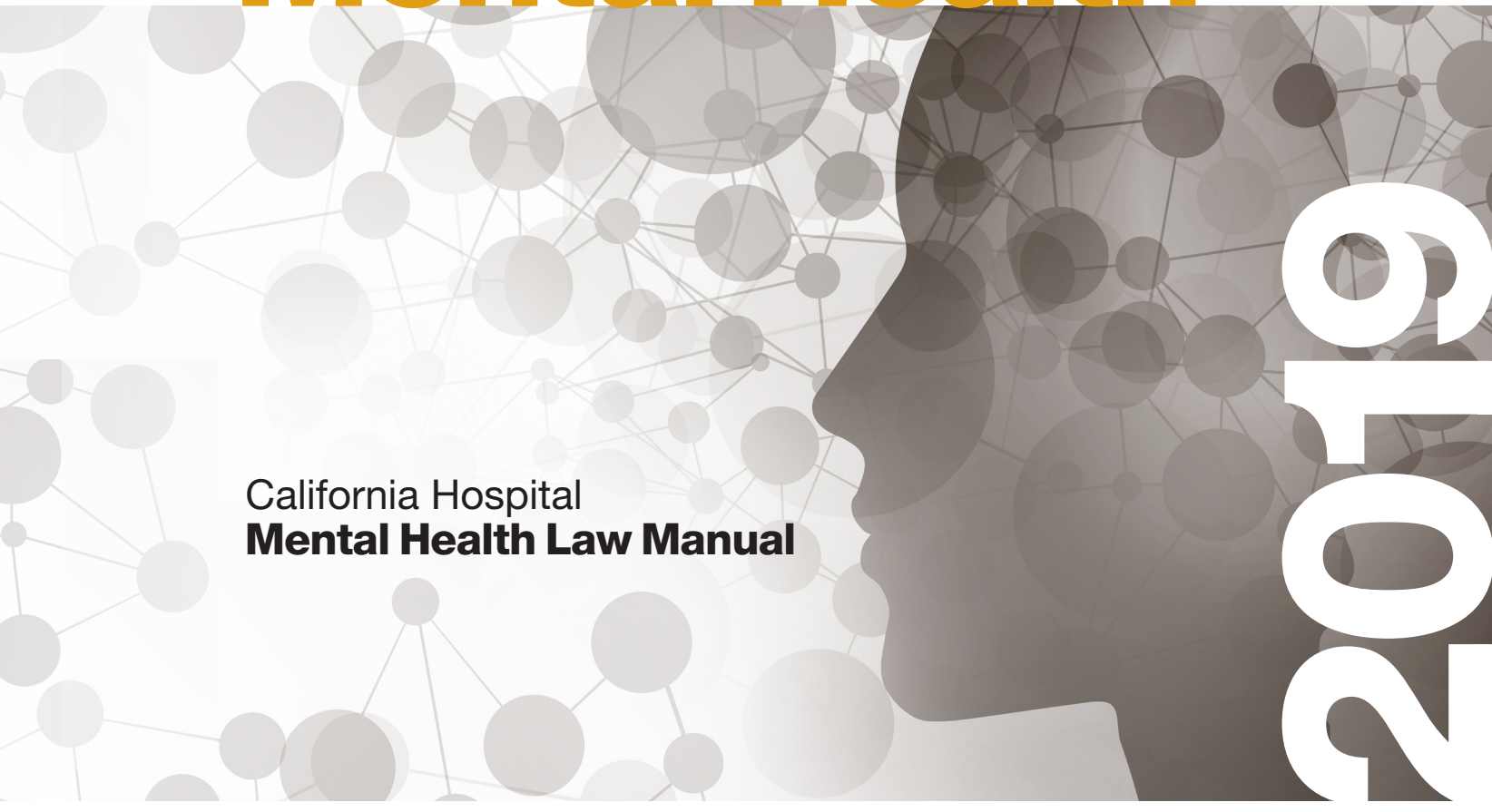
Mental Health



2019

California Hospital
Mental Health Law Manual

CALIFORNIA HOSPITAL ASSOCIATION

Mental Health Law Manual

A handbook on laws governing mental health treatment

September 2019
13th Edition

CALIFORNIA HOSPITAL ASSOCIATION

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Preface

Welcome to the thirteenth edition of the *Mental Health Law Manual* — a handbook on laws governing mental health treatment. The California Hospital Association has published this manual to help health care professionals understand the laws governing mental health treatment as well as the rights and protections of the patients they serve.

This manual is comprised of information taken from two other CHA publications: the *Consent Manual* and the *California Health Information Privacy Manual*. It also contains a chapter on the state and federal laws governing the use of seclusions and restraint. This edition reflects all state and federal legislation, regulations, and judicial decisions through January 2019.

We are pleased to publish this manual as a service to our members and others. We hope you will find it useful.

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Introduction

Providing care to patients with mental health issues is complicated. Knowing what is in the best interest of the patient — and what is legal — isn't always easy.

Special protections are afforded to individuals with mental health issues who may be unable to make rational decisions regarding their care. These individuals have the right to be treated by a provider who protects their interests and preserves their basic rights.

Medical information about mental health treatment is particularly sensitive and therefore add another layer of complexity to the treatment process. This information must be handled with the utmost of care. At the same time, disclosure of information to patient advocacy groups, clinical reviewers, county behavioral health directors and others is sometimes required. And, there are unique reporting requirements for facilities and individuals that treat mental health patients.

Sorting through the maze of laws governing mental health treatment is particularly difficult because there are multiple bodies of law. In this manual, all laws governing mental health treatment and medical privacy are discussed — the Lanterman-Petris-Short (LPS) Act, the Confidentiality of Medical Information Act (CMIA), the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and other state and federal laws.

At the back of the manual you will find sample forms and appendices that can be adapted to fit your specific operations. (These forms can also be found online for CHA members at www.calhospital.org/free-resources, along with Spanish versions where available.)

Where to Find Laws Referenced in the Manual

All of the laws discussed in the *Mental Health Law Manual* can be found on the Internet.

I. FEDERAL LAW

A federal statute is written by a United States Senator or Representative. It is voted on by the United States Senate and the House of Representatives, and then signed by the President. A federal statute is referenced like this: 42 U.S.C. Section 1395. "U.S.C." stands for "United States Code." Federal statutes may be found at www.gpo.gov/fdsys or at www.law.cornell.edu.

A federal regulation is written by a federal agency such as the U.S. Department of Health and Human Services or the U.S. Food and Drug Administration. The proposed regulation is published in the Federal Register, along with an explanation (called the "preamble") of the regulation, so that the general public and lobbyists may comment on it. The federal agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. The final regulation is also published in the *Federal Register*. A federal regulation is referenced like this: 42 C.F.R. Section 482.1 or 42 C.F.R. Part 2. "C.F.R." stands for "Code of Federal Regulations." Federal regulations may be found at www.gpo.gov/fdsys or at www.ecfr.gov. The preamble, however, is only published in the Federal Register and not in the Code of Federal Regulations. The Federal Register may be found at www.gpo.gov/fdsys or at www.federalregister.gov.

The Centers for Medicare & Medicaid Services (CMS) publishes its *Interpretive Guidelines* on the internet. The *Interpretive Guidelines* include information for surveyors on how CMS interprets the Conditions of Participation, and instructions for surveyors on how to assess hospitals' compliance with the Conditions of Participation. They may be found at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html (click on Publication 100-07, "State Operations Manual, then "Appendices Table of Contents"). There are several appendices that hospitals will find useful, for example, A (hospitals), AA (psychiatric hospitals), V (EMTALA), and W (critical access hospitals).

A federal law must be obeyed throughout the United States, including in California, unless the federal law expressly states otherwise. As a general rule, if a federal law conflicts with a state law, the federal law prevails, unless the federal law expressly states otherwise.

If there is no conflict, such as when one law is stricter but they don't actually conflict with each other, both laws generally must be followed. For example, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal law states that providers must conform to whichever provision of federal or state law provides patients with greater privacy protection or gives them greater access to their medical information.

II. STATE LAW

A state statute is written by a California Senator or Assembly Member. It is voted on by the California Senate and Assembly, and then signed by the Governor. A state statute is referenced like this: Civil Code Section 56 or Health and Safety Code Section 819. State statutes may be found at www.leginfo.legislature.ca.gov. Proposed laws (Assembly Bills and Senate Bills) may also be found at this website.

A state regulation is written by a state agency such as the California Department of Public Health or the California Department of Managed Health Care. A short description of the proposed regulation is published in the California Regulatory Notice Register, more commonly called the Z Register, so that the general public and lobbyists may request a copy of the exact text of the proposed regulation and comment on it. The state agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to

the proposed regulation based on the comments. A notice that the final regulation has been officially adopted is also published in the Z Register. The Z Register may be found at www.oal.ca.gov/notice_register.htm.

A state regulation is referenced like this: Title 22, C.C.R., Section 70707. "C.C.R." stands for "California Code of Regulations." State regulations may be found at www.calregs.com.

A state law must be obeyed in California only. As a general rule, if a California law conflicts with a federal law, the federal law prevails, unless the federal law expressly states otherwise. (If there is no conflict, such as when one law is stricter but they don't actually conflict with each other, both laws generally must be followed.)

List of Forms and Appendices by Chapter

These documents are provided in English in the back of the manual. All forms can be found online for CHA members at www.calhospital.org/free-resources, including Spanish versions, when available. "S" denotes that the form is provided in English and Spanish.

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1 Overview of Mental Health Laws

I. INTRODUCTION

State and federal law recognize that every adult with the capacity to make health care decisions has the fundamental right of self-determination over his or her body and property. A patient's right to determine the course of his or her own medical or mental health treatment may be limited by the government in only the narrowest of circumstances; for example, to protect the public health (in the instance of communicable diseases), and to protect vulnerable persons who may not be able to protect or care for themselves. In many cases, the latter category includes persons who may be seriously mentally ill.

Persons who are mentally ill may not recognize their need for medical or mental health treatment. Indeed, the very nature of their illness may cause them to resist the treatment they desperately need.

State and federal laws seek to balance the conflicting interests of seriously mentally ill persons. In limited circumstances, the liberty of a person who may be a danger to self or others or gravely disabled may be curtailed while that person undergoes mental health evaluation and/or treatment. Because our system of government recognizes the seriousness of curtailing a person's liberty for even a short time, laws permitting involuntary hospitalization include strong procedural and substantive protections to ensure that these citizens do not become the victims of abuse.

State and federal laws have also been enacted to provide protections for mental health patients who have not been involuntarily hospitalized, in recognition of the fact that even less seriously mentally ill patients may not be completely able to protect and advocate for themselves.

This manual describes the laws regulating mental health evaluation and treatment, whether voluntarily or involuntarily accessed by the patient. This manual also describes the rights and responsibilities of health care providers who evaluate and treat mental health patients.

II. THE LANTERMAN-PETRIS-SHORT ACT: INVOLUNTARY EVALUATION AND PATIENT RIGHTS

In California, the main law governing mental health evaluation and treatment is the Lanterman-Petris-Short (LPS) Act [Welfare and Institutions Code Section 5000 *et seq.*]. This law, enacted in 1967 (and amended many times since then), sets forth the procedures that law enforcement and health care providers must follow prior to involuntarily detaining a person for mental health evaluation and treatment. LPS also sets forth the rights of mental health patients, whether voluntarily or involuntarily admitted, and contains procedural requirements that must be followed prior to providing specified types of treatment to mental health patients. *(See chapters 3 and 4 for detailed information.)*

III. LAWS REGARDING RESTRAINT AND SECLUSION

Both state and federal law protect patients from the inappropriate use of seclusion and restraint, and establish requirements to be followed when the use of either intervention is necessary. A complete discussion of these requirements is found in chapter 5.

IV. PATIENT ADVOCACY PROGRAMS

Both state and federal law have appointed independent parties to safeguard the rights of mental health patients. The laws regarding patient advocates are found in chapter 4.

V. PRIVACY RIGHTS OF MENTAL HEALTH PATIENTS

Both the state and federal constitutions recognize the privacy rights of all individuals. Due to the sensitive nature of mental health information, many statutes and regulations have been enacted to provide confidentiality protections. A brief overview of these laws follows, with more detailed information in chapter 6.

The privacy of a patient's medical information, including the use of such information and its disclosure to third parties, is governed by both California and federal law. Specific state protections for medical information are provided in the Confidentiality of Medical Information Act (CMIA) [Civil Code Section 56 *et seq.*] and, for specified mental health patients, in LPS [Welfare and Institutions Code Section 5328 *et seq.*].

Both the CMIA and LPS govern the disclosure to third parties of patient-identifiable information by hospitals and other health care providers. These laws generally specify that health care providers may not disclose information relating to patients, their care and treatment, unless the disclosure is specifically authorized by law or by the patient. In addition, the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 protects medical information, including mental health information, held by hospitals, physicians, health plans and others.

A. State Law

California law provides heightened protection to information relating to mental health treatment delivered in institutional and other specified outpatient settings under LPS. In addition, the California legislature has seen fit to protect mental health treatment information through the creation of a psychotherapist-patient privilege instead of relying on the physician-patient privilege that applies to routine medical information but which has numerous exceptions.

MENTAL HEALTH TREATMENT INFORMATION PROTECTED BY LPS

Since 1969, LPS [Welfare and Institutions Code sections 5328-5328.9] has provided strict confidentiality protection to information and records obtained in the course of providing services to:

1. Patients who are treated or evaluated under Welfare and Institutions Code Sections 5150-5344. These code sections include involuntary evaluation and treatment in a designated facility for patients who are a danger to self or others or gravely disabled. These patients do not include patients who may be detained involuntarily for up to 24 hours in a non-designated hospital on an emergency basis (usually, but not always, in the emergency department) under Health and Safety Code Section 1799.111 (chapter 3 contains a thorough description of all of these patients); and
2. Patients who are receiving voluntary or involuntary mental health treatment in a:
    a. State mental hospital;
    b. County psychiatric ward, facility or hospital;
    c. University of California psychiatric facility: Langley Porter Psychiatric Institute and the Neuropsychiatric Institute at UCLA. Other University of California mental health services providers should consult University of California counsel regarding their status under LPS;
    d. Federal hospital, psychiatric hospital or unit;
    e. Private institution, hospital, clinic or sanitarium which is conducted for, or that includes a department or ward conducted for, the care and treatment of persons who are mentally disordered;
    f. Psychiatric health facility as described in Health and Safety Code Section 1250.2;
    g. Mental health rehabilitation center as defined in Welfare and Institutions Code Section 5675;
    h. Skilled nursing facility with a special treatment program service unit for patients with chronic psychiatric impairments *(see Title 22, California Code of Regulations, Sections 51335 and 72443-72475 regarding such special treatment programs)*;
    i. Community program funded by the Bronzan-McCorquodale Act. Because it is often difficult to determine which patients received services funded under the Bronzan-McCorquodale Act, each program and its legal counsel should review any funds received under the Bronzan-McCorquodale Act to determine the applicability, if any, of those confidentiality provisions as a result of such funding [Welfare and Institutions Code Sections 5600-5778]; and
    j. Community program specified in the Welfare and Institutions Code Sections 4000-4390 and Welfare and Institutions Code Sections 6000-6008.

LPS also protects information and records obtained in the course of providing services to persons with developmental disabilities. In some instances, overlapping protection is provided to records of such individuals under the Lanterman Developmental Disabilities Services Act [Welfare and Institutions Code Sections 4514-4518], whose provisions are substantially the same as the provisions of LPS and apply only to persons with developmental disabilities, primarily in settings other than private hospitals.

Although LPS became law in 1969, its confidentiality provisions apply to records and information obtained in the course of providing similar services to patients prior to 1969.

More information about the LPS confidentiality protections is found in chapter 6.

MENTAL HEALTH TREATMENT INFORMATION NOT PROTECTED BY LPS

Absent some tie-in to one of the above described programs, LPS does not apply to other mental health patients or their records, even though those records may describe mental health treatment similar to what is protected under LPS. These records are instead subject to the Confidentiality of Medical Information Act (CMIA) *(see chapter 6)*. For example, mental health services provided to a voluntary patient in a private general acute care hospital that has no psychiatric unit are subject to the CMIA rather than LPS. Mental health services provided to an involuntary patient in a private, non-designated hospital emergency department are subject to the CMIA rather than LPS. Mental health services provided by a consulting psychotherapist to a medical patient (who is not on a psychiatric hold) are subject to the CMIA rather than LPS. Also, mental health services provided by a private psychotherapist in the community are subject to the CMIA. The information generated by these psychotherapists does not fall under LPS.

More information about CMIA confidentiality protections is found in chapter 6.

PSYCHOTHERAPIST-PATIENT PRIVILEGE

The psychotherapist-patient privilege applies to patients covered by both LPS and CMIA. This privilege is relevant to health care providers only when patient information is requested for court proceedings, such as in response to a subpoena or court order, or for a deposition or testimony in court. Providers don't need to consider this privilege when using or disclosing information for treatment or payment purposes.

Under the psychotherapist-patient privilege [Evidence Code Section 1010 *et seq.*], a patient may refuse to disclose, and prevent other persons (such as the psychotherapist) from disclosing, the patient's confidential communication with a psychotherapist in the context of legal proceedings. **"Confidential communication"** refers to information, including information obtained by an examination of the patient, transmitted between a patient and his or her psychotherapist in the course of that relationship and in confidence by a means which, so far as the patient is aware, discloses the information to no third persons other than those who are present to further the interest of the patient in the consultation, or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the psychotherapist is consulted. Confidential communication also includes a diagnosis made and the advice given by the psychotherapist in the course of that relationship. [Evidence Code Section 1012]

The term psychotherapist includes psychiatrists, psychologists, licensed clinical social workers, school psychologists, marriage and family therapists, professional clinical counselors, psychological assistants, and various interns and trainees for such categories. Interestingly, the definition of psychotherapist also includes persons authorized, or reasonably believed by the patient to be authorized, to practice the professions listed above. Thus, California law seeks to protect the confidentiality of mental health information disclosed by patients so long as the patient reasonably believes that the professional receiving it is a psychotherapist, regardless of whether the person actually is a psychotherapist or not.

HIV TEST RESULTS

AIDS became recognized as a specific disease in the United States in 1981. Because of the stigma associated with the disease then, the California legislature gave HIV test results extra confidentiality protection in 1985. These strict laws are still on the books. The confidentiality protections afforded to HIV test results are discussed in chapter 6.

B. Federal Law

HIPAA

The state laws described above are augmented by federal privacy protections pursuant to HIPAA. HIPAA provides federal protection to all medical information, including mental health information, held by hospitals, physicians, health plans and other "covered entities." With the exception of a narrow category relating to psychotherapy notes, HIPAA does not distinguish between mental health and other forms of medical information. State provisions that are more stringent than HIPAA continue in effect; as a result, many of the California protections specific to mental health information continue to provide additional protection.

HIPAA calls for providers to conform to whichever federal or state law provides patients with greater privacy protection or with greater access to their own health information. Specifically, providers must comply with whichever *provision* of each law is more strict. Thus if HIPAA is more stringent than California law, with the exception of one provision, providers must comply with HIPAA and

the provision in state law that gives the individual greater protection.

HIPAA contains patient privacy rights including the right to a Notice of Privacy Practices, the right to access medical information, the right to request amendments, and the right to an accounting of disclosures, among others. These rights are discussed in chapter 6.

HIPAA also restricts the use and disclosure of medical information. These restrictions are described in chapter 6.

Psychotherapy Notes

HIPAA introduced the concept of "psychotherapy notes." There is no such concept in California law. **"Psychotherapy notes"** means:

> notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session *and that are separated from the rest of the individual's medical record*. (emphasis added)

Most hospitals, skilled nursing facilities, and other institutional providers will not have psychotherapy notes, as defined in HIPAA, because the definition requires the notes to be separate from the rest of the medical record.

The special provisions in HIPAA regarding the use and disclosure of psychotherapy notes must be complied with for all patient types in California — patients whose records are covered by the CMIA, patients whose records are covered by LPS, and patients receiving services in a federally-assisted drug or alcohol abuse program.

More information about psychotherapy notes is found in chapter 6.

FEDERALLY-ASSISTED SUBSTANCE USE DISORDER PROGRAMS

The federal government has promulgated confidentiality rules that apply to drug and alcohol abuse treatment programs. These rules do not apply to all substance abuse patients; they apply only to patients served by "federally-assisted programs." These rules are described in detail in CHA's *California Health Information Privacy Manual*, available online at www.calhospital.org/privacy.

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Forms and Appendices can be found at the back of the manual and online for CHA members at www.calhospital.org/free-resources.

"S" denotes that the form is provided in English and Spanish.

2 Principles of Consent for Mental Health Patients

I. INTRODUCTION

State and federal laws grant patients certain rights. Foremost among these is the right for a competent adult to make his or her health care decisions. A patient does not lose this right solely because he or she has been diagnosed with a psychiatric disorder. *(See "Required Statement of California Law," page 4.3.)* This chapter discusses the basic principles of consent, including when consent is necessary, the difference between "simple" consent and informed consent, how consent may be obtained, who may give consent and procedures that require special consent. *(See CHA's* Consent Manual *for a more detailed discussion of these topics with respect to nonmental health patients.)*

II. WHY CONSENT IS NECESSARY

Every competent adult has the fundamental right of self-determination over his or her body and property. Individuals who are unable to exercise their rights, such as minors and incapacitated adults, have the right to be represented by another person who will protect their interests and preserve their basic rights. In some cases, such as involuntary mental health treatment, the law determines when and how a person will be treated rather than requiring or permitting a surrogate decision maker to do so. However, involuntarily hospitalized mental health patients retain the right to consent to (or refuse) other types of medical care, unless a judge orders otherwise.

A. The Patient's Right to Consent to, or Refuse, Medical Treatment

A person does not give up the right to control what is done with his or her body and property when seeking care at a hospital or from a doctor or therapist. Indeed, a physician has both a legal and an ethical duty to obtain the patient's consent, or the consent of the patient's legal representative, to medical treatment.

Failure to obtain the proper consent to treatment in accordance with applicable legal standards may result in a charge of battery, professional negligence (malpractice), and/or unprofessional conduct against the physician, nurses or other health care providers, for even the simplest of procedures.

If the nature of the treatment involved is complicated, such that the average layperson would not understand it, or its risks and benefits (for example, ECT), the recognition of the patient's right to self-determination may require that "informed" consent be obtained. [*Cobbs v. Grant*, 8 Cal.3d 229 (1972)] The distinction between "simple" consent and "informed" consent is described in IV. "Informed Consent," page 2.5. In such a case, the physician must explain the nature of the treatment, the risks, possible complications, and expected benefits or effects of the treatment, as well as the alternatives to the treatment and their risks and benefits. The physician must also inform the patient of any potentially conflicting interests he or she may have, such as research or financial interests. Informed consent is not required for the performance of "simple and common" procedures, where the related risks are commonly understood — for example, typical outpatient psychotherapy.

FAILURE TO OBTAIN CONSENT: BATTERY

"Battery" is defined legally as an intentional touching of a person in a harmful or offensive manner without his or her consent. Consequently, a claim of battery may be made against a physician or other health care provider who performs a medical procedure on a patient without the patient's consent. A battery may also arise if the patient consents to a particular procedure and the provider either exceeds the scope of the consent or performs a different procedure for which consent was not obtained. It is important to note that no wrongful intent need be present; a physician may sincerely intend to aid the patient, but still be liable for committing a battery. A medical procedure may be considered to be a "harmful touching" (a battery) even if it is performed competently with no adverse outcome.

FAILURE TO OBTAIN INFORMED CONSENT: MALPRACTICE

A patient's right to decide whether or not to submit to medical treatment establishes the physician's corresponding duty to inform the patient about the recommended care so that the patient's decision is meaningful. The physician's duty of disclosure arises from the fiduciary quality of the physician-patient relationship, which is based upon the patient's dependence on the physician's specialized knowledge. [*Cobbs v. Grant*, supra, at 242]

A physician who fails to adequately disclose the nature of the procedure and its risks and alternatives may be liable for negligence (malpractice). In *Cobbs v. Grant*, the California Supreme Court established guidelines regarding the physician's duty of disclosure that are explained at length in IV. "Informed Consent," page 2.5. If the recommended treatment involves the performance of a "complicated" procedure, a physician must explain the nature of the treatment, the risks, possible complications, and expected benefits or effects of the treatment, as well as the alternatives to the treatment and their risks and benefits. The physician must also inform the patient of any potentially conflicting interests he or she may have, such as research or financial interests. Informed consent is not required for the performance of "simple and common" procedures, where the related risks are commonly understood. Examples of simple and common procedures include routine blood tests or chest X-rays.

INFORMED REFUSAL

The California Supreme Court has specifically ruled that the physician's duty of disclosure includes the responsibility to inform the patient of the risks of refusing to undergo a simple and common procedure that has been recommended [*Truman v. Thomas*, 27 Cal.3d 285 (1980)]. In the *Truman* case, the court held that the defendant doctor breached his duty to his patient by failing to inform her of the risks resulting from her failure to authorize and undergo a Pap smear test. The court stated:

> If a patient indicates that he or she is going to decline a risk free test or treatment, then the doctor has the additional duty of advising of all material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure … If the recommended test or treatment is itself risky, the physician should always explain the potential consequences of declining to follow the recommended course of action. [Id. at 292]

Consequently, depending upon the type of procedure involved, a physician may be liable for professional negligence (malpractice) if he or she fails to obtain the patient's "informed refusal."

B. The Patient's Right to Consent to Hospital Services

The patient's personal and property rights may also be affected by certain activities conducted by the hospital and its personnel (as distinct from activities conducted by the physician). Although a hospital is not subject to the physician's fiduciary duty to the patient and is not directly responsible for obtaining the patient's informed consent to medical treatment, the hospital is responsible for the care of its patients and for obtaining their consent, or the consent of their legal representatives, to those hospital activities which, without such consent, would impinge on patients' rights. Examples of hospital activities that require consent (although not necessarily informed consent) include routine blood tests, chest X-rays and nursing services. Consent to these activities is included in the model "Conditions of Admission" form (CHA Form 8-1).

A hospital's failure to obtain a patient's consent may raise allegations of battery, false imprisonment, and possibly other charges.

In summary, the patient's consent to medical treatment and hospital services is necessary because, as a general rule, without such consent, the physician and the hospital have no authority to subject the patient to medical treatment or hospitalization and related services. One notable exception to this general rule involves patients who are a danger to themselves or others or gravely disabled. The laws applicable to such persons are discussed in detail in chapter 3.

III. WHEN CONSENT IS NECESSARY

The general rules for determining when consent is required are presented below. Subsequent chapters address the requirements that apply in specific situations. The exceptions to the general rule are described below. *(See also chapter 3 regarding involuntary mental health evaluation and treatment.)*

A. General Rule

The hospital may not permit any treatment, without the risk of liability, unless the patient, or a person legally authorized to act on the patient's behalf, has consented to

the treatment. The consent may be simple or informed *(see B. "Identifying Procedures That Require Informed Consent," page 2.6)*. The exceptions to this general rule are described below. *(See also chapter 3 regarding involuntary mental health evaluation and treatment.)*

B. Emergency Treatment Exception

STATEMENT OF PRINCIPLE

Treatment of a medical emergency may be provided without consent where the provider reasonably believes that a medical procedure should be undertaken immediately, and that there is insufficient time to obtain the consent of the patient or of a person authorized to consent for the patient. The law implies consent in these circumstances on the theory that if the patient were able, or if a qualified legal representative were present, the consent would be given. This exception applies to minors as well as to adult patients.

The location of the patient is not relevant to the determination of whether the patient has a medical emergency. A patient may be in the emergency department, yet may not have a medical emergency that obviates the necessity to obtain consent. Similarly, the patient may be located in a medical/surgical unit or outpatient department and develop a medical emergency that requires treatment to be provided without consent.

California law defines a medical emergency for certain purposes, such as the provision of immunity to physicians who provide treatment in emergency situations, the rendering of care to incompetent adults without court authorization, and the rendering of care to minors in custody of the juvenile court. According to these laws, a medical emergency exists when:

1. Immediate services are required for the alleviation of severe pain; or
2. Immediate diagnosis and treatment of unforeseeable medical conditions are required, if such conditions would lead to serious disability or death if not immediately diagnosed and treated.

[Business and Professions Code Section 2397(c)(2) and (3); Probate Code Section 3210(b); Welfare and Institutions Code Sections 369(d)]

LIMITATIONS

It is important to note that only the emergency condition may be treated. Treatment that exceeds the necessary response to the emergency condition may not be rendered without consent from someone authorized to consent to treatment on a nonemergency basis.

As a general rule, if a patient or the patient's legal representative has validly exercised his or her right to refuse particular medical treatment, the treatment may not be provided. Since the emergency treatment exception is based on the theory of implied consent, it does not apply when a patient has validly refused medical treatment, and the emergency arises from the fact that treatment was not given. However, if the medical emergency is the result of a condition or injury that is not specifically related to the condition or injury for which the patient previously refused treatment, the emergency treatment exception generally applies.

If evidence exists to indicate that the patient (or the patient's legal representative) would refuse the treatment — such as a wallet card stating that the patient is a Jehovah's Witness and refuses blood products — legal counsel should be consulted.

RECOMMENDED PROCEDURE FOR PROVIDING CARE PURSUANT TO THE EMERGENCY MEDICAL TREATMENT EXCEPTION

Determination of Existence and Nature of Emergency

The physician must initially determine whether the patient has the capacity to give consent, since the emergency exception applies only when consent cannot be given. In addition, the scope of the emergency must be determined, and any treatment provided must be limited to that necessary to alleviate the severe pain, or to prevent the patient's severe disability or death. The treatment provided may be a matter of first aid, temporary medical care in lieu of surgery, or actual surgical procedures. However, only the emergency medical condition may be treated under this exception.

Consultation

There is no legal requirement that the physician consult a second physician to confirm the existence of an emergency. However, such consultation may be required by hospital or medical staff policy, if desired. Otherwise, the treating physician has discretion to determine if consultation is advisable to confirm the existence of the emergency.

Otherwise Obtaining Consent

The possibility of obtaining consent from the patient, if he or she is able to give consent (e.g., a conscious adult with capacity), or another person legally capable of consenting,

should be assessed and weighed against the possibility that a delay in treatment to obtain consent would result in the patient's severe disability, death or continuing severe pain. If a delay in treatment for purposes of obtaining consent would not jeopardize the condition of the patient, treatment must be delayed and consent obtained pursuant to the guidelines contained in this manual.

Documentation in the Medical Record

The physician should document his or her determination that an emergency exists (e.g., "The immediate treatment of the patient is necessary because ..."). The physician does not sign a consent form on behalf of the patient. Consent is implied by law from the existence of the emergency.

If the physician has obtained a consultation, the consulting physician should similarly document his or her findings and opinion in the patient's medical record.

IMMUNITY FROM LIABILITY

The emergency treatment exception has been recognized in several statutes that provide immunity to a physician who does not inform a patient and obtain his or her consent to treatment under certain emergency circumstances. Business and Professions Code Section 2397 provides that a physician is not liable for civil damages for injury or death caused in an emergency situation occurring in his or her office or in a hospital on account of a failure to inform a patient of the possible consequences of a medical procedure where the failure to inform is caused by any of the following:

1. The patient was unconscious.
2. The medical procedure was undertaken without the consent of the patient because the physician reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient.
3. A medical procedure was performed on a person legally incapable of giving consent, and the physician reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of a person authorized to give such consent for the patient.

This law applies only to lawsuits for injuries arising because of a physician's failure to inform, not to actions for a physician's negligence in rendering or failing to render treatment. Business and Professions Code Section 1627.7 provides similar protections for dentists.

In addition, Health and Safety Code Section 1317 provides immunity from liability for an act or omission (which includes the failure to obtain consent) that occurs while a rescue team established by a licensed health facility or government entity attempts to resuscitate a person who is in immediate danger of death or serious injury or illness, if the rescue team acts in good faith. This immunity extends to the facility, its officers, staff, and employees.

C. Other Circumstances in Which a Physician is Not Required to Obtain Informed Consent

CIRCUMSTANCES

In *Cobbs v. Grant*, the court noted two special circumstances in which a physician is not required to disclose all of the information that is required to obtain the patient's informed consent.

First, the court indicated that a physician need not disclose the risks of the recommended treatment when the patient has requested that he or she not be so informed.

Second, a physician is not required to disclose information to the patient if such disclosure would seriously harm, rather than benefit, the patient. In this regard, the court explained:

> A disclosure need not be made beyond that required within the medical community when a doctor can prove by a preponderance of the evidence [that the doctor] relied upon facts which would demonstrate to a reasonable [person that] the disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment. [*Cobbs v. Grant*, 8 Cal.3d at 245-246]

This second exception to the physician's duty of disclosure is commonly known as the "therapeutic privilege."

Neither exception should be relied upon by the physician unless it is extremely clear that the facts and circumstances of the case justify invoking it. The court stated that these two exceptions constitute situations in which a physician who fails to make the disclosure required by law may defend his or her actions, and specified that any such defense "must be consistent with what has been termed the 'fiducial qualities' of the physician-patient relationship."

The physician's decision to not disclose information will be measured in terms of what "a reasonable person" would have done, not what another physician would have done. Also, the court's discussion about the exceptions generally referred to the disclosure of information about the potential risks of the recommended procedure and did

not specifically state that a physician may be justified in not disclosing other information, such as that pertaining to the diagnosis, the nature of the recommended treatment, its expected benefits or effects, alternatives and any potentially conflicting interests of the physician (such as research or financial interests).

The use of these two exceptions should be very rare in the case of adult patients who have the capacity to make health care decisions. It is not clear that either exception is available in the case of a patient who lacks the legal authority to consent to his/her own care or the capacity to make a health care decision. If the parent, guardian, or other legal representative who ordinarily would make health care decisions for a minor or patient who lacks capacity requests not to be given certain information, or is not able to emotionally handle the information, legal counsel should be consulted. In such situations, it should be determined whether a different decision maker would be appropriate.

PROCEDURE

If the physician determines that the patient specifically asked to not receive information about the proposed procedure or treatment, or that the "therapeutic privilege" applies, the physician should fully document in the patient's medical record the facts that resulted in this conclusion. The physician should also document what, if any, information was disclosed to the patient. It may be appropriate for the physician to discuss the information that was not disclosed to the patient with the patient's closest available relative (if the patient consents to the release of medical information to, and the involvement of, the relative) and secure that person's approval for proceeding with the procedure in view of this full disclosure. The physician should document in the patient's medical record the nature and results of any such consultation with the patient's family.

The hospital's role is to verify, by checking the documentation in the medical record, that the physician's failure to disclose information resulted from a determination that one of the two exceptions applied. The hospital may wish to refer such cases to hospital administration or risk management for review prior to beginning the procedure.

