admitted to the regional facilities between April 2015 to June 2019 were discharged — meaning “a considerable number of therapeutic measures for these patients were successful.” Still, Italy’s system is facing its own bottlenecks, with waitlists hundreds of patients long and many providers dealing with burnout and trauma.

Italy’s example shows us the potential of a more compassionate, state-led system of care laser-focused on the hardest-to-treat populations. But it’s also a reminder of the danger of change without adequate investment. California needs significantly more facilities — at all levels of care — that can do what right now essentially only state hospitals can: accept and treat patients regardless of their criminal background, medical conditions, specialized needs or insurance coverage.

If California falls short of that mandate, any changes it makes to its mental health system will be nothing more than a Band-Aid on a gaping wound — and the streets of cities like San Francisco will continue to be mired in misery that they can’t fully overcome on their own.

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BHCIP Awards (Planning & Grant Overview)

Property	Location	Applicant	BHCIP Round	Uses	Capacity	Capital Funds	Status	Annualized Costs
Galindo	Oakland	La Familia	3	CRT and Outpatient	CRT: 16	$5,132,883	Awarded	$5M
Gladman	Oakland	Telecare	3	CRT	CRT: 16	$4,348,706	Awarded	$3M
Mocine	Hayward	La Familia	3	CSU/CRT	CSU: 16 CRT:16	$3,853,298	Awarded	$7M
Fuller Campus	Hayward	La Familia	4	CSU, CCRP	CSU: 6 CRT: 6	**pending response*	Submitted	$2.5M
Greater New Beginnings	Oakland	Greater New Beginnings	4 & CCE	Community Wellness Center, STRTP, Transitional Housing	STRTP: 16	$22M	BHCIP submitted, CCE in development	$2M
Willow Rock	Oakland/ San Leandro	ACBH	4	CCRP, PHF	PHF: 20 CCRP: 16	$36M	Submitted	$1.5M
Telegraph Ave	Oakland	Horizon Services	5	Sobering, Detox, Residential	Up to 25	TBD	In development	$4M
San Leandro Hospital	Oakland/ San Leandro	AHS	5	Med/Psych Hospital	12 to 14	TBD	In development	TBD
St. Regis	Hayward	BACS	5	MHRC, SUDS	MHRC: 42 SUD 35	$14.6M	In development	$8.6M
Livermore	Livermore	La Familia	5 / 6	TBD	TBD	TBD	In development	$5M

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, June 20, 2023 7:43 AM
To: Works-Wright, Jamie
Subject: FW: Mental Health Advisory Board Meeting (June 21, 2023)
Attachments: MHAB Main Board Agenda (June 2023).pdf; MHAB Unapproved Meeting Minutes (May 2023).pdf; Resolution Designating 26M for MH Program and Services Unit.pdf; Sen Skinner's Letter re MH Program and Services Unit.pdf; MHAB Letter to Board of Supervisors re Jail Expansion Plan.pdf; Memo - ACBH Departmental Response to MHAB Annual Report Recommendations.pdf; ACBH Departmental Response to MHAB FY2021-2022 Annual Report.pdf

Hello Commissioners,
Please see the information below and attached

Jamie Works-Wright
Consumer Liaison
Jworks-wright@berkeleyca.gov
510-423-8365 cl
510-981-7721 office

Please be aware that e-mail communication can be intercepted in transmission or misdirected. The information contained in this message may be privileged and confidential. If you are NOT the intended recipient, please notify the sender immediately with a copy to HIPAAPrivacy@cityofberkeley.info and destroy this message immediately.

From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Sent: Friday, June 16, 2023 8:23 PM
Subject: Mental Health Advisory Board Meeting (June 21, 2023)

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

Greetings,

Please see attached materials for the Mental Health Advisory Board (MHAB) meeting scheduled for **Wednesday, June 21, 2023**.

This will be an in-person meeting to be held at 2000 Embarcadero Cove, Suite 400 (*Gail Steele Conference Room*), Oakland, CA. Members of the public are invited to observe and participate in person or remotely via Zoom.

To participate via Zoom, please click on the meeting link below:

Join from PC, Mac, Linux, iOS or Android:
https://us06web.zoom.us/j/87366080958?pwd=YWZaQkd5RWEwZW1sbjRTVTh4Q3pNUT09
Password: 774947

Or Telephone:

USA 404 443 6397
USA 877 3361831 (US Toll Free)
Conference code: 937417

Find local AT&T
Numbers: https://www.teleconference.att.com/servlet/glbAccess?process=1&accessNumber=4044436397&accessCode=937417

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Agenda

Wednesday, June 21, 2023 ◊ 3:00 PM – 5:00 PM

2000 Embarcadero Cove, Suite 400 (Gail Steele Room) Oakland, CA

This meeting will also be conducted through videoconference and teleconference

https://us02web.zoom.us/j/87366080958?pwd=YWZaQkd5RWEwZW1sbjRTVTh4Q3pNUT09

Teleconference: (877) 336-1831 | Meeting ID: 873 6608 0958 | Code: 937417

MHAB Members:	**Brian Bloom** *(Interim Chair, District 4)* **Warren Cushman** *(Interim Vice Chair, District 3)* **Terry Land** *(District 1)*	**Thu Quach** *(District 2)* **Ashlee Jemmott** *(District 3)* **Anh Thu Bui** *(District 5)*	**Juliet Leftwich** *(District 5)* **Abigail West** *(District 5)* **Amy Shrago** (*BOS Representative)*

Committees

Adult Committee
Terry Land, Co-Chair
Thu Quach, Co-Chair

Children's Advisory Committee
Vacant

Criminal Justice Committee
Brian Bloom, Co-Chair
Juliet Leftwich, Co-Chair

MHAB Mission Statement

The Alameda County Mental Health Advisory Board has a commitment to ensure that the County's Behavioral Health Care Services provide quality care in treating members of the diverse community with dignity, courtesy and respect. This shall be accomplished through advocacy, education, review and evaluation of Alameda County's mental health needs.

3:00 PM Call to Order ______________________ Interim Chair Bloom

3:00 PM I. Roll Call

3:05 PM II. Approval of Minutes

3:10 PM III. Public Comments (Agenda Items)

3:15 PM IV. Interim Chair's Report

- **A. Measure A Citizen Oversight Committee**
- **B. MHAB Recruitment Update**
- **C. MHAB Banquet (May 2024)**
- **D. Future MHAB Meeting Topics/Discussions**
  1. **CalAIM (July 2023)**
  2. **Crisis System of Care (August 2023)**
  3. **Children's System of Care (September 2023)**
- **E. Update on MHAB Letter to the Board of Supervisors regarding the MHSA Three-Year Plan**
- **F. Virtual Meeting Chat Feature**

3:25 PM V. Jay Mahler Crisis Residential Facility Tour Report

3:30 PM VI. Letter to Board of Supervisors Opposing $26.6 Million Jail Expansion Plan (Action Item)

3:45 PM VII. ACBH Departmental Response to MHAB Recommendations

4:40 PM VIII. Committee & Liaison Reports

- **A. Adult Committee**
- **B. Criminal Justice Committee**
- **C. Care First, Jails Last Task Force Liaison**
- **D. MHSA Liaison**

4:45 PM IX. Public Comment (Non-agenda items)

5:00 PM X. Adjournment

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Mental Health Advisory Board UNAPPROVED Minutes
Monday, May 15, 2023 ◊ 3:00pm-5:00pm

Meeting Conducted In-Person and through Video/Telephone Conference

Alameda County
Mental Health Advisory Board

MHAB Members:	☒ **Brian Bloom** *(Interim Chair, District 4)* ☒ **Warren Cushman** *(Interim Vice Chair, District 3)* ☒ **Terry Land** *(District 1)*	☒ **Thu Quach** *(District 2)* ☒ **Ashlee Jemmott** *(District 3)* ☐ **Anh Thu Bui** *(District 5)*	☒ **Juliet Leftwich** *(District 5)* ☒ **Abigail West** *(District 5)* ☐ **Amy Shrago** *(BOS Representative)*
ACBH Staff:	☒ **Dr. Karyn Tribble** *(ACBH Director);* ☒ **James Wagner;** ☒ **Asia Jenkins;** ☒ **Dainty Castro** *(Administrative Liaison);*		
Unexcused Absences:			

Meeting called to order at 3:03 PM by **Interim Chair Brian Bloom**

ITEM	DISCUSSION	DECISION/ACTION
Roll Call / Introductions	Roll Call completed.	
Approval of Minutes	Minutes from last month's meeting were reviewed and minutes were approved.	
Announcement	There will be two *Public Comments* on future MHAB agendas for agenda and non-agenda items.	
Chair's Report	**Santa Rita Jail** Chair Bloom stated that there was another death at Santa Rita Jail. This is the fifth death reported this year of an incarcerated person. The name of the inmate has not yet been released. It is not known if this was related to mental health. **MHAB Resignation** Loren Farrar has submitted a letter of resignation to the MHAB and the BOS, effective immediately. At this time, both District 3 and District 1 have two vacancies. **MHAB Recruitment Flyer** The recruitment flyer was approved and is currently posted on the MHAB website. Also, it will be sent to the Board of Supervisors (BOS) for additional distribution.	

<table>
<tr><th>ITEM</th><th>DISCUSSION</th><th>DECISION/ACTION</th></tr>
<tr><td></td><td><u>Executive Committee</u>
It was stated that following next month's meeting, it was suggested that a social event/mixer take place at Quinn's Lighthouse beginning at 5:00 p.m.

<u>Measure A Citizens' Oversight Committee</u>
This committee has an opening position for a member of the MHAB. Interim Chair Bloom believes that they meet monthly on 4th Friday of each month in the morning, but this needs to be confirmed. A volunteer to attend the meeting is requested until the position is filled.

<u>John George Psychiatric Hospital Tour</u>
Members Leftwich, Quach, Cushman and Land went on a tour of John George Psychiatric Hospital. One of the main challenges that John George stated is that they have difficulty making connection with the patients once they leave the facility. Also, the facility's capacity has not been maximized. However, more stepdown units are needed.

The site visit was considered very valuable and suggested that more visits should be scheduled and that an ad hoc committee be established to submit recommendation(s) and/or follow-up after each visit. The Adult Committee could possibly undertake the John George follow-up. Whereas the Criminal Justice Committee could undertake the Santa Rita Jail matter.</td><td>✓ Julie Leftwich volunteered to attend the initial meeting.</td></tr>
<tr><td>ACBH Director's Report</td><td>New Position Appointment: Interim WET Manager: ACBH Director, Dr. Tribble announced that Cheryl Narvaez has been appointed as Interim Workforce Development, Education & Training (WET) Manager and will function in this capacity until a permanent replacement has been selected.

Care Courts: Regarding the Governor's May Revise, an additional $60M was allocated to Behavioral Health counties for Care Courts. Alameda County's portion is not yet known.

BHCIP: There is a continued delay in Round 6 of BHCIP. As a result, the delay amount of approximately $480M will be carried over until FY 2024-2025. It is believed that the delay of award for Round 5 is delayed until next year. Rounds 2-4 have already been allocated, but funds from Round 2 was not applied for.

MHSA: The MHSA is slated to be redesigned. This will have to go back to the voters (Prop 63) for approval, as this is a ballot measure.

Bridge Housing: There is no longer a delay, but the general funds will be removed and replaced with state-level MHSA administrative functions.</td><td></td></tr>
</table>

DRAFT

ITEM	DISCUSSION	DECISION/ACTION
	Opioid Settlement: We intend to move forward with actual funding as soon as possible. Funds will be available in July 2023. Funds are a result of a settlement as a result of the large number of opioid deaths. Alameda County's share is estimated at $40-46M, received over 20 years.	
Committee Reports	**<u>Adult Committee</u>** H&L Services and La Clinica has been invited to the next meeting to discuss access lines and what the patients and clients are dealing with. **<u>Criminal Justice Committee (CJC)</u>** ACBH's Forensic, Diversion and Re-entry Services Director Juan Taizan, made a presentation regarding Santa Rita Jail. There is also a plan to have someone from Alameda County Sheriff's Office come and speak to the Committee regarding the settlement and consent decree. CJC plans to focus on Behavioral Health Court and the next meeting. The matter regarding the ability for parents to have interaction with their adult children and access to their case history in light of HIPAA was mentioned. Dr. Tribble stated that this is currently being reviewed to determine what options might be made available. **<u>Care First, Jails Last Taskforce</u>** Meets every last Thursdays of each month and will continue to discuss the intercepts. **<u>Mental Health Services Act (MHSA)</u>** The last meeting included a presentation on the African American Wellness Hub. While there was general support for the concept, there was serious concern from the participants in the stakeholder group, including lack of a well-defined program in place before procuring a building, clarity on the type of services available (referral service vs. on-site service), clarity on what the overall program is, and no plan for therapists or psychologists on site. There are community listening sessions planned for April so that questions may be asked, and more information will be made available. ACBH MHSA Director, Tracy Hazelton, made a brief presentation during this meeting as time permitted.	
110 **Discussion Items**	**<u>Mental Health Services Act (MHSA) Information Session and Three-Year Plan Update</u>**	

DRAFT

ITEM	DISCUSSION	DECISION/ACTION
	A draft of the MHAB Comments regarding MHSA was presented by ACBH MHSA Director, Tracy Hazelton. This plan is for activity for FY 23-26. The draft was inclusive of comments from MHAB members and the public comments. Eventually, this will be presented in a formal letter to the BOS. The deadline for this was scheduled for June 1, or June 10 at the latest, with the intent of presenting to the BOS for approval on June 26. The statute expires on June 30. A motion was made and seconded that the MHSA daft letter be approved and authorize the MHAB Executive Committee to finalize the letter at their June 8 meeting. Motion carried with one abstention. Tracy Hazelton also provided a presentation related to Mental Health Services Act Public Hearing regarding the MHSA (Draft) Three Year Plan FY 23-26. For the current proposed plan (between 10/2022 – 01/2023), there were 100,000+ outreach summaries, 581 survey responses, 13,145 focus group participants and 23 public comments. Plan Changes/Next Steps include: **<u>Immediate Changes</u>** • Quality Control Changes • Increased funding for implementation of 988 system • ACBH Leadership Discussions on additional future changes **<u>Short Term Changes</u>** • Board of Supervisors and HCSA review **<u>Long Term Changes</u>** • Tracking of Possible Changes for the next MHSA Cycle • Potential for Expanded Executive Summary & Public Comment timeframe • Documenting Additional Programmatic Outcomes • Aligning MHSA annual reports to MHSA regulations The MHSA Three-Year Plan is available online. The major content areas are all hyperlinked in the Table of Contents. In conclusion, Tracy Hazelton is working to finalize the public comments, and the MHSA team is currently in the process of editing and revising the errors and quality control pieces.	

DRAFT

ITEM	DISCUSSION	DECISION/ACTION
	There will be additional opportunity for public comment when the MHSA goes to the BOS meeting scheduled for June 26 at 10:00am. Public comment will be allowed at this meeting and the agenda will be available via the BOS website.	
Public Comment	Public comment provided.	
Adjournment	Adjourned at 5:05 PM	

DRAFT

AGENDA # **May 9, 2023**

KIMBERLY GASAWAY, Director

1401 LAKESIDE DRIVE, OAKLAND, CALIFORNIA 94612 510 208 9700 FAX 510 208 9711 WWW.ACGOV.ORG/GSA/

April 10, 2023

Honorable Board of Supervisors
County of Alameda
1221 Oak Street, Suite 536
Oakland, California 94612-4305

SUBJECT: ADOPT A RESOLUTION DESIGNATING $26,662,922 COUNTY MATCH FUNDING FOR THE SANTA RITA JAIL MENTAL HEALTH PROGRAM AND SERVICES UNIT PROJECT THROUGH THE SENATE BILL 863 FINANCING PROGRAM; APPROVE THE USE OF CAPITAL DESIGNATIONS FOR THE BALANCE OF THE COUNTY MATCH FUNDING; AMOUNT: $26,249,950; AMEND THE FISCAL YEAR 2023-2027 CAPITAL IMPROVEMENT PLAN TO INCREASE THE PROJECT BUDGET, 5325 BRODER BOULEVARD, DUBLIN; PROJECT NO. CPP17C160160000; PROJECT BUDGET INCREASE AMOUNT: $18,954,950

Dear Board Members:

RECOMMENDATIONS:

A. Adopt a Resolution designating $26,662,922 County match funding, comprised of $25,119,887 cash match and $1,543,035 in-kind match for the Santa Rita Jail Mental Health Program and Services Unit Project under the Senate Bill 863 Local Criminal Justice Facilities Financing Program;

B. Amend the Fiscal Year 2023-2027 Capital Improvement Plan to increase the budget for the Santa Rita Jail Mental Health Program and Services Unit Project, Project No. CPP17C160160000, from $62,047,972 to $81,002,922 ($18,954,950 increase);

C. Approve the use of Capital Financing Plan Designation in the amount of up to $26,249,950 for the balance of the County match funding for the Santa Rita Jail Mental Health Program and Services Unit Project; Project No. CPP17C160160000; and

D. Authorize and direct the Auditor-Controller to make the related budget adjustments.

DISCUSSION/SUMMARY:

The Santa Rita Jail (SRJ), originally constructed in 1988, was not designed to serve the programming, health care, mental health, rehabilitative services, and related administrative functions currently provided in the facility by the Alameda County Sheriff's Office (ACSO) and other County of Alameda agencies. To meet these needs, ACSO applied for and received approval for the planning and construction of the new SRJ Mental Health Program and Services Unit (MHPSU) Project ("the Project") utilizing bond financing under Senate Bill (SB) 863.

On June 30, 2015, your Board approved (Item No. 26, File No. 29602) Resolution No. 2015-248, authorizing the submission of a proposal to the Board of State and Community Corrections (BSCC) for SB 863 funding the Project.

On September 15, 2015, your Board approved (Item No. 66, File No. 29648) an amendment to Resolution No. 2015-248, attesting to $333,000 as the current fair market land value for the proposed project and approving the form of documents deemed necessary identified by the State Public Works Board (SPWB) to the BSCC.

On June 14, 2016, your Board approved (Item No. 37.2, File No. 29780) Resolution 2016-169 setting aside County matching funds and amended Category I of the Fiscal Year (FY) 2015-20 Capital Improvement Plan (CIP) to add improvements for the SRJ facility, which included the Project.

On January 10, 2017, your Board approved (Item No. 21) an award to DLR Group Architects (DLR) for the initial portion of architectural and engineering (A/E) services followed by an amendment for the bridging phase of the Project approved by your Board on December 5, 2017 (Item No. 19).

On September 18, 2018, your Board approved (Item No. 39) a Professional Services Agreement with Kitchell Capital Expenditures Managers, Incorporated (Kitchell) for project and construction services.

The Project was formally established with SPWB and State Department of Finance (DOF) in 2019 with the County of Alameda's execution of the Project Delivery and Construction Agreement and Forms of Agreement on January 15, 2019 (Item No. 58, File No. 30263) and the execution of the Jail Construction Agreement, between the County of Alameda and BSCC on June 18, 2019 (Item No. 15, File No. 30325).

The architectural bridging design services began on January 22, 2019, and concluded on January 10, 2020. As formerly designed, the SRJ MHPSU was an approximately 38,000 square foot, two-story building located between Housing Units (HU) 23 and 24. Shortly upon the conclusion of architectural bridging, ongoing litigation required additional staffing at SRJ.

On May 12, 2020, your Board approved (Item No. 72) 107 Full-Time Equivalent (FTE) positions for the Alameda County Health Care Services Agency/Behavioral Health Care Services (BHCS) to augment staffing and care coordination at SRJ.