D. Exceptions for Minors

Consent is not required in very limited situations involving minors who are suspected victims of child abuse or who become sick or injured at school. *(See D. "Special Situations Involving Minors Lacking Legal Authority to Consent," page 2.32 for further information.)*

IV. INFORMED CONSENT

A. Elements of Informed Consent

As discussed above, the California Supreme Court held in *Cobbs v. Grant*, that a patient must give "informed consent" prior to certain medical treatment. The court stated that in order to give informed consent, the patient must be informed of:

1. The nature of the procedure;
2. The risks, complications, and expected benefits or effects of the procedure;
3. Any alternatives to the treatment and their risks and benefits.

In addition, a later court held that the patient must also be informed of any potentially conflicting interest the physician may have (such as research or financial interests).

The *Cobbs* court explained that:

> The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision. [*Cobbs v. Grant*, supra, 8 Cal.3d 229, 245]

In a subsequent case, the court clarified its definition of "material information" as follows:

> [T]hat which the physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject the recommended procedure…To be material, a fact must also be one that is not commonly appreciated. . . . If the physician knows or should know of a patient's unique concern or lack of familiarity with medical procedures, this may expand the scope of required disclosure. [*Truman v. Thomas*, 27 Cal.3d 285, 291 (1980)]

The Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoP) *Interpretive Guidelines* (Tag A-0466) state that material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity. The *Interpretive Guidelines* also state that hospitals are free to delegate to the responsible practitioner (the physician, podiatrist or dentist) who uses the available clinical evidence as informed by the practitioner's professional judgment, the determination of which material risks, benefits and alternatives will be discussed with the patient. The *Interpretive Guidelines* can be found at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html,

then Publication 100-07 *State Operations Manual*, then "Appendices Table of Contents." The *State Operations Manual* has several appendices that apply to hospitals, for example, A (hospitals), AA (psychiatric hospitals), V (EMTALA), and W (critical access hospitals).

For some procedures and treatments, the California legislature has passed laws requiring the physician to give specified additional information. Some of these treatments include electroconvulsive therapy, psychosurgery, and antipsychotic medications. *(See X. "Treatments That Require Special Consent," page 2.42.)*

A physician is not required to inform a patient about treatment that cannot legally be administered in California [*Schiff v. Prados*, 92 Cal.App.4th 692 (2001)]. A physician must inform a patient about alternative treatments only to the extent required for competent practice within the medical community. [*Vandi v. Permanente Medical Group*, 7 Cal.App.4th 1064 (1992)] For example, a physician need not discuss coffee enemas with patients.

In certain circumstances the patient's physician is not required to disclose all information that would otherwise be required to be given to the patient to obtain the patient's informed consent. *(See C. "Other Circumstances in Which a Physician is Not Required to Obtain Informed Consent," page 2.4.)*

B. Identifying Procedures That Require Informed Consent

"Informed" consent, as distinguished from "simple" consent, is not required for all medical treatments. The *Cobbs* court held that treatments or procedures that are "complicated" require that informed consent (as described above) be obtained. Procedures that are "simple and common" do not require informed consent (although they still require consent, usually obtained in the "Conditions of Admission" form (CHA Form 8-1)). The court stated that a physician is not expected to explain risks that are commonly understood to be remote. The performance of a blood count was cited as an example of a simple and common procedure.

The determination of which procedures are "complicated" and, therefore, require informed consent, is medical in nature. It is the position of CMS that medical staff policies should address which procedures and treatments require written informed consent. *(See Hospital Interpretive Guidelines, Tag A-0466.)* The medical staff bylaws themselves would not seem to be the best place for this information. The rules and regulations or a policy and procedure would seem to be better choices. However it is done, it should be appropriately documented and approved by the medical staff executive committee. Procedures for which the law specifically requires informed consent should also be included *(see X. "Treatments That Require Special Consent," page 2.42)*. To determine whether a procedure is "simple and common" or "complicated," the medical staff should consider whether the average layperson would understand the nature of the procedure and its risks and benefits.

C. The Role of the Physician in Obtaining Informed Consent

It is the physician's responsibility to determine the patient's capacity and to obtain informed consent. Generally, the physician who performs the procedure is responsible for obtaining the patient's consent. If a nonphysician will perform the procedure, then the ordering physician is responsible for obtaining consent. If more than one doctor is involved, they can determine together which one will obtain consent, or hospital policy may determine which physician will obtain consent. Hospital personnel should not be involved in providing the information necessary to secure the patient's informed consent or responding to the patient's questions concerning the procedure. The duty to provide this information and obtain informed consent is the exclusive duty of the physician. Nurses and other hospital personnel may provide general patient or family education, however.

PROCESS BY WHICH PHYSICIAN INFORMS PATIENT

Physicians may use verbal discussion, written information, audio and video recordings to give the patient the information to the patient or legal representative necessary to obtain informed consent.

The physician should also always give the patient a personal explanation of the procedure or treatment, its possible complications, risks and alternatives. This verbal discussion gives the patient the opportunity (as required by the legal doctrine of informed consent) to ask questions about the information presented by the physician. A patient's consent given after a discussion with the physician and the opportunity for inquiry is more likely to be truly "informed."

Written or Recorded Patient Information

Written handouts and audiovisual recordings may play an important part in the informed consent process since they give the patient the information in a form that may be reviewed later. However, the use of the hospital's name or

the distribution of information by hospital personnel might cause a patient to conclude that the hospital employs the physician and/or is responsible for the physician's provision of medical services, including the physician's duty to provide the patient with information about the procedure. Thus, any written information sheets, audio or video recordings, etc. that contain medical information that a physician is responsible for giving to a patient to obtain informed consent should be designated as the physician's information. If the information contains the hospital's name, or hospital personnel are involved in distributing the information, describing the procedure to the patient, or responding to the patient's questions about the procedure or the information, this could suggest that the physician is a hospital agent or otherwise confuse a patient regarding the legal responsibility for obtaining informed consent. For these reasons, involvement by the hospital or its staff is discouraged.

If a hospital chooses to distribute such information or put the hospital's name on information sheets, etc., it should be clearly noted that the form or information is being provided by the hospital as a courtesy and that the patient should review the information with his or her physician. It should also clearly state that the physician is not the employee or agent of the hospital (if that is the case).

INFORMED CONSENT FORMS THAT CONTAIN MEDICAL INFORMATION

Some physicians prefer to give patients an "informed consent" form that contains within it the medical information the patient must be provided. This procedure promotes complete disclosure and allows patients to study the information. While such forms should not be prepared or distributed by hospital personnel for the reasons discussed above, forms may be used by hospitals to verify and document that informed consent was given by each patient.

A physician who prepares an informed consent form that contains the medical information which must be provided to the patient may use as a guide the "Informed Consent to Surgery or Special Procedure" form (CHA Form 1-2). The physician should include the name of the procedure(s), nature of the treatment, its expected benefits or effects, its possible risks and complications, and any alternatives to the proposed treatment and their possible risks and complications. The physician should also include any potentially conflicting interests, such as research or financial interests.

It is often not possible to include all information relevant to a particular patient's condition on a written form. Accordingly, the form must either be supplemented through verbal discussions with the patient and/or by written additions containing the information. For example, the risks of a treatment will differ depending upon whether the patient is a young, healthy person; a pregnant woman; or an elderly, brittle diabetic. A standardized list of risks may be used, but must be supplemented with any additional information pertinent to the particular patient.

Written forms are helpful only if they are understood by the patient. Therefore, it is important that the medical information included in the forms be written in clear, simple, and easily understood terms. In addition, the forms should clearly state that the patient should ask any and all questions he or she may have concerning the proposed treatment.

Also, some forms may ask patients to respond to questions such as: "Have you been given all the information you desire about the proposed treatment?" or "Do you understand the nature of the proposed treatment, its expected benefits and the possible risks and complications?" However, if this type of question is included in a consent form, the physician must verify it has been answered affirmatively on the form; otherwise, the patient will have established in the document that he or she did not give informed consent. The format provided in CHA Form 1-2 does not include such questions; rather, it requires the patient to acknowledge receipt of the relevant information.

PHYSICIAN DOCUMENTATION

It is recommended that the physician carefully document in the hospital medical record that a discussion was held with the patient and that informed consent was obtained. This documentation can be accomplished in a variety of ways — through a certification on the consent form itself *(see the certifications on the"Consent to Surgery or Special Procedure" form (CHA Form 1-1))*, through a progress note in the patient's record, through a note in the patient's history and physical, or through documentation provided from the physician's office (e.g., an informed consent form signed by both the patient and the physician). The physician should also place in the medical record a copy of any written material provided to the patient. Any special circumstances should also be documented.

D. The Role of the Hospital in the Informed Consent Process

VERIFICATION THAT INFORMED CONSENT HAS BEEN OBTAINED

The hospital's role in the consent process should be limited to verifying that the physician obtained and properly documented the patient's informed consent before the physician is permitted to perform the medical procedure. The physician, not the hospital, has the duty to disclose all information relevant to the patient's decision and to obtain the patient's informed consent.

Obtaining informed consent involves the practice of medicine, in which the hospital and its employees should not intervene. Hospital employees are not licensed or qualified to adequately explain the various types of medical procedures to the patient, why the physician has recommended a particular procedure over another, and to respond to the patient's potential questions. Only the physician has both the technical medical knowledge and the knowledge of the particular patient's history and current condition necessary to assure that an adequate disclosure of information, including information about the risks of treatment, has been given to the patient and that proper responses have been given to the patient's questions.

Although hospital personnel should not be responsible for securing the patient's informed consent (or for providing the information required to secure the patient's informed consent), it is foreseeable that a patient may ask questions of hospital employees who perform a procedure pursuant to the doctor's orders. Hospital personnel generally may answer such questions. However, if it appears that the patient has significant questions about the nature of the procedure, its benefits or risks which indicate that the patient may not have been given sufficient information about the procedure or did not understand the information, hospital personnel should contact the patient's physician to allow him or her to assure that the patient indeed gave informed consent to the procedure.

OBTAINING VERIFICATION

The form "Consent to Surgery or Special Procedure" (CHA Form 1-1) or a similar form should be used after informed consent is given by the patient to the physician. This form serves the dual purposes of:

1. Assuring that the physician obtained informed consent from the patient for the contemplated procedure, and
2. Documenting that the patient is aware of the right to give informed consent or refusal to the procedure recommended by the physician.

By signing this form, the patient acknowledges that the physician adequately explained the procedure to the patient and gave the patient all the information he or she desired. This form does not list the risks of the procedure nor alternative therapies; thus, if this form is used by the hospital, an additional form, prepared by the physician, which lists the risks and alternatives (signed by the patient and the physician) must also be included in the medical record.

NOTE: The form itself is not informed consent; it is evidence for both the hospital and the physician that informed consent was obtained. The form is not a substitute for the critical role of the attending physician in the informed consent process.

RECOMMENDED PROCEDURE FOR COMPLETING THE HOSPITAL'S FORM

The consent form should include the name of the patient, and when appropriate, the patient's legal representative.

Identification of the Procedure or Treatment

The medical terminology for the procedure and the type of anesthesia to be used (if applicable) should be entered into the space provided on the form. In addition, it is recommended that a description of the procedure or treatment in lay terminology be entered in the space along with the medical terminology to provide a more meaningful description of the procedure.

If lay terminology is used, there should be consistency within an institution in describing such procedures. The medical staff and nursing staff may want to establish a glossary of lay terms corresponding to the medical terminology for procedures performed in the facility.

Identification of the Practitioner(s)

In the Hospital *Interpretive Guidelines*, CMS states that the consent form include the name of the practitioner performing the procedure or administering the treatment. The *Guidelines* also recommend, but do not require, that the form state, if applicable, that:

1. Physicians other than the operating practitioner, including but not limited to residents, will perform important tasks related to the surgery, in accordance with the hospital's policies (and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner); and
2. Qualified medical practitioners who are not physicians will perform important parts of the surgery or administration of anesthesia within their scope of

practice, as determined under state law and regulation, and for which they have been granted privileges by the hospital. *(See Hospital Interpretive Guidelines, Tags A-0466 and A-0955.)*

This supersedes CMS' previous position that informed consent forms must state the names of practitioners other than the primary surgeon who will perform important aspects of the surgical procedure.

Medical Information

The Hospital *Interpretive Guidelines* require that informed consent forms include a statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative. The *Guidelines* also recommend, but do not require, that the form include an indication or list of the material risks of the procedure or treatment that were discussed with the patient or the patient's legal representative. *(See Hospital Interpretive Guidelines, Tag A-0466.)* This reverses CMS' previous position that the form itself must include all information about the procedure or treatment and its alternatives.

PROCEDURE WHEN PHYSICIAN USES INFORMED CONSENT FORMS THAT CONTAIN MEDICAL INFORMATION

Review and Approval of Forms

Before a form is relied upon by the hospital as evidence that the physician secured the patient's informed consent, the hospital may wish to review it to see that it contains all the information that must be provided to the patient.

When the physician uses an informed consent form that contains medical information that has been approved by the hospital and appropriate medical staff committees, the hospital may verify that the patient gave informed consent by relying on this form. The hospital should check the original form signed by the patient to ensure it is complete and that the patient or the patient's legal representative properly completed the document. The original consent form should be placed in the patient's medical record. The patient should be given a copy of the consent form if this has not already been done.

E. Two-Doctor Consent

A common misconception related to consent law is that if two doctors agree that a patient would benefit from a particular procedure or treatment, the two doctors may consent on behalf of the patient. This is a myth.

There is no provision in California or federal law that permits two doctors to consent on behalf of a patient. This is true whether the patient has the capacity to make health care decisions or not. The patient or a legal representative must provide consent to medical treatment, except in an emergency or as otherwise permitted by law. In an emergency, patient consent is implied by law *(see III. "When Consent is Necessary," page 2.2)*.

F. Duration of Informed Consent

A patient's consent to treatment remains effective until the patient revokes it or until circumstances change so as to materially affect the nature of, or the risks of, the procedure and/or the alternatives to the procedure to which the patient consented.

For example, if a patient has been admitted to a hospital for a specific course of treatment, or a specific operation, but in the course of studying the patient several days elapse and the anticipated treatment or operation changes considerably, the physician should obtain a new informed consent. Similarly, if the patient's condition changes or new information is learned about the patient's condition, resulting in increased or different risks to the patient from the contemplated procedure or treatment, a new consent should be obtained.

G. Patient Doubt or Confusion Concerning Informed Consent

If, when the verification of consent form is presented to the patient, he or she voluntarily indicates doubt or confusion about the procedure and consequently the question is raised whether an informed consent was obtained, the physician should be contacted immediately. The physician should obtain the patient's informed consent (again, if necessary). Under no circumstances should an employee of the hospital attempt to obtain the patient's informed consent in such a situation.

V. HOW CONSENT SHOULD BE OBTAINED

Obtaining informed consent is a communication process, not a signature on a paper form. Getting patients to sign consent forms does not mean they have read them or that they understand them. While documentation is important, and often required, the ultimate goal of patient understanding must also be met.

All requirements regarding translation and interpreter services must be followed *(see E. "Securing Consent When Communication Barriers Exist," page 2.11)*.

A. Capacity to Consent

The patient or legal representative must be conscious and have the capacity to understand the purpose and effect of the decision to be made and the form to be signed. It is the treating physician's responsibility to determine whether the patient has this capacity. *(See ""Capacity" Defined," page 2.12.)*

B. Consent Must Be Knowingly Made and Freely Given

To be effective, consent must be made knowingly and given freely. Consent must not be obtained through the exercise of duress or coercion.

C. The Nature of Consent

Consent may be express (oral or written statement) or implied (for example, by voluntary submission to the procedure or by the existence of a medical emergency). Express consent should be obtained whenever possible.

D. Consent Evidenced in Writing

The "Conditions of Admission" form contains a clause that documents the patient's consent to noncomplicated procedures such as routine blood tests, X-rays, nursing and other services that may be performed during the patient's hospitalization, outpatient visit, or emergency room treatment. *(See CHA Form 8-1 "Conditions of Admission.")*

In certain instances, particularly when the patient is authorizing complicated medical treatment or refusing recommended care, it is *recommended* that the patient's consent (or refusal) be evidenced in writing. If a dispute arises as to whether consent was given, proof of consent is more readily established when it is in writing.

California law *requires* that consent for some procedures be documented in writing. These laws are discussed in X. "Treatments That Require Special Consent," page 2.42. In addition, Title 22, California Code of Regulations, Section 70223(d)(3) requires that, prior to nonemergency surgery, the person responsible for administering anesthesia, or the general surgeon if a general anesthetic will not be administered, must ascertain that a written informed consent form for the contemplated surgical procedure is in the medical record. All necessary consent forms must be made a part of the medical record. [Title 22, California Code of Regulations, Sections 70749, 70527(d) and 71549]

CMS requires each medical staff to review those procedures that are performed at the facility and identify which require informed consent. For those procedures that are identified as requiring informed consent, written verification that informed consent was given should be obtained and placed in the patient's medical record. [Hospital *Interpretive Guidelines*, Tag A-0466] The CoP *Interpretive Guidelines* state that a properly executed informed consent form contains the signature of the patient or the patient's legal representative [Hospital *Interpretive Guidelines*, Tag A-0466].

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RECOMMENDED FORMS

In order to provide written evidence of consent, various forms have been developed for use by hospitals and physicians. These forms are included and discussed in this manual. In addition, as discussed in subsequent chapters, several statutes and regulations require specific information to be included in consent forms or require the use of prescribed forms under certain circumstances. The forms included in this manual fulfill these requirements.

PRINCIPLES GUIDING COMPLETION OF FORMS

Signature of Person Consenting

The hospital should accept the name given by the patient unless there are legitimate business reasons to demand a specific name or a name in a specific form (for example, the name required by third-party payers).

When a person other than the patient signs a form, the relationship to the patient (for example, parent, guardian, conservator) should be noted below the signature, and a brief statement included as to why the patient cannot personally sign the form. Hospitals should consider asking the patient to also sign when able, if the inability to sign was due to a temporary condition.

If the person who is required to sign is physically unable to write his or her name, but has mental capacity to make the decision, the person's mark should be obtained. This is done by the hospital representative first writing the person's name in full and then having the person place an "X" beneath it. Two people should witness the signer place his or her mark on the consent form, and they should sign the consent form as witnesses.

Patient Declines to Sign Due to Religious Beliefs

Some patients may decline to sign forms on certain days with religious significance. For example, the Orthodox Jewish faith proscribes any writing on the Jewish Sabbath (sundown Friday to sundown Saturday) and recognized Jewish holidays. The wishes of such patients should be respected.

In these instances it is important to remember that oral consent to treatment is, in most cases, as valid as written consent. Consent forms and acknowledging signatures merely document consent. However, when a surgical procedure is involved, California law requires that the anesthesiologist or surgeon assure that the patient's medical record contains informed consent, in writing, prior to commencing surgery [Title 22, California Code of Regulations, Section 70223(d)]. When it is possible to accept the patient's oral consent, the informed consent process is the same as when written consent is obtained.

In such cases, the patient should read the relevant documents and acknowledge the information given. The patient should then orally consent to or refuse the recommended treatment. The oral consent should be documented in the patient's medical record and appropriate written documentation obtained from the patient later, with an appropriate explanation for the date of the patient's signature. The following note should be entered and dated at an appropriate place on each form:

> This patient read this document on this date, but declined to sign it today for religious reasons. The patient agreed to sign this document tomorrow or as soon thereafter as his/her religious faith will allow.

This statement should be initialed by a second hospital employee who witnessed the consent discussion.

Time and Date of Signature

The time and date on the form should be the time and date the form is signed by the patient or the patient's legal representative, not the time and date of the procedure or operation.

Witnesses

Consent forms need not be notarized. It is recommended (but not required) that one hospital employee serve as a witness to the signature by the patient. (However, an advance health care directive requires two witnesses.)

Unless otherwise indicated, admitting personnel, registered nurses, licensed vocational nurses, ward clerks, or other hospital employees of similar responsibility may act as witnesses to hospital forms. All witnesses should be 18 years of age or over.

Each witness should be present when the form is signed by the patient or the patient's legal representative. The witness need not be present during the discussion between the patient and the physician about the procedure — the witness only needs to observe the patient signing the document. The witness should indicate that he or she witnessed the signing by placing his or her signature in the designated space on the form.

Copies of Consent Forms

The original consent form should always be placed in the patient's medical record.

In certain circumstances the law requires that a copy of the consent form be given to the patient. Such requirements are discussed throughout this manual.

In addition, it is recommended, but not legally required, that a copy of the facility's "Conditions of Admission" (CHA Form 8-1), or other similar document, and a copy of the "Informed Consent to Surgery or Special Procedure" (CHA Form 1-2) always be given to the patient.

A copy of any other form signed by the patient should be given upon request.

E. Securing Consent When Communication Barriers Exist

If a patient or his or her legal representative cannot communicate with the physician because of language or communication barriers, the physician, with the hospital's assistance, should arrange for an interpreter. The interpreter's responsibilities will include translating the information regarding the recommended medical treatment that the patient or the patient's legal representative needs to receive before deciding whether to give consent, as well as instructions regarding medical care.

Similarly, vital documents, including consent forms, presented by hospital staff to a patient must be written in a language that the patient can understand or translated into such a language.

Both state and federal laws contain detailed requirements regarding interpreter and translator services. *(See CHA's* Consent Manual, *chapter 1, for further information.)*

VI. WHO MAY GIVE CONSENT: ADULTS

An adult patient generally has the right to make his or her own health care decisions. However, in some cases, a patient's physical or mental condition may render him or her unable to consent to medical treatment, either temporarily or permanently. If the patient lacks "capacity," someone else must consent to the treatment on his or her behalf, except in emergency situations *(see B. "Emergency Treatment Exception," page 2.3)*.

For purposes of consent for medical treatment, an adult patient may be in one of the following categories:

1. Adult with capacity.
2. Adult who has appointed an agent or surrogate to make health care decisions *(see chapter 3 of CHA's* Consent Manual *regarding agents and surrogates)*. An agent or surrogate may be named in an advance health care directive or other similar document; surrogates may be appointed verbally by the patient.
3. Conservatee specifically adjudicated to lack the capacity to make health care decisions.
4. Conservatee not specifically adjudicated to lack the capacity to make health care decisions.
5. Adult lacking capacity without a conservator, agent, or surrogate for health care decisions (whether the patient temporarily or permanently lacks capacity).

The laws applicable to consent for inpatient mental health admission and treatment for adults, both voluntary and involuntary, are found in chapter 3. The laws regarding involuntary outpatient mental health treatment for adults are also described in chapter 3. There are no special requirements regarding voluntary outpatient mental health treatment. Many mental health patients have concurrent medical conditions and may need medical treatment requiring informed consent. This part of the manual addresses those circumstances.

A. Adults With Capacity to Make Health Care Decisions

An adult patient with capacity has the right to make his or her own health care decisions [Probate Code Section 4670]. This includes consenting to medical treatment and refusing medical treatment, including life-sustaining treatment.

"ADULT" DEFINED

For the purpose of making health care decisions, an **"adult"** is a person who has reached the age of 18, or a minor who has entered into a valid marriage or domestic partnership (whether or not it was later terminated by divorce or death of the spouse/partner), who is on active duty with the armed forces of the United States of America, or who has been declared emancipated pursuant to Family Code Section 7122 *et seq.* [Family Code Section 7002]. *(See IX. "Minors with Legal Authority to Consent," page 2.36.)*

"CAPACITY" DEFINED

A patient is presumed to have the capacity to make a health care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate [Probate Code Section 4657]. However, if there are indications that the patient lacks the capacity to make health care decisions, the primary physician should evaluate the patient.

"Capacity" means a person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives [Probate Code Section 4609; *see also Probate Code Sections 812 and 813*].

The primary physician usually makes the determination that a patient lacks or has recovered capacity, or that another condition exists that affects an individual health care instruction or the authority of an agent or surrogate. However, the patient may state in the advance directive that someone else is required to make this determination. [Probate Code Section 4658]

DETERMINATION OF CAPACITY

The primary physician should determine whether a patient has the capacity to make health care decisions [Probate Code Section 4658]. The **"primary physician"** is the physician designated by the patient to have primary responsibility for the patient's health care, or, in the absence of such a designation or if the designated physician is not reasonably available or declines to act as the primary physician, any physician who undertakes the responsibility [Probate Code Section 4631]. A psychiatric consult is not required, although it may be useful in unusual situations, particularly when the patient has a serious mental illness or another psychiatric or neurologic condition.

A physician determining a patient's capacity to give informed consent may wish to consider the same factors a judge would be required to consider in the context of

judicial determination of incapacity. A judge would evaluate whether a patient is able to do all of the following:

1. Respond knowingly and intelligently to queries about the proposed medical treatment.
2. Participate in the treatment decision by means of a rational thought process.
3. Understand all of the following items of minimum basic treatment information with respect to the proposed treatment:
    a. The nature and seriousness of the illness, disorder or defect that the person has.
    b. The nature of the medical treatment that is being recommended by the person's health care providers.
    c. The probable degree and duration of any benefits and risks of any medical intervention that is being recommended by the person's health care providers, and the consequences of lack of treatment.
    d. The nature, risks and benefits of any reasonable alternatives.

A patient who has the capacity to give informed consent to a proposed treatment also has the capacity to refuse consent to that treatment. [Probate Code Section 813]

The mere fact that a patient has a mental health or neurologic condition, or has recently taken prescription or recreational drugs, does not determine whether the patient has the requisite mental ability to make a treatment decision. The physician must make an individual assessment, which should be clearly documented.

A patient may lack capacity permanently (for example, a patient with late-stage Alzheimer's disease) or temporarily (for example, a patient with a head injury or under the influence of illegal drugs). The primary physician should make the determination of capacity on a case-by-case basis, reasonably close in time to the performance of the procedure for which consent is sought.

Generally, it may be assumed that a patient presenting himself or herself for treatment has the capacity to make health care decisions unless there is evidence to the contrary [Probate Code Sections 810 and 4657]. In the case of mental health patients, it should be noted that Welfare and Institutions Code Section 5331 provides that:

> No person may be presumed to be incompetent because he or she has been evaluated or treated for a mental disorder or chronic alcoholism, regardless of whether such evaluation or treatment was voluntarily or involuntarily received.

Patients who have been diagnosed with a mental illness may or may not have the capacity to give informed consent, depending upon the degree to which their illness affects their thought processes. The primary physician may make this determination. A psychiatric consult is not required, but may be useful.

DOCUMENTATION

A primary physician who determines that a patient lacks (or has recovered) capacity must promptly record that determination in the patient's medical record. The physician must communicate the determination to the patient, if possible, and to any person then authorized to make health care decisions for the patient. [Probate Code Section 4732]

SPECIAL CIRCUMSTANCES INVOLVING ADULTS WITH CAPACITY

Married Patients

The patient has the right to consent to, or to refuse, medical treatment. A patient's spouse does not have the legal authority to make health care decisions for the patient simply because they are married. However, in some circumstances a spouse may make health care decisions on the basis of another legal relationship (for example, the spouse is the patient's conservator or agent appointed pursuant to a power of attorney for health care) or on the basis that the patient lacks capacity and the spouse is the closest available relative.

Adults in Custody of Law Enforcement Officers

A person in the custody of law enforcement officers must still consent to a nonemergency medical examination, treatment, or operation before such procedures may be performed. If the person in custody lacks the capacity to make health care decisions, an appropriate legal representative should be found, if possible. Although law enforcement officers may not consent for the patient, in narrowly defined circumstances law enforcement officers may request limited medical examinations and tests pursuant to their authority to make constitutionally permissible searches. In addition, specific rules govern drug and alcohol tests performed pursuant to Vehicle Code Section 23612. *(See CHA's* Consent Manual*, chapter 9, for more information regarding the hospital's rights and responsibilities with regard to patients in the custody of law enforcement officers.)*

Developmentally Disabled Adults

A developmentally disabled adult should not be presumed incompetent to make his or her medical treatment decisions. If a developmentally disabled adult is determined by his or her physician to be mentally incapable of consenting to treatment, consent can be provided by the patient's agent or surrogate, conservator legally authorized to consent to treatment, the closest available relative, or by court order *(see "Court Order Authorizing Medical Treatment," page 2.20)*.

The director of a regional center (an agency that contracts with the state to provide services to developmentally disabled persons) or his or her designee may consent to medical, dental and surgical treatment of a regional center client in certain circumstances. The hospital should consult its legal counsel in these cases. [Welfare and Institutions Code Section 4655]

Potential Exposure of Public Safety Workers and Medical Personnel to Communicable Diseases

There is a limited ability to test for the presence of communicable diseases without the patient's consent when a public safety worker or medical personnel may have been exposed. The specific procedures and legal requirements for these exceptions are described in chapter 5 of CHA's *Consent Manual*.

B. Adults Who Have Appointed an Agent or Surrogate

An adult having capacity may execute an advance health care directive or similar document that contains a power of attorney for health care. The power of attorney for health care may authorize another person, called an agent, to make health care decisions on behalf of the patient. The power of attorney for health care may also include directions concerning health care decisions for the patient. [Probate Code Section 4671]

An adult may also designate another adult as a surrogate to make health care decisions by personally informing the primary physician (or another health care provider in specified circumstances) [Probate Code Section 4711].

Generally, an agent or surrogate has the same authority as a patient to make health care decisions. However, an agent or surrogate may not consent to the following on behalf of a patient:

1. Commitment to or placement in a mental health treatment facility *(see chapter 3)*.
2. Convulsive treatment *(see D. "Convulsive Therapy and Insulin Coma Treatment," page 2.49)*.
3. Psychosurgery *(see C. "Psychosurgery," page 2.47)*.
4. Sterilization or abortion *(see chapter 5 of CHA's* Consent Manual*)*.

A detailed discussion of the laws regarding the appointment of an agent or surrogate is found in chapter 3 of CHA's *Consent Manual*.

PSYCHIATRIC ADVANCE DIRECTIVES

A psychiatric advance directive is an instrument that mental health patients may use to document their preferences regarding future mental health treatment, in preparation for the possibility of losing capacity to give or withhold consent to treatment in the future. The mental health advocacy community advocates the use of such documents, particularly with respect to involuntary treatment, psychiatric medications, restraint and seclusion.

Neither California nor federal law recognizes a special document called a "psychiatric advance directive." The California advance health care directive laws and statutory form were created with end-of-life issues in mind, not mental health matters. However, the law does not prohibit a person who executes an advance health care directive from including instructions regarding mental health treatment. Whether such wishes are required to be followed by a health care provider if the patient loses capacity depends upon several factors, including:

1. Whether the patient would have the legal ability to consent or withhold consent to the recommended treatment if he or she were competent. For example, a patient who is detained pursuant to Welfare and Institutions Code Section 5150 *et seq.* is, by law, unable to withhold consent to be evaluated for a mental disorder and may not leave the facility. Therefore, if such a patient has executed an advance directive denying consent to such care, a hospital need not comply with this instruction.
2. Whether the wishes stated in the advance directive are medically ineffective or contrary to generally accepted health standards. In such a case, the facility need not comply with the patient's instructions. However, a provider that declines to comply must follow certain procedures *(see Probate Code Sections 4735 and 4736)*.

There are no statutes, regulations, or judicial decisions regarding "psychiatric" advance directives in California. However, California law does contain one reference to advance directives in the context of mental health care.

Health and Safety Code Section 1180.4(a) requires psychiatric units of general acute care hospitals, acute psychiatric hospitals, skilled nursing facilities, and other specified facilities to conduct an assessment of each patient prior to a placement decision or upon admission, or as soon thereafter as possible. This assessment must include, based on the information available at the time, the patient's advance directive regarding de-escalation or the use of seclusion or behavioral restraints. This law does not authorize "psychiatric advance directives," nor does it require a provider to comply with a patient's stated preferences. It merely requires the specified providers to assess a patient's advance directive, if any. *(See chapter 5 regarding restraint and seclusion.)*

A hospital should consult legal counsel if a situation arises regarding a psychiatric advance directive. *(See chapter 3 of CHA's* Consent Manual *for a complete discussion of the law regarding advance directives.)*

C. Adults Under Conservatorship

An adult patient under a conservatorship may be able to make health care decisions. The determination of who may make health care decisions — the patient (the conservatee) and/or the conservator — will depend on whether or not the conservatee has been adjudicated to lack the capacity to make health care decisions. The letters of conservatorship should specify whether a patient has been adjudicated to lack the capacity to make health care decisions.

The hospital should obtain a copy of the certified letters of conservatorship, review them carefully and place them in the patient's medical record. If the hospital has any questions about the documents, legal counsel should be consulted.

[Probate Code Sections 1880-1898 and 2353-2357]

CAUTION: TYPE OF CONSERVATORSHIP

A conservatorship under the Lanterman-Petris-Short Act (LPS) (which is found in the Welfare and Institutions Code) is different from a conservatorship under the Probate Code. If a patient is under a conservatorship, hospitals should review the conservatorship documents issued by the court to determine the type of conservatorship and the conservator's scope of authority. A patient may be subject to both an LPS conservatorship and a Probate Code conservatorship; however, this is not common. Both types of conservatorship are described below.

LPS CONSERVATORSHIP

An LPS conservatorship is meant for psychiatric patients. The purpose of an LPS conservatorship is the provision of individualized psychiatric treatment, supervision, and placement for a patient who is gravely disabled as a result of a mental disorder or impairment by chronic alcoholism. An LPS conservator may authorize the admission of the conservatee to a mental health facility. (A Probate Code conservator may not authorize admission to a mental health facility.)

An LPS conservator may consent to, or refuse, routine medical treatment (other than psychiatric treatment) of the conservatee *only* if the court order establishing the conservatorship specifically states that the conservator may consent to routine medical treatment unrelated to remedying or preventing the recurrence of the conservatee's being gravely disabled. An LPS conservator may not, however, consent for surgery. Surgery may be performed on an LPS conservatee only if:

1. The conservatee consents;
2. The emergency exception applies *(see B. "Emergency Treatment Exception," page 2.3)*; or
3. The conservator petitions for and receives a court order issued under Welfare and Institutions Code Section 5358.3 authorizing the surgery. [Welfare and Institutions Code Sections 5357, 5358 and 5358.2]

[Welfare and Institutions Code Section 5350 *et seq.*] *(See F. "Additional Treatment for Gravely Disabled Person (LPS Conservatorship)," page 3.31. More information about LPS conservatorships is found in chapter 3.)*

PROBATE CODE CONSERVATORSHIP

A conservatorship under the Probate Code is meant to ensure that the conservatee's basic needs for food, clothing, shelter, money management, and health care are met. Conservatees may be comatose, developmentally disabled, or have dementia or other medical problems. Some patients under a Probate Code conservatorship may have the ability to make their own health care decisions, while others may not — the letters of conservatorship will state the authority of the conservator. A Probate Code conservator may not authorize admission to a mental health facility.

The remainder of this section of the manual describes the law governing Probate Code conservatorships.

Probate Code Conservatees Adjudicated to Lack Capacity

A petition for a court order that the conservatee does not have the capacity to make health care decisions may be filed by the conservator, the conservatee, the spouse, the registered domestic partner, a relative or a friend of the conservatee [Probate Code Sections 1880 and 1891].

If the letters of conservatorship state that the patient lacks the capacity to make health care decisions, then the conservator has exclusive authority to do so. However, a conservator may not consent in those situations discussed under "Limitations on a Guardian's Consent," page 2.29.

The conservator must make health care decisions for the conservatee in good faith based on medical advice. The decisions must be made in accordance with the conservatee's individual health care instructions, if any, and other wishes to the extent known to the conservator. Otherwise, the conservator must make the decision in accordance with the conservator's determination of the conservatee's best interest. In determining the conservatee's best interest, the conservator must consider the conservatee's personal values to the extent known to the conservator. Provided these requirements are met, treatment may be legally given even if the patient objects. [Probate Code Section 2355(a)] Although the conservatee's consent need not be secured, the physician may wish to explain to the conservatee the decision that has been made for the patient, the nature of the procedure that will be performed and any possible risks or discomforts associated with the procedure *(see Probate Code Section 4730)*.

Visitors, Phone Calls and Mail

A court may issue an order that grants a conservator the power to enforce a conservatee's right to receive visitors, telephone calls, and personal mail. The law also allows the court to issue an order directing a conservator to allow specific visitors, telephone calls, and personal mail. The conservator may be required to inform certain persons of the patient's death. This law was enacted to address a situation in which a conservator (wife) refused to allow the conservatee's children from a prior marriage to visit the conservatee (husband) in his home or anywhere else, despite the conservatee's desire to have them visit. This law was not intended to be specific to hospital visitation, and hospitals may continue to enforce their usual visitation policy and reasonable visitation restrictions. [Probate Code Sections 2351 and 2361] Hospitals should always get a copy of conservatorship orders for conserved patients and read them to fully understand the authority of the conservator and any limitations. [Probate Code Section 2351]

Prayer Healing

If, prior to the establishment of the conservatorship, the conservatee was an adherent of a religion that calls for reliance on prayer alone for healing, the law states that the treatment authorized by the conservator must be administered by an accredited practitioner of that religion [Probate Code Section 2355(b)]. A hospital that has a patient in this category should consult legal counsel to determine the character of care, if any, that legally may be provided.

Limitations on Consent by Conservator

Authorization must be obtained pursuant to the specific statute indicated below if the treatment proposed involves any of the following (the consent of the conservator is not sufficient):

1. Placing a patient in a mental health treatment facility against his or her will [Probate Code Section 2356(a)]. *(See chapter 3 regarding establishing a Lanterman-Petris-Short Act conservatorship and involuntary detainment for mental health evaluation and treatment.)*
2. Prescribing or administering an experimental drug as defined in Health and Safety Code Section 111515 *et seq.* [Probate Code Section 2356(b)]. *(See chapter 10 of CHA's* Consent Manual *on the specific situations in which a conservator may consent to the prescription or administration of an experimental drug.)*
3. Administering convulsive treatment as defined in Welfare and Institutions Code Section 5325 [Probate Code Section 2356(c)]. *(See D. "Convulsive Therapy and Insulin Coma Treatment," page 2.49 for more information on conservator consent to convulsive treatment.)*
4. Sterilizing a minor [Probate Code Section 2356(d)].The California Supreme Court's decision in *Conservatorship of Valerie N.*, 40 Cal.3d 143 (1985), allows a conservator to obtain a court order authorizing an adult conservatee's sterilization. Application should be made pursuant to Probate Code Section 2357 and strict criteria must be met.

Further, a conservator may not consent to treatment that thwarts a valid and effective advance health care directive and may not authorize the administration of an aid-in-dying medication [Probate Code Section 2356(e)].

Conservatees with Dementia

Probate Code Section 2356.5 permits a conservator, with a court order, to authorize the placement of a conservatee

with a major neurocognitive disorder (dementia) in certain secured perimeter residential care facilities for the elderly operated pursuant to Health and Safety Code Section 1569.698, or a locked and secured nursing facility that specializes in the care of people with major neurocognitive disorders pursuant to Health and Safety Code Section 1569.691(c), and that has a care plan that meets the requirements of Title 22, California Code of Regulations, Section 87705. The court must find all of the following:

1. The conservatee has a major neurocognitive disorder, as defined in the most recently published edition of the "Diagnostic and Statistical Manual of Mental Disorders."
2. The conservatee lacks capacity to give informed consent to this placement and has at least one mental function deficit pursuant to Probate Code Section 811(a) that significantly impairs the patient's ability to understand and appreciate the consequences of the decision to be made.
3. The conservatee needs or will benefit from a restricted and secure environment.
4. The proposed placement in a locked facility is the least restrictive placement appropriate to the needs of the patient.

The court order may also give the conservator the authority to consent to the administration of medications appropriate to the care of major neurocognitive disorders on behalf of the conservatee, if the court makes findings similar to those listed above.

If the patient is an adherent of a religion that calls for reliance on prayer alone for healing, the treatment required must be provided by an accredited practitioner of that religion in lieu of administration of medications.

A conservatee may not be placed in a mental health rehabilitation center or an institution for mental disease under this law [Probate Code Section 2356.5(e)].

Probate Code Conservatees Not Adjudicated to Lack Capacity

Consent by Conservatee. If the letters of conservatorship are silent about the capacity of the patient to consent to medical treatment, the conservatee may consent to treatment if the physician finds the conservatee has the capacity to give consent. The consent of the conservator is not required, and is not sufficient, in this circumstance. The conservatee must provide consent. [Probate Code Section 2354(a)]

However, the conservator may consent, even if the conservatee objects to the treatment, if the conservator has determined in good faith, on the basis of medical advice, that there is an emergency and that treatment is required for the alleviation of severe pain or that the medical condition of the patient, if not immediately treated, will lead to serious disability or death [Probate Code Section 2354(c)]. A conservator of a patient who has not been adjudicated to lack capacity to give informed consent may also give consent if a court has authorized the conservator to do so [Probate Code Section 2354(b)].

If the physician has determined that the patient has capacity to consent, a conservator who wishes to authorize or prevent treatment that the conservatee has refused or authorized must seek a court decision under Probate Code Section 1880 that the patient lacks the capacity to give informed consent (as discussed above). The conservator also may seek a court order pursuant to Probate Code Section 2357 that authorizes the conservator to give consent for the specific medical treatment that is proposed.

If the physician is unwilling to rely on the consent of the patient because the physician is uncertain of the patient's capacity, the physician may require the conservator to consent also *(see Law Revision Commission comment to Probate Code Section 2354(a))*. If the conservator refuses to consent, the physician may seek a court order authorizing the treatment under Probate Code Section 2357(i) (as discussed below).

Court Order Authorizing Treatment of Conservatee. A conservator or other interested person may file a petition for a court order authorizing the conservator to consent on behalf of the conservatee for specified medical treatment. The court may authorize the recommended medical procedure pursuant to Probate Code Section 2357(i).

The hospital should obtain a copy of the court order, review it carefully and place it in the patient's medical record. The only procedures that should be performed pursuant to the court's authorization are those that are specifically included in the court order.

D. Adults Lacking Capacity and Not Under a Conservatorship

GENERAL RULE

If a patient temporarily or permanently lacks capacity to make health care decisions, and the emergency medical situation exception does not apply *(see B. "Emergency Treatment Exception," page 2.3)*, medical treatment should be withheld until:

1. The patient regains capacity;

2. An agent appointed in an advance health care directive or a surrogate is available and gives consent;
3. A court order is issued under Probate Code Section 3200 *et seq.* authorizing the treatment (as discussed in "Court Order Authorizing Medical Treatment," page 2.20);
4. A conservator who may make health care decisions is appointed (as discussed in "Temporary or Permanent Conservatorship," page 2.22, and "Petition for Appointment of Public Guardian," page 2.22);
5. In the circumstances discussed in "Family Members," page 2.22, the patient's closest available relative gives consent; or
6. Consent is obtained from an interdisciplinary team as described in "Unrepresented Patients in Skilled Nursing Facilities," page 2.18, or "Unrepresented Patients in Acute Care Facilities," page 2.19.

UNREPRESENTED PATIENTS IN SKILLED NURSING FACILITIES

Prior to 1992, if a patient in a skilled nursing or intermediate care facility lacked capacity and had no family member who was available and willing to make health care decisions, no conservator, and no other person with legal authority to make health care decisions on his or her behalf, the facility was forced to seek court authorization for treatment pursuant to Probate Code Section 3200 *et seq. (see "Court Order Authorizing Medical Treatment," page 2.20)*. Health and Safety Code Section 1418.8, adopted in 1992 and amended in 1994, allows the facility's interdisciplinary team (IDT) to authorize the initiation of medical intervention ordered by the attending physician that requires informed consent. The use of this process has recently been questioned by a court *(see "CANHR v. Chapman," page 2.19)*.

This law creates a process for authorizing affirmative care, not for authorizing the withholding or withdrawal of life-sustaining treatment. The IDT process is triggered "if the attending physician ... prescribes or orders a medical intervention that requires that informed consent be obtained ..." [Health and Safety Code Section 1418.8(a)].

The IDT process must be undertaken as follows:

1. The attending physician must determine, through direct patient interview, review of the patient's medical record, and consultation with facility staff, family members and friends, that the patient is unable to understand the nature and consequences of the proposed treatment, including its risks and benefits, or is unable to express a preference regarding the treatment;
2. The attending physician must determine, through direct patient interview, review of the patient's medical record, and consultation with facility staff, family members and friends, that there is no person with legal authority to make health care decisions for the patient (that is, no agent appointed in a valid power of attorney for health care, guardian, conservator, or next of kin);
3. Except in an emergency *(see h. below)*, the facility must conduct an IDT review of the medical intervention prior to its administration. This review must include all of the following:
    a. A review of the physician's assessment of the patient's condition.
    b. The reason for the proposed use of the medical intervention.
    c. A discussion of the desires of the patient, where known. To determine the desires of the patient, the IDT must interview the patient, review the patient's medical records and consult with family members or friends, if any have been identified.
    d. The type of medical intervention to be used in the patient's care, including its probable frequency and duration.
    e. The probable impact on the patient's condition, with and without the use of the medical intervention.
    f. Reasonable alternative medical interventions considered or utilized, and reasons for their discontinuance or inappropriateness.
    g. Evaluation by the IDT of the use of the prescribed medical intervention at least quarterly or upon a significant change in the patient's medical condition.
    h. In the case of an emergency, after obtaining a physician's order as necessary, a skilled nursing or intermediate care facility may administer a medical intervention that requires informed consent prior to convening an IDT review. If the emergency results in the application of physical or chemical restraints, the IDT must meet within one week of the emergency for an evaluation of the medical intervention.
4. The IDT must oversee the care of the patient utilizing a team approach to assessment and care planning and must include the patient's attending physician, a registered nurse with responsibility for the patient, and other appropriate staff in disciplines as determined by

the patient's needs. A patient representative must be included on the IDT, where practicable. The patient representative may include a family member or friend of the patient who is unable to take full responsibility for the health care decisions of the patient, but has agreed to serve on the IDT, or another person authorized by state or federal law, such as the public guardian or the ombudsman.

5. All determinations, and the bases therefore, must be documented in the patient's medical record and must be made available to the patient's representative for review.

This interdisciplinary team process was upheld by the California Court of Appeal in *Rains v. Belshé*, 32 Cal. App. 4th 157 (1995), as meeting constitutional standards for the privacy and due process rights of the patient. The court said the arduous requirements on the physician and the facility, the inclusion of a patient representative on the interdisciplinary team and the right of the patient, or the patient's representative, to judicial intervention, constituted a fair process that balanced the privacy and due process rights of the patient with the patient's right to medically necessary care. However, a later court has ruled in *CANHR v. Chapman* (discussed below) that this process may be unconstitutional. This decision has been appealed and is not in effect at the time of publication of this manual (June 2019).

CANHR v. Chapman

The Alameda County Superior Court on Jan. 27, 2016, held that Health and Safety Code Section 1418.8 is unconstitutional because it doesn't require SNFs to notify the patient that:

1. He or she has been determined to be incapable of making medical decisions,
2. There is no substitute decision maker available,
3. The nature of the prescribed medical intervention, and
4. How to seek review.

In addition, the court explicitly stated that interdisciplinary team consent may not be used to approve the administration of antipsychotic drugs or end-of-life care, such as withholding or withdrawing life-sustaining treatment. The court indicated that judicial review or an independent physician review would be required for these decisions. The decision in the case, *California Advocates for Nursing Home Reform (CANHR) v. Chapman*, has been appealed and is not in effect at the time of publication of this manual (June 2019).

As a strict legal matter, Health and Safety Code Section 1418.8 applies only to SNFs and not acute care hospitals. Acute care hospitals can expect to be affected, however, if the court order becomes final, because SNFs may transfer unrepresented patients who lack capacity to acute care hospitals if they develop conditions that trigger the need for an informed consent. SNFs may also decline to admit new patients who lack capacity and a decision maker. Hospitals may, therefore, see an increase in unrepresented patients.

In addition, many acute care hospitals have adopted the California Medical Association/California Hospital Association/Alliance of Catholic Hospitals model policy on making decisions for unrepresented patients (CHA Appendix 2-D), which is based on Health and Safety Code Section 1418.8. Hospitals that use this policy should consult legal counsel. They may wish to add appropriate safeguards to address the Superior Court's concerns, or seek conservatorship for unrepresented patients or court approval for prescribed care under Probate Code Section 3200 *et seq. (see "Court Order Authorizing Medical Treatment," page 2.20).* CHA has developed a check list of safeguards to consider; see CHA Appendix 2-E, "Considerations for Revising the Hospital's Policy & Procedure Regarding Decision Making for Unrepresented Patients." In addition, CHA has revised CHA Appendix 2-D to add appropriate safeguards.

UNREPRESENTED PATIENTS IN ACUTE CARE FACILITIES

California law has no provisions for consent to treatment on behalf of patients in general acute care hospitals who lack the capacity to make health care decisions, and who have no known family member or other legally authorized person available and willing to make those decisions.

In such cases, a hospital may wish to contact the public guardian or conservator in its geographic area, file a petition seeking a private conservator, or obtain a court order authorizing medical treatment. However, the California legislature has recognized that, "[i]n the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment" [Probate Code Section 4650(c)].

The California Hospital Association, California Medical Association, and Alliance for Catholic Health Care have developed a model policy for general acute care hospitals regarding health care decisions for unrepresented patients. This policy, "Health Care Decisions for Unrepresented Patients," is found at the end of this chapter as CHA Appendix 2-D.

Because there is no provision in California law for consent for treatment for unrepresented patients, hospitals are advised to consult legal counsel and risk management regarding whether to adopt this policy, and if so, how to implement it. Each hospital will need to carefully consider which patients the policy will apply to, the circumstances under which an independent physician consultation will be sought, when to seek a court order authorizing medical treatment, and when to seek the appointment of a conservator. Hospitals using this policy, or considering using this policy, should read the discussion under "CANHR v. Chapman," page 2.19. These are difficult and important decisions that each hospital will need to make.

COURT ORDER AUTHORIZING MEDICAL TREATMENT

Probate Code Sections 3200 to 3212 provide a procedure for petitioning a court to:

1. Determine that a patient has the capacity to make a health care decision; or
2. Determine that a patient lacks the capacity to make a health care decision and to designate a person to make a health care decision on behalf of the patient. [Probate Code Section 3201]

For purposes of this law, a **"health care decision"** means a decision regarding the patient's health care, including:

1. Selection and discharge of health care providers and institutions;
2. Approval or disapproval of diagnostic tests, surgical procedures, and programs of medication; and
3. Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

[Probate Code Section 3200(b)]

The law specifically states that it is not necessary to obtain a court order in an emergency situations in which health care is required for the alleviation of severe pain or the patient's condition, if not immediately diagnosed and treated, will lead to serious disability or death [Probate Code Section 3210(b)].

Persons Authorized to Petition for Court Order

A petition for a court order under this law may be filed by:

1. The patient.
2. The patient's spouse.
3. A relative or friend of the patient or other interested person, including the patient's agent under a power of attorney for health care.
4. The patient's physician.
5. A person acting on behalf of the health care facility in which the patient is located.
6. The public guardian or other county officer designated by the board of supervisors of the county in which the patient is located or resides or is temporarily living.

[Probate Code Section 3203]

Although the law allows the petition to be filed by a person acting on behalf of the hospital, it is recommended that the hospital not assume this responsibility except in extraordinary situations. The recommended alternative is to encourage another party authorized by the law to file a petition.

Contents of the Petition

The petition must state all of the following, so far as is known to the petitioner at the time the petition is filed:

1. The condition of the patient's health that requires treatment.
2. The recommended health care that is considered to be medically appropriate.
3. The threat to the patient's condition if authorization for the recommended health care is delayed or denied by the court.
4. The predictable or probable outcome of the recommended health care.
5. The medically available alternatives, if any, to the recommended health care.
6. The efforts made to obtain consent from the patient.
7. The name of the person to be designated to consent to the recommended health care on behalf of the patient, if the petition is filed by a person on behalf of a health care facility.
8. The deficit(s) in the patient's mental functions, as listed in Probate Code Section 811(a), that are impaired, and identification of a link between the deficit(s) and the patient's inability to respond knowingly and intelligently to queries about the recommended health care or inability to participate in a decision about the recommended health care by means of a rational thought process. The mental functions enumerated in Probate Code Section 811(a) fall into the following categories: alertness and attention; information processing; thought processes; and ability to modulate mood and affect.

9. The names and addresses, so far as they are known to the petitioner or proposed conservator, of the spouse or domestic partner and the relatives of the proposed conservatee within the second degree. If no spouse or domestic partner or relatives within the second degree are known to the petitioner, the names and addresses of certain other persons must be listed [Probate Code Section 1821(b)].

[Probate Code Section 3204]

This information may be included in the petition itself or in an attached affidavit.

The mere diagnosis of a mental or physical disorder is not sufficient in and of itself to support a determination that a person is of unsound mind or lacks the capacity to consent to medical treatment [Probate Code Section 811(d)].

Court Action on Petition

After the petition is filed, the court will determine whether the patient is represented by legal counsel, whether it will consider the petition in summary proceedings, and what, if any, notice of the hearing must be given.

Legal Counsel. If the patient has not retained an attorney and does not plan to do so, the court will appoint the public defender or a private attorney to consult with and represent the patient in the court proceedings [Probate Code Section 3205].

Summary Proceedings. The petition may be submitted for the determination of the court, without a hearing, upon proper and sufficient medical declarations if the attorney for the petitioner and the attorney for the patient so stipulate, provided they also stipulate that there remains no issue of fact to be determined. If, however, the parties do not stipulate to summary proceedings, a hearing must take place. [Probate Code Section 3207]

Notice of Hearing. If a hearing is required, notice of the time and place of the hearing on the petition, and a copy of the petition, must be:

1. Personally served on the patient, the patient's attorney, and the agent under the patient's power of attorney for health care, if any, and
2. Mailed to the patient's spouse, if any, and the patient's relatives named in the petition.

The personal service and mail service must take place not less than 15 days before the hearing. The court may shorten or waive notice of the hearing for good cause. In determining the period of notice to be required, the court must take into account the existing medical facts and circumstances and the desirability, where the condition of the patient permits, of giving adequate notice to all interested persons. [Probate Code Section 3206]

Circumstances in Which the Court May Issue an Order

Except in those situations discussed in "Limitations on a Guardian's Consent," page 2.29, the court may issue an order authorizing the recommended health care for the patient and designating a person to consent to the recommended health care on behalf of the patient if it determines from the evidence all of the following:

1. The existing or continuing condition of the patient's health requires the recommended health care.
2. There is a probability that the condition will become life-endangering or result in a serious threat to the physical or mental health of the patient, if untreated.
3. The patient is unable to consent to the recommended health care.

[Probate Code Section 3208(a)]

The court may also order the withholding or withdrawal of artificial nutrition and hydration and all other forms of health care, and designate a person to give or withhold consent to the recommended health care if the court determines that:

1. The recommended health care is in accordance with the patient's best interest, taking into consideration the patient's personal values to the extent known, and
2. The patient is unable to consent to the recommended health care.

[Probate Code Section 3208(c)]

Limitations on Court Order

Authorization must be obtained under the specific law indicated below if the treatment proposed involves any of the following (the court order obtained pursuant to Probate Code Section 3200 *et seq.* is not sufficient):

1. Placing a patient in a mental health treatment facility against his or her will [Probate Code Section 3211(a)]. *(See chapter 3 regarding establishing a Lanterman-Petris-Short Act conservatorship and involuntary detainment.)*
2. Prescribing or administering an experimental drug as defined in Health and Safety Code Section 111515 *et seq.* [Probate Code Section 3211(b)]. *(See chapter 7 of CHA's* Consent Manual *on the specific situations in which a conservator may consent to the prescription or administration of an experimental drug.)*

3. Administering convulsive treatment as defined in Welfare and Institutions Code Section 5325 [Probate Code Section 3211(c)]. *(See D. "Convulsive Therapy and Insulin Coma Treatment," page 2.49 for more information on conservator consent to convulsive treatment.)*
4. Sterilizing a patient [Probate Code Section 3211(d)]. The California Supreme Court's decision in *Conservatorship of Valerie N.*, 40 Cal.3d 143 (1985), allows a conservator to obtain a court order authorizing an adult conservatee's sterilization. Application should be made pursuant to Probate Code Section 2357 and strict criteria must be met.

Further, a court may not order treatment that thwarts a valid and effective advance health care directive [Probate Code Section 3211(e)].

Finding that Patient has Capacity to Consent

If the court finds that the patient has the capacity to consent to the recommended health care, the court will so state in its order [Probate Code Section 3208.5(a)].

If the court has determined that the patient has the capacity to consent to the recommended health care, the court must, if requested, determine whether the patient has accepted or refused the recommended health care, and whether the patient's consent to the recommended health care is an informed consent [Probate Code Section 3208.5(b)].

Where the court finds that the patient has the capacity to consent to the recommended health care, but refuses to do so, the court may not make an order authorizing the treatment or designating a person to give consent to the treatment. Furthermore, if an order has been made authorizing the treatment and designating a person to give consent, the order must be revoked if the court determines that the patient has recovered the capacity to give informed consent to the recommended course of medical treatment. Until revoked or modified, the order is effective authorization for the course of medical treatment [Probate Code Section 3208.5(c)].

TEMPORARY OR PERMANENT CONSERVATORSHIP

Any interested party may request a temporary and/or permanent conservatorship under Probate Code Section 1820. Although this often is the most desirable means of resolving the situation, it may not be a viable alternative if:

1. The patient needs relatively expedited care that cannot be postponed while the request for a conservatorship is being processed; and/or
2. The patient may only temporarily lack capacity (e.g., as a result of the patient's immediate medical condition) and therefore a conservatorship may not be warranted.

Once a petition for conservatorship is filed, a court investigator must interview the proposed conservatee, petitioners, proposed conservators, the proposed conservatee's spouse or registered domestic partner and relatives. The investigator will prepare a written report about the mental capacity of the proposed conservatee, which will be made available to the proposed conservatee, petitioners and relatives.

The conservatee has the right to have the matter tried by jury, be represented by legal counsel, and have legal counsel appointed by the court if unable to retain legal counsel.

If a conservatorship is ordered, the court investigator will interview the conservatee from time to time to determine if continuation of the conservatorship is warranted.

PETITION FOR APPOINTMENT OF PUBLIC GUARDIAN

Any interested person may initiate a proceeding to have the county public guardian appointed as the guardian or conservator of a:

> person domiciled in the county who appears to require a guardian or conservator, if it appears that there is no one else who is qualified and willing to act, and if that appointment as guardian or conservator would be in the best interests of the person.

In fact, the law *requires* the public guardian to apply for appointment as guardian or conservator of the person, the estate, or both, if there is an imminent threat to the person's health or safety or the person's estate.

A hospital that is interested in having the public guardian appointed as a patient's guardian or conservator should consult the public guardian's office. [Probate Code Section 2920]

FAMILY MEMBERS

Basis for Relying on Consent

In some circumstances, it may be necessary or desirable to rely upon the consent given by family members of a patient lacking capacity to make health care decisions. The California Supreme Court has indicated that in some cases it is appropriate for a relative to give consent. The court said:

> [I]f the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian *or closest available relative* (emphasis added). [*Cobbs v. Grant*, 8 Cal.3d 229, 244 (1972)]

Also, a California appellate court, in *Barber v. Superior Court*, 147 Cal.App.3d 1006 (1983), held that a hospital and physicians properly relied upon the decisions regarding discontinuance of medical treatment that were made by a patient's wife and children. The court explained that California law does not state that only court-appointed guardians or conservators have the authority to act on behalf of another person, and that in the absence of such a statement in the law, an incompetent patient's immediate family could make health care decisions for the patient. The court cautioned, however, that such persons must be guided first by the patient's own desires and feelings, to the extent they were expressed before the patient became incompetent. If the patient's desires were not expressed or cannot be ascertained, the court stated that surrogate decision makers must be guided by the patient's best interests.

The *Barber* decision adds an important element of protection for health facilities that rely on the consent of immediate family members. Accordingly, such reliance may be considered a reasonable means of dealing with situations in which an adult patient who does not have an agent or a conservator is unable to consent to required treatment. By obtaining the consent or concurrence of concerned relatives, the risk of liability will be minimized.

Basis for Not Relying on Consent

The hospital should not rely on consent from family members if any of the following circumstances are present:

1. The relative's capacity to make health care decisions or motives are questionable.
2. There is a substantial question as to whether the patient, if he or she had the capacity to make health care decisions, would consent to the procedure.
3. Another close relative objects to the medical procedure.

The facility should carefully consider the situation if the medical procedure required has uncertain or minimal expected benefits; will result in severe debilitation; and/or involves a significant risk of a negative outcome, such as paralysis. Also, if the relative's refusal to consent appears to be unreasonable, the refusal should not be relied upon. In each of these situations, it is probably preferable to rely upon the use of a Probate Code Section 3200 *et seq.* petition. *(See "Court Order Authorizing Medical Treatment," page 2.20.)* Legal counsel should be consulted.

Identifying an Appropriate Family Member to Consent

Once it is determined that it is appropriate to rely upon the consent of a family member, it is necessary to determine which family member is the most appropriate surrogate decision maker. The California Medical Association and the California Hospital Association have developed guidelines to assist physicians and hospitals in identifying an appropriate surrogate decision maker for a patient who lacks capacity and who has no guardian, conservator or agent appointed in a valid advance directive. These guidelines are found in CHA's *Consent Manual*, chapter 2.

If there is reason to suspect that the patient's family members are not acting in the best interests of the patient, the use of a Probate Code Section 3200 *et seq.* petition may be appropriate *(see "Court Order Authorizing Medical Treatment," page 2.20)*. Legal counsel should be consulted.

Registered Domestic Partners

California law states that a registered domestic partner has the same authority to make a health care decision for his or her incapacitated domestic partner as a spouse would have to make a health care decision for his or her incapacitated spouse [Family Code Section 297.5 and Probate Code Section 4716].

The physician must make a determination that the patient lacks capacity, prior to looking to the registered domestic partner to provide consent *(see ""Capacity" Defined," page 2.12)*.

The law permitting persons to register as domestic partners is found at Family Code Sections 297 and 297.1. **"Domestic partners"** are "two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring." The following requirements must be met in order to register as domestic partners:

1. Neither person is married or a member of another domestic partnership.
2. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
3. Both persons are at least 18 years of age. Persons under 18 must obtain parental permission and/or a court order.
4. Either of the following apply:
    a. Both persons are members of the same sex.
    b. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act for old-age insurance benefits or Title XVI of the Social Security Act for aged individuals. However, persons of opposite sexes may not constitute a domestic partnership unless one or both are over 62 years of age.

5. Both persons are capable of consenting to the domestic partnership.

The Secretary of State produces forms entitled "Declaration of Domestic Partnership" and "Notice of Termination of Domestic Partnership" to document the beginning and ending of a domestic partnership. The forms must be signed by each partner and also by a notary public. The Secretary of State will register the partnership and return a copy of the registered form to the domestic partners.

Hospitals are advised to develop and implement policies regarding proof of marriage and proof of domestic partnership equally. For example, if a hospital requires a person to produce a marriage certificate to prove that he is indeed the spouse of a patient, then the hospital should require a person to produce a registered "Declaration of Domestic Partnership" form to prove that he is indeed the registered domestic partner of a patient.

Under California law, registered domestic partners have the same rights and responsibilities as spouses. This may include paying medical and hospital bills.

E. Summary of Consent Requirements Regarding Adults

CHA has included a table at the end of this manual titled "Consent Requirements for Medical Treatment of Adults" (CHA Table 2-A) summarizing consent issues regarding adults.

VII. WHO MAY GIVE CONSENT: MINORS

A. Introduction

Parents have a legal obligation to provide the necessities of life for their minor children, including medical care [Penal Code Section 270]. It is generally accepted that, until their children reach 18 years of age, parents also have the right to control that care.

Some exceptions to this general rule exist. Some exceptions are based on the status of the minor (emancipated, married, serving in the military, etc.). Other exceptions are based upon the nature of the treatment sought (pregnancy-related care, communicable disease, mental health, etc.). This portion of the manual discusses who may consent for treatment on behalf of minors. Additional requirements for inpatient mental health admissions and treatment for minors, both voluntary and involuntary, are discussed in chapter 3.

The person who has the legal authority to consent for the treatment of a minor also has the legal authority to refuse the treatment. Thus, if a minor is legally authorized to consent to treatment, the minor also has the legal authority to refuse the treatment. The minor must also have the capacity to make health care decisions *(see B. "Capacity to Consent," page 2.37)*. However, if a parent or other legal representative refuses treatment for a minor and serious harm to the minor may result, legal counsel should be consulted. *(See F. "Where Refusal of Treatment May Cause Serious Harm to the Minor," page 2.26, for additional information.)*

"Minors" are all persons under 18 years of age [Family Code Section 6500].

B. The Evolution of the Rights of Minors

Minors, because of their legal status, have generally been recognized as lacking the legal capacity to give consent for health care services. In recognition of the interests of minors in health care decisions affecting them, and in appreciation of their actual capacity to understand and evaluate the nature of health care decisions confronting them, state legislatures and courts have determined that under specific circumstances, minors are to be treated as adults for purposes of consenting to care.

The early court cases that laid the foundation for this transformation found minors capable of providing consent to medical treatment through the doctrine of the "mature minor." This doctrine provides that a minor may give consent to medical care when the treating physician finds that:

1. The minor is of sufficient age (typically 14 years of age or over) to appreciate the risks and benefits of the proposed treatment;
2. The minor understands the risks and benefits of the treatment, and the consequences of the decision (i.e., the minor can give informed consent); and
3. The treatment will benefit the minor, not another person.

California has not adopted the mature minor doctrine. However, in 1953, the California Legislature gave unmarried pregnant minors the authority to consent to treatment related to their reproductive care. In 1961, minors on active duty in the armed services and those who were married, divorced, or widowed were given the right to consent to medical treatment. By 1970, the rights of minors were broadened to include the ability to consent to treatment if the minor is 15 years of age or over, living away from home and managing his or her own finances.

Whether a minor has the legal right to consent to medical treatment independent of the minor's parents will depend on several factors. In California, the law permits a minor to obtain medical treatment independent of parental authorization when:

1. The minor has achieved a status of "emancipation" as established by law;
2. The minor is seeking treatment for a statutorily specified medical need; or
3. There is some other specialized situation recognized by the law in which parental consent is not required.

These exceptions to the general rule requiring parental consent are discussed in this manual.

C. Financial Responsibility for Treatment of Minors

The person legally responsible for a minor (i.e., the minor's parent(s) or guardian) is generally responsible for the minor's financial obligations, including payment of medical bills. However, Welfare and Institutions Code Section 14010 states that the parents of a minor are not financially responsible for health care or related services to which the minor may legally consent. There is a limited exception to this general rule for emancipated minors living in the home of the parent(s) *(see C. "Emancipation Pursuant to Court Order," page 2.37)*, or if the parents are participating in counseling with the minor *(see "Parental Involvement/ Liability," page 2.39)*.

Health care providers should establish a system to ensure that they do not bill parents for services for which the parents are not financially responsible, as this may be considered a breach of the minor's privacy rights (unless the minor's authorization is obtained). Medi-Cal has a "minor consent" program (also known as "sensitive services" program) that enrolls minors regardless of parental income or assets, insurance status, or citizenship status. Parents will not be contacted. This program covers health care services for pregnancy, family planning, abortion, sexual assault, sexually transmitted diseases, mental health outpatient treatment (with some limitations), and substance abuse treatment. [Title 22, California Code of Regulations, Sections 50063.5, 50147.1, 50157, 50167 and 50195(d)] It is acceptable to bill insurance companies, even if the parent is the named subscriber on the policy; payers are required to have a procedure in place to ensure the minor's confidentiality.

D. Privacy Rights of Minors

Under state and federal law, a minor has a privacy right in health information resulting from services to which the minor is *authorized* to consent. This is true even if, as a practical matter, the minor's parent actually gives consent. For example, a parent may take his teenager to a physician for treatment of a reportable communicable disease. Even though the parent solicits and consents to the services, privacy laws prevent the health care provider from disclosing health information to the parent or guardian without the minor's authorization because, under state law, the minor *could have* obtained those services independent of the parent.