With no space for the additional FTE positions within the jail, the SRJ MHPSU building needed to be redesigned to accommodate the increased BHCS staffing. The redesign also eliminated all medical program components from the Project's scope. The former site at HU 23 and 24 could not accommodate the building and it was requested that the Project scope be revised to relocate to the HU 5 location. This location provided the space needed to redesign the building to include workspace for the additional FTE positions. Additionally, the HU 5 site allowed the new MHPSU building to operate independently of the current SRJ utility infrastructure loops (mechanical, electrical, and plumbing) that complicated the former design.

On May 18, 2021, your Board approved (Item No. 30650, File No. 43.1) amendments and contributed $412,972 County funding for consultant services related to the building redesign: Amendment No. 3 to the Professional Services Agreement with DLR for A/E services; and Amendment No. 1 to the Professional Services Agreement with Kitchell for construction management services.

In order to obtain the State of California SB 863 award, the budget, schedule and bridging documents must be submitted to BSCC. Also, the County of Alameda is required to identify the source and authority of use of the local match funds as well as demonstrate the commitment of said monies. The bridging documents and cost estimates are now completed and the document submission to BSCC is finalized. BSCC has reviewed all documents and is in the process of forwarding them to DOF with a recommendation for approval of State funding. DOF requires the attached Resolution as well as this board letter to confirm County funds. At that time, ground lease negotiations will begin, the parcel will be adjusted, bonds will be removed, followed by Ground Lease execution. DOF will then send a letter to the Legislature. SPWB will then approve the Project's scope and the Request for Proposal, followed by an award to a Design/Build Entity, at which point design can begin.

FINANCING:

The revised Project costs estimated at $81,002,922 are financed through the State of California BSCC under the SB 863 Local Criminal Justice Facilities Financing Program in the amount of $54,340,000 and the County match funding in the amount of $26,662,922. Appropriations for the balance of the County match funding in the amount of $26,249,950 will be transferred to the General Services Agency Capital Projects Fund Fiscal Year 2022-23 budget for the Project. Funding for the County match will be through a combination of sources including but not limited to the Capital Financing Plan Designation and other eligible departmental revenue sources. There will be no increase in net County cost.

VISION 2026 GOAL:

The Project meets the 10X goal pathway of **Healthcare for All and Accessible Infrastructure** in support of our shared vision of **Safe and Livable Communities**.

Respectfully submitted,

DocuSigned by:
Kimberly Gasaway
8D4CA131AA0B4C2...
Kimberly Gasaway
Director, General Services Agency

DocuSigned by:
Yesenia Sanchez
D7A375C24694430...
Yesenia Sanchez
Sheriff-Coroner, Alameda County Sheriff's Office

Attachment

cc: County Administrator
Auditor-Controller
County Counsel

RESOLUTION NO. 2023-___

A RESOLUTION DESIGNATING COUNTY MATCH FUNDING FOR THE SANTA RITA JAIL MENTAL HEALTH PROGRAM AND SERVICES UNIT PROJECT UNDER THE SB 863 ADULT LOCAL CRIMINAL JUSTICE FACILITIES CONSTRUCTION FINANCING PROGRAM

WHEREAS, the State of California made available a lease revenue bond financing program to construct and renovate adult local criminal justice facilities through the SB 863 Adult Local Criminal Justice Facilities Construction Financing Program (the Program); and

WHEREAS, on June 30, 2015, the Board of Supervisors adopted Resolution No. 2015-248 authorizing the Alameda County Sheriff to apply for funding the Santa Rita Jail (SRJ) Mental Health Program and Services Unit (MHPSU) Project (the Project) under SB 863; and

WHEREAS, by adopting Resolution 2015-248, the Board approved the existing SRJ site located at 5325 Broder Boulevard, Dublin, California, for the MHPSU, complying with the site assurance requirements of SB 863; and

WHEREAS, the application for the MHPSU facility was submitted and found worthy of funding by the Board of State and Community Corrections (BSCC) at a BSCC meeting on November 12, 2015; and

WHEREAS, on December 17, 2015, the State of California, through its BSCC, conditionally awarded the County $54,340,000 in Program Funds toward the Project; and

WHEREAS, the BSCC approved a revised scope of work on November 18, 2021, which included the relocation of the Project to allow for a standalone building as well as the removal of medical health treatment and OB/GYN clinic and the addition of office space for Behavioral Healthcare Services staff from the space program; and

WHEREAS, the total estimated cost of the MHPSU is $81,002,922; and

WHEREAS, BSCC has requested that the County of Alameda identify and designate all County funds that will be used to complete the Project; and

WHEREAS, the County of Alameda will provide General Fund funding totaling $26,662,922 which consists of $25,119,887 cash match and $1,543,035 in-kind match designated for the MHPSU;

NOW, THEREFORE BE IT RESOLVED as follows:

Section 1: That the Board of Supervisors hereby designates toward the Project County Funding in the total amount of $26,662,922, consisting of revenue from the sources and in the amounts identified below:

A. That $25,119,887 of General Fund Capital Designation funds be set aside and dedicated as the County's Cash Match for the sole use of the Project.

B. That $1,543,035 of General Fund Capital Designation funds be set aside and dedicated as the County's In-Kind Match for the sole use of the Project's County administration costs.

Section 2: That the Board of Supervisors does hereby represent, warrant and covenant as follows:

A. Lawfully Available Funds. The County cash contribution funds, as identified in Section 1, have been derived exclusively from lawfully available funds of the County.

B. County Cash Contribution Funds Are Legal and Authorized. The payment of the County Cash Contribution Funds for the Project (i) is within the power, legal right, and authority of the County; (ii) is legal and will not conflict with or constitute on the part of the County a material violation of, a material breach of, a material default, under, or result in the creation or imposition of any lien, charge, restriction, or encumbrance upon any property, mortgage, deed of trust, pledge, note, lease, loan, installment sale agreement, contract, or other material agreement or instrument to which the County is a party or by which the County or its properties or funds are otherwise bound; decree, or demand of any court or governmental agency or body having jurisdiction over the County or any of its activities, properties or funds; and (iii) have been duly authorized by all necessary and appropriate action on the part of the governing body of the County.

C. No Prior Pledge. The County Cash Contribution Funds and the Project are not and will not be mortgaged, pledged or hypothecated by the County in any manner or for any purpose and have not been and will not be the subject of a grant of a security interest by the County; the County Cash Contribution Funds and the Project are not and will not be mortgaged, pledged, or hypothecated for the benefit of the County or its creditors in any manner or for any purpose and have not been and will not be the subject of a grant of a security interest in favor of the County or its creditors. The County shall not in any manner impair, impede, or challenge the security, rights, and benefits of the owners of any lease-revenue bonds sold by the State Public Works Board the Project (the Bonds) or the trustees for the Bonds.

D. County Designated Funds. The County hereby assures that is has designated $26,662,922 in local funds to satisfy the County's contribution toward the Project; the identified funds are compatible with the State's lease revenue bond financing; and the cash match contribution does not supplant funds otherwise dedicated or appropriated to construction activities.

Section 3: That, except to the extent modified herein, Resolution No. 2016-169, governing, among other things, Program application submittal and delegation of authority with respect to Project design and construction, remains in full force and effect.

This Resolution was passed and adopted by the Board of Supervisors at a meeting held on the ____ day of ________________, 2023 by the following vote:

AYES:

NOES:

EXCUSED:

ABSTAINED:

____
Nate Miley
President, Board of Supervisors

ATTEST:

By: ___________________________
Clerk of Board of Supervisors

APPROVED AS TO FORM:

DONNA R. ZIEGLER
COUNTY COUNSEL

DocuSigned by:

By ______________________________________
658D28A8033A493...
Andrea L. Weddle
Chief Assistant County Counsel

FINANCIAL RECOMMENDATION (A) **AGENDA DATE:** 4/25/2023

SUBJECT OF BOARD LETTER Amend the FY 2023-2027 CIP to increase the project budget by $18,954,950; transfer balance of the County match funding from designation to project fund - $26,249,950

BY: 2023 **FUND:** 27041

The use of Designations, as follows:

NAME OF DESIGNATION	ORG	AMOUNT

The increase (decrease) in anticipated revenue, as follows:

ORG	ACCT	PROG	PROJ/GR *(Informational)*	AMOUNT
200700	485110	00000	*CPP17C160160000*	$26,249,950
			ORG TOTAL	$26,249,950

ORG	ACCT	PROG	PROJ/GR *(Informational)*	AMOUNT
			ORG TOTAL	$0

GRAND TOTAL ANTICIPATED REVENUE $26,249,950

The increase (decrease) in appropriations, as follows:

ORG	ACCT	PROG	PROJ/GR *(Informational)*	AMOUNT
200700	650011	00000	*CPP17C160160000*	$26,249,950
			ORG TOTAL	$26,249,950

ORG	ACCT	PROG	PROJ/GR *(Informational)*	AMOUNT
			ORG TOTAL	$0

GRAND TOTAL APPROPRIATION $26,249,950

FINANCIAL RECOMMENDATION (A) **AGENDA DATE:** 4/25/2023

Subject of Board Letter: Amend the FY 2023-2027 CIP to increase the project budget by $18,954,950; transfer balance of the County match funding from designation to project fund - $26,249,950

BY: 2023 **FUND:** 10000

The use of Designations, as follows:

NAME OF DESIGNATION	ORG	AMOUNT
Capital Financing Plan		$26,249,950

The increase (decrease) in anticipated revenue, as follows:

ORG	ACCT	PROG	PROJ/GR *(Informational)*	AMOUNT
			ORG TOTAL	$0.00

ORG	ACCT	PROG	PROJ/GR *(Informational)*	AMOUNT
			ORG TOTAL	$0

GRAND TOTAL ANTICIPATED REVENUE $0.00

The increase (decrease) in appropriations, as follows:

ORG	ACCT	PROG	PROJ/GR *(Informational)*	AMOUNT
200700	670011	00000		26,249,950
			ORG TOTAL	$26,249,950

ORG	ACCT	PROG	PROJ/GR *(Informational)*	AMOUNT
			ORG TOTAL	$0.00

GRAND TOTAL APPROPRIATION $26,249,950

CHAIR
NANCY SKINNER

SENATE

JOSH BECKER
BRIAN DAHLE
MARÍA ELENA DURAZO
SUSAN TALAMANTES EGGMAN
ROGER W NIELLO
STEPHEN C PADILLA
RICHARD D ROTH

Joint Legislative Budget Committee

CALIFORNIA LEGISLATURE

LEGISLATIVE ANALYST
GABRIEL PETEK

VICE CHAIR
PHILIP Y. TING

ASSEMBLY

Dr JOAQUIN ARAMBULA
STEVE BENNETT
MIA BONTA
WENDY CARRILLO
VINCE FONG
KEVIN MCCARTY
JIM PATTERSON

May 18, 2023

Mr. Joe Stephenshaw, Director
Department of Finance
1021 O Street, Suite 3110
Sacramento, California 95814

Dear Mr. Stephenshaw:

In a letter dated May 4, 2023, you notified the Joint Legislative Budget Committee (JLBC), of a request from the Board of State and Community Corrections (BSCC), on behalf of Alameda County (County), of a scope change to the new Mental Health Program and Services Unit proposed for the Santa Rita Jail. The letter states that it is your intent to approve the scope change and recommend the State Public Works Board (PWB) recognize the revised scope no sooner than 20 days from the date of the letter.