Both the Confidentiality of Medical Information Act and HIPAA contain an exception to privacy requirements to permit disclosure of limited information to a family member if the information is directly relevant to the family member's involvement with the patient's care. However, there are limitations on this exception *(see I. "Minor's Medical Records," page 6.12, and E. "Family and Friends: Patients Covered by CMIA," page 6.7)*. In addition, this exception does not apply to records and information covered by the Lanterman-Petris-Short (LPS) Act or to substance abuse information from federally-assisted substance use disorder treatment programs *(see chapter 6)*. The safest course of action if a provider wishes to discuss outpatient mental health treatment with a parent or guardian is to obtain the minor's written authorization for disclosure of health information. [45 C.F.R. Sections 164.502(g) and 164.510(b); Civil Code Sections 56.11(c) and 56.1007; Health and Safety Code Sections 123110 and 123115; Welfare and Institutions Code Section 5328]

Thus, in order to ensure HIPAA compliance and to avoid privacy breaches, providers must also understand the instances in which a minor has legal authority to consent to treatment. *(See chapter 6 for more information about minors' privacy rights.)*

E. Minor's Disagreement with Parent or Other Legal Representative Regarding Treatment

Medical providers occasionally encounter situations in which minors who do not have the legal authority to make health care decisions indicate a desire to refuse treatment that their parents or other legal representatives wish them to have — or conversely, wish to have treatment that their parents or other legal representatives decline. Although minors are considered legally incompetent to make decisions in many areas of medical care by virtue of their age, nevertheless it is appropriate to discuss medical

decisions with them in a manner appropriate to their age. Ascertainment of the child's preference for treatment was specifically approved in the case *In re Christopher I. (see "Minors in Custody of the Juvenile Court/Foster Children," page 2.47)*.

A minor's refusal to participate in mental health treatment presents special challenges for the therapist and may make treatment unproductive. A therapist is not required to treat a minor who is voluntarily admitted or who is an outpatient if the minor declines to cooperate, even if the parent(s) are insistent. Minors who are involuntarily admitted have a right to treatment *(see E. "Special Requirements for a Minor," page 3.16)*.

Providers should proceed cautiously in situations where the minor disagrees with the parents or other legal representatives, particularly if the treatment or refusal involves a significant risk of serious adverse consequences. Providers faced with such situations may wish to consider the following.

MINOR'S AGE, MATURITY, AND EXPERIENCE WITH THE TREATMENT IN QUESTION

Remember that the law permits minors as young as 12 years of age to consent to certain treatments, including outpatient mental health treatment *(see G. "Minors in Need of Outpatient Mental Health Treatment or Residential Shelter Services," page 2.39)*. This suggests that minors of that age may be in a position to appreciate the risks and burdens of other treatments as well, and may have reasonable grounds for wishing to consent to, or refuse, such treatment.

DISAGREEMENT REGARDING THE TREATMENT DECISION

The provider may be in a position to discuss the treatment with the minor, clarify any confusion or misunderstanding, and bring the matter into perspective. It may be helpful to involve a social worker, psychologist, or other person with a positive relationship with the minor to help resolve the disagreement between the minor and the parents or other legal representative.

If the provider is uncomfortable in providing treatment over the minor's objection, the provider may wish to reconsider the clinical appropriateness of the treatment, or may decline to participate in the case after taking appropriate steps to transfer the care of the patient to another health care provider. It may be appropriate to consult legal counsel in such situations. Consultation with legal counsel is strongly encouraged where refusal of care may cause serious harm to the minor *(see F. "Where Refusal of Treatment May Cause Serious Harm to the Minor," page 2.26)*.

F. Where Refusal of Treatment May Cause Serious Harm to the Minor

At times a health care provider may encounter a situation in which the parent, guardian, or other legal representative of a minor declines medically necessary care, and the refusal of that care may cause serious harm to the minor. In such cases, legal counsel should be consulted immediately. A parent or other legal representative may not decline treatment where such refusal may cause serious physical harm or illness to the minor; judicial intervention should be sought. This portion of the manual provides a very brief description of basic legal principles regarding such situations, but it is emphasized that legal counsel should always be sought in these cases.

If a minor, as a result of a mental disorder, is a danger to self or others or gravely disabled, the minor may be involuntarily detained for mental health evaluation and treatment even if the parent(s) will not authorize voluntary treatment [Welfare and Institutions Code Section 5585.53]. *(See E. "Special Requirements for a Minor," page 3.16.)*

REFUSAL FOR RELIGIOUS REASONS

Two of the more common situations involving refusal of care for religious reasons involve Jehovah's Witnesses, who may decline blood products, and Christian Scientists, who may decline traditional medical care in favor of treatment by spiritual means. *(See CHA's* Consent Manual*, chapter 6, for further information about refusal of blood products.)*

California law explicitly permits a parent to provide a minor with "treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, by a duly accredited practitioner thereof" [Penal Code Section 270]. *(See also Welfare and Institutions Code Sections 300, 5006, 7104 and 16509.1.)* However, provision of prayer alone to a minor child is permitted only insofar as the child is not threatened with serious physical harm or illness [*Walker v. Superior Court*, 253 Cal.Rptr. 1, 47 Cal.3d 112 (1988), rehearing denied, cert.den.109 S.Ct. 3186, 491 U.S. 905].

If the refusal of treatment may cause serious harm to the minor, California courts may order life-saving medical treatment despite the parents' refusal to consent to such treatment on religious grounds. The *Walker* court stated that "parents have no right to free exercise of religion at the price of a child's life…" The threatened harm does not

need to rise to the level of death for the courts to intervene. Health care providers should seek court intervention in such cases, rather than attempting to balance the competing interests involved and making the decision themselves whether to treat a minor over the parent's (or other legal representative's) objection.

Thus, the state may intervene in the parent-child relationship to protect the child.

COURT INTERVENTION

Welfare and Institutions Code Section 300 delineates the circumstances under which a child can be declared a dependent of the court. Any child who comes within the following description is within the jurisdiction of the juvenile court and may be declared a dependent child of the court:

> The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm or illness, as a result of the failure or inability of his or her parent or guardian to … provide the child with adequate food, clothing, shelter, or medical treatment … Whenever it is alleged that a child comes within the jurisdiction of the court on the basis of the parent's or guardian's willful failure to provide adequate medical treatment or specific decision to provide spiritual treatment through prayer, the court shall give deference to the parent's or guardian's medical treatment, nontreatment, or spiritual treatment through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, by an accredited practitioner thereof, and shall not assume jurisdiction unless necessary to protect the child from suffering serious physical harm or illness. In making its determination, the court shall consider (1) the nature of the treatment proposed by the parent or guardian, (2) the risks to the child posed by the course of treatment or nontreatment proposed by the parent or guardian, (3) the risk, if any, of the course of treatment being proposed by the petitioning agency, and (4) the likely success of the courses of treatment or nontreatment proposed by the parent or guardian and agency. The child shall continue to be a dependent child pursuant to this subdivision only so long as is necessary to protect the child from risk of suffering serious physical harm or illness. [Welfare and Institutions Code Section 300(b)]

In many counties, particular agencies provide assistance in securing the court's authorization to treat a minor when the parents have refused to consent (e.g., Child Protective Services). Such agencies are usually a part of the county's juvenile court services or department of social services. Also, assistance for securing court authorization for juveniles on probation may often be secured from the county's probation department.

VIII. MINORS LACKING LEGAL AUTHORITY TO CONSENT

By statutory definition, a person under the age of 18 is unable to consent to medical treatment except as otherwise allowed by law *(see IX. "Minors with Legal Authority to Consent," page 2.36)*. When a minor needs medical treatment, health care providers usually must look to a parent, guardian or other person to consent.

However, as with adults, consent to treatment may be presumed in medical emergencies, i.e., where a minor requires immediate care for alleviation of severe pain or immediate diagnosis and treatment of unforeseeable medical conditions which, if not immediately diagnosed and treated, would lead to serious disability or death [Business and Professions Code Section 2397(c)(2) and (3)]. *(See B. "Emergency Treatment Exception," page 2.3, for more information.)*

A. Parental Consent for Treatment of Minors

MINORS WITH MARRIED PARENTS

In the absence of evidence of a disagreement between the parents of a minor, either parent has the legal authority to consent [Family Code Section 6903]. Where one parent consents to treatment but the other parent is opposed, treatment should not be provided until the conflict is resolved.

MINORS WITH DIVORCED PARENTS

If both parents agree on the proposed treatment of the minor, the health care provider should have both parents sign the applicable consent forms.

If a disagreement exists about the treatment of a minor with divorced parents, a copy of the custody order should be obtained to determine which parent has the authority to make health care decisions for the child. The copy of the court order should be placed in the minor's medical record.

If one parent has sole legal custody, then that parent has the right and responsibility to make health care decisions for the child [Family Code Sections 3006 and 6903].

Where, as is often the case, the parents have joint legal custody, either parent has the right and responsibility to make health care decisions for the child unless the court has specified, in its custody order, that the consent of both parents is required [Family Code Sections 3003, 3083 and 6903].

If the parents having joint legal custody disagree regarding treatment of the minor, they should be instructed to obtain a court order resolving the dispute before medical treatment is provided, if the procedure can be delayed without jeopardizing the minor's health. If the delay might harm the minor, the physician and hospital may decide that treatment should be provided, notwithstanding one parent's objection. The rationale for such a decision should be carefully documented in the minor's medical record. Providers should consult with legal counsel regarding individual cases, as appropriate.

Access to a minor's medical records and information, to which the parent is otherwise entitled, may not be denied to a parent *solely* because that parent is not the minor's custodial parent [Family Code Section 3025]. *(See* In re Daniel C. H.*, 220 Cal. App.3d 814 (1990).)* However, other reasons may apply to deny a non-custodial parent access to the record (for example, the minor may consent to his or her own care and denies the parent access to the related information, or the parent has abused the child, etc.).

MINORS WITH STEPPARENTS

A stepparent who has not legally adopted a minor does not have the authority to consent to treatment on the minor's behalf without written authorization from the natural parent or guardian or a valid Caregiver's Authorization Affidavit *(see C. "Third-Party Consent for Treatment of Minors," page 2.30)*.

ADOPTED MINORS

Where a minor has been legally adopted (by order of the court), the adoptive parents have the same right to consent to medical care on behalf of the minor as would birth parents [Family Code Section 8616]. The birth parents have no rights or responsibilities for the child after adoption and thus may not consent to, or object to, medical treatment for the minor [Family Code Section 8617]. *(See also "Minors Placed for Adoption," page 2.32.)*

MINORS BORN OUT OF WEDLOCK

The mother has the legal authority to consent to medical treatment for a minor born out of wedlock.

The father also has the legal authority to consent to medical treatment for the minor. However, where there is reason to doubt the status of someone claiming to be a child's father, the provider should require a copy of a birth certificate or court judgment or order determining the existence of the father-child relationship before accepting the consent of the alleged father *(see California Uniform Parentage Act, Family Code Section 7600 et seq.).*

Where one parent consents to treatment but the other parent is opposed, treatment should not be provided until the conflict is resolved, if the procedure can be delayed without jeopardizing the child's health. If the delay might harm the child, the physician and hospital may decide that treatment should be provided, notwithstanding one parent's objection. The rationale for such a decision should be carefully documented in the minor's medical record. Legal counsel should be consulted in such cases.

MINORS WITH A REGISTERED DOMESTIC PARTNER PARENT(S)

California permits adults to register as domestic partners [Family Code Section 297] *(see "Registered Domestic Partners," page 2.23, for information about the requirements for registration as domestic partners)*. State law gives registered domestic partners (or former or surviving registered domestic partners) the same rights and obligations as are granted spouses in a marriage. This includes the rights and obligations of registered domestic partners with respect to a child of their partner. [Family Code Section 297.5]

However, becoming the spouse of a parent is not the same as becoming a parent, even for legally married heterosexual couples. For example, as noted above, even though a stepmother is legally married to a minor's natural father, the stepmother does not have the authority to consent to treatment on the minor's behalf without written authorization from the father or mother, or a valid Caregiver's Authorization Affidavit.

These same rules apply to registered domestic partners. In order for the registered domestic partner of a child's parent to consent for medical care for that child, the domestic partner must do one of the following:

1. The registered domestic partner must have legally adopted the child;
2. The registered domestic partner must provide a signed third-party authorization form giving him or her the ability to consent to medical care for the child *(see "Other Third-Party Consent," page 2.30)*; or
3. The registered domestic partner must complete a valid Caregiver's Authorization Affidavit *(see "The Caregiver's Authorization Affidavit," page 2.30)*.

Given the variety of relationships that can arise, if questions arise, or there is reason to doubt the status of someone claiming to be a child's parent, the provider may rely on the birth certificate or custody order to determine who may legally provide consent. If a registered domestic partner

is not named on the birth certificate or custody order, the registered domestic partner should be treated as a stepparent.

OTHER SITUATIONS INVOLVING NONBIOLOGICAL PARENTS OR MULTIPLE PARENTS

The courts are continuing to address a variety of situations in which men and women not biologically related to a child are being recognized as having parental rights and obligations, even in the absence of marriage or a registered domestic partnership. Several cases involving female same sex couples were decided in 2005. *(See* Elisa B. v. Superior Court, *37 Cal.4th 108 (2005) (woman held to have parental support obligations for children born to former partner during time that the women were in a committed relationship)*; K.M. v. E.G., *37 Cal.4th 130 (2005) (woman who donated ovum to birth mother and helped raised children acknowledged to have parental rights following their separation).)* These situations may present challenges where medical decision making for children is involved. One difficulty in such instances is that an individual's legal relationship to a child may be contested and require judicial intervention to determine. Hospitals should consult their legal counsel should they have reason to question the authority of purported decision makers.

A court may declare that a child has more than two parents [Family Code Sections 3040 and 7612]. Each parent should be treated as a natural parent, unless a court order says otherwise.

B. Guardian Consent for Treatment of Minors

If a guardian has been appointed for a minor, the ability of the guardian to consent to medical treatment for the minor depends on the specific authority granted by the court and the type of treatment.

A copy of the official certified letters of guardianship should be obtained and placed in the minor's medical record before proceeding with treatment. The official letters of guardianship should be reviewed to determine the scope of the guardian's legal authority to consent to medical treatment and that, if any, of the parents. If a conflict arises between the guardian and the parent(s), legal counsel should be contacted.

Except as otherwise specified in the letters of guardianship, the guardian may consent to medical treatment of the minor as follows.

NONSURGICAL TREATMENT

The guardian has the same rights as a parent to consent to nonsurgical treatment for the minor [Probate Code Section 2353(a)].

SURGICAL TREATMENT

The guardian's consent is necessary for surgical treatment. However, if the minor is 14 years of age or older, surgery may not be performed upon the minor without:

1. The consent of both the minor and the guardian; or
2. A court order obtained by the guardian; or
3. The consent of the guardian alone provided that the guardian determines in good faith, based on medical advice, that the case involves an emergency in which the minor faces loss of life or serious bodily injury if the surgery is not performed. In this situation, there is immunity from liability for an allegation of lack of consent.

[Probate Code Section 2353(b) and (c)]

LIMITATIONS ON A GUARDIAN'S CONSENT

The guardian's consent for certain types of treatment for the minor is insufficient or must meet additional specific requirements if the treatment involves:

1. Placing the patient in a mental health treatment facility [Probate Code Section 2356(a)]. A guardian may admit a ward to a private psychiatric facility pursuant to Welfare and Institutions Code Section 6002.15 or to a state hospital pursuant to Welfare and Institutions Code Section 6000. *(See chapter 3 about the admission of minors to psychiatric facilities, establishing Lanterman-Petris-Short Act conservatorships, and involuntary detainment.)*
2. Prescribing or administering an experimental drug as defined in Health and Safety Code Section 111515 *et seq.* [Probate Code Section 2356(b)]. *(See chapter 10 of CHA's* Consent Manual *on the specific situations in which a guardian may consent to the prescription or administration of an experimental drug.)*
3. Administering convulsive treatment as defined in Welfare and Institutions Code Section 5325 [Probate Code Section 2356(c)]. *(See X. "Treatments That Require Special Consent," page 2.42, on the protocol for and restrictions on a guardian's consent for administration of convulsive treatment.)*
4. Sterilization of the patient [Probate Code Section 2356(d)]. This prohibition applies only to elective

sterilizations (i.e., procedures performed primarily for the purpose of rendering the patient sterile), but not to treatment that is not for the purpose of, but results in, sterility (i.e., secondary sterilization). *(See chapter 5 of CHA's* Consent Manual *regarding the prohibition against elective sterilization of a minor.)*

5. Psychosurgery. Under no circumstances may psychosurgery be performed on a minor [Welfare and Institutions Code Section 5326.6].

6. Administering aid-in-dying medication. Only a mentally competent adult may request and self-administer an aid-in-dying medication [Health and Safety Code Section 443.2].

C. Third-Party Consent for Treatment of Minors

Children are often under the supervision of a person other than their parents or guardians for a major part of the day. Apart from the time minors spend in school, care for minors is often left in the hands of a babysitter, relative, neighbor, camp counselor, sports coach, preschool teacher or day care provider. *(See "Minors Who Are Ill or Injured During School Hours," page 2.32, about medical treatment of a minor's injury or illness at school.)* These persons are "third parties" within the context of health care law.

In specified circumstances, a third party (not the minor and not the parent/guardian) may consent to medical treatment on behalf of a minor. These circumstances are discussed below.

THE CAREGIVER'S AUTHORIZATION AFFIDAVIT

A nonparent adult relative with whom a minor is living may authorize medical and dental care (for which the minor lacks authority to consent) for the minor by completing and signing a "Caregiver's Authorization Affidavit" (CHA Form 2-2; form also found at). The relative has the same rights to authorize medical care as does a guardian *(see B. "Guardian Consent for Treatment of Minors," page 2.29).* It should be noted that this authority is not as extensive as a parent's authority when the treatment involved is surgical.

The law specifies that the relative may authorize mental health treatment, except for involuntary commitment, experimental treatment and convulsive treatment.

All of the following must apply for the authorization to be valid:

1. The minor must be living with the adult family member. **"Living with"** is not defined in the law, but presumably would not include a minor who is temporarily visiting an adult relative.

2. The adult must be a **"qualified relative,"** which is defined in the law as a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great," or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or divorce.

3. The adult must advise the parent(s) of the proposed medical treatment and have received no objection thereto, or the adult must be unable to contact the parents.

4. The adult must complete a "Caregiver's Authorization Affidavit" (CHA Form 2-2 or similar form) in which he or she attests that the elements outlined above are true and correct.

The affidavit becomes invalid when the health care provider learns that the minor no longer lives with the caregiver. However, affidavits printed before Jan. 1, 2005, contain the statement, "This affidavit is valid for only one year after the date on which it is executed." If a hospital is presented with an affidavit containing this statement, and the one-year time period has expired, the hospital should request that the caregiver complete a new affidavit.

Health care providers who treat minors in good faith reliance on the signed affidavit of a qualified relative are not subject to criminal or civil liability or subject to professional disciplinary action for such reliance if the applicable portions of the affidavit are completed. Health care providers have no obligation to make any further inquiry or investigation.

Providers should be careful to require that the affidavit is completed in its entirety, and that an attempt has been made to reach the minor's parents, prior to care being delivered to the minor.

OTHER THIRD-PARTY CONSENT

Family Code Section 6910 permits a parent, guardian or relative caregiver under the Caregiver's Authorization Affidavit to authorize someone else to consent to medical or dental care for the minor. For purposes of this law, the following definitions apply.

"Dental care" means X-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care by a dentist licensed under the Dental Practice Act [Family Code Section 6901].

"Medical care" means X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act [Family Code Section 6902].

"Parent or guardian" means either parent if both parents have legal custody, or the parent or person having legal custody, or the guardian, of a minor [Family Code Section 6903].

This procedure should be used only when the minor is not legally authorized to consent to his or her own treatment and when the minor's parents, guardians or caregiver under the Caregiver's Authorization Affidavit, are not available. CHA has developed a form, "Authorization for Third-Party Consent to Treatment of Minor Lacking Capacity to Consent" (CHA Form 2-3) for parents to complete when they wish to authorize another person to consent for health care for their child.

The "Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent" (CHA Form 2-3) also authorizes the hospital to surrender the physical custody of a minor to the authorized agent(s) of the parent(s) upon completion of treatment. Such an authorization is required before the hospital may surrender the physical custody of a minor who is not authorized to give consent and who is under the age of 16 to someone other than the minor's parent, guardian, or caregiver pursuant to the caregiver's authorization affidavit. In addition, the law requires the hospital to report such releases [Health and Safety Code Section 1283].

Content and Form of Authorization

Written Authorization. The authorization must be in writing. It may be prepared by a parent who has legal custody or another person who has legal custody (e.g., guardian). There is no requirement that the authorization be completed in the presence of hospital personnel or that it be dated.

Authorized Third Person. The designated third person may be any adult into whose care the minor has been entrusted.

It is permissible to identify the authorized adult person by title and employer rather than by name (e.g., Athletic Coach, John F. Kennedy High School, Sacramento). The treating health care provider should not be authorized as a third party to consent to the treatment of a minor. *(See "Authorizing the Provider as the Third Party" below.)*

Preference for CHA Form. The form "Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent" (CHA Form 2-3) has been developed to comply with Family Code Section 6910. While it is the preferred authorization in content and form, a comparable authorization signed by the parent(s) or guardian can be used.

Recommended Procedure

Where an adult who is not the parent or guardian seeks care for a minor with injury or illness which is not an emergency, the provider should request a copy of the parent's authorization and include it in the minor's medical record. Even where third party authorization is provided, it is prudent to attempt to contact the parent to confirm consent, and to inform the parent of the status of the minor.

If the adult does not have a written authorization and emergency care is not necessary, the provider should contact the parent(s) or guardian to obtain consent for treatment. If it is not possible to contact the parent(s) or guardian, the provider should apply first aid, where necessary, and consult with the adult regarding the necessary steps to be taken for further care.

Neighbors, Sitters and Other Noninstitutional Child Care Custodians

It is advisable that parents provide neighbors, adult babysitters and others to whom they entrust their children, a written authorization for consent to treatment along with a list of emergency phone numbers. When such an authorization is presented to a health care provider, an attempt should be made to contact and confer with the parents or other responsible person regarding the situation; however, the minor would still be able to get medically necessary care pursuant to the authorization.

When no authorization is provided and emergency care is not necessary, the provider must contact the parent(s) or guardian to obtain consent prior to treatment. If it is not possible to contact the parent(s) or guardian, the provider should apply first aid, if necessary, and consult with the adult regarding the necessary steps to be taken for further care.

Authorizing the Provider as the Third Party

Except for special circumstances addressed in the law (e.g., interdisciplinary teams in long-term care facilities), the treating health care provider should not be authorized as a third party to consent to treatment of a minor. The treating physician should discuss the situation and

proposed treatment with another person who is authorized to consent.

Health care providers can best serve their communities by:

1. Educating parents in their service area about the need to provide written authorizations for specified third parties to give consent for medical treatment for their children;
2. Developing model forms for parents to use that meet the legal requirement for authorization to consent to treatment of a minor; and
3. Providing local parents with the opportunity to keep a record of information about their child's basic health history, medications, and emergency contacts at the facility.

D. Special Situations Involving Minors Lacking Legal Authority to Consent

MINORS PLACED FOR ADOPTION

Where an adoption agency has obtained a relinquishment from the birth parent but the minor has not yet been legally adopted, the adoption agency may consent to medically necessary treatment.

Where the birth parents have not yet formally relinquished the child for adoption, a continuing consent for medical treatment should be obtained from the birth parents. This may be done by completing the "Health Facility Minor Release Report" (California Department of Social Services form AD-22). This form may be downloaded at www.dss.cahwnet.gov/cdssweb/entres/forms/english/ad22.pdf.

CHILDREN OF MINOR PARENTS

The law requiring parental consent to treat minors makes no distinction based on the age of the parent [Uniform Parentage Act, Family Code Section 7600 *et seq.*]. Thus, a minor parent may validly consent to medical or surgical treatment for his or her child. However, the minor parent must demonstrate the ability to understand the nature of the treatment, its risks and benefits, and any alternatives to the treatment, as with any situation requiring informed consent *(see B. "Capacity to Consent," page 2.37)*. Therefore, a provider may determine that a minor parent does not have the requisite maturity to make health care decisions for his or her child. Typically, the minor parent will authorize the grandparent to make health care decisions on behalf of the child. However, where there is conflict between the minor parent and other responsible adults, the provider should seek legal advice.

In order to assure financial responsibility if the minor parent is not emancipated or self-sufficient, the signature of some responsible adult, such as the mother's parents, also should be obtained on the "Conditions of Admission" form (CHA Form 8-1).

MINORS WHO ARE ALSO PARENTS

Since parenthood is not an emancipating event, an unmarried minor parent who is living with his or her parents or other responsible adult is not authorized under the law to consent to his or her own medical treatment. Thus, although it does not seem logical, a 14-year-old girl living with her parents may not legally consent to her own medical treatment (with those exceptions that apply to all minors), but she may legally consent to medical treatment for her baby.

MINORS WHO ARE ILL OR INJURED DURING SCHOOL HOURS

When a minor is ill or injured during regular school hours, reasonable medical treatment may be provided without parental consent if the minor's parent(s) or guardian cannot be reached. This does not apply if the parent(s) or guardian has filed with the school district a written objection to any medical treatment other than first aid. [Education Code Section 49407] Treatment is limited to medical treatment that is "reasonable" under the circumstances. This does not include procedures involving significant risk or invasiveness.

The law provides immunity from liability to a school district, officer of a school district, school principal, physician or hospital treating any child in any school in any district. It is not clear whether this law also applies when minors attending private schools are treated.

Before relying on this law, however, a provider should attempt to contact parents and determine whether a written objection has been filed with the school (or the school district). Schools typically have on file the name and telephone number of a student's parent or guardian authorized to consent to medical treatment for the student.

NONABANDONED MINORS WHOSE PARENTS ARE UNAVAILABLE

A minor may have parents who are unavailable. This situation usually arises when the parents are incarcerated or on a trip, or when the minor is away from home or in the care or custody of law enforcement agencies, a camp, sitter, foster home, foster parents pending adoption, and the like.

In such cases, the parents, guardian, or a legally authorized caregiver may authorize a third party to consent to medical treatment of the minor *(see C. "Third-Party Consent for Treatment of Minors," page 2.30)*. The third party must be an adult, and the authorization must be in writing. [Family Code Section 6910]

Also, as discussed below, Family Code Section 6911 provides that a superior court, upon a petition to the court by a minor, may summarily grant consent if the parents of a minor who is 16 years of age or older are unavailable to provide consent.

COURT AUTHORIZATION: MINORS 16 YEARS OF AGE OR OLDER

If the parents or guardian of a minor 16 years of age or older are unavailable to consent to medical treatment that requires their consent, a superior court may summarily grant consent upon an application of the minor. The minor must be a California resident. [Family Code Section 6911]

A copy of the court order should be obtained and placed in the patient's medical record before treatment is furnished pursuant to the order. No fee is charged by the court for proceedings under this law.

ABANDONED MINORS

It must first be established that the minor has been abandoned or deserted by the parents. If so, the local juvenile court or probation department should be contacted for assistance.

Family Code Section 6911, regarding consent by the superior court (discussed above), also applies under these circumstances.

DEPENDENTS AND WARDS OF THE JUVENILE COURT

Under certain circumstances, a minor may be adjudged either:

1. A dependent child of the juvenile court under Welfare and Institutions Code Section 300 (a child in danger of abuse or neglect); or
2. A ward of the juvenile court under Welfare and Institutions Code Sections 601 (a disobedient or truant child) or 602 (a child who has committed a crime).

After adjudication, parents are allowed to consent to health care for the child, unless the court takes away that right. A copy of the court order should be obtained, reviewed carefully, and placed in the child's medical record before treatment is furnished. In addition, the court may authorize medical treatment for the child. [Welfare and Institutions Code Sections 362 (dependent) and 727 (ward)]

Even before a final adjudication is made, the court may order medical treatment for a minor who is the subject of a petition for dependent child or ward status if the parent/guardian or other person who is authorized to consent is unwilling or unable to consent to treatment and a written recommendation for treatment has been obtained from a physician [Welfare and Institutions Code Sections 369(b) and 739(b)].

Psychotropic Medications

If a child is in the custody of the juvenile court (whether as a dependent child or a ward) and the child has been removed from the physical custody of the parent, only a juvenile court judicial officer has the authority to order the administration of psychotropic medications for the child. However, the juvenile court may issue an order delegating this authority to a parent upon finding that the parent poses no danger to the child and has the capacity to authorize the administration of psychotropic medications.

Court authorization for the administration of psychotropic medication is based on:

1. The child's overall mental health assessment and treatment plan,
2. The rationale for the proposed medication (provided in the context of past and current treatment efforts),
3. Other pharmacological and nonpharmacological treatments that have been used and the child's response to those treatments,
4. A discussion of symptoms not alleviated or ameliorated by other current or past treatment efforts, and
5. An explanation of how the psychotropic medication being prescribed is expected to improve the child's symptoms.

The court and various state agencies have developed policies and procedures and forms to implement this requirement. The process includes periodic oversight by the court of orders for psychotropic medications, facilitated by the county social worker, public health nurse, or other appropriate county staff. This oversight process is conducted in conjunction with other regularly scheduled court hearings and reports provided to the court by the county child welfare agency. The forms to implement this law are found at www.courts.ca.gov/forms.htm. *(See form JV-217-INFO, for information about the various Judicial Council forms regarding consent for psychotropic medications.)*

For the purposes of this law, **"psychotropic medications"** means medications administered for the purpose of

affecting the central nervous system to treat psychiatric disorders or illnesses. These medications include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psychostimulants. [Welfare and Institutions Code Section 369.5 and 739.5]. *(See B. "Antipsychotic Medications," page 2.42, regarding consent to antipsychotic medications.)*

A copy of the applicable court order, if any, should be obtained and placed in the medical record.

MINORS IN CUSTODY OF A SOCIAL WORKER OR PROBATION OFFICER

Absent special circumstances, social workers and probation officers do not have the authority to consent to treatment for minors in their custody. The parents retain this right. Exceptions to this general rule are described below. In addition to the exceptions in the law described below, the juvenile court may order that the social worker or probation officer be given the power to authorize medical treatment if the parent or guardian is unwilling or unable to do so [Welfare and Institutions Code Sections 369(c) and 739(c)]. Many courts have issued "standing orders" that give social workers and probation officers in the court's jurisdiction the right to consent for specified medical treatment. Hospitals should consult their county juvenile court for information.

Minor in Temporary Custody

If a minor is in temporary custody, a social worker or probation officer may, upon recommendation of the attending physician, authorize necessary medical treatment if he or she first notifies the parent or guardian. If the parent or guardian objects, treatment can be provided only upon order of the court. [Welfare and Institutions Code Sections 369(a) and 739(a)]

Minor in Custody of Probation Officer

If the court has ordered the custody of a minor to be under the supervision of a probation officer, the officer may place the minor in the home of a relative. In that case, the court may authorize the relative to consent for the minor's medical, surgical and dental care. [Welfare and Institutions Code Section 727(a)(1)]

Providers who are caring for these minors must request a copy of either the parent's consent or an order from the court authorizing treatment or specifying that the probation officer or relative may consent on behalf of the minor.

Emergency

In an emergency situation, emergency medical, surgical or dental treatment may be provided by a physician or dentist, as appropriate, without a court order and upon authorization of a social worker or probation officer. The consent of a parent, guardian or other legally-authorized person is not required, but reasonable efforts must be made by the social worker or probation officer to obtain such consent or at least to notify the parent(s) or guardian prior to authorizing the treatment. [Welfare and Institutions Code Sections 369(d) and 739(d)]

Minor Has Authority to Consent

For those treatments for which a minor can legally provide his or her own consent, no court order or other authorization is necessary.

MINORS IN CUSTODY OF FOSTER PARENTS

A child may become a "dependent child of the juvenile court" (often referred to as a "foster child") when the parent is not properly caring for the child. This usually happens after a complaint to a local child protective services agency is investigated by a social worker. After investigating, the social worker will do one of the following:

1. Not take any action, if there is no evidence of abuse or neglect that requires court involvement.
2. Offer the parent services to help him or her learn how to parent the child more safely.
3. Leave the child in the parent's care and file a petition with the court that asks to the court to open a case to protect the child.
4. Take custody of the child from the parent and file a petition with the court that asks the court to open a case to protect the child. The social worker must file the petition within two court days of removing the child. The social worker may place the child with the other parent (if they are separated), with a relative, or in a foster home.

The parents retain the legal authority to consent to health care on behalf of the child, unless a court order says otherwise. In addition, foster parents may provide consent in some circumstances.

A foster parent's right to consent to treatment for a minor depends upon whether the child has been placed with the foster parent:

1. By court order or with the consent of the child's legal custodians; or

2. On a temporary basis before a detention hearing has been held.

Licensed foster care providers may consent to "ordinary" medical and dental treatment for a minor placed with them pursuant to a court order or with the voluntary consent of the parent or guardian. **"Ordinary"** medical and dental treatment includes, but is not limited to, immunizations, physical examinations and X-rays [Health and Safety Code Section 1530.6].

Foster parents who have custody of a child on only a temporary basis prior to a detention hearing and court ordered placement do not have this same authority. Therefore, they do not have the right to consent to medical treatment for the child under that law.

However, providers should look to the local juvenile court for guidance in such situations. Many courts have issued "standing orders" that give all foster parents in the court's jurisdiction the right to consent for specified medical treatment. Hospitals should consult their county juvenile court for information.

Written evidence of the foster parent's authority (e.g., a copy of a court order or the consent of the child's parent or guardian) should be obtained and placed in the child's medical record before proceeding with treatment. The provider should consult legal counsel if questions arise about consent for minors in the custody of foster parents.

MINORS WHO ARE SUSPECTED VICTIMS OF CHILD ABUSE

Special Law for X-Rays

Health care providers are required to report suspected cases of child abuse and neglect to law enforcement officers. Chapter 11 contains detailed information about child abuse reporting requirements as well as consent for examination and treatment of suspected child abuse victims.

A physician or dentist (or their agents at their direction) may take skeletal X-rays of a child without the consent of the child's parent or guardian, but only for the purpose of diagnosing the case as one of possible child abuse or neglect and determining the extent of the abuse or neglect [Penal Code Section 11171.2].

Additionally, if a peace officer in the course of investigation of child abuse or neglect has reasonable cause to believe that the child has been physically abused, the officer may apply to a magistrate for an order directing that the child be X-rayed without parental consent [Penal Code Section 11171.5]. X-rays performed pursuant to such an order must be performed by a physician or dentist or their agents. Reimbursement by the county for administrative costs of these X-rays will not exceed 5 percent of the cost of the X-rays.

Other Treatment

If further treatment beyond X-rays is necessary and the parents object, the hospital should consult legal counsel. It may be appropriate to seek a petition to declare the minor a dependent child of the juvenile court under Welfare and Institutions Code Section 300 for the purposes of assuring that he or she receives the proper medical care.

If the minor has been raped or sexually assaulted, the minor may give consent to medical treatment *(see "Minor Victims of Sexual Assault," page 2.41, and "Minor Rape Victims," page 2.41)*.

MINORS RECEIVING MEDICATION ASSISTED TREATMENT FOR OPIOID USE DISORDERS

An opioid treatment program (OTP) must be certified by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to dispense opioid drugs to treat opioid use disorder. In addition, a practitioner who intends to dispense opioid drugs to treat opioid use disorder must first obtain from SAMHSA a certification that he or she is qualified and will comply with SAMHSA rules.

An OTP must ensure that patients are admitted to maintenance treatment by qualified personnel who have determined, using accepted medical criteria such as those listed in the Diagnostic and Statistical Manual for Mental Disorders, that the person is currently addicted to an opioid drug, and that the person became addicted at least one year before admission for treatment. In addition, a program physician shall ensure that each patient voluntarily chooses maintenance treatment and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient, and that each patient provides informed written consent to treatment.

A person under 18 years of age is required to have had two documented unsuccessful attempts at short-term detoxification or drug-free treatment within a 12-month period to be eligible for maintenance treatment. No person under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by state law consents in writing to such treatment.

"Maintenance treatment" means the dispensing of an opioid agonist treatment medication at stable dosage levels for a period in excess of 21 days in the treatment of an individual for opioid use disorder.

[42 C.F.R. Sections 8.2, 8.11 and 8.12]

E. Minor's Disagreement with Parent or Other Legal Representative Regarding Treatment

Medical providers occasionally encounter situations in which minors who do not have the legal authority to make health care decisions indicate a desire to refuse treatment that their parents or other legal representatives wish them to have — or conversely, wish to have treatment that their parents or other legal representatives decline. Although minors are considered legally incompetent to make decisions in many areas of medical care by virtue of their age, nevertheless it is appropriate to discuss medical decisions with them in a manner appropriate to their age. Ascertainment of the child's preference for treatment was specifically approved in the case *In re Christopher I. (see "Dependents and Wards of the Juvenile Court," page 2.33)*.

A minor's refusal to participate in mental health treatment presents special challenges for the therapist and may make treatment unproductive. A therapist is not required to treat a minor who is voluntarily admitted or who is an outpatient if the minor declines to cooperate, even if the parent(s) are insistent. Minors who are involuntarily admitted have a right to treatment *(see D. "Special Situations Involving Minors Lacking Legal Authority to Consent," page 2.32)*.

Providers should proceed cautiously in situations where the minor disagrees with the parents or other legal representatives, particularly if the treatment or refusal involves a significant risk of serious adverse consequences. Providers faced with such situations may wish to consider the following.

MINOR'S AGE, MATURITY, AND EXPERIENCE WITH THE TREATMENT IN QUESTION

Remember that the law permits minors as young as 12 years of age to consent to certain treatments. This suggests that minors of that age may be in a position to appreciate the risks and burdens of other treatments as well, and may have reasonable grounds for wishing to consent to, or refuse, such treatment.

DISAGREEMENT REGARDING THE TREATMENT DECISION

The provider may be in a position to discuss the treatment with the minor, clarify any confusion or misunderstanding, and bring the matter into perspective. It may be helpful to involve a social worker, psychologist, or other person with a positive relationship with the minor to help resolve the disagreement between the minor and the parents or other legal representative.

If the provider is uncomfortable in providing treatment over the minor's objection, the provider may wish to reconsider the clinical appropriateness of the treatment, or may decline to participate in the case after taking appropriate steps to transfer the care of the patient to another health care provider. It may be appropriate to consult legal counsel in such situations. Consultation with legal counsel is strongly encouraged where refusal of care may cause serious harm to the minor.

IX. MINORS WITH LEGAL AUTHORITY TO CONSENT

A. Introduction

The California Legislature has enacted a series of laws, discussed below, authorizing particular categories of minors to consent to various medical services. Many of these laws also include provisions relating to parental notice and payment for the minor's medical care. Minors may be legally authorized to consent to their own medical care in two different ways:

1. Because of their quasi-adult status (emancipated, self-sufficient, on active duty in the military, or married/previously married), or
2. Because of the type of treatment they are seeking (pregnancy or contraceptive care, communicable reportable disease, rape or sexual assault treatment, etc.).

This section of the manual describes those circumstances.

Welfare and Institutions Code Section 14010 states that the parents of a minor are not financially responsible for health care or related services to which the minor may legally give consent. *(See C. "Financial Responsibility for Treatment of Minors," page 2.25, for further information.)*

Under state and federal law, a minor has a privacy right in health information resulting from services to which the minor is *authorized* to consent. This is true even if, as a practical matter, the minor's parent or guardian actually gives consent. Thus, in order to ensure HIPAA compliance and to avoid privacy breaches, providers must also understand the instances in which a minor has legal authority to consent to treatment. *(See D. "Privacy Rights of Minors," page 2.25, for additional information.)*

A minor who would otherwise have the legal authority to consent to medical treatment may not do so if he or she does not understand the nature and consequences of the proposed health care, including its significant benefits,

risks, and alternatives *(see B. "Capacity to Consent" below)*. Legal counsel should be consulted if doubt exists about whether a particular minor may consent to medical treatment.

B. Capacity to Consent

Even where the law specifies that a minor is legally authorized to consent to his or her own care, the doctrine of informed consent requires that a determination be made that, in fact, the minor has the capacity to make health care decisions. California law defines capacity for adults in the context of advance health care directives. **"Capacity"** means that the person has the ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes, in the case of proposed health care, the ability to understand its significant benefits, risks and alternatives [Probate Code Section 4609]. The primary physician determines the patient's capacity to make health care decisions [Probate Code Sections 4657 and 4658].

"Primary physician" means a physician designated by a patient or the patient's agent, conservator, or surrogate, to have primary responsibility for the patient's health care or, in the absence of a designation or if the designated physician is not reasonably available or declines to act as primary physician, a physician who undertakes the responsibility [Probate Code Section 4631].

There is no specific statute defining capacity for a minor. Providers should consult the adult standard as a guideline *(see "Determination of Capacity," page 2.12)*. In addition, providers may look to the mature minor doctrine, applicable in other states (not in California), that suggests that a minor who has reached a certain age (typically 14), and demonstrates an understanding of the risks and benefits of a medical treatment, does not need parental consent for such treatment, regardless of the minor's legal status. Under the mature minor doctrine, some key considerations when working with minors who are seeking treatment without the consent of a parent or other legal representative are:

1. Does the minor understand the nature of the treatment, its risks, benefits, and alternatives?
2. Does the minor appreciate the potential consequences of the treatment and of foregoing treatment?
3. Can the minor make a reasoned decision based on the information provided?
4. Is the proposed treatment for the benefit of the minor, and not for the benefit of another person?
5. Is the proposed treatment medically necessary?
6. Does the treatment, or its consequences, involve complex, high-risk medical care?

(See B. "The Evolution of the Rights of Minors," page 2.24, for more information about the mature minor doctrine.)

If the minor has the legal authority to consent to his or her own health care, the provider should take extra care to explain, in terms that are understandable to the minor, the elements necessary to making an informed decision about the proposed treatment *(see A. "Elements of Informed Consent," page 2.5)*.

If a minor lacks the capacity to provide informed consent to treatment which the law otherwise would allow, the health care provider does not necessarily have the authority or responsibility to contact the minor's parents. Communications with the minor, as with any adult patient, are generally confidential and subject to medical privacy laws. In such circumstances the health care provider should attempt to obtain the agreement of the minor to contact the parent or guardian. Legal counsel should be consulted if the minor refuses and may forego necessary medical care.

If a parent or other legal representative is providing consent on behalf of a patient who lacks the capacity to make a health care decision, the parent or other legal representative must have the capacity to make health care decisions.

C. Emancipation Pursuant to Court Order

A minor 14 years of age or older may petition the court for emancipation. If the court grants the request, the Department of Motor Vehicles will issue an identification card that states that the minor is emancipated. The provider should obtain a copy of the identification card and place it in the patient's medical record. A person who, in good faith, examines a minor's identification card and relies on a minor's representation that he/she is emancipated, will be protected under the law [Family Code Sections 7120, 7140 and 7141].

An emancipated minor may consent to his or her own medical, dental or psychiatric care without parental consent, knowledge, or liability [Family Code Sections 7002 and 7050(e)(1)].

However, the parents of an emancipated minor who is living in the home of the parent(s) may be responsible for the minor's medical expenses, with the exception of

services described in Family Code Sections 6924 through 6929 *(see CHA Appendix 2-B, "Consent Requirements for Medical Treatment of Minors," for a description of what these services are)* [Welfare and Institutions Code Section 14010(b)]. Hospitals should be aware of the privacy rights of such minors and obtain the minor's consent prior to sending the parents a bill *(see C. "Financial Responsibility for Treatment of Minors," page 2.25).*

If the minor does not have an identification card, the facility should determine if he or she is self sufficient under Family Code Section 6922 *(see D. "Self-Sufficient Minors," page 2.38)* and, therefore, capable of granting a valid consent under that law.

D. Self-Sufficient Minors

A self-sufficient minor is legally authorized to consent to medical or dental care without parental or guardian consent, knowledge, or financial liability. To be considered a self-sufficient minor, the minor must:

1. Be 15 years of age or older;
2. Be living separate and apart from his or her parent(s) or legal guardian, whether with or without the consent or acquiescence of his or her parent(s) or legal guardian. The duration of the separate residence is irrelevant; and
3. Be managing his or her financial affairs, regardless of the source of income.

[Family Code Section 6922]

A health care provider should make a good faith attempt to determine whether the above requirements are met. While a provider may be able to verify the minor's age (e.g., by reference to a driver's license, school identification card, or birth certificate), the other requirements are more difficult to verify. A health care provider may ask questions to help determine whether the minor is living separate and apart from his parents or is managing his or her financial affairs, but it may be difficult to verify the truthfulness of the minor's answers. Furthermore, the law provides no guidance whatsoever to making those determinations. For example, the law does not specify that the minor must have a job or a bank account to be considered self-sufficient — or that if the minor has a job or bank account, this demonstrates that he or she is self-sufficient. Providers are advised to make a good faith effort to determine whether the minor meets the requirements listed above, and document the information obtained from the minor thoroughly.

DEFINITIONS

"Medical care" means "X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care" under the supervision and upon the advice of a licensed physician [Family Code Section 6902].

"Dental care" means "X-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care" by a licensed dentist [Family Code Section 6901].

Psychiatric care is not explicitly included within the definition of "medical care" to which a self-sufficient minor may consent. Because the definition of health care to which an *emancipated* minor may consent explicitly discusses psychiatric care, and because there is a statute that explicitly discusses minor consent to *outpatient* psychiatric care, an argument may be made that a self-sufficient minor may not consent to psychiatric care pursuant to Family Code Section 6922. A health care facility should consult its own legal counsel regarding the advisability of permitting a self-sufficient minor to consent to his or her own inpatient psychiatric care (or outpatient care if the requirements of Family Code Section 6924 or Health and Safety Code Section 124260 do not apply). *(See G. "Minors in Need of Outpatient Mental Health Treatment or Residential Shelter Services," page 2.39, regarding consent by minors to outpatient mental health treatment.)*

DOCUMENTATION

The minor should affirm that the above conditions are met and complete the "Self-Sufficient Minor Information" (CHA Form 2-1). In the absence of evidence to the contrary, the hospital may reasonably believe that the affirmations made in CHA Form 2-1 are correct without independent verification.

NOTIFYING PARENT/GUARDIAN

The treating physician may inform a self-sufficient minor's parent(s) or guardian of the treatment given or needed with or without the minor's consent, if the minor has told the physician where the parents or guardian may be contacted. [Family Code Section 6922(c)] However, this authority should be exercised with caution and with due respect for the minor's privacy rights.

E. Minors on Active Duty with U.S. Armed Forces

A minor, regardless of age, while serving on active duty with any branch of the U.S. armed services is emancipated and may consent to medical, dental, or psychiatric care without

parental consent, knowledge, or liability [Family Code Sections 7002 and 7050(e)(1)]. The hospital may wish to photocopy the patient's active duty military identification card and include it in the medical record.

F. Married or Previously Married Minors

A minor who has entered into a valid marriage or domestic partnership, whether or not it was later terminated by dissolution (divorce) or death of the spouse or partner, is emancipated and may consent to medical, dental or psychiatric care without parental consent, knowledge, or liability [Family Code Sections 7002 and 7050(e)(1)].

The provider may wish to require a person under 18 years of age who claims that he or she is or was married or in a domestic partnership to present a copy of the marriage or domestic partnership certificate.

California does not recognize so-called "common law" marriages.

G. Minors in Need of Outpatient Mental Health Treatment or Residential Shelter Services

A minor 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis or to residential shelter services if:

1. He or she is, in the opinion of the attending professional person, mature enough to participate intelligently in the outpatient services or residential shelter services; and
2. The minor would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or the minor is the alleged victim of incest or child abuse. This requirement need not be met with respect to mental health treatment or counseling services (it still applies to residential shelter services); however, Medi-Cal may not cover these services unless this requirement is met. *(See C. "Financial Responsibility for Treatment of Minors," page 2.25.)*

[Family Code Section 6924; Health and Safety Code Section 124260]

However, this law does not allow minors to consent to convulsive therapy, psychosurgery or psychotropic drugs. Psychotropic drugs include antidepressants, antianxiety medications, antipsychotics, and other medications commonly prescribed for mental health patients.

DEFINITIONS

"Mental health treatment or counseling services" means the provision of such services on an outpatient basis by any of the following:

1. A governmental agency.
2. A person or agency having a contract with a governmental agency to provide the services.
3. An agency that receives funding from community united funds.
4. A runaway house or crisis resolution center.
5. A professional person (as defined below).

A **"professional person"** includes a psychiatrist, clinical psychologist, marriage and family therapist, licensed educational psychologist, credentialed school psychologist, licensed professional clinical counselor, licensed clinical social worker, and others [Family Code Section 6924(a)(2); Health and Safety Code Section 124260(a)(2); Title 9, California Code of Regulations, Sections 622-626].

"Residential shelter services" means the provision of residential and other support services to minors on a temporary or emergency basis in a facility that services only minors by a governmental agency, a person or agency having a contract with a governmental agency to provide these services, an agency that receives funding from community funds, or a licensed community care facility or crisis resolution center. Residential shelter services also include other support services on a temporary or emergency basis by a professional person.

PARENTAL INVOLVEMENT/LIABILITY

The consent of the parent(s) or guardian for mental health treatment or counseling is not necessary and they will not be liable for payment for the minor's care unless they participate, and then only for the services rendered with such participation. The minor's parent(s) or guardian must be given the opportunity to participate in the treatment or counseling unless the professional person who is providing the treatment or counseling deems it inappropriate. The professional person must consult with the minor prior to making this determination. (This law does not require the professional to cease treating a minor if the parents are contacted but refuse to participate in and/or object to the minor's receiving such treatment.) The professional responsible for treating the minor must document in the patient's record whether and when he or she attempted to contact the minor's parent(s) or guardian, whether or not they were contacted, *or* the reason why it would not be appropriate to contact the parent(s) or guardian.

A professional person offering residential shelter services, whether as an individual or as a representative of an entity, must make his or her best efforts to notify the parent or guardian of the provision of services. The minor's parents or guardian are not liable for payment for residential shelter services unless they consent to the provision of those services.

PRIVACY IMPLICATIONS

Under state and federal law, a minor has a privacy right in health information resulting from services to which the minor is *authorized* to consent. This is true even if, as a practical matter, the minor's parent or guardian actually gives consent. Thus, a parent may take his adolescent child to a private therapist for treatment of an eating disorder. Even though the parent or guardian solicits and consents to the services, privacy laws prevent the therapist from disclosing health information to the parent or guardian (without the minor's authorization) because, under state law, the minor *could have* obtained those services independent of the parent or guardian, and the minor has not requested that the parent or guardian be treated as the minor's personal representative under the Health Insurance Portability and Accountability Act (HIPAA). Both the Confidentiality of Medical Information Act and HIPAA contain an exception to privacy requirements to permit disclosure of limited information to a family member if the information is directly relevant to the family member's involvement with the patient's care. However, there are limitations on this exception *(see I. "Minor's Medical Records," page 6.12, and E. "Family and Friends: Patients Covered by CMIA," page 6.7)*. In addition, this exception does not apply to records and information covered by the Lanterman-Petris-Short Act. [45 C.F.R. Sections 164.502(g) and 164.510(b); Civil Code Sections 56.11(c) and 56.1007; Health and Safety Code Sections 123110 and 123115; Welfare and Institutions Code Section 5328]

LIMITATIONS

This law does not authorize a minor to receive convulsive therapy, psychosurgery, or psychotropic drugs without the consent of his parent(s) or guardian according to the appropriate legal requirements. *(See X. "Treatments That Require Special Consent," page 2.42.)*

H. Minors with Drug- or Alcohol-Related Problems

A minor 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem. **"Counseling"** is defined, for the purposes of this law, as the provision of counseling services by a provider under a contract with the state or a county to provide alcohol or drug abuse counseling services. **"Medical care"** is defined, for the purposes of this law, as X-ray examination, anesthetic, medical or surgical diagnosis or treatment, as well as hospital care under the supervision of a physician. [Family Code Sections 6902 and 6929]

The consent of the minor's parent(s) or guardian is not necessary and they will not be liable for payment of the minor's care unless they participate in a counseling program related to such treatment. The minor's parent(s) or guardian must be given the opportunity to participate in the treatment or counseling unless the professional who is providing the treatment or counseling deems it inappropriate. (This law does not require the professional to cease treating the minor if the parents are contacted but refuse to participate and/or object to the minor's receiving such treatment.) The professional responsible for treating the minor must document whether and when he or she tried to contact the minor's parent(s) or guardian, whether or not they were contacted, or the reason why it would not be appropriate to contact the parents or guardian.

"Professional person" means a physician and surgeon, registered nurse, psychologist, clinical social worker, marriage and family therapist, marriage and family therapist registered intern (when appropriately employed and supervised pursuant to Business and Professions Code Section 4980.43), psychological assistant (when appropriately employed and supervised pursuant to Business and Professions Code Section 2913), associate clinical social worker (when appropriately employed and supervised pursuant to Business and Professions Code Section 4996.18), or associate professional clinical counselor (when appropriately employed and supervised pursuant to Business and Professions Code Section 4999.42).

The law explicitly states that a parent or guardian has the right to seek medical care and counseling for the drug- or alcohol-related problem of a minor, even if the minor does not consent to the medical care and counseling [Family Code Section 6929(f)]. However, if a provider is uncomfortable treating a minor without his or her consent, the provider need not do so.

This law does not authorize a minor to receive replacement narcotic abuse treatment (such as methadone, levo-alpha-acetylmethadol (LAAM) or buprenorphine products) without the consent of his or her parent(s) or guardian [Family Code Section 6929(e)].

The law explicitly states that where the parent or guardian has sought medical care and counseling for a drug- or alcohol-related problem, and the minor receives the care sought, the physician must disclose medical information regarding such care to the minor's parents or guardian upon their request, even where the minor objects [Family Code Section 6929(g)]. (However, where the care is provided in a federally-assisted substance use disorder program, federal law requires the minor's consent prior to release of any patient information.) There is no liability for such disclosure. This law does not explicitly permit a hospital or practitioner other than a physician to disclose information in such circumstances; therefore, it is recommended that requests for information from a minor's parents or guardian be directed to the minor's physician.

Health and Safety Code Section 1607.5 permits a minor 17 years of age or older to consent to blood donation. A minor between the ages of 15 and 17 may consent to blood donation, but the blood bank may accept such donation only with the written consent of the minor's parent(s) or guardian and the written authorization of a physician.

A minor who is at least 15 years of age may make an anatomical gift with the written consent of a parent or guardian [Health and Safety Code Section 7150.15].

I. Minors Consenting to Other Procedures

MINORS RECEIVING PREGNANCY OR CONTRACEPTIVE CARE

A minor, regardless of age or marital status, may consent to hospital, medical, or surgical care related to treatment or prevention of pregnancy [Family Code Section 6925]. While the law does not specify the medical treatments that come within this authorization, it is generally assumed that contraceptive care (including emergency contraceptive drugs), abortion, pelvic exams, pregnancy testing, and prenatal care are medical procedures related to treatment or prevention of pregnancy. However, this law does not apply to sterilization procedures.

COMMUNICABLE REPORTABLE DISEASES

When a minor 12 years of age or older may have come into contact with an infectious, contagious, or communicable disease that must be reported to the local health officer, or a related sexually transmitted disease, the minor is able to consent to medical care related to the diagnosis or treatment of the disease [Family Code Section 6926]. *(See Title 17, California Code of Regulations, Section 2500(j), for a list of reportable diseases.)* This provision of law authorizes minors to consent to HIV tests *(see "Minors 12 and Older," page 2.56)*.

In addition, a minor who is 12 years of age or older may consent to medical care related to the prevention of a sexually transmitted disease. This provision authorizes minors to consent to, or refuse to consent to, the HPV vaccine.

MINOR RAPE VICTIMS

A minor 12 years of age or older who has allegedly been raped may consent to the furnishing of hospital, medical, and surgical care related to the diagnosis or treatment of such condition. This includes access to the "morning after" pill [*Brownfield v. Daniel Freeman Marina Hospital*, 208 Cal.App.3d 405(1989)]. The minor may also consent to the collection of evidence with regard to the alleged rape. The consent of the minor's parent(s) or guardian is not necessary. [Family Code Section 6927; Title 11, California Code of Regulations, Section 925]

A minor who has been raped has also been sexually assaulted, according to the legal definitions. It is unclear why California law contains two different laws pertaining to these victims (Family Code Sections 6927 and 6928, which is discussed below). The only difference in the two laws is that Family Code Section 6928 (regarding sexual assault) requires the professional person providing medical treatment to a minor victim of sexual assault to try to contact the minor's parent/guardian (unless the treating professional person reasonably believes the parent/guardian was the perpetrator). CHA recommends that the treating professional talk to the minor sexual assault victim about contacting the parent, and then contact the parent unless the minor voices significant concern. This discussion and the outcome should be documented.

NOTE: Providers are required to report cases of alleged or suspected rape or sexual assault of a minor to local law enforcement *(see chapter 7)*.

MINOR VICTIMS OF SEXUAL ASSAULT

A minor who has allegedly been sexually assaulted may consent to the furnishing of hospital, medical, and surgical care related to the diagnosis and treatment of such condition. Sexual assault includes, but is not limited to, rape, sodomy, or oral copulation. The minor may also consent to collection of medical evidence with regard to the alleged sexual assault. The consent of the minor's parent(s) or guardian is not necessary. [Family Code Section 6928; Title 11, California Code of Regulations, Section 925]

The professional person providing the medical treatment must attempt to contact the minor's parent(s) or guardian and note the date and time of such contact or, if unsuccessful, when contact was attempted. However, the professional person need not make this contact if he or she reasonably believes that the parent(s) or guardian committed the sexual assault on the minor. [Family Code Section 6928; Title 11, California Code of Regulations, Section 925]

NOTE: Providers are required to report cases of alleged or suspected rape or sexual assault of a minor to local law enforcement *(see chapter 7)*.

MINOR VICTIMS OF INTIMATE PARTNER VIOLENCE

A minor 12 years of age or older and who states he or she was injured as a result of intimate partner violence may consent to medical care related to the diagnosis or treatment of the injury as well as the collection of evidence.

"Intimate partner violence" means an intentional or reckless infliction of bodily harm perpetrated by a person with whom the minor has or has had a sexual, dating, or spousal relationship.

The law states that if a report is made under Penal Code Section 11160 *(see III. "Reporting Injuries by Firearm or Assaultive or Abusive Conduct ("Suspicious Injuries")," page 7.3)*, the provider must:

1. Inform the minor that the report will be made, and
2. Attempt to contact the minor's parent or guardian and inform them of the report. The provider must document in the minor's medical record the date and time of the attempt to contact the parent or guardian, and whether the attempt was successful or unsuccessful. However, this paragraph does not apply if the provider believes the minor's parent or guardian committed the intimate partner violence.

The law does not say whether the above steps must be taken if a child abuse report is made. *(See chapter 7 for detailed information about suspicious injury and child abuse reports.)*

[Family Code Section 6930]

NOTE: If the minor is allegedly a victim of rape or sexual assault, the provider should follow the laws described under "Minor Rape Victims," page 2.41 or "Minor Victims of Sexual Assault," page 2.41, instead of this law. This law likely applies to physical violence that is not sexual in nature.

J. Summary of Consent Requirements Regarding Minors

CHA has included a table at the end of this manual titled "Consent Requirements for Medical Treatment of Minors" (CHA Table 2-B) summarizing consent issues regarding minors.

X. TREATMENTS THAT REQUIRE SPECIAL CONSENT

A. Background

As discussed in II. "Why Consent is Necessary," page 2.1, California law imposes a duty on physicians to obtain the patient's informed consent for a complex procedure. [*Cobbs v. Grant*, 8 Cal.3d 229 (1972)] To enable a patient to make an informed decision about whether to consent to a procedure, the law requires the physician to explain to the patient the nature of the proposed treatment; its expected benefits and effects; its possible risks and complications; any alternative forms of treatment; their benefits, risks and complications; and any potentially conflicting interests (such as research or financial interests) the physician may have.

The physician generally has discretion to determine the types of information to provide a patient. However, the California Legislature, regulatory agencies, and the courts have imposed special requirements with respect to the information to be given to a patient in several circumstances. This chapter details those requirements that may affect mental health facilities. A complete list of these circumstances (for example, hysterectomy, sterilization, reuse of hemodialysis filters, etc.) may be found in chapter 4 of CHA's *Consent Manual*.

B. Antipsychotic Medications

This section of the manual describes the laws related to consent for antipsychotic medications given to mental health patients, both voluntary and involuntary, in acute psychiatric hospitals and in psychiatric units of general acute care hospitals. Skilled nursing facility residents and inmates in county jails and state prisons are protected by different laws *(see Health and Safety Code Section 1418.9; Penal Code Sections 2602 and 2603; Title 22, California Code of Regulations, Sections 72082, 72092 and 72828)*.

Specific procedures must be followed with respect to the administration of antipsychotic medications to both voluntary and involuntary patients. This section describes

these requirements. If a use of an antipsychotic medication falls within the definition of a drug used as a restraint, the requirements that apply to the use of restraints should also be followed *(see chapter 5)*.

"Antipsychotic medication" is defined as any drug customarily used for the treatment of symptoms of psychoses and other severe mental and emotional disorders [Welfare and Institutions Code Section 5008(l); Title 9, California Code of Regulations, Section 856].

VOLUNTARY PATIENTS

Who May Refuse Antipsychotic Medications

Every person admitted as a voluntary patient to a facility for psychiatric evaluation or treatment has the right to refuse the administration of antipsychotic medications. This includes state and county hospitals, private acute psychiatric hospitals, skilled nursing facilities, and general acute care hospitals that provide psychiatric services.

However, for this purpose, a voluntary patient does not include:

1. Voluntary minor patients, unless the minor is otherwise authorized by law to seek and consent to treatment for mental illness; or
2. Conservatees (defined in Welfare and Institutions Code Section 5350 *et seq.*) whose conservators have been given the right to require their conservatees to receive treatment related specifically to remedying or preventing the recurrence of the conservatees' being gravely disabled.

[Title 9, California Code of Regulations, Section 850]

The right to consent to, or to refuse, antipsychotic medications on behalf of a voluntary minor patient who is not authorized by law to consent to his or her own mental health treatment devolves to the parent, guardian, or other legal representative.

Although not specifically required by law, it is recommended that the procedures described below for obtaining and documenting informed consent for the administration of antipsychotic medications to voluntary patients be followed to obtain such consent from a parent or guardian of a voluntary minor patient who is not authorized by law to consent to the treatment, and from a conservator who has the right to require the conservatee to receive the treatment.

Informed Consent of Voluntary Patient Generally Required

A voluntary patient may be treated with antipsychotic medications only after being informed of the right to accept or refuse the medications and consenting to the administration of the medications [Title 9, California Code of Regulations, Section 851].

Although not specifically required by law, it is recommended that the procedures described below for obtaining and documenting informed consent for the administration of antipsychotic medications to voluntary patients be followed to obtain such consent from a parent or guardian of a voluntary minor patient who is not authorized by law to consent to the treatment, and from a conservator who has the right to require the conservatee to receive the treatment.

To make an informed decision, the patient must be provided sufficient information by the physician who prescribes the medications. The information must include the following and should be presented in the patient's native language, if possible:

1. The nature of the patient's mental condition.
2. The reason for taking the medication, including the likelihood of the patient's improving or not improving without the medication.
3. A statement that the patient may withdraw his or her consent at any time. The patient should be advised that he or she may withdraw the consent by stating such intention to any member of the treating staff.
4. The reasonable alternative treatments available, if any.
5. The name and type of medication, range of frequency of administration, range of dosage amount (including the use of PRN orders), method of administration (oral or injection) and duration of taking the medications.
6. The probable side effects of the medication that are known to commonly occur and any particular side effects likely to occur to the particular patient.
7. The possible additional side effects that may occur in patients taking the medication longer than three months. If applicable, the patient must be advised that side effects may include persistent involuntary movement of the face or mouth and might also include similar movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after the medication has been discontinued.
8. The right to refuse the medication.

CHA has developed a form, "Consent to Receive Antipsychotic Medications" (CHA Form 4-7), that may be used to provide this information to the patient.

Documentation Requirements

The facility must maintain a written record of each voluntary patient's decision to consent to receive antipsychotic medications. The written record must be a written consent form signed by the patient indicating that each item listed above has been discussed with the patient by the prescribing physician. "Consent to Receive Antipsychotic Medications" (CHA Form 4-7) complies with the applicable regulations.

If a voluntary patient has been shown but does not wish to sign the written consent form, it is sufficient for the physician to place the unsigned form in the patient's medical record that is maintained by the facility, together with a note indicating that while the patient understands the nature and effect of antipsychotic medications and consents to these, the patient does not wish to sign a written consent form. Space has been provided on the "Consent to Receive Antipsychotic Medications" form for such a note. [Title 9, California Code of Regulations, Section 852]

Exception for Emergency Situations

A physician may administer antipsychotic medications without consent, if it is impracticable to obtain patient consent, in emergency situations where:

1. There is a sudden marked change in the patient's condition which necessitates immediate action in order to preserve the life of the patient or others, or
2. To prevent serious bodily harm to the patient or others.

If antipsychotic medication is administered during an emergency, the medication should be only that which is required to treat the emergency condition and must be provided in ways that are least restrictive of the personal liberty of the patient. [Title 9, California Code of Regulations, Section 853]

Withdrawal of Consent

A voluntary patient may withdraw consent to the administration of antipsychotic medications at any time by stating such intention to any member of the treatment staff [Title 9, California Code of Regulations, Section 854].

Consequence of Refusal to Consent

The refusal of the patient to consent to the administration of antipsychotic medications does not, in itself, constitute sufficient grounds for initiating an involuntary commitment [Title 9, California Code of Regulations, Section 855].

Guidelines developed by the former California Department of Mental Health indicate that physicians must exercise professional judgment to determine which methods of treatment are available and best suited for individual patients. If a voluntary patient refuses to consent to antipsychotic medications, the prescribing physician might consider:

1. Negotiating with the patient regarding the use of antipsychotic medications; or
2. Using an alternative method of treatment; or
3. Discharging the person if no other form of treatment is suitable or available.

If none of the above is a viable alternative, and if (and only if) the patient meets the requirements for involuntary detention, then the patient may be involuntarily detained in an appropriate facility. *(See chapter 3 regarding involuntary detention.)*

Violation Reports and Available Remedies

All alleged or suspected violations of the rights of patients as listed in the law must be reported to the county patients' rights advocate or, for state hospital patients, to the state hospital patients' rights advocate, who must report all complaints to the director of the California Department of State Hospitals. The director must take appropriate action which, depending on the nature of the complaint, could include:

1. Referral for disciplinary action to the facility governing body for review and monitoring.
2. Referral to the Medical Board of California regarding a review of the individual practitioner's license.
3. Referral for review of the facility license.
4. Compelling negotiations to ensure compliance with these regulations, withholding part or all of state mental health funds or taking appropriate court action.

The individual patient may also seek any other remedies that are available under the law. [Title 9, California Code of Regulations, Section 857]

INVOLUNTARY PATIENTS

In a 1988 lawsuit, *Riese v. St. Mary's Hospital and Medical Center*, 209 Cal.App.3d 1303 (1987, modified 1988), the California Supreme Court held that involuntary patients must not be given antipsychotic medications without their

informed consent unless there is an emergency or a court has determined that the patient is incompetent to make an informed decision concerning medication. In 1991 the California Legislature enacted a law which slightly modified the *Riese* holding, allowing involuntary patients to be given antipsychotic medications without their informed consent in certain situations:

1. If they do not refuse the medication following disclosure of the pertinent information discussed below;
2. In an emergency; or
3. If a court has determined that the patient lacks capacity to make an informed decision concerning medication.

[Welfare and Institutions Code Section 5332]

This statutory scheme applies to patients detained under Welfare and Institutions Code Sections 5150 (72-hour hold), 5250 (14-day hold), 5260 (additional 14-day hold for persons imminently suicidal), or 5270.15 (additional 30-day hold for persons gravely disabled) [Welfare and Institutions Code Section 5325.2]. When a patient is detained under one of these laws, the agency or facility providing the treatment must obtain the patient's medication history if possible [Welfare and Institutions Code Section 5332(d)].

Requirements for Administering Antipsychotic Medication

Antipsychotic medications may be given to involuntary psychiatric patients only if one of the following conditions is met:

1. The patient has given informed consent;
2. The patient has been given the information discussed below and he or she has not refused the medication;
3. An emergency condition exists; or
4. A court order of incapacity has been issued.

(See below for further explanation of each condition.)

Patient Gives Informed Consent

Informed consent requires that a full explanation of the proposed course of treatment be given to the patient. This includes discussing the elements described in "Informed Consent Forms That Contain Medical Information," page 2.7.

If the patient agrees with the administration of the medication, he or she should sign a form indicating that the patient has received the information desired from a physician and has consented to the medication. The "Consent to Receive Antipsychotic Medications" form (CHA Form 4-7) has been developed for this purpose. The signed form should be placed in the medical record and a copy given to the patient.

As with any consent to medical treatment, the patient is free to withdraw consent at any time during the course of treatment.

The Patient is Given the Necessary Information and Does Not Refuse the Medication

Antipsychotic medication may be administered to an involuntary patient if the patient is given the information discussed in "Informed Consent of Voluntary Patient Generally Required," page 2.43, and does not refuse the medication, even if the patient does not expressly agree to the administration of the medication [Welfare and Institutions Code Section 5332(a)]. The patient should sign a form indicating that he or she has received the necessary information. The "Consent to Receive Antipsychotic Medications" form (CHA Form 4-7) may be used for this purpose.

If the patient does not refuse the medication, but does not wish to sign the form, a note to this effect should be written on the form or in the medical record and signed by the person who gives the patient the necessary information. If the form is used, it should be placed in the medical record and a copy given to the patient.