In 2015, the BSCC awarded the County $54,340,000 for construction of the new unit, with the County contributing an additional $7,266,000—for a total project cost of $61,606,000.

Since then, the County has revised its plans and is proposing to move the location of the project and remove all remodeling. According to your letter, the original scope included the construction of a two-story building attached to two housing units at Santa Rita Jail which would be remodeled. The revised scope includes the construction of a new standalone building and elimination of remodeling activities in the two housing units.

The new estimated total project cost associated with this scope change is $81,003,000. The County's portion of the cost will increase from $7,266,000 to $26,663,000 which was approved by the Board of Supervisors on May 9, 2023.

The request for scope change is scheduled to be heard by the PWB on May 19, before the 20-day notification period expires.

1020 N STREET SUITE 553
SACRAMENTO, CALIFORNIA 95814
(916) 651-1891

I have a number of questions that I would like the County to answer before it is heard by the PWB. To that end, I respectfully request the PWB reschedule the item to its August meeting and ask that DOF submit the following questions and obtain the County's response in adequate time for JLBC to review prior to PWB's August hearing:

1. Please provide additional background on how the new Mental Health Program and Services (MHPS) Unit helps the County meet the conditions of the Court approved Consent Decree in the case of *Babu et al v. County of Alameda*. Are there conditions in the Consent Decree that specifically require the County to construct additional mental health infrastructure?

2. Please provide the detailed design plan, identifying the different components of the MHPS Unit, that the project's cost estimate is based on.

3. How many treatment beds are planned for the new MHPS Unit? Will the new building include facilities for individuals in mental health crises? Please describe how the new facility will provide space or facilities to stabilize patients in crisis. Will there be long-term living units for people with severe or serious mental illness while they are incarcerated? How much of the new building will be dedicated to offices? Counseling rooms? Will people with serious mental illness be diverted to non-jail mental health facilities?

4. The County's original plan included remodeling of the housing units, the new plan eliminates this remodel. What it is the County's intent for that housing and will the new proposal include housing units, in addition to mental health beds?

5. Since the design is not final, will the Mental Health Advisory Board and the Care First Taskforce be informed or involved in the design modification process?

6. According to the Board of Supervisors' May 9, 2023 agenda item, the County funds will be provided through a combination of sources including but not limited to the Capital Financing Plan Designation and other eligible departmental revenue sources. Please provide a breakdown of where the matching funds will come from. If any of them are bond funds, what are the annual costs on the debt service on those bonds?

7. Prior to the Board of Supervisors' approval of the County's share of cost of $26.6 million, were any County Advisory Boards or community interest groups informed of the hearing? What community outreach was conducted before the hearing?

8. Once the new MHPS Unit is constructed, what is the estimated annual cost increase associated with the enhanced mental health services and staffing levels? Please provide a staffing plan for the new unit.

9. Will the new facility be run by the Sherriff or Alameda County Behavioral Health Care Services?

10. Is there anything that prevents the County from changing the use of the new unit in the future? For example, is there anything that prevents the County from repurposing some of the new building into non-mental health housing units in the future?

11. According to the BSCC's November 18, 2021 agenda item, the County reported that the new location will result in significant savings in construction costs, however the County's new plan has a cost estimate that is almost $19 million above the previously approved plan. Please provide information/background on how the new location is the more cost effective, given the increase in projected cost and the apparent elimination of the housing units.

12. And finally, please explain why the 20-day notification letter from the Department of Finance was sent to the JLBC five days prior to the Board of Supervisors action to approve the $26,662,922, an addition of $18,954,950, in County funds. The usual timing of such a notification letter would seem to be triggered after the local action was taken.

In conclusion, I have a number of questions about how the new Mental Health Program and Services Unit project will impact the operation and management of Santa Rita Jail. Therefore, I respectfully request the proposed scope change be rescheduled for the PWB's August meeting, which will give the County time to provide the requested information and time for me and my staff to review it.

Sincerely,

Nancy Skinner
Chair

cc: Members of the Joint Legislative Budget Committee
Members of the State Public Works Board
Alameda County Board of Supervisors
Kathleen T. Howard, Executive Director, Board of State and Community Corrections
Aaron Maguire, Chief Deputy Director, Board of State and Community Corrections
Ryan Okimura, Manager, Board of State and Community Corrections

To the Alameda County Board of Supervisors:

On May 9, 2023, the Board of Supervisors adopted a Resolution designating $26,662,922 of county match funding to construct a Mental Health Program and Services Unit Project ("MHPSU") at the Santa Rita Jail ("SRJ"). As explained in the Resolution (which accompanied the Agenda as Attachment #51), the full cost of this Jail Expansion Project is just over 81 million dollars, to be financed with $54.3 million dollars from the State of California and $26.6 million from Alameda County. The Resolution further suggests that the new building at SRJ is needed to accommodate increased staffing which will provide behavioral health care at the jail.[1]

On May 18, 2023, Senator Nancy Skinner wrote to the Director of the State Dept. of Finance requesting that a number of questions about the proposed project be answered before the State approved the project. Senator Skinner set forth twelve questions that she wanted Alameda County to answer and the Joint Legislative Budget Committee to review before the matter was brought before the State Public Works Board for consideration.

The Mental Health Advisory Board ("MHAB") has read and discussed the proposed Jail Expansion Project and Senator Skinner's letter to the Dept. of Finance. It appears to the MHAB that the Jail Expansion Project is antithetical to the principles set forth in the "Care First, Jail Last" Resolution which your Board unanimously enacted in April 2021. Furthermore, the MHAB believes that such a significant investment in a new building at the jail is at odds with the goals of the Care First Task Force which your Board created over a year ago to implement the Care First Resolution. As the Board knows, the Task Force -- which includes a representative from the Mental Health Advisory Board -- has been working diligently to design a full continuum of behavioral healthcare that aims to significantly **reduce** the number of people with mental illness, substance abuse and co-occurring disorders in our jail.

In light of this, the Mental Health Advisory Board ("MHAB") has voted in favor of a motion that the Jail Expansion Plan should not go forward at all, or at the very least, should be put on hold until the Care First Task Force concludes its work and makes its recommendations to the Board of Supervisors in April 2024.

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[1] The jail expansion plan originated in 2015 with a proposal to construct a new unit at the jail at a cost of $61.6 million dollars, with the state of California providing $54.3 million and Alameda County providing an additional $7.2 million. The new plan greatly expands the scope and design of the original plan.

DRAFT

Rather than spend 26.6 million dollars to construct a new building at Santa Rita Jail (which would constitute a "Jail First" policy), the MHAB believes that the County must invest in the kind of facilities and programs which will both divert mentally ill people out of jail and into medically appropriate treatment and will support those who are at risk of becoming incarcerated.

Moreover, the MHAB questions the rationale of building the new MHPSU to accommodate the additional ACBH staff at the jail. According the most recent figures from the experts who are assisting in the *Babu* Consent Decree, as much as 70% of ACBH positions at the jail are still vacant, three years later.

Finally, while Santa Rita Jail has a rated capacity of over 3,700 incarcerated people, it is currently half-full, today holding less than 1,800 individuals, with proposals to reduce that number through the Reimagining Adult Justice initiative and no evidence that the population will increase in the future. Notably, the original staffing analysis on which the *Babu* settlement was based assumed a jail population of as many as 3,000 persons. The MHAB questions whether all the unused space at the jail could be repurposed and redesigned, as opposed to constructing a new 81-million-dollar building.

For all these reasons, the MHAB recommends that the Board of Supervisors put the Jail Expansion Project on hold and instead prioritize investments in community-based services that have been proven to reduce crime and recidivism.

Please don't hesitate to contact the MHAB if you have any questions.

Respectfully,

Brian Bloom
MHAB Interim Chair

DRAFT

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510-567-8100 / TTY 510-533-5018
Karyn L. Tribble, PsyD, LCSW

Communication from the Office of the ACBH Director -

DATE: **May 8, 2023**

TO: **Alameda County Mental Health Advisory Board (MHAB)**

FROM: Karyn L. Tribble, PsyD, LCSW | Director

CC: Office of the ACBH Director, MHAB Communications

SUBJECT: ACBH Departmental Response to the MHAB Presentation to the Alameda County Board of Supervisors' Joint Health/Public Protection Committee (October 24, 2022) – Agenda Item Link

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Greetings, Mental Health Advisory Board (MHAB) Members:

As you know, on Monday, October 24, 2022 Executive Members of your MHAB presented an Informational Item entitled "***Alameda County Mental Health Advisory Board Annual Report Fiscal Year 2021-2022***," during a joint Board of Supervisors' (BOS) Health and Public Protection Committee Meeting.