The patient may later refuse the administration of antipsychotic medication, in which case no medication may be administered unless an emergency exists or an order of incapacity is issued by a judge.

Exception for Emergency Situations

Antipsychotic medication may be administered to an involuntary patient despite the patient's objection if an emergency exists. An emergency is defined for this purpose as a situation in which action to impose treatment over the person's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first obtain consent. It is not necessary for harm to take place or become unavoidable prior to treatment. [Welfare and Institutions Code Section 5008(m)]

The emergency exception justifies administration of antipsychotic medications over the patient's objection only so long as the emergency condition exists. Once the condition is stabilized, the patient's informed consent (or lack of refusal after the necessary information is given) is again required. In addition, the medication administered

in emergencies must be only that required to treat the emergency condition and must be provided in the manner least restrictive to the personal liberty of the patient [Welfare and Institutions Code Section 5332(e)].

Judicial Determination of Incapacity

Antipsychotic medication may be administered over the patient's objection in nonemergency situations only if:

1. The treatment staff has determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient, and
2. A judicial determination of incapacity to refuse the treatment has been made after a hearing.

[Welfare and Institutions Code Section 5332(b)]

Scope of Hearing. The purpose of the hearing is for the judge or hearing officer to determine whether the patient has the capacity to make an informed decision regarding the proposed treatment. The purpose of the hearing is *not* for the judge or hearing officer to decide medical questions such as whether the patient needs antipsychotic medication. This issue, if discussed in the hearing, is pertinent only to help the judge or hearing officer decide if the patient's thought processes related to making decisions regarding treatment are rational or not.

Procedure for Initiating Hearing. If a hospital wishes to administer antipsychotic medication to an involuntary patient over the patient's objection in nonemergency situations, the hospital must file a petition for a capacity hearing with the superior court [Welfare and Institutions Code Section 5333(b)]. The director of the treatment facility or a designee must:

1. Deliver a copy of the notice of the filing of the petition along with a copy of the petition to the patient and the patient's advocate or counsel;
2. Inform the patient of his or her legal right to a capacity hearing; and
3. Inform the patient of his or her right to the assistance of the patients' rights advocate or an attorney to prepare for the hearing and to answer any questions or concerns [Welfare and Institutions Code Sections 5333(c) and 5334(a)].

Treatment facilities, in conjunction with their medical staffs, must develop internal procedures for facilitating the filing of petitions for capacity hearings [Welfare and Institutions Code Section 5332(c)].

The Hearing. A patients' rights advocate or attorney will meet with the patient to discuss the capacity hearing process as soon after the filing of the petition as is practicable. The patients' rights advocate or attorney will assist the patient in preparing for the capacity hearing and will answer questions or otherwise assist the patient as appropriate [Welfare and Institutions Code Section 5333(d)].

Capacity hearings must be held within 24 hours of the filing of the petition whenever possible. If any party needs additional time to prepare for the hearing, the hearing will be postponed for 24 hours. In case of hardship, hearings may also be postponed for an additional 24 hours, pursuant to local policy developed by the county mental health director and the presiding judge of the superior court. In no event may hearings be delayed beyond 72 hours of the filing of the petition. [Welfare and Institutions Code Section 5334(a)]

Capacity hearings must be held in an appropriate location in the facility where the patient is receiving treatment, and must be held in a manner compatible with, and the least disruptive of, the treatment [Welfare and Institutions Code Section 5334(b)]. Hearings will be conducted by a superior court judge, a court-appointed commissioner or referee, or a court-appointed hearing officer [Welfare and Institutions Code Section 5334(c)]. The patient will be given oral notification of the determination of the judge or hearing officer at the conclusion of the hearing. As soon thereafter as is practicable, the patient, his or her advocate or attorney, and the director of the facility will be given written notification of the determination, which will include a statement of the evidence relied upon and the reasons for the determination [Welfare and Institutions Code Section 5334(d)]. A copy of the determination will be submitted to the superior court.

Appeal of the Determination. The patient may appeal the determination to the superior court or the court of appeal. However, antipsychotic medication may be administered to the patient pending appeal. [Welfare and Institutions Code Section 5334(e)(1) and (3)]

The hospital may request the district attorney or county counsel in the county in which the person is receiving treatment to appeal the determination to the superior court or the court of appeal, on behalf of the state [Welfare and Institutions Code Section 5334(e)(2)].

Duration of Judicial Determination of Incapacity. A judicial determination of a patient's incapacity to refuse treatment with antipsychotic medication remains in effect only for the duration of the detention period described in Welfare and Institutions Code 5150 or 5250, or both, or until capacity has been restored according to standards developed by the treatment facility in conjunction with its medical staff, or by court determination, whichever is sooner [Welfare and Institutions Code Section 5336].

(See "Notice of Effects of Medication," page 3.11, if medications will be given to a person detained under Welfare and Institutions Code Section 5150.)

MINORS IN CUSTODY OF THE JUVENILE COURT/ FOSTER CHILDREN

If a child is in the custody of the juvenile court and the child has been removed from the physical custody of the parent, only a juvenile court judicial officer has the authority to order the administration of psychotropic medications for the child. The juvenile court may issue an order delegating this authority to a parent upon finding that the parent poses no danger to the child and has the capacity to authorize the administration of psychotropic medications. *(See "Psychotropic Medications," page 2.33, for more information about the administration of psychotropic medications to a child in the custody of the juvenile court.)*

C. Psychosurgery

"Psychosurgery" is defined as any of those operations referred to as lobotomy, psychiatric surgery, behavioral surgery and all other forms of brain surgery if the surgery is performed for the purpose of any of the following:

1. Modification, alteration, or control of thoughts, feelings, actions or behavior rather than the treatment of a known and diagnosed physical disease of the brain;
2. Modification or alteration of normal brain function, brain tissue or brain cells in order to modify, alter or control thoughts, feelings, actions or behavior; or
3. Treatment of abnormal brain function, brain tissue or brain cells in order to modify, alter or control thoughts, feelings, actions or behavior when the abnormality is not an established cause for those thoughts, feelings, actions or behavior.

Psychosurgery does not include surgery for relief of pain caused by physical disease elsewhere in the body.

Psychosurgery also does not include prefrontal sonic treatment where there is no destruction of brain tissue. However, all requirements pertaining to psychosurgery must be followed when prefrontal sonic treatment is administered and there exists any possibility there will be destruction of brain cells or brain tissue. [Welfare and Institutions Code Section 5325(g); Title 9, California Code of Regulations, Sections 836 and 837] *(See D. "Convulsive Therapy and Insulin Coma Treatment," page 2.49, for definitions as well as other requirements regarding prefrontal sonic treatment.)*

CONDITIONS UNDER WHICH PSYCHOSURGERY MAY BE PERFORMED

Welfare and Institutions Code Section 5326.6 governs the performance of psychosurgery. In order to perform psychosurgery on a patient, whether admitted to a facility as a voluntary or involuntary patient, wherever administered, the following conditions must be met.

Age of Patient

The patient must be over 18 years of age. Under no circumstances may psychosurgery be performed on a person under 18 years of age [Title 9, California Code of Regulations, Section 845].

Informed Consent

The patient must give a valid, written informed consent [Welfare and Institutions Code Section 5326.6(a)]. For these purposes, **"written informed consent"** means that a person knowingly and intelligently, without duress or coercion, clearly and explicitly gives written consent to the treating physician for the proposed therapy. Welfare and Institutions Code Sections 5326.2, 5326.3, 5326.4 and 5326.5, discussed below, state the requirements for obtaining and documenting a valid informed consent.

Required Information. To create the basis for a voluntary informed consent, the following information must be given to the patient in a clear and explicit manner:

1. The reason for the treatment; that is, the nature and seriousness of the patient's illness, disorder or defect.
2. The nature of the procedures to be used in the proposed treatment, including its probable frequency and duration.
3. The probable degree and duration (temporary or permanent) of improvement or remission expected with and without the treatment.
4. The nature, degree, duration and probability of the side effects and significant risks, commonly known by the medical profession, of the treatment, including its associated therapeutic modalities, especially noting the degree and duration of memory loss (including its irreversibility) and how and to what extent side effects may be controlled, if at all.
5. That there exists a division of opinion as to the efficacy of the proposed treatment, why and how it works, and its commonly known risks and side effects.
6. The reasonable alternative treatments.
7. Why the physician recommends this particular treatment.

8. That the patient has the right to accept or refuse the proposed treatment, and that, if consent is given, the patient has the right to revoke the consent for any reason, and at any time prior to or between treatments.

Waiting Period Required. The patient may be asked to give his or her written informed consent only after 24 hours have elapsed from the time the required information above has been given to the patient [Welfare and Institutions Code Section 5326.5(e)].

Consent Form. The law states that the California Departments of Health Care Services and State Hospitals must promulgate a standard written consent form setting forth clearly and in detail the matters listed in Welfare and Institutions Code Section 5326.2 *(see "Required Information," page 2.55)* and any further information with respect to each item as deemed generally appropriate to all patients [Welfare and Institutions Code Section 5326.3]. However, the forms presently available from the departments are for use by state hospitals only. Until a form is promulgated by the department for use by other hospitals, each hospital should prepare a written consent form in accordance with the requirements in Welfare and Institutions Code Sections 5326.2, 5326.3, 5326.4 and 5326.5. It is also advisable for each hospital to contact its local mental health agency to determine whether a form has been developed for use by local facilities.

The treating physician must use the standard written consent form, and must also supplement it in writing with those details that pertain to the particular patient being treated.

Presentation of "Supplemented" Consent Form and Oral Explanation to Patient. The treating physician must present to the patient the supplemented consent form and orally give a clear and detailed explanation to the patient of all of the above required information.

Signature of Patient and Witness. After the required waiting period, the treating physician must obtain the dated signature of the patient and a witness on the supplemented consent form.

Documentation Requirements. The fact of the execution of the written consent form and of the oral explanation must be entered into the patient's medical record along with a copy of the consent form itself. The consent form must be made available to the patient and to his or her attorney, guardian, conservator and, if the patient consents, to a responsible relative of the patient's choosing.

Consent Process Devoid of Duress or Coercion. The physician may urge the proposed treatment as the best one, but may not use, in an effort to gain consent, any reward or threat, express or implied, nor any other form of inducement or coercion, including, but not limited to, placing the patient in a more restricted setting, transfer of the patient to another facility or loss of the patient's privileges. A patient may not be denied any benefits for refusing treatment.

Patient Capacity to Consent. A person is deemed to have the capacity to consent or to refuse consent if it is determined that the person has actually understood and can knowingly and intelligently act upon the information specified in "Required Information," page 2.55. Understanding of the potential benefits and risks of the proposed treatment or surgery is the primary factor in determining the capacity to consent or to refuse. A person must not be deemed to lack capacity to consent or refuse consent solely by virtue of a psychiatric or medical diagnosis [Title 9, California Code of Regulations, Section 840].

Discretionary Involvement of Responsible Relative

A responsible relative of the patient's choosing (with the patient's consent) and the guardian or conservator, if there is one, must read the consent form and must be given the information discussed in "Required Information," page 2.55 by the treating physician. If the patient does not wish to inform a relative, or if the chosen relative is unavailable (and the patient either does not wish to designate another relative or that relative is also unavailable), this requirement may be dispensed with.

A **"responsible relative"** for these purposes includes the spouse, parent, adult child, or adult brother or sister of the patient.

Documentation by Physician of Reasons for Procedure

The attending physician must enter adequate documentation in the patient's medical record of the reasons for the procedure, that all other appropriate treatment modalities have been exhausted, and that this mode of treatment is definitely indicated and is the least drastic alternative available for the treatment of the patient at this time. This statement must be signed by the attending and treating physician(s).

Consultation

Three physicians, one appointed by the facility and two appointed by the local mental health director, two of whom must be board certified or board-eligible psychiatrists or neurosurgeons, must personally examine the patient and unanimously agree with the attending physician's determinations and agree that the patient has the capacity

to give informed consent. This agreement must be documented in the patient's medical record and signed by each physician. [Welfare and Institutions Code Section 5326.6]

Time Delay Between Written Informed Consent and Surgery

In no case may psychosurgery be performed less than 72 hours following the time the patient gave written consent [Welfare and Institutions Code Section 5326.6(d)].

Effect of Consent on Right to Refuse Treatment

The giving of consent may not be construed as a waiver of the right to refuse treatment at a future time. Consent may be withdrawn at any time, orally or in writing, and must be given immediate effect.

DOCUMENTATION OF REFUSAL OF PSYCHOSURGERY

If a patient is deemed by the physician to have the capacity to give informed consent, but refuses to do so, the physician must indicate in the medical record that the treatment was refused despite the physician's advice, and that he or she explained to the patient the patient's responsibility for any untoward consequence of the refusal. However, this explanation must not be made in a manner that constitutes duress or coercion. The patient must not be subject to any loss of privileges due to a refusal to consent. [Title 9, California Code of Regulations, Section 841]

REPORTS OF PSYCHOSURGERY

A doctor or facility that administers psychosurgery must report quarterly to the local behavioral health director, who is required to transmit a copy of the report to the director of mental health. The report must include the number of persons who received psychosurgery, wherever administered, in the following categories:

1. Involuntary patients who gave informed consent.
2. Voluntary patients who gave informed consent.

(Patients incapable of giving consent must not undergo psychosurgery.)

The report must also include psychiatric diagnosis, type of psychosurgery performed, date surgery performed, and complications that arose during or after the psychosurgery.

A facility that considers psychosurgery a part of its treatment program must file a quarterly report, regardless of whether any of these treatment methods were used during the quarter. [Welfare and Institutions Code Section 5326.15; Title 9, California Code of Regulations, Section 838.1]

D. Convulsive Therapy and Insulin Coma Treatment

State law sets forth various requirements, discussed below, to be met prior to initiation of convulsive therapy or insulin coma treatment on a patient.

All requirements pertaining to the administration of convulsive treatment must be followed when insulin coma treatment is administered, or when prefrontal sonic treatment is administered that involves only direct stimulation of brain cells or brain tissue. All requirements pertaining to psychosurgery must be followed when prefrontal sonic treatment is administered and there exists any possibility there will be destruction of brain cells or brain tissue *(see C. "Psychosurgery," page 2.47)*.

DEFINITIONS

"Convulsive treatment" is the planned induction of a seizure through electrical or chemical means for therapeutic purposes. When more than one seizure is induced in a single treatment session, each seizure shall be considered a separate treatment for record keeping and reporting purposes.

"Insulin coma treatment" consists of producing a coma for therapeutic purposes, with or without convulsions, through the intramuscular administration of insulin.

"Prefrontal sonic treatment" is the direct stimulation and/or destruction of brain cells or brain tissue by ultrasound for therapeutic purposes.

[Title 9, California Code of Regulations, Sections 836 and 837]

INVOLUNTARY ADULT PATIENTS

Before convulsive treatment or insulin coma treatment is administered to an involuntary adult patient, the conditions described in this section of the manual must be met. Involuntary patients include the following:

1. Persons involuntarily detained for 72-hour evaluation and treatment under Welfare and Institutions Code Section 5150;
2. Persons certified for intensive treatment under Welfare and Institutions Code Section 5250;
3. Persons certified for additional intensive treatment as suicidal under Welfare and Institutions Code Section 5260;
4. Persons post-certified as a demonstrated danger of substantial physical harm to others under Welfare and Institutions Code Section 5300;

5. Persons under temporary or permanent conservatorship or guardianship;
6. Persons who have been judicially committed, as defined under Welfare and Institutions Code Section 5008.1 (mentally disordered sex offenders; developmentally disabled persons admitted to a state hospital due to dangerousness; or other persons committed to the State Department of State Hospitals). If these provisions conflict with regulations dealing with the developmentally disabled promulgated under Chapter 1 (commencing with Section 4500) of the Welfare and Institutions Code, the latter statute and regulations shall control.

[Title 9, California Code of Regulations, Section 836.1]

Documentation of Reasons for Treatment

The attending or treating physician must enter adequate documentation in the patient's medical record of the reasons for the procedure, that all reasonable treatment modalities have been carefully considered, and that the treatment is definitely indicated and is the least drastic alternative available for this patient at this time. This statement in the medical record must be signed by the attending and treating physician(s).

Committee Review of Treatment

A review of the patient's medical record must be conducted by a committee of two physicians, at least one of whom must have personally examined the patient.

One physician must be appointed by the facility and one must be appointed by the local mental health director. Both must be board-certified or board-eligible psychiatrists or neurologists. This review committee must unanimously agree with the treating physician's determinations entered in the medical record. This agreement must be documented in the patient's medical record and signed by both physicians. [Welfare and Institutions Code Section 5326.7]

The physicians who serve on review committees must not be personally involved in the treatment of the patient whose case they are reviewing [Welfare and Institutions Code Section 5326.55].

Discretionary Involvement of Responsible Relative

A responsible relative of the patient's choosing and the patient's guardian or conservator, if there is one, must be given the oral explanation by the attending physician of the information required by Welfare and Institutions Code Section 5326.2, which is discussed in "Required Information," page 2.55. If the patient does not wish to inform a relative, or if the chosen relative is unavailable and the patient either does not wish to designate another relative or that relative is also unavailable, this requirement may be dispensed with.

A **"responsible relative"** for these purposes, includes the spouse, parent, adult child, or adult brother or sister of the patient [Welfare and Institutions Code Section 5326.6(d)].

Basic Requirements of Informed Consent

The patient must give a valid written informed consent [Welfare and Institutions Code Section 5326.7(d)]. For these purposes, a **"written informed consent"** means that a person knowingly and intelligently, without duress or coercion, clearly and explicitly gives written consent to the treating physician for the proposed therapy. Welfare and Institutions Code Sections 5326.2, 5326.3, 5326.4 and 5326.5, discussed in "Informed Consent," page 2.47, state the requirements for obtaining and documenting a valid informed consent.

Consent Form

For purposes of obtaining written informed consent to electroconvulsive treatment, the law requires the treating physician to use the consent form developed by the state [Title 9, California Code of Regulations, Section 839]. The form, DHCS 1800/MH 300, may be found at www.dhcs.ca.gov/formsandpubs/forms/pages/mental_health-forms.aspx. The treating physician must use the standard written consent form, and must also supplement it in writing with those details that pertain to the particular patient being treated.

Patient Capacity to Consent. A patient has the capacity to consent or to refuse to consent if he or she has actually understood and can knowingly and intelligently act upon the information required to be given to the patient by the physician. Understanding of the potential benefits and risks of the proposed treatment is the primary factor in determining capacity to consent or refuse consent. A person does not lack capacity solely by virtue of a psychiatric or medical diagnosis. [Title 9, California Code of Regulations, Section 840]

Waiting Period Required

The patient may be asked to give his or her written informed consent only after 24 hours have elapsed from the time the required information above has been given to the patient. [Welfare and Institutions Code Section 5326.5(e)]

Presentation of "Supplemented" Consent Form and Oral Explanation to Patient

The treating physician must present to the patient the supplemented consent form and orally give a clear and detailed explanation to the patient of all of the above required information.

Additional Informed Consent Requirements

Duration of Written Informed Consent. The written informed consent must be given for a specified maximum number of treatments over a specified maximum period of time that may not exceed 30 days. It is revocable at any time before or between treatments and any withdrawal of consent, which may be given orally or in writing, must be given immediate effect. If the patient subsequently changes his or her mind, a new consent must be obtained. A renewed written informed consent must be given for any additional treatments in number or in time, not to exceed 30 days.

Agreement on Capacity to Consent

Review by Patient's Attorney or Public Defender. The patient's attorney, or if none, a public defender appointed by the court, must agree with the attending physician that the patient has the capacity to give written informed consent and actually gave such consent. The attorney must make an independent judgment of capacity [Welfare and Institutions Code Section 5326.7(e); Title 9, California Code of Regulations, Section 840(c)].

Court Review if Capacity Disputed. If either the attending physician or the attorney believes that the patient does not have the capacity to give written informed consent, then a petition must be filed in superior court to determine the patient's capacity to give written informed consent. The court will hold an evidentiary hearing after giving appropriate notice to the patient, and within three days after the petition is filed. At the hearing the patient must be present and represented by legal counsel. If the court deems the attorney to have a conflict of interest, the attorney may not represent the patient in this proceeding.

Consent by Other than Patient. If the court determines that the patient does not have the capacity to give written informed consent, then treatment may be performed if written informed consent (as defined in Welfare and Institutions Code Sections 5326.2 and 5326.5) is given by the responsible relative chosen by the patient, if any, or the patient's conservator or guardian.

Claim of Regained Competency

At any time during the course of treatment of a person who has been deemed incompetent, that person has the right to claim regained competency. Should he or she do so, the person's competency must be reevaluated according to "Agreement on Capacity to Consent," page 2.51.

Documentation of Refusal of Convulsive Treatment

No convulsive treatment or insulin coma treatment may be performed if the patient, whether admitted to the facility as a voluntary or involuntary patient, is deemed to be able to give informed consent and refuses to do so. The physician must indicate in the medical record that the treatment was refused despite the physician's advice and that the physician has explained to the patient the patient's responsibility for any untoward consequences of his or her refusal. However, this explanation must not be made in a manner that constitutes duress or coercion. The patient must not be subject to any loss of privileges due to a refusal to consent [Welfare and Institutions Code Section 5326.85; Title 9, California Code of Regulations, Section 841].

VOLUNTARY ADULT PATIENTS

Before convulsive treatment or insulin coma treatment may be performed on voluntary patients, including but not limited to those voluntarily admitted to a facility or receiving the treatment in a physician's office, a clinic, or a private home, the following conditions must be met.

Patient Has Capacity to Consent

If the patient has the capacity to consent to the treatment, the following steps must be taken.

Documentation of Treatment Reasons, Oral Explanation, Written Informed Consent. As discussed in "Involuntary Adult Patients," page 2.49, there must be documentation of reasons for treatment, the discretionary oral explanation to a responsible relative chosen by the patient, if any, and written informed consent.

Verification of Capacity to Consent. A board-certified or board-eligible psychiatrist or neurologist other than the patient's attending or treating physician must have examined the patient and verified that the patient has the capacity to give and has given written informed consent. This verification must be documented in the patient's medical record and signed by the treating physician. [Welfare and Institutions Code Section 5326.75]

Patient Lacks Capacity to Consent

If the required verification of capacity to consent is not obtained, then all of the requirements for treatment for involuntary adult patients must be met, as discussed in "Involuntary Adult Patients," page 2.49.

MINORS UNDER THE AGE OF 12

Under no circumstances may convulsive treatment or insulin coma treatment be performed on a minor under the age of 12 years [Welfare and Institutions Code Section 5326.8]. Under no circumstances may prefrontal sonic treatment be performed on a person under 18 years of age [Title 9, California Code of Regulations, Section 845(a)].

MINORS BETWEEN 12 AND 16 YEARS OF AGE

Before convulsive treatment or insulin coma treatment may be administered to a minor who is 12 years of age to under 16 years of age, the following conditions must be met [Welfare and Institutions Code Section 5326.8]. However, under no circumstances may prefrontal sonic treatment be performed on a person under 18 years of age [Title 9, California Code of Regulations, Section 845(a)].

Emergency Situation

It is an emergency situation and the treatment is deemed a lifesaving treatment.

Emergency Certified by Review Committee

The fact of the emergency and the need for and appropriateness of the treatment are certified unanimously by a review board of three board-eligible or board-certified child psychiatrists appointed by the local mental health director.

Physicians who serve on a review committee must not be personally involved in the treatment of the patient whose case they are reviewing [Welfare and Institutions Code Section 5326.55].

Compliance with Other Laws

The requirements set forth under "Involuntary Adult Patients," page 2.49, must be followed. Unless the minor is emancipated, the custodial parents or the person/agency with legal custody is considered the guardian for purposes of granting or withholding consent for convulsive therapy. [Title 9, California Code of Regulations, Section 845]

Documentation

The treatment must be thoroughly documented and reported immediately to the director of the Department of Health Care Services.

MINORS 16 AND 17 YEARS OF AGE

A minor aged 16 or 17 years of age must be treated as an adult for purposes of consent to convulsive therapy or insulin coma treatment. *(See "Involuntary Adult Patients," page 2.49, for the requirements that apply to minors 16 and 17 years of age who are involuntary patients or who lack verification of capacity to provide informed consent. See "Voluntary Adult Patients," page 2.51, for the requirements that apply to voluntarily admitted minors 16 and 17 years of age.)*

An unemancipated minor's parent(s) or the person/agency with legal custody is considered the guardian for purposes of granting or withholding consent. [Welfare and Institutions Code Sections 5326.7 and 5326.8; Title 9, California Code of Regulations, Section 845]

However, under no circumstances may prefrontal sonic treatment be performed on a person under 18 years of age [Title 9, California Code of Regulations, Section 845(a)].

COMMITTEE REVIEW OF TREATMENT

Facilities in which convulsive treatment or insulin coma treatment is performed on voluntary or involuntary persons must designate a qualified committee to review all of these treatments and to verify their appropriateness and need. *(See Title 9, California Code of Regulations, Section 847 regarding posttreatment review committees.)* The local mental health director is required to establish a review committee for convulsive treatments administered anywhere other than in a facility (as defined in Health and Safety Code Section 1250) in which psychiatric evaluation or treatment is offered. Records of these committees will be available in the same manner as are the records of other hospital utilization and audit committees, and may be subject to other regulations. Persons serving on these review committees will enjoy the same immunities as other persons serving on utilization, peer review, and audit committees of health care facilities. [Welfare and Institutions Code Section 5326.91]

REPORTS TO LOCAL BEHAVIORAL HEALTH DIRECTOR

A physician or facility that administers convulsive treatments must report quarterly to the local behavioral health director, who is required to transmit a copy of the report to the director of mental health. The report must include the number of persons who received such treatments, wherever administered, in each of the following categories:

1. Involuntary patients who gave informed consent.
2. Involuntary patients who were deemed incapable of giving informed consent and received convulsive treatment against their will.
3. Voluntary patients who gave informed consent.

4. Voluntary patients deemed incapable of giving consent.

A facility that considers convulsive treatment a part of its treatment program must file a quarterly report, regardless of whether any of these treatment methods were used during the quarter [Welfare and Institutions Code Section 5326.15; Title 9, California Code of Regulations, Section 838]

The reports must be made on a form (MH 309) issued by the state, available at www.dhcs.ca.gov/formsandpubs/forms/pages/mental_health-forms.aspx.

EXCESSIVE USE OF CONVULSIVE TREATMENT

The director of the Department of State Hospitals defines the excessive use of convulsive treatment as more than 15 treatments given to a patient within a 30-day period or a total of more than 30 treatments given within a one-year period [Welfare and Institutions Code Section 5326.95; Title 9, California Code of Regulations, Section 849].

If additional convulsive treatments are indicated in the judgment of the attending physician, prior approval must be obtained from the review committee of the facility or county *(see "Involuntary Adult Patients," page 2.49)*.

LOCAL REGULATION OF CONVULSIVE TREATMENT VOID

Administration of convulsive treatment is regulated by numerous state statutes. As such, attempts by local ordinances to prohibit convulsive treatment have been found to be preempted by state law and thus are void [*Northern California Psychiatric Society v. City of Berkeley*, 178 Cal.App.3d 90 (1986)]. *(See also Business and Professions Code Section 460, which limits the authority of local governments to regulate health professionals.)*

E. Mandatory Consultation — Outpatient and Discharge Medications

DISCHARGE MEDICATIONS

California law requires that hospitals establish and implement a written policy to ensure that each patient receiving discharge medications receives information regarding each medication. The written policy must be developed in collaboration with a physician, a pharmacist and a registered nurse, and approved by the medical staff.

The information given must include directions regarding the use and storage of each medication, the precautions and relevant warnings (including any potential impairment of the ability to operate a vehicle or vessel), and the importance of compliance with directions. The information must be given by a pharmacist or registered nurse, unless it has already been provided by a patient's prescriber [Business and Professions Code Section 4074, Health and Safety Code Section 1262.5(e)].

(See IV. "Aftercare Plan," page 4.6 regarding the required provision of a written aftercare plan to mental health patients upon discharge.)

OUTPATIENT MEDICATIONS

Pharmacists must provide oral consultation to outpatients (or their legal representatives) under the following conditions:

1. Whenever a prescription drug has not previously been dispensed to a patient;
2. Whenever a prescription drug not previously dispensed to a patient in the same dosage form, strength or with the same written directions is dispensed by the pharmacy;
3. Upon request of the patient; and
4. Whenever the pharmacist deems it warranted in the exercise of his or her professional judgment.

The oral consultation must include, at least:

1. Directions for use and storage and the importance of compliance with directions; and
2. Precautions and relevant warnings, including common severe side or adverse effects or interactions that may be encountered.

[Title 16, California Code of Regulations, Section 1707.2]

In addition, whenever a pharmacist deems it warranted in the exercise of his or her professional judgment, oral consultation must also include:

1. The name and description of the medication;
2. The route of administration, dosage form, dosage and duration of drug therapy;
3. Any special directions for use and storage;
4. Precautions for preparation and administration by the patient, including techniques for self-monitoring drug therapy;
5. Prescription refill information;
6. Therapeutic contra-indications, avoidance of common severe side or adverse effects or known interactions, including serious potential interactions with known nonprescription medications and therapeutic contra-indications and the action required if such

side or adverse effects or interactions or therapeutic contra-indications are present or occur; and

7. Action to be taken in the event of a missed dose.

In addition, Business and Professions Code Section 4074 requires a pharmacist to inform a patient orally or in writing of the harmful effects of a prescription drug if:

1. It poses substantial risk to the patient when taken in combination with alcohol or the drug may impair the patient's ability to drive a motor vehicle; and
2. The Board of Pharmacy has determined that the prescribed drug requires this warning.

If the pharmacist determines that a drug may impair a patient's ability to operate a vehicle or vessel, a written warning label must be affixed to the drug container.

PATIENT DECLINES OR IS UNAVAILABLE

A pharmacist is not required to provide oral consultation when a patient or the patient's agent refuses such consultation.

When the patient or agent is not present (i.e., the medication is shipped or delivered to the patient), the pharmacy must ensure that the patient receives written notice of his or her right to request consultation and a phone number from which the patient may obtain oral consultation from a pharmacist who has ready access to the patient's record.

Documentation

It is recommended that the pharmacist document any consultation provided to the patient (or agent) or, if applicable, a refusal by the patient (or agent) of offered consultation.

DRUG SUBSTITUTIONS

A pharmacist may make certain drug substitutions such as dispensing a generic drug in place of a brand-name drug. In such cases, the patient must be informed of the substitution [Business and Professions Code Sections 4052.5(e) and 4073(e)].

F. Telemedicine/Telehealth

CONSENT REQUIRED

California law requires that, prior to delivery of health care via telehealth, the health care provider initiating the use of telehealth must:

1. Inform the patient about the use of telehealth;
2. Obtain verbal or written consent from the patient for this use; and
3. Document the consent.

This law does not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

CHA Form 8-1, "Conditions of Admission," includes a statement that the patient consents to telehealth services. *(See CHA Form 8-1, "Conditions of Admission.")*

ADDITIONAL REQUIREMENTS FOR MEDI-CAL PATIENTS

A Medi-Cal patient receiving teleophthalmology, teledermatology or teledentistry by store and forward must be notified of the right to receive interactive communication with the distant specialist physician, optometrist or dentist.

If requested, communication with the distant specialist physician, optometrist or dentist must occur either at the time of the consultation, or within 30 days of the patient's notification of the results of the consultation. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Business and Professions Code Section 3041, that consultation or referral must be with an ophthalmologist or other appropriate physician and surgeon.

DEFINITIONS

"Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

"Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

"Health care provider" means a person who is licensed under Division 2 of the Business and Professions Code. This includes almost every type of licensed health care provider that exists in California, such as physicians, nurses, psychologists, marriage and family therapists, physician assistants, dentists, chiropractors, massage therapists, and veterinarians.

"Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

"Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

"Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth includes synchronous interactions and asynchronous store and forward transfers.

"Teleophthalmology," "teledermatology and teledentistry by store and forward" means an asynchronous transmission of medical or dental information for review at a later time by an ophthalmologist, dermatologist, optometrist, or a dentist, where the professional at the distant site reviews the information without the patient being present in real time.

[Business and Professions Code Section 2290.5; Welfare and Institutions Code Section 14132.725]

G. Consent for HIV Testing

California law establishes special requirements for consent to HIV tests and the disclosure of HIV test results.

"HIV test" is defined as any clinical test, laboratory or otherwise, used to identify HIV, a component of HIV, or antibodies or antigens to HIV [Health and Safety Code Section 120775(c)]. California law also has very strict laws governing the confidentiality of HIV test results.

Providers should remember that a positive result to an HIV test must be reported to the local health officer *(see chapter 18)*.

REQUIRED INFORMATION

Prior to *ordering* an HIV test, a "medical care provider" must:

1. Inform the patient that the test is planned,
2. Provide information about the test to the patient,
3. Inform the patient that there are numerous treatment options available for a person who tests positive for HIV and that a person who tests negative for HIV should continue to be routinely tested, and
4. Advise the patient that he or she has the right to decline the test.

[Health and Safety Code Section 120990(a)]

There are additional disclosure requirements if the patient is pregnant *(see CHA's* Consent Manual*, chapter 13)*. The disclosure requirements do not apply to a clinical laboratory [Health and Safety Code Section 120990(i)].

NOTE: The term **"medical care provider"** is not defined in this law but is defined elsewhere to mean a health care professional licensed under Division 2 of the Business and Professions Code (e.g., physicians, dentists, nurses and other individual professionals) [Health and Safety Code Section 109278(b)].

Exception

The disclosure requirement above does not apply when a patient independently requests an HIV test from a medical care provider [Health and Safety Code Section 120990(b)]. If the patient independently requests the test, the provider should document that fact in the medical record. It is not clear what "independently requesting" an HIV test means. The sponsors of this language in the law meant it to mean patients who proactively request an HIV test from their physician, rather than the physician recommending to the patient that the test be run.

Alternatively, a provider may wish to give the disclosures to all patients, whether the provider suggested the test or the patient requested it. CHA has developed the form "Consent for the HIV Test" (CHA Form 23-1) that includes the information that must be disclosed to patients. The provider may give this form to all patients who undergo HIV testing (regardless of who initially suggested the test), and put a copy of the signed form in the patient's medical record to fulfill the documentation requirements.

INFORMED CONSENT

The law states that, except for tests ordered in connection with the required disclosures described above, no person shall "administer" an HIV test unless the patient or his or her parent, guardian, conservator, or other person authorized to make health care decisions for the patient has provided informed consent to the test. It is not clear what this provision means. The sponsors of this language in the law said that they meant it to apply in cases where a person who was not a health care provider was taking the sample from the patient to test using a home test kit or to send to a mail-order lab for HIV testing. They intended the law to prohibit this without the test subject's informed consent. However, it may also apply to instances where the patient lacks capacity to make his or her own health care decisions, and consent is provided by a legal representative.