As requested by former Supervisor, Honorable Richard Valle, and supported by your MHAB Leadership, the following information has been provided in response to the recommendations included within the October 24, 2022 MHAB Presentation. For your consideration, comment, and review this document and the corresponding presentation (including reference materials the MHAB Executive Committee provided during the October 2022 presentation to the BOS Committee) have also been attached.

I sincerely hope that the information provided is responsive to your queries, but I am happy to provide in any additional information as requested at any time and during the Mental Health Advisory Board meeting scheduled for Monday, May 15, 2023.

Please see the departmental response to each of the ten (10) Fiscal Year (FY) 2021-2022 MHAB Annual Report recommendations.

Thank you for your time and attention in this matter.

Respectfully submitted.

Alameda County Mental Health Board Annual Report Recommendations (excerpt from the October 24, 2023 presentation, Slide 7):

ANNUAL REPORT: RECOMMENDATIONS SUMMARIZED

1. Conduct a comprehensive needs assessment and evaluation of existing programs serving the seriously mentally ill in Alameda County.
2. Fully fund ACBH's Forensic Plan.
3. Expand the capacity of court-based and other diversion programs.
4. Create Full-Service Partnerships ("FSPs"), Collaborative Courts, and other programs focused specifically on the needs of those who suffer from Co-Occurring Disorders.
5. Expand the services and capacity of the Safe Landing Project.
6. Expand Effective Full-Service Partnerships ("FSPs").
7. Significantly increase the capacity of residential treatment beds countywide (including those at Villa Fairmont) to ensure that effective, humane treatment is available at all levels of need.
8. Provide better treatment options for incarcerated individuals who are "5150'd" from Santa Rita Jail to John George Psychiatric Hospital.
9. Support the repeal of the IMD (Institution for Mental Disease) Medicaid Exclusion.
10. Prioritize strategies to address the mental health workforce shortage.

7

ACBH Departmental Response

1) **Conduct a comprehensive needs assessment and evaluation of existing programs serving the seriously mentally ill in Alameda County.**

ACBH Response: *ACBH believes that a comprehensive needs assessment and evaluation of the existing programs serving the seriously mentally ill (SMI) population across Alameda County is a critical aspect of program planning and is fundamentally important to the work of any governmental jurisdiction.*

Several State-sponsored initiatives have prompted recent assessments including, but not limited to, activities related to Behavioral Health Continuum Infrastructure Program (BHCIP) planning, California Advancing and Innovating Medi-Cal (CalAIM); as well as changes at the Federal Level such as the launch of "988" designed to redirect system calls and response through a centrally coordinated number across the county as opposed to reliance upon 911. Planning and preparation associated with these initiatives have prompted the department to engage in a thoughtful approach to system assessment, performance evaluation, and program/systems gap analyses.

Additionally, the department's efforts related to improving quality overall are linked with this focus on system assessment. Given the numerous new and pending legislative proposals currently being considered by the State of California, including but not limited to, CARE Courts (Community, Assistance, Recovery, and Empowerment), ACBH recognizes that any further system assessment must be informed by the implementation and analysis of such programs in order to ensure that a comprehensive assessment is responsive to the ever-changing landscape of behavioral health programs and service entitlements available to the SMI and broader county community, overall. The initiation of a formal needs assessment prior to the implementation of new programs, therefore, will be an incomplete picture of overall county need and will not likely fully represent the breadth and depth of need experienced by SMI individuals and families.

As noted in the County's Grand Jury Response, the department maintains that it utilizes several strategies to evaluate county-wide needs and gaps, including recent Mental Health Services Act (MHSA) outreach and other strategies since 2015. Although it does not approach this this type of assessment from a single, "needs/gaps" viewpoint, ACBH does instead evaluate current programs, client services, utilization and demographic data, systems of care, and location to determine whether additional investment, expansion, or program recalibration is needed.

For example, MHSA Community Program Planning (CPP) is the state-mandated, community collaboration process that is used to: assess the current capacity, define the populations to be served and determine strategies to provide effective MHSA-funded programs that are: (1) Culturally Competent; (2) Client and Family-Driven; (3) Wellness, Recovery and Resilience-focused; and (4) Provide an Integrated Service Experience for Clients and their Families.

An External Quality Review (EQR) is another method the department undertakes twice yearly, and it is the analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid beneficiaries. The EQR results in the generation of an annual EQR technical report. This report includes an analysis of system needs, and how the department meets these standards system wide.

Network adequacy is often defined as having enough providers within a health plan network to ensure reasonable and timely access to care. At a minimum, health plans, such as ACBH (Mental Health Plan and a Drug MediCal Health Plan) should include enough providers who deliver mental health and substance use disorder (SUD) services (collectively referred to in this report as behavioral health services) to support access to those services. Beyond a minimum number of providers, adequate networks should have an appropriate geographic distribution of providers who have the capacity to deliver a wide range of services that align with enrollees' needs.

Federal Network Adequacy rules governing managed health care plans, including those operated by ACBH, require that states (through counties) have the following responsibilities:

- *Develop and implement time and distance standards for primary and specialty care (adult and pediatric),*

- *Develop and implement timely access standards for long-term services and supports (LTSS) providers who travel to the beneficiary to provide services; and*

- *Assess and certify the adequacy of a managed care plan's provider network at least annually.*

In this case, as ACBH serves as the managed care plan for both mental health and substance use beneficiaries, we are consistently evaluating our system needs both as a regulatory practice but also to evaluate the performance of our county clinics and providers in relation to service delivery needs and responsiveness.

In 2020, ACBH recalibrated its Forensic System Redesign & Stakeholder work to include a comprehensive plan to serve forensically-involved behavioral health clients. This work included an (1) External Stakeholder Process; (2) Extensive Department-wide Internal Research, Planning & Direct Stakeholder Engagement (In-reach/ Outreach); and (3) Consultation from content experts. The resulting plan helped the department to identify short, medium, and long-term objectives to increase and improve upon behavioral health services for forensically-involved clients; as well as recommending improvements to the county behavioral health system overall.

In early February 2022, ACBH also partnered with California Institute for Behavioral Health Solutions (CIBHS) and Equity and Wellness Institute (EqWi) to lead the efforts in a strategic planning process, in which the department is actively engaged at this time. The strategic planning process has included a variety of strategies to enable clients, family members, stakeholders, organizations, community partners, and governmental agencies to help identify system needs, gaps, and strategies to better inform ongoing departmental planning. This systemwide opportunity for input will help to inform the data gathering already underway through the avenues noted above and will also serve to further enhance the development of systemwide needs assessment. It is anticipated that the ACBH Strategic Planning stakeholder sessions will provide key data to inform the Department and its stakeholders and will be available by early 2024.

2) **Fully fund ACBH's Forensic Plan.**

ACBH Response: *It should be noted that this item was presented to County BOS Leadership (during the October 24, 2022 Board Meeting). As a result, ACBH cannot make determinations regarding funding as it relates to overall county operations. However, ACBH can provide an update that was presented by the county's Chief Administrator's Office (CAO) during a more recent Board Work Session. As a result of this presentation, the BOS approved ACBH to continue to allocate funding towards the implementation of the Forensic Plan by an additional inclusion of $9 Million Dollars in its overall departmental budget. If approved through the county budgeting process, these resources will be allocated to the Forensic Plan as approved and directed by the County BOS' beginning in Fiscal Year 2023-2024 (as of July 1, 2023).*

According to this April 25, 2023 *CAO Presentation to the Board of Supervisors (Special Meeting), an overall funding gap is anticipated in Fiscal Year 2024-2025, at approximately $6.8M dollars; and later increasing to $32.3M dollars thereafter in future fiscal years.*

Additional consideration of county allocations of funding towards the ACBH Forensic Plan continues to be at the discretion of County Leadership, beyond any internal resources allocated by department.

3) **Expand the capacity of court-based and other diversion programs.**

ACBH Response: *ACBH agrees that it will continue to expand upon existing court-based and other diversion programs. The department has already expanded several court programs last fiscal year, and as a result of changes to populations including those experiencing substance use disorder issues and/or those at risk of homelessness and other factors, ongoing assessment and expansion is aligned with current planning as resources are identified.*

4) **Create Full-Service Partnerships ("FSPs"), Collaborative Courts, and other programs focused specifically on the needs of those who suffer from Co-Occurring Disorders.**

ACBH Response: *ACBH agrees that it will continue to create and expand upon FSP, collaborative courts, and other programs targeting individuals with co-occurring disorders. The department has already begun preparing for pending legislative changes which is intended to both provide a path forward for enabling persons with substance use disorder conditions to be treated psychiatrically through the changes to existing Lanterman-Petris-Short (LPS) laws; and through the CARE Courts program. Additionally, ACBH is already developing plans to re-invest dollars allocated to Alameda County through Opioid Settlement dollars to combat this epidemic through a variety of strategies. In addition to the above, ACBH anticipates the*

creation of new programs relying upon FSPs to be consistent with planning as it relates to the legally required implementation of CARE Courts. As such, the department has already begun planning for the expansion of programs as highlighted and named above.

5) **Expand the services and capacity of the Safe Landing Project.**

ACBH Response: *During this past year, ACBH has worked with the Alameda County Sherriff's Office (ACSO) to identify adequate space and facilities to accommodate the 100% increase in augmented contracted services already allocated to the Safe Landing Project in the last fiscal year. As such, this recommendation is already in progress and is subject to the availability of said space to allow for the increase of dedicated staff and program growth supported by the current community based organization (CBO) providing the Safe Landing services. Additional expansion beyond the doubling of the program will be evaluated on an ongoing basis and through the department's Forensic, Diversion, and Re-Entry Services System of Care.*

6) **Expand Effective Full-Service Partnerships ("FSPs").**

ACBH Response: *See also ACBH response to Item #4. ACBH has also completed a Fidelity review to ensure that clinical programs, including FSP programs, are providing services consistent with the appropriate evidenced based model. To that end, Fidelity results indicated that "effective" programming is most closely aligned with providers associated with these proven models. As of Fiscal Year 2021-2022, all FSPs were found to be aligned with evidence-based models and programming. Operational leadership continues to monitor performance of contracted providers to evaluate performance differences based upon location, staff demographics, and operational approaches specific to a particular provider and the overall impacts to clients. When workforce and staffing issues were identified, the department also concluded that contracted programs who were able to fully staff such services were correspondingly more apt to continually demonstrate successful trends and outcomes. The latter finding reinforced the department's ultimate decision to release $80,000 - $88,000 per provider in 'mini grants' (increased contract allocations) to system providers that could be flexibly applied to innovative workforce recruitment, retention, or hiring practices not otherwise funded through traditional billing or contract agreements.*

To date, FSP programs system wide continue to show significant positive trends in client outcomes such as reducing and preventing re-incarceration, hospitalization, and length of stay in psychiatric facilities. Overall, system trends continue to demonstrate that ACBH and CBO FSP programs are effective and will continue to be expanded upon as appropriate, required, and as funding permits.

7) **Significantly increase the capacity of residential treatment beds countywide (including those at Villa Fairmont) to ensure that effective, humane treatment is available at all levels of need.**

ACBH Response: *ACBH has already committed to increasing the capacity of residential treatment beds through consistent and proactive application submissions for BHCIP and Community Care Expansion Program (CCE) opportunities, with much success. During the prior fiscal year, the department also began working with the current contracted CBO provider of sub-acute services (i.e., Villa Fairmont) to restore the eighteen (18) beds contracted out to other counties by prior ACBH Leadership in 2017. As of April 2023, ACBH had identified funding for ten (10) of those 18 beds, slated for use effective of July 1, 2023; and is aggressively identifying funding for the remaining eight (8) which will also be restored to support the needs of Alameda County residents suffering from SMI conditions.*

Although the department believes that a reliance upon voluntary or outpatient treatment is most advantageous to persons recovering from severe mental illness, ACBH also recognizes the significant needs system wide and will continue to work towards providing a variety of services to those who require this level of support.

8) **Provide better treatment options for incarcerated individuals who are "5150'd" from Santa Rita Jail to John George Psychiatric Hospital.**

ACBH Response: *Although the item was directed to the County BOS, ACBH is unable to respond on their behalf given the current structural oversight and authority afforded by the County to the Alameda Health System Board of Trustees. However, ACBH is currently working within and across the system, including with Alameda Health System (who operates John George Psychiatric Hospital), to identify strategies designed to improve psychiatric treatment to incarcerated individuals. It is important to note that the County does not currently operate its own psychiatric inpatient unit within or outside of Santa Rita Jail.*

9) **Support the repeal of the IMD (Institution for Mental Disease) Medicaid Exclusion.**

ACBH Response: *ACBH is currently evaluating the impacts of the IMD Exclusion (Section 1115(a) Demonstration Opportunity: "IMD Exclusion Waiver") including those related to certain federally-guided requirements associated with the Waiver.*

Section 1115 demonstration waivers for serious mental illness (SMI) and serious emotional disturbance (SED) for youth is a complex issue. Guidance has been issued by the Centers for Medicare & Medicaid Services (CMS) in November 2018 which allows states to pay for short-term psychiatric care for adults in Institutions of Mental

Disease (IMD) settings. In addition, states may also seek Medicaid payment for services provided to individuals 21 years of age or younger in settings that do not meet CMS requirements to qualify for the inpatient psychiatric services for individuals under age 21 benefit (commonly referred to as the psych under 21 benefit).

In order to receive demonstration approval, states must meet several criteria, including providing access to a continuum of mental health services, use of a utilization review entity, and certain provider requirements. ACBH's analysis is based upon the following areas required by and allowed for through the 1115(a) Demonstration Opportunity (IMD Exclusion Waiver):

- *Allows the 115 waiver process to cover short-term stays in IMDs **if** certain conditions are met focused on increasing high-quality of care.*

- *Short-Term stays **are limited to 60 days**, with a state-wide average of 30 days.*

- *California's expansion of SUD services obtained through a similar waiver which:*
  - *Strengthens continuum of SUD services under the Drug MediCal Organized Delivery System; and*
  - *Allows counties to claim federal reimbursement for SUD residential treatment.*

- *Counties with longer average length of stays (beyond 60 days) that impact the State of California's average length of stay requirement of 30 days, may potentially place into jeopardy the state's ability to maintain this federal waiver at all.*

As a result of the above, and other factors, ACBH is continuing to seek state and professional consultation regarding whether/not it will opt into this opportunity at this time despite significant length of stay improvements seen systemwide.

10) **Prioritize strategies to address the mental health workforce shortage.**

ACBH Response: *Again, as noted throughout this document, ACBH is unable to comment on behalf of county leadership. However, the department continues to engage in several activities designed to support the prioritization of the mental health (behavioral health) workforce shortage.*

Those strategies include, but are not limited to;

- *Contract augmentations for Community Based provider organizations;*

- *The realignment of the Workforce, Education, and Training (WET) Unit to the Office of the ACBH Director in the Fall of 2022;*

- *The development of new/novel civil service classifications targeting recruitment of behavioral health specialties through salary incentives;*

- *Expanded use of Sign-On bonuses, longevity pay, and loosening of loan assumption eligibility requirements; and*

- *Increased focus on Peer-based work positions, including the investment in Peer Certification Programs, staffing, and a more diverse workforce.*

It is my sincere hope that the above responses sufficiently articulate ACBH's commitment to the county system, as well as respond directly to the underlying data and assumptions presented through the MHAB annual report recommendations. As noted previously, ACBH stands ready to provide additional information, clarity or response should that be need in relation to this item.

Thank you.

Alameda County Behavioral Health Care Services

acbh

Departmental Update: 2023

Mental Health Advisory Board (MHAB) Presentation: June 21, 2023

MHAB Fiscal Year 2021-2022 Annual Report – Departmental Response

Presenter:

Karyn L. Tribble, PsyD, LCSW | ACBH Director

Overview:

- Context & Background
- MHAB Fiscal Year (FY) 2021-2021 Recommendations Review
- Departmental Response (Questions 1-10)
- Summary & Departmental Next Steps

Context & Background

Purpose and Intended Audience for MHAB Annual Report Presentation

Purpose & Intended Audience

- **Alameda County Board of Supervisors' Meeting:**
  - Joint Health & Public Protection Committee Hearing
- **Renewed focus on System Review & MHAB Statutory Functions & Role**
- **Provide an Update to the BOS for Informational Awareness:**
  - With recommended Action

MHAB FY 2021-22 Recommendations:

Review & Summary

Source:

Alameda County Board of Supervisors' Special Meeting & Joint Health & Public Protection Committee Hearing

Alameda County MHAB Presentation
Monday, October 24, 2022 – 9:30am
Link – BOS Health Committee (acgov.org)

1. **Conduct a comprehensive needs assessment and evaluation of existing programs serving the seriously mentally ill in Alameda County.**
2. **Fully fund ACBH's Forensic Plan.**
3. **Expand the capacity of court-based and other diversion programs.**
4. **Create Full-Service Partnerships ("FSPs"), Collaborative Courts, and other programs focused specifically on the needs of those who suffer from Co-Occurring Disorders.**
5. **Expand the services and capacity of the Safe Landing Project.**
6. **Expand Effective Full-Service Partnerships ("FSPs").**
7. **Significantly increase the capacity of residential treatment beds countywide (including those at Villa Fairmont) to ensure that effective, humane treatment is available at all levels of need.**
8. **Provide better treatment options for incarcerated individuals who are "5150'd" from Santa Rita Jail to John George Psychiatric Hospital.**
9. **Support the repeal of the IMD (Institution for Mental Disease) Medicaid Exclusion.**
10. **Prioritize strategies to address the mental health workforce shortage.**

Recommendation #1

"Conduct a comprehensive needs assessment and evaluation of existing programs serving the seriously mentally ill in Alameda County."

Departmental Response:

- **In Agreement**:

ACBH believes that a comprehensive needs assessment and evaluation of the existing programs serving the seriously mentally ill (SMI) population across Alameda County is a critical aspect of program planning and is fundamentally important to the work of any governmental jurisdiction. Planning and preparation associated with many county, state, and federal initiatives continue to require that the department engage in a thoughtful approach to system assessment, performance evaluation, and program/systems gap analyses.

Recommendation #2

"Fully fund ACBH's Forensic Plan."

Departmental Response:

- **Contingent Upon BOS Direction & County Action**:

It should be noted that this item was presented to County BOS Leadership (during the October 24, 2022 Board Meeting). As a result, ACBH cannot make determinations regarding funding as it relates to overall county operations. However, ACBH can provide an update that was presented by the county's Chief Administrator's Office (CAO) during a more recent Board Work Session. As a result of this presentation, the BOS approved ACBH to continue to allocate funding towards the implementation of the Forensic Plan by an additional inclusion of $9 Million Dollars in its overall departmental budget. If approved through the county budgeting process, these resources will be allocated to the Forensic Plan as approved and directed by the County BOS' beginning in Fiscal Year 2023-2024 (as of July 1, 2023).

Recommendation #3

"Expand the capacity of court-based and other diversion programs."

Departmental Response:

- **In Agreement:**

ACBH agrees that it will continue to expand upon existing court-based and other diversion programs. The department has already expanded several court programs last fiscal year, and as a result of changes to populations including those experiencing substance use disorder issues and/or those at risk of homelessness and other factors, ongoing assessment and expansion is aligned with current planning as resources are identified.

Recommendation #4

"Create Full-Service Partnerships ("FSPs"), Collaborative Courts, and other programs specifically on the needs of those who suffer from Co-Occurring Disorders."