In these cases, The patient or the patient's legal representative may provide consent orally or in writing.

The person "administering" the HIV test must maintain documentation of consent in the patient's medical record. This may be accomplished by having the patient or legal representative sign a consent form or by having the ordering practitioner make a note in the medical record. *(See below for information on who may be a legal representative of a patient for purposes of consenting to an HIV test.)* [Health and Safety Code Section 120990(c)]

CHA has developed the form "Consent for the HIV Test" (CHA Form 23-1) to include the information that must be disclosed to patients. (This form should be used only when the test is performed for purposes *other than* testing donated blood since a different form is required to be used by blood banks and plasma centers.)

Since this consent form contains medical information, it should be reviewed by an appropriate medical staff committee or designated physician prior to use in the hospital.

DOCUMENTING REFUSALS

If a patient declines an HIV test, the medical care provider must note that fact in the patient's medical record [Health and Safety Code Section 120990(a)].

MINORS 12 AND OLDER

A minor 12 years of age or older who may have come into contact with a communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if it is a disease that is required by law to be reported to the local health officer, or for a related sexually transmitted disease as determined by CDPH. Both AIDS and HIV infection are required by law to be reported [Family Code Section 6926; Health and Safety Code Sections 120250 and 121022; Title 17, California Code of Regulations, Sections 2500 and 2641.30-2643.20].

The California Office of AIDS has taken the position, in connection with its operation of alternative testing sites, that Family Code Section 6926 gives a minor 12 years of age or older the legal capacity to consent to the HIV test. Taken together, these authorities suggest that minors age 12 or older have the legal authority to consent to the HIV test.

Care must be taken when applying this principle in particular situations. It is important to determine that a minor consenting to the HIV test is competent to give his or her consent — i.e., that the minor is sufficiently knowledgeable and mature to appreciate the nature and consequences of his or her decision *(see B. "Capacity to Consent," page 2.37)*. Given these concerns, except in those instances in which the minor has indicated that privacy is a primary concern and it is clear that the minor has an appreciation of AIDS and of the HIV test, the health care provider may wish to recommend that a parent or guardian be involved in the decision whether to consent to the HIV test. At the same time, when a minor 12 years or older initiates the test request, indicates his or her preference not to involve a parent or guardian, and shows appreciation of the issues involved, the minor is entitled to consent to the test. Conversely, if a minor age 12 or older refuses the HIV test, that refusal should be respected even if the parent or guardian wants the minor to be tested, if the minor appreciates the issues and consequences.

The minor's parents or guardian are not liable for payment for the HIV testing or treatment [Family Code Section 6926(c)]. Providers should establish procedures to ensure that parents do not receive a bill for this service, unless authorized by the minor in writing. The law does not specify who is responsible for payment. *(See C. "Financial Responsibility for Treatment of Minors," page 2.25.)*

ADULTS LACKING CAPACITY AND MINORS UNDER 12

The law is clear that a minor is not authorized to consent to an HIV test if he or she is under 12 years of age [Health and Safety Code Section 121020(a)].

When an individual is under 12 years of age or, as a result of his or her mental or physical condition, or lack of maturity, lacks the capacity to consent to the HIV test *and* the test is necessary to render appropriate care or to practice preventative measures, written consent may be obtained from persons lawfully authorized to make health care decisions for the individual [Health and Safety Code Section 121020(a)(1)]. This includes agents appointed in a power of attorney for health care (unless the power of attorney for health care expressly denies the agent the right to consent to an HIV test), parents of minors *(see "Minors 12 and Older," page 2.56)*, and conservators and guardians who have been authorized by the court to make health care decisions for the patient. Where appropriate, this may also include an adult patient's closest available relative *(see "Family Members," page 2.22, for a discussion of the basis for relying upon consent from a patient's closest available relative)*. CHA Form 23-1, "Consent for the HIV Test" may be used to document consent. The patient's lack of capacity and the necessity for the test result should be documented in the medical record.

FOSTER CHILD/DEPENDENT CHILD OF THE COURT/ INFANT IN TEMPORARY CUSTODY

A parent of a child who is a dependent of the juvenile court (foster child) continues to have the legal authority to consent to HIV testing, if the child is under 12 years of age. In addition, a court or social worker may be able to consent, as described below.

If the subject of the HIV test is a minor adjudged to be a dependent child of the court (foster child) under Welfare and Institutions Code Section 360, written consent for the test may be obtained from the court pursuant to its authority under Welfare and Institutions Code Sections 362 or 369. The hospital should obtain a copy of the court's order in these cases.

If the subject of an HIV test is an infant who is less than 12 months of age who has been taken into temporary custody under Welfare and Institutions Code Section 305 *et seq.* or who has been, or has a petition filed with the court to be, adjudged a dependent child of the court under Welfare and Institutions Code Section 360, the social worker may provide written consent for an HIV test to be performed when the infant is receiving medical care pursuant to Welfare and Institutions Code Section 369, if all of the following have occurred:

1. The attending physician determines that HIV testing is necessary to render appropriate care to the infant and documents that determination. When deciding whether HIV testing is necessary, the physician must consider appropriate factors, either known to the attending physician or provided to the attending physician by the social worker, including, but not limited to, whether the infant has a parent with a history of behavior that places the parent at an increased risk of exposure to HIV, or whether the infant is a victim of sexual abuse, which has placed the child at risk of exposure to HIV.
2. The social worker provides known information concerning the infant's possible risk factors regarding exposure to HIV to the attending physician.
3. The social worker has made reasonable efforts to contact the parent or guardian but was unable to do so, and the social worker has documented his or her efforts to contact that person.

The attending physician and the social worker must comply with all state and federal confidentiality laws to protect the privacy interests of both the infant and the biological mother.

If an infant tests positive for HIV in a test performed under this law, the social worker must provide the physician any available contact information for the biological mother for purposes of reporting the HIV infection to the local health officer.

If an infant tests positive for HIV in a test performed under this law, and the physician determines that immediate HIV medical care is necessary to render appropriate care to that infant, the provision of HIV medical care is considered emergency medical care under Welfare and Institutions Code Section 369(d). In such cases, care may be provided without a court order and upon the authorization of the social worker.

DECEASED PATIENT

The law does not directly authorize anyone to consent to the testing of a cadaver except in the context of an autopsy, organ donation, scientific investigation or in case of an occupational exposure. If the need for an HIV test outside of these circumstances arises, the hospital should consult its legal counsel. [Health and Safety Code Sections 120990 and 121020(b)]

OCCUPATIONAL EXPOSURES

Testing may in some instances be performed even without the patient's consent where there has been a significant exposure of health care personnel to potentially infectious materials. *(See CHA's* Consent Manual*, chapter 5, for the procedure for testing under these circumstances.)*

CRIMINAL DEFENDANTS AND INMATES OF CORRECTIONAL INSTITUTIONS

The law allows involuntary testing of criminal defendants and inmates of correctional institutions in the following instances:

1. Every person, including a juvenile, who is convicted of certain sexual offenses shall be ordered by the court to submit to a blood or oral mucosal transudate saliva test for evidence of antibodies to the probable causative agent of AIDS within 180 days of the date of conviction [Penal Code Section 1202.1]. A hospital that performs an HIV test pursuant to a court order under Penal Code Section 1202.1 must disclose the results of the test to the clerk of the court ordering the test. The court will then disclose the results to the California Department of Justice and the local health officer. The local health officer will then disclose the results to the test subject and, where requested, to the victim, but only after professional counseling is provided, as appropriate.
2. Defendants (including minors) charged with certain crimes involving sexual offenses and certain other

arrestees are subject to testing for HIV, AIDS-related conditions and other communicable diseases *pursuant to court order* if a peace officer, custodial officer, firefighter, emergency medical personnel or specified nonsworn employees of law enforcement agencies have been exposed to a defendant's or arrestee's blood or bodily fluids [Health and Safety Code Sections 121050-121065]. A forensic scientist or employee who is exposed may also petition a court for an order for testing. Prior to the filing of a petition for court-ordered testing, a health care provider must attempt to obtain the voluntary informed consent of the arrestee (or the authorized legal representative) to perform a test for HIV, hepatitis B, and hepatitis C. The voluntary informed consent must be in writing. CHA Form 23-1, "Consent for the HIV Test," may be used to comply with this requirement. If the arrestee declines to consent, the peace officer, custodial officer, firefighter, emergency medical personnel or nonsworn employee of a law enforcement agency petitioning the court must obtain a written certification by a health care professional that an exposure, including the nature and extent of the exposure, has occurred.

Testing must be performed on specimens of blood withdrawn from the defendant in a medically approved manner. Only a physician, registered nurse, licensed vocational nurse, licensed medical technician or licensed phlebotomist may withdraw blood for these purposes. The court's order should specify the tests to be performed and designate the persons to whom disclosure of the results may be made. The test results must be sent to the designated recipients with the following disclaimer:

> The tests were conducted in a medically approved manner. Persons receiving this test result should continue to monitor their own health and should consult a physician as appropriate. Recipients of these test results are subject to existing confidentiality protections for any identifying information about HIV, hepatitis B, or hepatitis C test results. Medical information regarding the HIV, hepatitis B, or hepatitis C status of the source patient shall be kept confidential and may not be further disclosed, except as otherwise authorized by law.

The peace officer, custodial officer, firefighter, emergency medical personnel or nonsworn employee of a law enforcement agency who was exposed must also be informed of the penalties for unlawful disclosure of medical information about the defendant/arrestee pursuant to Health and Safety Code Section 120980. In some cases, the subject of the HIV test must be asked if he or she wishes to know the results, and must sign a form if he or she does not wish to be informed [Health and Safety Code Section 121056(c)(2) and 121060(c)(2)]. An arrestee's refusal to sign the form is deemed to be a refusal to be informed of the test results.

3. Adults or minors charged with *any* crime are subject to testing when, at the request of a victim of the crime, a court finds that there is probable cause to believe that the accused committed the crime and that blood, semen or other bodily fluid capable of transmitting HIV has been transferred from the accused to the victim. Testing in such cases may be performed only by the local health officer as specified in a search warrant issued by the court. [Penal Code Section 1524.1]
4. Inmates of correctional institutions and other persons in custody or on probation or parole are subject to testing for hepatitis B and C and HIV under circumstances where there is a significant risk that HIV was transmitted. The test may be ordered by the chief medical officer of a correctional institution (subject to review by the superior court). [Penal Code Sections 7500-7554]

EXCEPTIONS: WHEN INFORMED CONSENT IS NOT REQUIRED

The law clearly allows testing without the patient's informed consent in the following cases:

1. A test performed at an alternative testing site. (The individual's consent is still required, but to preserve that person's anonymity, no consent form need be signed.)
2. Testing performed to determine the suitability of organs or tissue donated pursuant to the Uniform Anatomical Gift Act *(see Health and Safety Code Section 7150.65)*.
3. A test ordered by a medical examiner or other physician on a cadaver when an autopsy is performed.
4. Testing performed as part of a scientific investigation conducted either by medical researchers operating under institutional review board approval or by CDPH under a protocol for unlinked testing. The testing must be anonymous with the individual's name and other identifying information removed so the test results will not be linked to a particular individual in the study.
5. Where a health care worker has been exposed to the potentially infectious materials of a patient, provided that strict procedures for attempting to obtain consent and testing are followed. These procedures are described in CHA's *Consent Manual*, chapter 5.

[Health and Safety Code Section 120990]

INFORMING THE PATIENT OF TEST RESULTS

The provider who administers or orders the test must ensure that the patient receives timely information and counseling, as appropriate, to explain the test results and the implications for the patient's health.

If the patient tests positive for HIV infection, the provider must inform the patient that there are numerous treatment options available and identify follow-up testing and care that may be recommended, including contact information for medical and psychological services. In addition, the provider must warn the patient about the dangers of contagion and counsel the patient about precautionary measures to prevent the spread of the disease to others [*Reisner v. Regents of the University of California*, 31 Cal. App.4th 1195 (1995)].

If the patient tests negative for HIV infection and is known to be at high risk for HIV infection, the provider must:

1. Advise the patient of the need for periodic retesting,
2. Explain the limitations of current testing technology and the current window period for verification of results, and
3. Provide information about methods that prevent or reduce the risk of contracting HIV, including, but not limited to, preexposure prophylaxis and postexposure prophylaxis, consistent with guidance of the Centers for Disease Control and Prevention.

The provider may offer prevention counseling or a referral to prevention counseling.

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3 Voluntary Admission and Involuntary Detainment for Mental Health Treatment

I. INTRODUCTION

A. Background

This chapter discusses the rights and procedural protections that California law gives to persons who are voluntarily or involuntarily detained for mental health services, including evaluation and treatment of a mental health disorder, inebriation or drug use. These rights and protections are set forth primarily in the Lanterman-Petris-Short (LPS) Act [Welfare and Institutions Code Section 5000 *et seq.*].

Patients who are a danger to self or others or gravely disabled may be evaluated and treated on an involuntary basis under two different sets of laws:

1. Welfare and Institutions Code Section 5150 *et seq.*, which allows a patient to be held in a facility that is designated for these purposes by the county and approved by the California Department of Health Care Services. Patients may be detained for up to 72 hours (longer if specified criteria are met). Designated facilities may be general acute care hospitals or acute psychiatric hospitals. Patients treated under this set of laws are given the special rights described in chapter 16, and are protected by strict confidentiality laws in the Welfare and Institutions Code, described in CHA's *California Health Information Privacy Manual*. *(For more information about detaining these patients, see III. "Admission and Treatment of Involuntary Patients," page 3.7.)*

2. Health and Safety Code Section 1799.111, which allows a patient to be held in a non-designated facility for up to 24 hours while the facility tries to find an appropriate placement for the patient in a facility that provides mental health services. Non-designated facilities are general acute care hospitals, and usually do not have a psychiatric unit. Patients treated under this law are not given the special rights described in chapter 16, and are protected by the confidentiality laws in the Confidentiality of Medical Information Act. *(For more information about detaining these patients, see VI. "Detention of Patient in a Nondesignated Facility," page 3.32.)*

B. Patient Privacy Considerations

This chapter describes several instances in which California law requires the disclosure of protected health information (PHI) to patients' rights advocates, independent clinical reviewers, certification review hearing officers, county behavioral health directors and others.

The federal privacy regulations issued under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 permit health care providers to disclose PHI to the persons or entities listed above under several provisions:

1. **For purposes of health care oversight** [45 C.F.R. Section 164.512(d)(1)(iv)]. The California Department of Public Health (CDPH) is one example of a health care oversight agency. A health care oversight agency also includes a person or entity acting under a contract (or other grant of authority) from a government entity (including a county) to enforce civil rights laws [45 C.F.R. Section 164.501]. Although the HIPAA rules are not completely clear on this point, if a particular disclosure of information is required to be made by California law (or a federal law) to a county patient's rights advocate, an independent clinical reviewer approved by a county, or a certification review hearing officer approved by the county for the purpose of determining whether a patient's civil rights are being properly protected (rather than the patient being hospitalized illegally), the disclosure is likely permissible under the HIPAA provisions for health care oversight. Alternatively, the disclosure may be permissible under the HIPAA provision for disclosures "required by law" [45 C.F.R. Section 164.512(a)].

2. **For law enforcement purposes.** These uses/disclosures have certain requirements that must be met prior to disclosure, as described in this chapter and chapters 6 and 7.

3. **For judicial and administrative proceedings.** These uses/disclosures have certain requirements that must be met prior to disclosure. When disclosure of PHI is made for purposes of judicial or administrative proceedings (such as a writ of habeas corpus), a hospital should consult legal counsel regarding the advisability of filing documents with the court under seal and/or obtaining a protective order.
4. **To prevent or lessen a serious and imminent threat to the health or safety of the patient or the public** [45 C.F.R. Section 164.512(j)]. *(See IX. "Potentially Dangerous Patients: Duty to Warn Potential Victims and Notify Law Enforcement," page 7.33.)*

Given the high sensitivity of mental health information, a hospital should consult legal counsel if a question arises as to whether it is permissible to disclose PHI in a particular instance.

II. ADMISSION AND TREATMENT OF VOLUNTARY PATIENTS

A. Voluntary Admission of Adult Patients

Adults, including persons under conservatorship, may be voluntarily admitted for treatment of mental disorders, alcoholism or drug abuse.

AUTHORITY TO REQUEST VOLUNTARY ADMISSION

The patient or, if applicable, the patient's conservator, may request admission. Welfare and Institutions Code Section 5350 provides for the appointment of a conservator of the estate, or of the person and the estate, for a person who is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism. Conservatorship proceedings are discussed under F. "Additional Treatment for Gravely Disabled Person (LPS Conservatorship)," page 3.31.

The conservator has the right, if specified in the court order, to place his or her conservatee in a medical, psychiatric, nursing, or other state-licensed facility, or a state hospital, county hospital, hospital operated by the Regents of the University of California, a U.S. government hospital, or other nonmedical facility approved by the California Department of Social Services (DSS) or an agency accredited by the California Department of Health Care Services (DHCS), or, in the case of chronic alcoholism, in a county alcoholic treatment center [Welfare and Institutions Code Section 5358].

An agent designated in an advance health care directive may not authorize voluntary or involuntary admission of a patient to a mental health facility [Probate Code Section 4652]. *(See chapter 2 for information about advance directives.)*

The law recognizes two types of "gravely disabled" conservatees. Each type is subject to different placement parameters, as described below.

Unable to Provide for Basic Needs

Welfare and Institutions Code Section 5008(h)(1)(A) defines **"grave disability"** 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.

For a conservatee who is gravely disabled under this definition, the conservator must place the patient in the least restrictive alternative placement as designated by the court. The conservator may transfer the patient to a less restrictive placement without a further court hearing or court order.

Mentally Incompetent to Stand Trial

Welfare and Institutions Code Section 5008(h)(1)(B) defines **"grave disability"** as a condition in which a person has been found mentally incompetent under Penal Code Section 1370 (mentally incompetent to stand trial) and all of the following facts exist:

1. The complaint, indictment or information pending against the person at the time of commitment charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person, and the indictment or information has not been dismissed.
2. There has been a finding of probable cause on a complaint pursuant to Penal Code Section 1368.1(a)(2) (which relates to a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person), a preliminary examination pursuant to Penal Code Section 859b (this is a particular type of hearing), or a grand jury indictment, and the complaint, indictment, or information has not been dismissed.
3. As a result of a mental health disorder, the person is unable to understand the nature and purpose of the proceedings against him or her and to assist counsel in the conduct of his or her defense in a rational manner.
4. The person represents a substantial danger of physical harm to others by reason of a mental disease, defect, or disorder.

For a conservatee who is gravely disabled under this definition, the conservator must place the patient in a placement that achieves the purposes of treatment of the conservatee and protection of the public. The conservator may not transfer the patient without written notice to the court.

CAUTION: TYPE OF CONSERVATORSHIP

A conservatorship under LPS (which is found in the Welfare and Institutions Code) is different from a conservatorship under the Probate Code. If a patient is under a conservatorship, hospitals should obtain and carefully review the conservatorship documents issued by the court to determine the type of conservatorship and the conservator's scope of authority. A patient may be subject to both an LPS conservatorship and a Probate Code conservatorship; however, this is not common.

LPS Conservatorship

An LPS conservatorship is meant for psychiatric patients. The purpose of an LPS conservatorship is the provision of individualized psychiatric treatment, supervision, and placement for a patient who is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism. An LPS conservator may authorize the admission of the conservatee to a mental health facility. An LPS conservator may consent to, or refuse, routine medical treatment (other than psychiatric treatment) only if the court order establishing the conservatorship specifically provides this authority. An LPS conservator usually may not consent for surgery or other complex medical procedures without an additional, specific court order. *(See F. "Additional Treatment for Gravely Disabled Person (LPS Conservatorship)," page 3.31, for more information about LPS conservatorships. See C. "Adults Under Conservatorship," page 2.15, for more information about an LPS conservator's authority to consent to, or refuse, nonpsychiatric medical treatment.)*

Probate Code Conservatorship

A conservatorship under the Probate Code is meant to ensure that the conservatee's basic needs for food, clothing, shelter, money management, and health care are met. Conservatees may be comatose, developmentally disabled, or have dementia or other medical problems. Some patients under a Probate Code conservatorship may have the ability to make their own health care decisions, while others may not — the letters of conservatorship will state the authority of the conservator. A Probate Code conservator may not authorize admission to a mental health facility. *(See C. "Adults Under Conservatorship," page 2.15, for more information about Probate Code conservatorships.)*

WRITTEN APPLICATION FOR VOLUNTARY ADMISSION

A patient should be voluntarily admitted only if the "Request for Voluntary Admission and Authorization for Treatment" form (CHA Form 12-1) or a similar form is completed.

Completion by Physician

The attending physician should certify that the voluntary patient is mentally competent to understand the nature of his or her admission and the treatment to be rendered. The certification should be executed upon admission or as soon as possible thereafter [Welfare and Institutions Code Section 6002]. A certification form is included in the "Request for Voluntary Admission and Authorization for Treatment" form (CHA Form 12-1).

Copies

One copy of the written application should be made. The original should be placed in the patient's medical record; the copy should be given to the patient or the person who made the written request for admission on behalf of the patient.

SEARCH OF THE PATIENT, POSSESSIONS AND ROOM

The "Request for Voluntary Admission and Authorization for Treatment" form (CHA Form 12-1) notifies the patient that hospital employees will inventory the patient's possessions and remove items that may create a danger to the patient, other patients, visitors or hospital staff.

As a reminder, mental health patients have the right to keep and use personal possessions and to have access to individual storage space for private use. Of course, this does not mean that patients have the right to keep potentially dangerous items. However, under some circumstances a search and/or removal of patient possessions may constitute a denial of rights, which is permissible but must be documented. *(See II. "Patient Rights Under State Law," page 4.1, for detailed information about patient rights and the requirements to be followed when denying a right.)* The hospital should consult its legal counsel regarding the development of policies and procedures regarding searches. *(See also V. "Searching Patients and Their Belongings," page 6.13.)*

OTHER ADMISSION FORMS

At the time of admission, the signature of the patient or the patient's legal representative on the "Conditions of Admission" (CHA Form 8-1) and other admission documents should also be obtained. If the patient lacks capacity to agree or refuses to agree to admission documents, the facility should attempt to obtain the patient's signature once he or she has regained capacity or is willing to sign.

RIGHT TO LEAVE THE HOSPITAL

A voluntary adult patient may leave the hospital, clinic, or institution at any time by giving notice to any member of the hospital staff of the patient's desire to leave and by completing usual discharge procedures. A conservatee may leave in a like manner if notice is given by the patient's conservator.

B. Voluntary Admission of Minors to Private Facilities

As a general rule, a parent may consent to a minor's admission for inpatient mental health treatment, subject to the limitations described below. There are special requirements that apply to certain treatments a minor might receive (e.g., antipsychotic medications and convulsive therapy), which are discussed in X. "Treatments That Require Special Consent," page 2.42.

California law specifies procedures and requirements for the voluntary admission to private acute psychiatric facilities of minors age 14 and older. State and county hospitals are not required to follow these procedures and requirements [Welfare and Institutions Code Sections 6002.10-6002.40].

"Voluntary admission" means, for a minor patient, that the parent, guardian or other legal representative wants the minor to be admitted to the hospital. It does not necessarily mean that the minor agrees or acquiesces to the hospitalization. *(See VII. "Who May Give Consent: Minors," page 2.24, regarding who may be considered a legal representative of a minor.)*

MINORS AFFECTED

The admission procedures apply to a minor between 14 and 18 years of age admitted to a private mental health facility and whose admitting diagnosis or condition is either a mental health disorder only or a mental health disorder and a substance use disorder. Admission based on substance use disorder alone is not covered by these procedures. Additionally, the law applies only when the costs of treatment are paid or reimbursed by a private insurer or private health plan or Medi-Cal, not when the parent personally pays for the service.

Mental Health Disorder

Although resistance to treatment may be a product of a mental health disorder, the resistance does not, in itself, imply the presence of a mental health disorder or constitute evidence that the minor meets admission criteria. A minor must not be considered to have a mental health disorder solely for exhibiting behaviors specified under Welfare and Institutions Code Section 601 (refusal to obey parents, violation of curfew, or truancy) or 602 (commission of a crime).

Exclusions

The admission procedures *do not apply* to the following minors:

1. Minors under 14 years of age.
2. Minors who are legally emancipated. Minors who are legally emancipated cannot be voluntarily admitted by a parent or guardian. They should be treated as voluntary or involuntary adults.
3. Minors who are detained involuntarily on a 72-hour hold as gravely disabled or as a danger to self or others under the Lanterman-Petris-Short Act, Welfare and Institutions Code Sections 5585.50 and 5585.53. (These procedures would apply, however, at the time of a change to voluntary status of a minor who was initially admitted on a 72-hour hold if the other criteria are met.)
4. Minors who are voluntarily committed as wards of the juvenile court under Welfare and Institutions Code Section 6552 *(see below)*.
5. Minors who have been declared dependents of the juvenile court under Welfare and Institutions Code Section 300 (abuse, neglect or abandonment) or wards of the court under Welfare and Institutions Code Section 602 (commission of a crime).

Wards and dependents of the juvenile court may, with the advice of counsel, voluntarily request inpatient mental health services [Welfare and Institutions Code Section 6552]. The juvenile court must authorize the minor to request these services first. The juvenile court may authorize the minor to request mental health services if the court is satisfied from the evidence that:

1. The minor suffers from a mental health disorder which may reasonably be expected to be cured or

ameliorated by a course of treatment offered by the hospital, facility or program in which the minor wishes to be placed; and

2. There is no other available hospital, facility or program that might better serve the minor's medical needs and best interest.

The juvenile court may issue an order to the minor and to the person in charge of the hospital, facility or program ordering that the minor be returned to the juvenile court if the minor tries to leave before being discharged.

REQUIRED PROCEDURES AT ADMISSION

The facility must see that the following requirements are met:

1. Prior to accepting the written authorization for treatment, a facility representative must give a full explanation of the facility's treatment philosophy to the parent, guardian or other person entitled to the minor's custody. This explanation must be given orally and in writing, and must include, where applicable, the use of seclusion, restraints, medication, and the degree of involvement of family members in the minor's treatment. This must be documented in the minor's medical record. The "Statement of Professional Person Responsible for Minor's Admission" form (CHA Form 12-2) may be used to document the oral discussion. Each facility should prepare a written document to be given to the minor or the minor's representative. The admitting parent's or guardian's signature on the "Conditions of Admission" (CHA Form 8-1) and other admission documents should also be obtained.
2. As part of the admission process, the professional responsible for the minor's admission must affirm *in writing* that the minor meets the following required admission criteria:
    a. That the minor has a mental health disorder, or a mental health disorder and a substance use disorder.
    b. That inpatient treatment in the facility is reasonably likely to be beneficial to the minor's mental health disorder.
    c. That inpatient treatment in the facility is the least restrictive, most appropriate available setting in which to treat the minor, within the constraints of reasonably available services, facilities, resources, and financial support.

    The "Statement of Professional Person Responsible for Minor's Admission" form (CHA Form 12-2) may be used for this purpose.
3. Upon admission, the facility is required to do the following:
    a. Notify the minor in writing of the availability of an independent clinical review of further inpatient treatment. This notice must be witnessed and signed by a facility representative.
    b. Within one working day, notify the county patients' rights advocate of the minor's admission.
    c. Provide each minor with a booklet prepared by DHCS outlining the rights of minors in mental health facilities. The booklet must include the telephone number of the local advocate and the hours that the advocate may be reached.

The "Notice to Minors" (CHA Form 12-3) may be used to provide the written notice to the minor of the availability of the independent clinical review and to document the minor's receipt of the minor's rights booklet.

INDEPENDENT CLINICAL REVIEW

The following guidelines apply to the independent clinical review.

Timing

The minor may request an independent clinical review up to 10 days after admission. The review must take place within five days of the request. The minor may rescind the request at any time.

Notification and Participation of Patients' Rights Advocate

If the minor requests a review, the facility must notify the patients' rights advocate of this within one working day of the request. The advocate must provide information and assistance to the minor in a manner least disruptive to patient care in the facility.

Selection of the Person Who Conducts the Hearing

The independent clinical review must be conducted by a licensed psychiatrist with training and experience in treating adolescent psychiatric patients. This reviewer must be a neutral party to the review, having no direct financial relationship with the treating clinician nor a personal or financial relationship with the minor's parents or guardian. The reviewer must be assigned, on a rotating basis, from a list prepared by the facility and approved by the county behavioral health director *(see Welfare and Institutions Code Section 6002.25 about the annual submission and approval process)*. The reviewer may be an active member of the medical staff of the facility so long as he or she has

no direct financial relationship with the facility (including, but not limited to, an employment or other contractual arrangement with the facility) except for compensation received for the service of providing clinical reviews.

Setting

The review must take place at the facility in a location that assures privacy and is compatible with, and least disruptive to, the treatment being provided to the minor. The review must be held in an informal setting to minimize the anxiety of the minor and his or her parents and to promote communication and cooperation among those involved.

Closed Review

The review must be closed to all but the minor, the parents or legal guardian, a facility representative, the minor's advocate, the reviewer, and the person who presents information in favor of, or in opposition to, the inpatient treatment. The reviewer has discretion to limit the number of participants.

Legal Representation

No party may have legal representation in the review process.

Interpreters

If a party to the review does not comprehend the language used at the review, the reviewer is responsible for retaining an interpreter.

Record of the Review

The reviewer must keep a record of the proceeding.

Participation by Minor

The minor has the right to be present, to be assisted by the patients' rights advocate, and to question persons recommending inpatient treatment. The reviewer must be informed if the minor has received medication while an inpatient and of the probable effects of the medication. If the minor is unwilling to attend, the review must be held without the minor, with the advocate representing the minor.

Information Considered

All reasonably available clinical data relevant to establishing whether the minor meets the admission criteria must be considered by the reviewer. The reviewer must privately interview the minor and must consult the treating clinician to review alternative treatment options. The person who presents the clinical information in favor of inpatient treatment must inform the person who conducts the interview of the proposed treatment plan for the minor and, if known, whether the minor has had any previous independent clinical reviews at any facility, and the results thereof.

Standard of Review

The standard of review must be:

1. Whether the minor continues to have a mental disorder;
2. Whether further inpatient treatment is reasonably likely to be beneficial to the minor's mental health disorder; and
3. Whether placement in the facility represents the least restrictive, most appropriate available setting in which to treat the minor, within the constraints of reasonably available services, facilities, resources, and financial support.

Decision

The reviewer must render a binding decision after considering all of the clinical information.

If the reviewer determines that further inpatient treatment is reasonably likely to be beneficial to the minor's mental health disorder and that placement in the facility is the least restrictive, most appropriate available setting in which to treat the minor, the minor's inpatient treatment must be authorized. This determination terminates upon the minor's discharge from the facility.

If the reviewer determines that further inpatient treatment is not reasonably likely to be beneficial to the minor's mental health disorder or is not the least restrictive, most appropriate available setting, the minor must be released from the facility to a custodial parent or guardian on the same day the determination is made.

Immunity From Liability

If the minor is released pursuant to the reviewer's determination, neither the attending psychiatrist, any licensed health professional providing treatment to the minor in the facility, the psychiatrist who releases the minor, nor the facility in which the minor was admitted or treated shall be civilly or criminally liable for any conduct of the released minor (or the conduct of a parent, legal guardian, or other persons entitled to custody of the minor). There is an exception to this immunity only to the extent that a person defined as a psychotherapist under Evidence Code Section 1010 has a duty to warn if the patient communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable

victim or victims. *(See A. "Duty to Warn Potential Victims," page 7.33, and B. "Duty to Notify Law Enforcement Agency," page 7.33, for information about these duties.)*

Costs

If a private insurer, certified medical plan or private health care service plan is financially responsible for the costs of medically necessary mental health services provided to a minor, then the costs of the clinical review (including the costs of the patients' rights advocate and the interpreter, if any) must be borne by the insurer, certified medical plan or health plan. For Medi-Cal patients, the costs of the review must be borne by the county.

Annual Reports

Mental health facilities must prepare and submit annually to DHCS information including, but not limited to:

1. The number of minors admitted by diagnosis, length of stay, and source of payment; and
2. The number of requests for an independent clinical review by diagnosis, source of payment, and outcome of the independent clinical review.

The California Department of Public Health is required to monitor compliance with this reporting requirement during surveys. [Welfare and Institutions Code Section 6002.40(c)]

C. Voluntary Admission of Minors to State and County Facilities

State and county facilities are excluded from the notice and review requirements described above. However, in the case *In re Roger S.*, 19 Cal.3d 921 (1977), the California Supreme Court held that a parent or guardian may not admit a minor 14 years of age or older to a state hospital without a pre-admission hearing to determine whether the minor is mentally ill. In addition, the U.S. Supreme Court ruled that postadmission independent review is also required [*Parham v. J.R.*, 442 U.S. 584 (1979)]. These rulings do not apply to minors under 14 years of age or to private facilities *(see B. "Voluntary Admission of Minors to Private Facilities," page 3.4)*.

"Voluntary admission" means, for a minor patient, that the parent, guardian or other legal representative wants the minor to be admitted to the hospital. It does not necessarily mean that the minor agrees or acquiesces to the hospitalization.

III. ADMISSION AND TREATMENT OF INVOLUNTARY PATIENTS

The Lanterman-Petris-Short (LPS) Act establishes procedural requirements under which persons dangerous to themselves or others or gravely disabled as a result of a mental health disorder, inebriation, or the use of narcotics or restricted dangerous drugs may be involuntarily detained for specified periods for evaluation and treatment, which include:

1. An initial 72-hour hold for evaluation and treatment;
2. An additional 14-day intensive treatment period *(see A. "Detention for 14-Day Intensive Treatment," page 3.17)*; and
3. An additional 30-day period of intensive treatment after the 14-day period of treatment (where the county board of supervisors authorizes such a procedure) *(see D. "Additional Intensive Treatment for Gravely Disabled Person," page 3.25)*; and
4. Further confinement depending on the person's condition:
    a. A second 14-day intensive treatment period for persons who are imminently suicidal *(see C. "Additional Intensive Treatment for Suicidal Patient," page 3.23)*;
    b. An additional 180-day confinement for persons who present a demonstrated danger of substantial physical harm to others *(see E. "Additional Confinement for a Person Dangerous to Others (Post-Certification Procedures)," page 3.28)*; or
    c. Confinement pursuant to a conservatorship for persons who are gravely disabled *(see D. "Additional Intensive Treatment for Gravely Disabled Person," page 3.25)*.