Departmental Response:

- **In Agreement:**

ACBH agrees that it will continue to create and expand upon FSP, collaborative courts, and other programs targeting individuals with co-occurring disorders. The department has already begun preparing for pending legislative changes…(and)…ACBH is already developing plans to re-invest dollars allocated to Alameda County through Opioid Settlement dollars to combat this epidemic through a variety of strategies.

Recommendation #5

"Expand the services and capacity of the Safe Landing Project."

Departmental Response:

- **Completed:**

During this past year, ACBH has worked with the Alameda County Sherriff's Office (ACSO) to identify adequate space and facilities to accommodate the 100% increase in augmented contracted services already allocated to the Safe Landing Project in the last fiscal year. As such, this recommendation is already in progress and is subject to the availability of said space to allow for the increase of dedicated staff and program growth supported by the current community based organization (CBO) providing the Safe Landing services. Additional expansion beyond the doubling of the program will be evaluated on an ongoing basis and through the department's Forensic, Diversion, and Re-Entry Services System of Care.

Recommendation #6

"Expand Effective Full-Service Partnerships ("FSPs")."

Departmental Response:

- **In Agreement & In Progress:**

ACBH has also completed a Fidelity review to ensure that clinical programs, including FSP programs, are providing services consistent with the appropriate evidenced based model. To that end, Fidelity results indicated that "effective" programming is most closely aligned with providers associated with these proven models.

Overall, system trends continue to demonstrate that ACBH and CBO FSP programs are effective and will continue to be expanded upon as appropriate, required, and as funding permits.

Recommendation #7

"Significantly increase the capacity of residential treatment beds countywide (including those at Villa Fairmont) to ensure that effective, humane treatment is available at all levels of need."

Departmental Response:

- **In Agreement. Subject to BOS Approval, ACBH targeting July 1, 2023 start date:**

ACBH has already committed to increasing the capacity of residential treatment beds through consistent and proactive application submissions for BHCIP and Community Care Expansion Program (CCE) opportunities, with much success. During the prior fiscal year, the department also began working with the current contracted CBO provider of sub-acute services (i.e., Villa Fairmont) to restore the eighteen (18) beds contracted out to other counties by prior ACBH Leadership in 2017.

Recommendation #8

“Provide better treatment options for incarcerated individuals who are “5150’d” from Santa Rita Jail to John George Psychiatric Hospital.”

Departmental Response:

- **In Agreement:**

Although the item was directed to the County BOS, ACBH is unable to respond on their behalf given the current structural oversight and authority afforded by the County to the Alameda Health System Board of Trustees. However, ACBH is currently working within and across the system, including with Alameda Health System (who operates John George Psychiatric Hospital), to identify strategies designed to improve psychiatric treatment to incarcerated individuals. It is important to note that the County does not currently operate its own psychiatric inpatient unit within or outside of Santa Rita Jail.

Recommendation #9

"Support the repeal of the IMD (Institution for Mental Disease) Medicaid Exclusion."

Departmental Response:

- **Under Consideration:**

ACBH is currently evaluating the impacts of the IMD Exclusion (Section 1115(a) Demonstration Opportunity: "IMD Exclusion Waiver") including those related to certain federally-guided requirements associated with the Waiver.

Recommendation #10

"Prioritize strategies to address the mental health workforce shortage."

Departmental Response:

- **In Agreement:**

...the department continues to engage in several activities designed to support the prioritization of the mental health (behavioral health) workforce shortage.

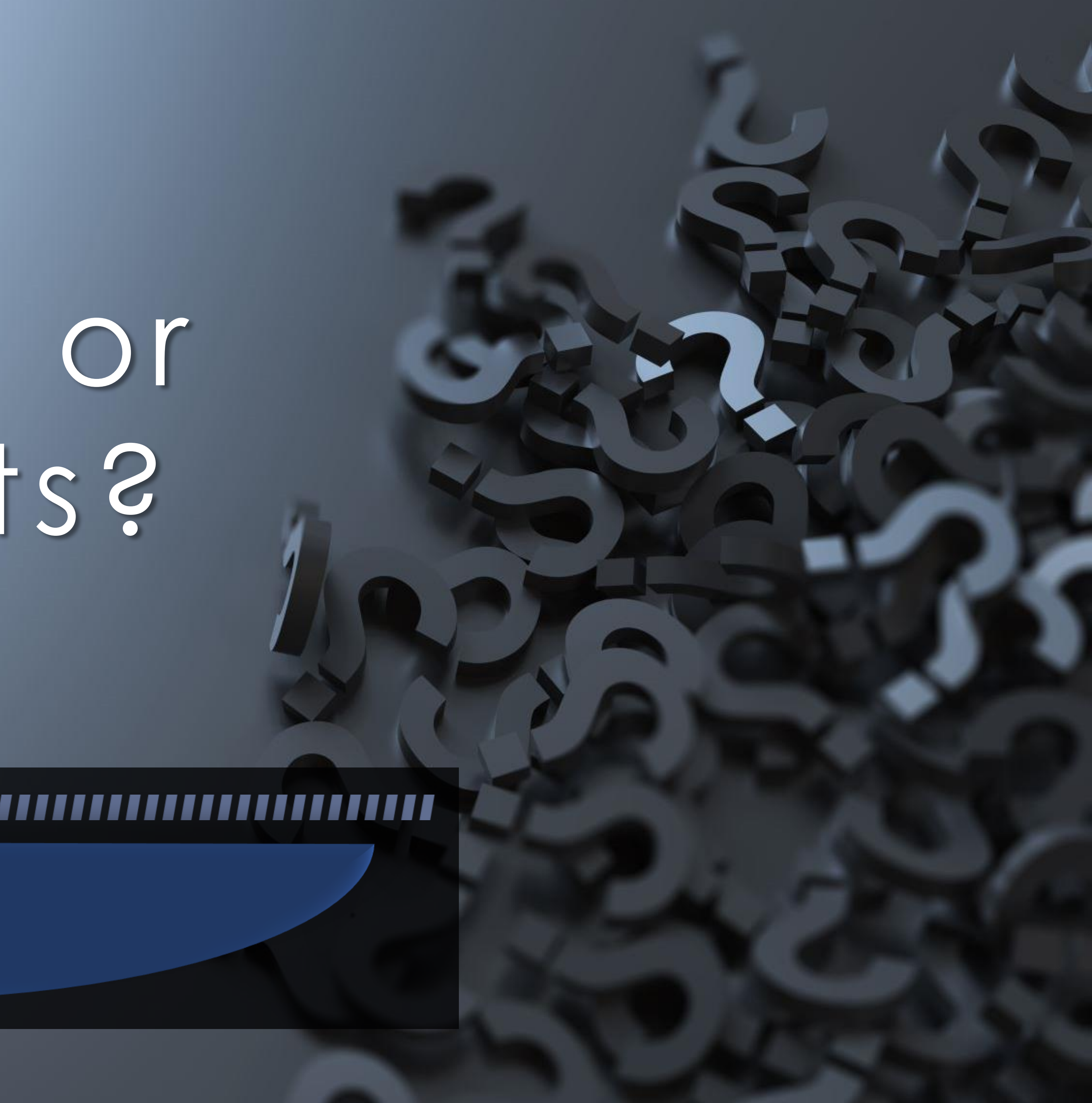
MHAB FY 2021-22 Recommendations:

Departmental Response Summary

- **General Support for MHAB Recommendations to the Alameda County Board of Supervisors.**
- **Departmental strategies to implement several of these recommendations have already been underway:**
  - Quality Improvement Efforts
  - Forensic Planning & System Enhancements
  - Regulatory and Required Changes
  - Network Adequacy & Local Need/State Requirements
- **Some recommendations are beyond the control of the Department, requiring consideration of BOS or County action or fiscal and budgetary considerations.**

Departmental Next Steps:

- **Continue to improve responsiveness to, and coordination with the MHAB;**
- **To implement and continually engage in Quality Improvement efforts system-wide, including those involving stakeholder planning;**
- **To fully implement all new and required legislative and regulatory changes; and to**
- **Prioritize the application of "True North Metrics" in Decision-Making & Departmental Trajectory:**
  - Quality; Investment in Excellence; Accountability; Financial Sustainability; & Outcome-Driven Goals.



Questions or Comments?

THANK YOU

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, June 14, 2023 11:37 AM
To: Works-Wright, Jamie
Subject: FW: MHSA act information.

Hello Commissioners,

Please see the information below from commissioner Glenn Turner

Jamie Works-Wright
Consumer Liaison
Jworks-wright@berkeleyca.gov
510-423-8365 cl
510-981-7721 office

Please be aware that e-mail communication can be intercepted in transmission or misdirected. The information contained in this message may be privileged and confidential. If you are NOT the intended recipient, please notify the sender immediately with a copy to HIPAAPrivacy@cityofberkeley.info and destroy this message immediately.

From: Glenn Turner <glennt13@gmail.com>
Sent: Wednesday, June 14, 2023 9:52 AM
To: Works-Wright, Jamie <JWorks-Wright@berkeleyca.gov>
Subject: MHSA act information.

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

Hi Jamie,
The group I am involved with FASMI (Families Advocating for the Seriously Mentally Ill) has a position paper on this topic that I want to share with our commission before our meeting tomorrow. Can you send this? or is it too late to send?

https://acfasmi.org/modernizing-the-mhsa/

The MHSA & "Modernization"

The MHSA & Proposed Changes

Background

In 2004, California voters approved **Proposition 63**, which imposed a 1% tax on personal income in excess of $1 million per year. The result was establishment of the **Mental Health Services Act (MHSA)** which was designated to expand and transform California's behavioral health system to **better serve people with – or at risk for – serious mental illness, and their families**. The funds **may only be used to pay for MHSA programs.**

The MHSA addresses a broad range of prevention, early intervention, service needs, infrastructure, technology and training issues and programs. Originally, the law was intended to supplement the already existing behavioral health funding sources so as to expand the services available for the seriously mentally ill (SMI), including preventing relapse in persons who have been treated before. However, as counties began to use the MHSA funds to maintain current levels of the services, the MHSA gradually *supplanted* the other funding available and it became the only stable source of funding for existing SMI services rather than expanding the services. [fn1]

The MHSA Oversight & Accountability Commission (MHSOAC) was established to monitor use of the funds. Each County is required to prepare and submit a 3-Year Program/Expenditure Plan & Annual Updates to the oversight committee. However, the commission has been ineffective and has consistently approved programs that do not meet the priority criteria of the MHSA.

There has been constant pressure to include persons with substance use disorders among those served by the MHSA. In an amendment Act (signed into law on 10/6/21), the legislature expanded the law. Under the amended law, MHSA funds may now be used "to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these *services, including prevention and early intervention strategies that address mental health needs, substance misuse or substance use disorders,* ***or needs relating to co-occurring*** *mental health and substance use* services." [fn2]

"Modernization"

Governor Newsom has a very broad vision to change California law and spending to "serve mental health needs, substance use disorders and homeless[ness]." In 2023, he is continuing to propose changes that reflect his conflated view of these three foundational issues. [fn3] Unfortunately, some proposals could hurt rather than help the SMI.

In 2023, the Governor's focus is on what he calls "modernizing California's behavioral health system."

The key components of his package are to:

(1) Authorize a $3-5 million general obligation bond to be put on the 2024 ballot to fund "unlocked" behavioral health residential settings and provide housing for homeless veterans.

(2) "Modernize" the MHSA:

(a) Revise MHSA funding allocations to

(i)30% for housing & enhanced care in residential settings for individuals with SMI/serious emotional disturbance and/or substance use disorder (SUD)

(ii) 35% for FSPs and

(iii)35% for other services including non-FSP Community Services & Supports (CSS), Prevention & Early Intervention (PEI), Capital Facilities & Technical Needs, Workforce Education & Training, and prudent reserve.

(b) Authorize MHSA funding to provide treatment/services to persons with SUD without a co-occurring mental health disorder.

(c) Require counties to bill Medi-Cal for all reimbursable services.

(d) Reduce prudent reserve amounts from 33% to 20-25% depending on size of the county, to be reassessed more frequently.

(e) Authorize up to 2% of local revenue to fund administrative needs.

(f) Pare back the counties' requirements for three-year program/expense plans.

(g) Move the oversight commission to be under state agencies, as advisory only, with director to be a gubernatorial appointee.

(3) Improve statewide accountability and access to behavioral health services:

(a) Require county reports to have more detailed fiscal information including allocations and unspent funds

(b) Develop outcome measures, not just process measures.

(c) Require state departments to develop a plan to achieve parity between private and Medi-Cal benefits for mental health and SUD.

The Administration says it is working "in close partnership" with the State Legislature, as well as with the State Assn of Counties, other critical local government stakeholders, community-based service organizations, advocates, & people with lived experience as bill language is developed. We need to continue advocating for a "modernization" that truly benefits our SMI family member

FOOTNOTES:

[1] Even in the first decade of its implementation, the Act appeared to have been a "bait-and-switch" such that its funding was diverted and the SMI continued to go unprovided-for. See D.J. Jaffe, "California tax was bait-and-switch," 8/14/2013, https://www.sandiegouniontribune.com/opinion/commentary/sdut-california-tax-was-bait-and-switch-2013aug14-story.html

[2] MHSA Act (text) as of Jan. 2020: https://mhsoac.ca.gov/sites/default/files/MHSA%20Jan2020_0.pdf

[3] California Department of Health Care Services and California Health and Human Services Agency, March 2023, "Modernizing California's Behavioral Health Care System" https://www.chhs.ca.gov/wp-content/uploads/2023/03/Modernizing-Our-Behavioral-Health-System-v4.pdf

FASMI'S POSITION

Any modernization of the MHSA law must remain true to the mission of the original law approved by the voters of California in 2004. It must focus on the unmet treatment needs of those with serious mental illness. Over the years, revenue from the tax has been diverted to programs that serve broader social service goals that do

not help the vulnerable and underserved population for whom it was intended. We are concerned that some of the current proposals will open the door to further mission creep. General homelessness and substance abuse are problems that deserve resources and attention but – except for SUD with co-occurring SMI – these resources should not come from MHSA tax revenue. The SMI population needs a dedicated and stable funding source to allow counties to develop all aspects of a quality continuum of care.

GOOD THINGS ABOUT THE PACKAGE:

—It includes funding for thousands of beds' worth of housing, at least some of which is of the licensed, very supportive caliber we need for our family members

–It gives the counties more flexibility in determining which programs have or have not been meeting the needs of those with serious mental illness

–It demotes the Oversight Commission, which has not provided effective oversight and has not focused on serious mental illness

–It introduces regional rather than county planning

–It gives us a chance, through its emphasis on outcomes, to hold government accountable for keeping our family members alive and well.

PROBLEMS WITH THE PACKAGE:

It fails to make clear that MHSA money can be used for treatment in secure inpatient facilities, whether voluntary or involuntary.

–The original intent of MHSA was to assure funding for medically necessary treatment of people with SMI according to what they needed. By forgetting that, we are missing a chance to restore what might make MHSA actually work for our family members.

–It is a myth that a voluntary-only system will help all the seriously mentally ill. We agree that voluntary treatment is preferred, but we also know that for those who lack insight into their illness, intervention is often necessary to assure treatment. In time, involuntary treatment leads many to develop the insight they need to engage in voluntary treatment.

–The worst option is no treatment at all. Untreated SMI leads to increasing brain deterioration, despair, death, and sometimes violence.

The proposal fails to address serious dearth of beds in *secure* acute and subacute facilities.

–The wording of the proposal only allows for funding of *unlocked* residential housing. We were very disappointed to be told in listening sessions that NONE of the $3-5 billion from the bond measure would go to *secure* beds. MHSA funds may rightly be used to build secure, locked facilities and involuntary treatment services as long as the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

–The 2021 Rand report says the state needs 4,767 acute and subacute *secure* beds, using an analysis similar to what other organizations have been using for years. (This is separate and apart from the additional 2,963 community (*unlocked*) residential beds that the report says we need.)

–For years, our SMI family members have been waiting months for beds in subacute facilities, if they can get onto the waiting list at all. One of us had a family member wait FIVE YEARS in jail for a locked bed in a state hospital.

–The shortfall in secure beds can't be made up by other programs. The BHCIP program is almost over. The Medi-Cal SMI Waiver Demonstration Pilot program seems weak and half-hearted at best, has been delayed for years, and leaves counties to opt-in.

It does not guarantee that the residential beds would be sufficiently supportive for our family members. We know from harsh experience that people with SMI who need help the most need intensive supportive services, best provided by licensed facilities that have services onsite and manage medications for clients. Funding "housing" via thousands of motel rooms, single-room occupancy hotels, or tiny houses may help some highly-functioning individuals but are not a solution for everyone.

Expansion of the target population to include people with substance use disorders, even if they have no diagnosis of mental illness, will likely dilute the resources needed for the originally-intended beneficiaries of the MHSA.

–The Act was intended to be a reliable and dedicated source of funds to provide for the unmet needs of the SMI. The reality is that prioritization of SMI *hasn't* been honored. In fact, the MHSOA's oversight has consistently put less severe/urgent "mental health needs" ahead of SMI in terms of investment. *The oversight failure* ***does*** *need to be corrected, but NOT by basically codifying what the oversight has already been doing!* We are *concerned that the choices and priorities will continue to FAIL to prioritize the most vulnerable*.

–We insist that MHSA funds be *dedicated to the most serious cases – whether of mental illness or substance abuse – and NOT spread out to cover the less severe ones.*

—Further, the term "prevention" in the original Act was intended to mean *prevention of RELAPSE on the part of someone who has experienced a serious condition,* NOT merely a general attempt to "prevent" serious mental illness (as by way of generic promotion of mental health).

The proposal does not address the real need for more and improved public psychiatric hospitals in California.

— As expert sociologist Alex Barnard put it, the psychiatric beds that California has "are disproportionately controlled by private and for-profit providers" which are "reluctant to provide costly, long-term care to people with the most chronic illnesses." **Public**, state hospital beds are disproportionately given to forensic patients. So, we need more and better **public** psychiatric hospitals.

–Also, California's psychiatric beds are used ineffectively; research shows *that slightly longer hospitalizations actually reduce readmissions*, but because of inadequate space, patients are discharged too soon and the patients end up cycling in and out via involuntary holds.

–We are not done with the job of providing quality, medically necessary, secure facilities. The proposal talks of "state-of-the-art" facilities; it is essential that we build "state of the art" **public hospitals** that are soothing and supportive environments, built using state-of-the-art design principles that improve patient health & well-being. Instead of dreary, dark and ominous rooms, they should "set patients at ease," incorporate "strategies to 'humanize the space' [like those] that are employed in other healthcare environments.

We must have the necessary funding and political commitment to make those a reality. That would be a genuine "modernization" of the mental health system in our state.

More Resources for information

"What We Are Asking and Why." https://acfasmi.org/what-we-ask-for-and-why/.

California for All and Calif. Dept. of Health Care Services, **"Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts."** https://www.chhs.ca.gov/wp-content/uploads/2023/03/CalHHS-Behavioral-Health-Roadmap-_-ADA-03.02.23.pdf.

Governor's Press Release, March 19, 2023: https://www.gov.ca.gov/2023/03/19/governor-newsom-proposes-modernization-of-californias-behavioral-health-system-and-more-mental-health-housing/

Governor of the State of California, "Fact Sheet:" Modernizing Our Behavioral Health System & Building More Mental Health Housing." https://www.gov.ca.gov/wp-content/uploads/2023/03/FACT-SHEET_-Modernizing-Our-Behavioral-Health-System-1.pdf?emrc=d1f55d.

McBain, Ryan, and others, 2022, "Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021." Copyright RAND Corporation. https://www.rand.org/pubs/research_reports/RRA1824-1-v2.html