A chart that may be useful in understanding LPS, entitled "Summary of the Lanterman-Petris-Short Act's Provision for Involuntary Evaluation and Treatment and Right of Review" (CHA Table 12-A), is included in the back of this manual.

A. Definitions

"Assessment" means the determination of whether a person shall be evaluated and treated pursuant to Welfare and Institutions Code Section 5150 [Welfare and Institutions Code Section 5150.4].

"Attending staff" is defined as a person who has responsibility for the care and treatment of the patient, as designated by the local mental health director, and who

is on the staff of a designated facility [Title 9, California Code of Regulations, Section 823]. **"A member of the attending staff who is authorized to admit a person to a designated facility"** is defined as a physician who is on the psychiatric attending staff of either a public or private designated facility to which the patient will be admitted.

"Crisis intervention" consists of an interview or series of interviews within a brief period of time, conducted by qualified professionals, and designed to alleviate personal or family situations that present a serious and imminent threat to the health or stability of the person or the family. The interview or interviews may be conducted in the home of the person or family, or on an inpatient or outpatient basis with therapy or other services, as appropriate. The interview or interviews may include family members, significant support persons, providers, or other entities or individuals, as appropriate and as authorized by law. Crisis intervention may, as appropriate, include suicide prevention, psychiatric, welfare, psychological, legal, or other social services. [Welfare and Institutions Code Section 5008(e)]

"Evaluation" consists of multidisciplinary professional analyses of a person's medical, psychological, educational, social, financial, and legal conditions as may appear to constitute a problem. Persons providing evaluation services must be properly qualified professionals and may be full-time, part-time, or contract employees of an agency providing face-to-face evaluation services, including telehealth. [Welfare and Institutions Code Section 5008(a)]

"Gravely disabled" means either of the following:

1. A condition in which a person, as a result of a mental health disorder or, in some cases, chronic alcoholism, is unable to provide for his or her basic personal needs for food, clothing or shelter [Welfare and Institutions Code Section 5008(h)(1)(A)]; or
2. A condition in which a person has been found mentally incompetent under Penal Code Section 1370 (mentally incompetent to stand trial) and all of the following facts exist:
    a. The complaint, indictment or information pending against the person at the time of commitment charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person, and the indictment or information has not been dismissed.
    b. There has been a finding of probable cause on a complaint pursuant to Penal Code Section 1368.1(a)(2) (which relates to a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person), a preliminary examination pursuant to Penal Code Section 859b (this is a particular type of hearing), or a grand jury indictment, and the complaint, indictment, or information has not been dismissed.
    c. As a result of a mental health disorder, the person is unable to understand the nature and purpose of the proceedings taken against him or her and to assist counsel in the conduct of his or her defense in a rational manner.
    d. The person represents a substantial danger of physical harm to others by reason of a mental disease, defect, or disorder.

    [Welfare and Institutions Code Section 5008 (h)(1)(B)]

The term "gravely disabled" does not include persons with intellectual disabilities by reason of that disability alone. [Welfare and Institutions Code Section 5008(h)].

Notwithstanding Welfare and Institutions Code Section 5008(h), 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 willing and able to help provide for the person's basic personal needs for food, clothing, or shelter. However, unless family, friends, or others specifically indicate in writing their willingness and ability to help, they must not be considered willing or able to provide this help [Welfare and Institutions Code Sections 5250(d) and 5350(e)]. This exception does not apply to patients who are considered gravely disabled under Welfare and Institutions Code Section 5008(h)(1)(B) (mentally incompetent to stand trial).

"Gravely disabled minor" is a minor who, as a result of a mental health disorder, 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. Intellectual disability or other developmental disabilities, epilepsy, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental health disorder. [Welfare and Institutions Code Section 5585.25]

"Professional person in charge of a facility" means a psychiatrist, psychologist, social worker, marriage and family therapist, or registered nurse with a master's degree in psychiatric or public health nursing who is designated by the governing board of the facility or person having control of the facility as the professional person clinically in charge of the facility for purposes of LPS. The designation must be in writing. [Title 9, California Code of Regulations, Sections 623-627 and 822]

"Mental health disorder" is a term that is not defined in the law. According to the California Attorney General, the

reference to "mental disorder" (or "mental health disorder," the term used as of Jan. 2014) in Welfare and Institutions Code Section 5150 draws no distinction between disorders of inorganic or organic origin and therefore includes, together with inorganic mental disorders, Alzheimer's disease, brain injuries and other organic brain disorders [72 Ops.Cal.Atty.Gen. 41 (1989)].

B. Facility Designation

Involuntary treatment and evaluation must take place only in a facility that is designated for such purposes by the county and approved by DHCS. These facilities are called "designated facilities."

C. Interactions With Peace Officers

Mental health professionals may not interfere with peace officers who are transporting a person to a designated facility for assessment under Welfare and Institutions Code Section 5150. These laws were passed to prevent mental health personnel from refusing to take a patient and telling law enforcement officers to take the patient to jail instead, and to prevent mental health personnel from unreasonably detaining law enforcement officers. [Welfare and Institutions Code Sections 5150.1 and 5150.2]

Welfare and Institutions Code Section 5150.1 provides:

> No peace officer seeking to transport, or having transported, a person to a designated facility for assessment under Welfare and Institutions Code Section 5150, may be instructed by mental health personnel to take the person to, or keep the person at, a jail solely because of the unavailability of an acute bed, nor may the peace officer be forbidden to transport the person directly to the designated facility. No mental health employee from any county, state, city, or any private agency providing Short-Doyle psychiatric emergency services may interfere with a peace officer performing duties under Welfare and Institutions Code Section 5150 by preventing the peace officer from entering a designated facility with the person to be assessed, nor may any employee of such an agency require the peace officer to remove the person without assessment as a condition of allowing the peace officer to depart.

Welfare and Institutions Code Section 5150.2 provides:

> In each county whenever a peace officer has transported a person to a designated facility for assessment under Welfare and Institutions Code Section 5150, that officer shall be detained no longer than the time necessary to complete documentation of the factual basis of the detention under Welfare and Institutions Code Section 5150 and a safe and orderly transfer of physical custody of the person. The documentation must include detailed information regarding the factual circumstances and observations constituting probable cause for the peace officer to believe that the individual required psychiatric evaluation under the standards of Welfare and Institutions Code Section 5150.
>
> Each county must establish disposition procedures and guidelines with local law enforcement agencies as necessary to relate to persons not admitted for evaluation and treatment and who decline alternative mental health services and to relate to the safe and orderly transfer of physical custody of persons under Welfare and Institutions Code Section 5150, including those who have a criminal detention pending.

IV. INVOLUNTARY DETENTION OF THE PATIENT ON A 72-HOUR HOLD

A. Patients With a Mental Health Disorder

CONDITIONS FOR DETENTION

Welfare and Institutions Code Section 5150 states that when a person, as a result of a mental health disorder, is a danger to self or others or is gravely disabled, any of the following persons may, upon probable cause, take the person into custody and place the person in a designated facility:

1. A peace officer (including park peace officers and regional park peace officers);
2. A professional person in charge of a designated facility; or
3. A member of the attending staff of a designated facility who is authorized to admit a patient involuntarily; or
4. Any other professional person designated by the county.

The person may be taken into custody for up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a designated facility. *(If the patient is a minor, see E. "Special Requirements for a Minor," page 3.16.)* At a minimum, assessment and evaluation must be conducted and provided on an ongoing basis. Crisis intervention may be provided concurrently with assessment, evaluation, or other services.

WRITTEN APPLICATION REQUIRED

The receiving/admitting facility must receive a written application stating:

1. The circumstances under which the person's condition was called to the attention of the peace officer, professional person in charge of the facility, member of the attending staff, or professional person designated by the county.
2. That the officer, member of the attending staff, or professional person has probable cause to believe that the person is, as a result of a mental health disorder, a danger to self or others or gravely disabled.
3. Whether the historical course of the person's mental disorder was considered in this determination *(see below)*.

A state law has been enacted, effective Jan. 1, 2019, to clarify that a copy of the application must be treated as the original. Formerly, some ambulance companies and other entities were declining to provide services to involuntary patients without having the original document.

When determining if probable cause exists to detain a person under Welfare and Institutions Section 5150, all available relevant information about the historical course of the person's mental disorder must be considered if it has a reasonable bearing on the determination as to whether the person is a danger to self or others or is gravely disabled. This includes evidence presented by a person who has provided or is providing mental health or related support services and evidence presented by family members. [Welfare and Institutions Code Section 5150.05]

If the probable cause is based on the statement of someone else, that person may be held liable in a civil action for intentionally giving a statement which he or she knows is false.

Recommended Form

In order to comply with the requirements of Welfare and Institutions Code Section 5150 for a written application, it is recommended that the DHCS 1801/DMH MH 302, "Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment," be used. This form may be found at www.dhcs.ca.gov/formsandpubs/forms/pages/mental_health-forms.aspx. CHA recommends supplementing the state form with the "Certificate of Admitting Physician" (CHA Form 12-4).

NOTICE BY PERSON TAKING PATIENT INTO CUSTODY

When a person is taken into custody under Welfare and Institutions Code Section 5150, the person who makes the detention must provide the following information orally in a language or modality accessible to the person. If the person cannot understand an oral advisement, the information must be provided in writing. This information is included in the DHCS 1801/DMH MH 302 form. The information should be substantially in the following form:

My name is _____.
I am a _____
(peace officer, mental health professional, etc.) 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 the person is taken into custody at his or her residence, the person must also be told the following information in substantially the following form:

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

The designated facility must keep a record of this advisement in the patient's medical record that includes:

1. The name of the person detained for evaluation.
2. The name and position of the peace officer or mental health professional taking the person into custody.
3. The date the advisement was completed.
4. Whether the advisement was completed.
5. The language or modality used to give the advisement.
6. If the advisement was not completed, a statement of good cause for not completing the advisement. *(See F. "Denial of Patient Rights," page 4.4, regarding the requirements for denial of a mental health patient's rights.)*

NOTICE BY FACILITY ADMISSION STAFF

The admission staff of the designated facility is required to give each person admitted under Welfare and Institutions Code Section 5150 specified information about the involuntary detention, both orally and in writing, in a language or modality accessible to the person. The written information must be in English and the language

that is the person's primary means of communication. Accommodations for other disabilities that may affect communications must also be provided. [Welfare and Institutions Code Section 5150(i)] DHCS has developed a form, DHCS 1802, "Involuntary Patient Advisement," that hospitals may use. The form is found at www.dhcs.ca.gov/formsandpubs/forms/pages/mental_health-forms.aspx.

A record of this advisement must be kept in the patient's medical record and must include the following:

1. The name of the person performing the advisement.
2. The date of the advisement.
3. Whether the advisement was completed.
4. The language or modality used to communicate the advisement.
5. If the advisement was not completed, a statement of good cause *(see F. "Denial of Patient Rights," page 4.4, regarding the requirements for denial of a mental health patient's rights)*.

ASSESSMENT

The professional person in charge of a designated facility, member of the attending staff, or professional person designated by the county must assess the patient to determine whether he or she can be properly served without being detained [Welfare and Institutions Code Section 5150(c)]. Prior to admitting a patient to a facility for a treatment and evaluation under Welfare and Institutions Code Section 5150, the professional person in charge of the facility, or a designee, must assess the patient in person to determine the appropriateness of the involuntary detention [Welfare and Institutions Code Section 5151].

If the patient cannot be properly served without being detained, the admitting facility must require an application in writing *(see "Written Application Required," page 3.9)*.

When a patient is evaluated by a professional person in charge of a designated facility, member of the attending staff, or professional person designated by the county and is found to need mental health services, but is not admitted to the facility, all available alternative services provided under Welfare and Institutions Code Section 5150(c) must be offered as determined by the county behavioral health director. These services include evaluation, crisis intervention, or other inpatient or outpatient services provided on a voluntary basis.

When a patient is subject to detention under Welfare and Institutions Code Section 5150, the treating facility must obtain the patient's medication history, if possible [Welfare and Institutions Code Section 5332].

NOTICE OF EFFECTS OF MEDICATION

A patient detained for evaluation and treatment who receives medications as a result of mental illness must be given, as soon as possible after detention, written and oral information about the probable effects and possible side effects of the medication [Welfare and Institutions Code Section 5152(c)].

The following information must be given orally to the patient:

1. The nature of the mental illness or behavior that is the reason the medication is being given or recommended.
2. The likelihood of improving or not improving without the medication.
3. Reasonable alternative treatments available.
4. The name, type, frequency, amount, and method of dispensing the medication, and the probable length of time the medication will be taken.

The fact that the information has or has not been given must be indicated in the patient's medical record. If the information has not been given, the facility must document in the patient's medical record the justification for not providing the information.

(See also B. "Antipsychotic Medications," page 2.42, for additional legal requirements if antipsychotic medications will be administered.)

SERVICES PROVIDED

Each patient admitted to a facility for a 72-hour treatment and evaluation period must receive an evaluation as soon as possible after admission, and must receive the treatment and care the condition requires for the full period that he or she is held [Welfare and Institutions Code Section 5152].

PERIOD OF DETENTION

If a designated facility admits a patient, it may detain him or her for evaluation and treatment for a period not to exceed 72 hours, including Saturdays, Sundays and holidays. If evaluation and treatment services are not available on Saturdays, Sundays and holidays, and if DHCS certifies that evaluation and treatment services cannot reasonably be made available on those days, they are not counted in the 72 hours. The certification by DHCS is subject to renewal every two years. [Welfare and Institutions Code Section 5151]

The 72 hours is counted from the time the person is admitted to the facility responsible for the evaluation and treatment. The time of admission runs from the time the

person is first detained in the facility and is not dependent upon completion of admissions procedures or paperwork. The time is not extended by a preadmission evaluation period at the facility.

The 72 hours does not include time spent transporting the patient to the treatment and evaluation facility by peace officers or other persons designated to take a person into custody under Welfare and Institutions Code Section 5150.

TERMINATION OF DETENTION

If the professional person in charge of the designated facility, member of the attending staff, or professional person designated by the county, determines that an individual may be properly served without being involuntarily detained, then evaluation, crisis intervention, or other inpatient or outpatient services must be provided on a voluntary basis. This authority shall not be interpreted to prevent a peace officer from delivering individuals to a designated facility for assessment. [Welfare and Institutions Code Section 5150(c)]

If detained, the patient may be released before 72 hours have elapsed only if the *psychiatrist* directly responsible for the person's treatment believes, as a result of his or her personal observations, that the person no longer requires evaluation or treatment. However, in those situations in which both a psychiatrist and psychologist have personally evaluated or examined a person on a 72-hour hold and there is a collaborative treatment relationship between the psychiatrist and psychologist, either the psychiatrist or psychologist may authorize the release of the person, but only after they have consulted with one another. In the event of a clinical or professional disagreement regarding the early release, the hold must be maintained unless the facility's medical director overrules the decision of the psychiatrist or psychologist opposing the release. Both the psychiatrist and psychologist must enter their findings, concerns, or objections in the patient's medical record.

If any other professional who is authorized to release the person believes the person should be released before 72 hours have elapsed, and the psychiatrist directly responsible for the person's treatment objects, the matter must be referred to the medical director of the facility for the final decision. However, if the medical director is not a psychiatrist, he or she must appoint a designee who is a psychiatrist to make these decisions. If the matter is referred, the person must be released before 72 hours have elapsed only if the psychiatrist who makes the final decision believes, as a result of his or her personal observations, that the person no longer requires evaluation or treatment. [Welfare and Institutions Code Section 5152] A psychologist may not order an early release without potential liability [*Ford v. Norton*, 89 Cal. App. 4th 974 (2001)], except in the narrow instance outlined in the previous paragraph.

A patient who has been detained for evaluation and treatment must be released at the end of the 72-hour period unless any of the following applies:

1. The patient is referred for further care and treatment on a voluntary basis;
2. The patient has been certified for intensive treatment *(see A. "Detention for 14-Day Intensive Treatment," page 3.17)*; or
3. A conservator or temporary conservator has been appointed for the patient under Welfare and Institutions Code Section 5350 *et seq. (see F. "Additional Treatment for Gravely Disabled Person (LPS Conservatorship)," page 3.31)*.

[Welfare and Institutions Code Section 5152(b)]

NOTIFICATION OF RELEASE TO COUNTY BEHAVIORAL HEALTH DIRECTOR AND PEACE OFFICER

The professional person in charge of a designated facility (or designee) must notify the county behavioral health director (or designee) and the peace officer who placed the 5150 hold (or a person designated by the law enforcement agency that employs the peace officer) of the patient's release if both of the following conditions apply:

1. The peace officer requested notification at the time of application, and
2. The peace officer certified in writing that the person was referred to the facility under circumstances that support the filing of criminal charges.

The only information that may be released is the person's name, address, date of admission for the 72-hour evaluation period, and the date of release [Welfare and Institutions Code Section 5152.1; 45 C.F.R. Section 164.512(a) and (f)].

The hospital should examine the paperwork completed by the law enforcement officer to determine if notification upon release is required.

IMMUNITY FROM LIABILITY

Provided they have complied with the provisions of applicable law discussed above, the following persons are not civilly or criminally liable for any action by a patient released at or before the end of the 72 hours:

1. The professional in charge of the designated facility, or a designee;
2. The medical director of the facility, or a designee, described in Welfare and Institutions Code Section 5152;
3. The psychiatrist directly responsible for the person's treatment;
4. The psychologist; and
5. The peace officer responsible for the detention of the person.

[Welfare and Institutions Code Section 5154]

RESPONSIBILITY FOR PROPERTY OF PERSON TAKEN INTO CUSTODY

Responsibility Defined

When a patient is taken into custody for evaluation, or within a reasonable time thereafter, the person who takes the patient into custody must take reasonable precautions to preserve and safeguard the personal property in the possession of, or on the premises occupied by, the patient. The person taking the patient into custody must give the court a report that generally describes the patient's property and its disposition (unless a responsible relative, guardian or conservator is in possession of the patient's personal property). The language outlined below may be used for this report. If a responsible relative, guardian, or conservator of the patient has possession of the property, the report must include only the name of the relative, guardian, or conservator and the location of the property. In such a case, the person who took the patient into custody is no longer responsible for the property once the report is completed.

For these purposes, **"responsible relative"** includes the spouse, parent, adult child, domestic partner, grandparent, grandchild, or adult brother or sister of the person.

[Welfare and Institutions Code Section 5150(f)]

Reporting Requirement

The required report of a patient's property made by the person taking the patient into custody should be substantially in the following form:

I hereby report to the Superior Court for the County of _____ that the personal property of the person apprehended, described generally as _____ _____ was preserved and safeguarded by *(insert name of person taking the patient into custody, responsible relative, guardian or conservator)* _____ _____. The property is now located at _____ _____.

Date: _____, 20_____

Signature: _____

Title: _____

[Welfare and Institutions Code Section 5211]

B. Patient Impaired by Inebriation

CONDITIONS FOR DETENTION

When a person is a danger to self or others or gravely disabled as a result of inebriation, a peace officer, member of the attending staff of a designated facility who is authorized to place a hold, or a person designated by the county may, upon reasonable cause, place the person in a facility designated by the county and approved by the California Department of Alcohol and Drug Programs as a facility for 72-hour treatment and evaluation of inebriates [Welfare and Institutions Code Section 5170]. A list of these facilities may be found at https://data.chhs.ca.gov/dataset/dhcs-licensed-residential-facilities-and-or-certified-alcohol-and-drug-programs/resource/1cbf39c4-0674-4dce-8f6f-4ff24eb8074e. (As of July 1, 2013, the California Department of Alcohol and Drug Programs became part of the California Department of Health Care Services.)

If, in the judgment of the admitting staff, the inebriate can be properly served without being detained, he or she must be treated on a voluntary basis [Title 9, California Code of Regulations, Section 9448]. Welfare and Institutions Code Section 5172.1 permits a person who is a danger to self or others or gravely disabled as a result of inebriation, to voluntarily apply for admission to a 72-hour evaluation and detoxification treatment facility.

WRITTEN APPLICATION REQUIRED

The designated facility must obtain an application in writing that states the circumstances under which the person's condition was called to the attention of the officer, member of the attending staff, or a designee. It must state that

the officer, member of the attending staff, or designee believes as a result of his or her personal observations that the person is, as a result of inebriation, a danger to self or others or gravely disabled, or has violated Penal Code Section 647(f), which makes it a misdemeanor to be in public under the influence of alcohol or other specified substances and thus unable to exercise care for one's own safety or the safety of others. [Welfare and Institutions Code Section 5170.3]

RECOMMENDED FORM FOR WRITTEN APPLICATION

It is recommended that in meeting the requirement for a written application that the "Application for Involuntary Admission — Inebriates" form (CHA Form 12-5) be used.

RIGHT TO MAKE TWO TELEPHONE CALLS

Immediately after being taken to a designated facility, a person has the right to make, at his or her own expense, at least two completed telephone calls (except where physically impossible). The person must be allowed to make these calls within three hours of detention. If the person placed in the evaluation facility does not have money to make these calls, he or she must be allowed to make at least two completed local toll-free or collect telephone calls at no charge. [Welfare and Institutions Code Section 5170.5]

RELEASE UPON REQUEST

A person who requests to be released from the facility before 72 hours have elapsed may be released only if the psychiatrist directly responsible for the person's treatment believes, as a result of his or her personal observations, that the person is not a danger to self or others. If any other professional who is authorized to release the person believes the person should be released before 72 hours have elapsed, and the psychiatrist directly responsible for the person's treatment objects, the matter should be referred to the medical director of the facility for the final decision. However, if the medical director is not a psychiatrist, he or she must appoint a designee who is a psychiatrist to make these decisions. If the matter is referred, the person may be released before 72 hours have elapsed only if the psychiatrist who makes the final decision believes, as a result of his or her personal observations, that the person is not a danger to self or others. A psychologist may not order an early release without potential liability [*Ford v. Norton*, 89 Cal. App. 4th 974 (2001)]. (If the person is determined to be gravely disabled as a result of a mental disorder, it may be appropriate to detain him or her under the provisions for treatment of mental health disorders.) [Welfare and Institutions Code Section 5170.7]

NOTE: The law that permits a psychologist, under certain circumstances, to release a patient before the end of his or her hold does not apply to patients who are detained because they are a danger to self or others or gravely disabled as a result of inebriation.

SERVICES PROVIDED

Each person admitted to a facility for 72-hour treatment and evaluation must receive an evaluation as soon after admission as possible and must receive the treatment and care his or her condition requires for the full period that he or she is held [Welfare and Institutions Code Section 5172].

PERIOD OF DETENTION

If the facility for 72-hour treatment and evaluation of inebriates admits the person, it may detain him or her for evaluation and detoxification treatment, and such other treatment as may be indicated, for a period not to exceed 72 hours. Saturdays, Sundays, and holidays must be included for the purpose of calculating the 72-hour period. However, a person may voluntarily remain in the facility for more than 72 hours if the professional in charge of the facility determines that the person needs and may benefit from further treatment. However, a person who is involuntarily detained in the facility has priority for available treatment and care over a person who has voluntarily remained in a facility for more than 72 hours. [Welfare and Institutions Code Section 5171]

TERMINATION OF DETENTION

If, in the judgment of the professional in charge of the facility that provides the evaluation and treatment, the person may be properly served without being detained, then evaluation, detoxification or other treatment, crisis intervention, or other inpatient or outpatient services must be provided on a voluntary basis [Welfare and Institutions Code Section 5171].

If detained, the person may be released before 72 hours have elapsed only if the psychiatrist directly responsible for the person's treatment believes, as a result of his must her personal observations, that the person no longer requires evaluation or treatment. If any other professional who is authorized to release the person believes the person should be released before 72 hours have elapsed, and the psychiatrist directly responsible for the person's treatment objects, the matter should be referred to the medical director of the facility for the final decision. However, if the medical director is not a psychiatrist, he or she must appoint a designee who is a psychiatrist to make these decisions. If the matter is referred, the person

may be released before 72 hours have elapsed only if the psychiatrist who makes the final decision believes, as a result of his or her personal observations, that the person no longer requires evaluation or treatment. A psychologist may not order an early release without potential liability [*Ford v. Norton*, 89 Cal. App. 4th 974 (2001)].

NOTE: The law that permits a psychologist, under certain circumstances, to release a patient before the end of his or her hold does not apply to patients who are detained because they are a danger to self or others or gravely disabled as a result of inebriation.

The patient who has been detained for evaluation and treatment must be released at the end of the 72-hour detention period unless any of the following applies:

1. The patient is referred for further treatment on a voluntary basis.
2. The patient is certified for intensive treatment on the basis that, as a result of impairment by chronic alcoholism, he or she is a danger to self or others or gravely disabled *(see A. "Detention for 14-Day Intensive Treatment," page 3.17)*.
3. A conservator or temporary conservator has been appointed for the patient under Welfare and Institutions Code Section 5350 *et seq. (see F. "Additional Treatment for Gravely Disabled Person (LPS Conservatorship)," page 3.31)*.

[Welfare and Institutions Code Section 5172]

IMMUNITY FROM LIABILITY

Provided they have complied with the provisions of Welfare and Institutions Code Sections 5170-5176, which are discussed above, the following persons are not civilly or criminally liable for any action by a patient released at or before the end of the 72 hours:

1. The professional in charge of the designated facility, or a designee;
2. The medical director of the facility, or a designee, described in Welfare and Institutions Code Sections 5170.7 and 5172;
3. The psychiatrist directly responsible for the person's treatment; and
4. The peace officer responsible for the detention of the person.

[Welfare and Institutions Code Section 5173]

NOTE: The law that permits a psychologist, under certain circumstances, to release a patient before the end of his or her hold does not apply to patients who are detained because they are a danger to self or others or gravely disabled as a result of inebriation. Thus, there is no immunity for a psychologist who releases such a patient.

C. Patient Impaired by Use of Controlled Substances

If a person is a danger to self or others or gravely disabled as a result of the use of controlled substances (the narcotics or restricted dangerous drugs referred to in Health and Safety Code Section 11000 *et seq.*), he or she is subject to the following provisions that apply to the involuntary detention of a person who is a danger to self or others or gravely disabled as a result of other causes:

1. An initial 72-hour hold for evaluation and treatment under Welfare and Institutions Code Section 5150 *et seq. (see A. "Patients With a Mental Health Disorder," page 3.9)*.
2. An additional 14-day intensive treatment period under Welfare and Institutions Code Section 5250 *et seq. (see A. "Detention for 14-Day Intensive Treatment," page 3.17)*.
3. Procedures for review of continued confinement, as provided in Welfare and Institutions Code Section 5275 *et seq. (see B. "Review of Commitment for 14 Additional Days of Intensive Treatment," page 3.20)*.
4. Provisions for court-ordered evaluation of persons with mental health disorders under Welfare and Institutions Code Section 5200 *et seq. (see VII. "Court-Ordered Evaluation of Persons Who May Have a Mental Health Disorder," page 3.33)*.
5. Protections of legal and civil rights of persons who are involuntarily detained, as described in Welfare and Institutions Code Section 5325 *et seq. (see II. "Patient Rights Under State Law," page 4.1)*.

Any custody, evaluation, treatment, or any other procedure initiated under these provisions must be related to the person's use of controlled substances.

[Welfare and Institutions Code Section 5343]

D. Other Admission Forms

At the time of admission, the signature of the patient or the patient's legal representative on the "Conditions of Admission" (CHA Form 8-1) and other admission documents should also be obtained. If the patient lacks capacity to agree or refuses to agree to admission

documents, the facility should attempt to obtain the patient's signature once he or she has regained capacity or is willing to sign.

E. Special Requirements for a Minor

As with adults, the state has the power to detain a minor involuntarily if it appears that the minor, as a result of a mental health disorder, is a danger to self or others or gravely disabled.

The Children's Civil Commitment and Mental Health Treatment Act of 1988 (CCCMHTA), Welfare and Institutions Code Sections 5585-5585.9, applies to the initial 72 hours of mental health treatment and evaluation provided to a minor who, as a result of a mental disorder, is a danger to self or others or gravely disabled. To the extent that the CCCMHTA conflicts with any other provisions of law that relate to 72-hour holds, the CCCMHTA prevails. Evaluation and treatment of a minor beyond the initial 72-hour period must comply with the provisions of LPS.

The CCCMHTA applies to minors under 18 years of age [Family Code Section 6500]. It does not apply to emancipated minors who are regarded as adults for the purpose of consenting to medical, dental or psychiatric care without parental consent, knowledge or liability [Family Code Section 7050(c)(1); Welfare and Institutions Code Section 5585.59].

While minors 12 years of age or older are authorized to consent to outpatient mental health care under Family Code Section 6924 and Health and Safety Code Section 124260, they are not authorized to consent to inpatient mental health treatment. *(See G. "Minors in Need of Outpatient Mental Health Treatment or Residential Shelter Services," page 2.39, for further information about minor consent to outpatient mental health treatment.)*

GRAVELY DISABLED MINOR

"Gravely disabled minor" means a minor who, as a result of a mental disorder, is unable to use the elements of life that are essential to health, safety, and development, including food, clothing, or shelter, even though provided to the minor by others. Intellectual disability or other developmental disabilities, epilepsy, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder. [Welfare and Institutions Code Section 5585.25]

REQUIREMENTS FOR COMMITMENT

A minor may be committed involuntarily for 72 hours where:

1. There is probable cause to believe that the minor, as a result of a mental health disorder, is a danger to self or others or gravely disabled.
2. Authorization for voluntary treatment by a parent, guardian or other legal representative is not available.
3. The minor is taken into custody, upon probable cause, by a peace officer, member of the attending staff of a designated facility or other professional person designated by the county. This person must make a written application to the facility for detention of the minor stating the circumstances under which the minor's condition was called to the attention of the peace officer or other person, and stating that the requirements in paragraphs 1 and 2, above, are met. [Welfare and Institutions Code Section 5585.50]
4. The facility must make every effort to notify the minor's parent or legal guardian as soon as possible.
5. Placement is at a facility designated by the county and approved by DHCS as a facility for 72-hour evaluation and treatment.

   Each county is required to assure that minors under the age of 16 years are not held with adults receiving psychiatric treatment under the provisions of LPS, unless the health facility has specific separate housing arrangements, treatment staff, and treatment programs designed to serve children or adolescents. The director of DSS may provide waivers to counties if this policy creates undue hardship due to inadequate or unavailable alternative resources.

   However, no minor may be admitted for psychiatric treatment into the same treatment ward as an adult who is in the custody of a jailor for a violent crime, is a known registered sex offender, or has a known history of, or exhibits inappropriate, sexual, or other violent behavior which would present a threat to the physical safety of minors.
6. A detained minor must receive a clinical evaluation conducted by professionals qualified in the diagnosis and treatment of minors. The evaluation must consist of multidisciplinary professional analyses of the minor's medical, psychological, developmental, educational, social, financial, and legal conditions as may appear to constitute a problem. This evaluation must include a psychosocial evaluation of the family or living environment, or both. Every effort must be made to involve the minor's parent or legal guardian in the clinical evaluation.

7. If, in the opinion of the professional who conducts the evaluation, the minor will require additional treatment, a treatment plan must be prepared that identifies the least restrictive placement alternative in which the minor can receive the necessary treatment. The family, guardian or caretaker and the minor must be consulted and informed of the basic recommendation for further treatment and placement. Every effort must be made to obtain the consent of the minor's parent or guardian prior to treatment and placement, but inability to obtain this consent does not preclude involuntary treatment, provided this treatment complies with the provisions of LPS.
8. The minor must be given an aftercare plan upon discharge. *(See IV. "Aftercare Plan," page 4.6.)*

V. CONTINUED TREATMENT OF AN INVOLUNTARY PATIENT

A. Detention for 14-Day Intensive Treatment

CONDITIONS FOR CERTIFICATION

If a person is detained as mentally disordered or as impaired by inebriation or use of narcotics or restricted dangerous drugs for 72 hours under the conditions discussed under IV. "Involuntary Detention of the Patient on a 72-Hour Hold," page 3.9, or by reason of a court-ordered evaluation [Welfare and Institutions Code Section 5200 *et seq.* and Section 5225 *et seq.*], the person may be certified for not more than 14 days of involuntary intensive treatment under the following conditions:

1. The professional staff of the agency or facility that provides evaluation services has analyzed the person's condition and found the person is, as a result of a mental health disorder or impairment by chronic alcoholism, a danger to self or others or gravely disabled.
2. The person has been advised of, but has not accepted, voluntary treatment.
3. The facility is equipped and staffed to provide intensive treatment, is designated by the county to provide intensive treatment, and agrees to admit the person.

[Welfare and Institutions Code Section 5250]

The facility must obtain the patient's medication history, if possible [Welfare and Institutions Code Section 5332].

SIGNATURES ON CERTIFICATION NOTICE

For a person to be certified as described above, the certification notice must be signed by two people.

The first person must be the professional, or a designee, in charge of the agency or facility that provides evaluation services. A designee of the professional must be a physician or a licensed psychologist who has a doctoral degree in psychology and at least five years of 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 evaluation. If possible, the physician should be a board-certified psychiatrist. The psychologist must be licensed and have at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders.

If the professional in charge, or the 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 social worker, marriage and family therapist, professional clinical counselor, or registered nurse who participated in the evaluation must sign the notice. [Welfare and Institutions Code Section 5251]

REQUIRED FORM OF CERTIFICATION NOTICE

The "Notice of Certification for Intensive Treatment" (CHA Form 12-6) complies with the requirements of Welfare and Institutions Code Section 5252. It is recommended that this form be used for these notification purposes.

DELIVERY OF COPIES OF THE CERTIFICATION NOTICE

A copy of the certification notice must be personally delivered to the patient. A copy must also be sent to the patient's attorney or the attorney or advocate designated to represent the patient in the certification review hearing.

The patient must be asked to designate another person to receive a copy of the certification notice. If the patient is incapable of making such a designation at the time of certification, he or she must be asked to designate a person as soon as he or she is capable.

A copy of the certification notice must be submitted to the superior court with a copy of the decision that results from the certification review hearing. [Welfare and Institutions Code Section 5253]

A hospital that certifies patients should consult legal counsel regarding the advisability of filing documents with the court under seal and/or obtaining a protective order *(see HIPAA provision at 45 C.F.R. Section 164.512(e))*.

ADVISEMENT OF RIGHTS TO PATIENT

The person who delivers the copy of the certification notice to the patient must, at the time of delivery, inform him or her of the right to have either a certification review hearing within four days or review by a court pursuant to a writ of habeas corpus to determine whether probable cause exists to detain him or her for intensive treatment related to the mental disorder or impairment by chronic alcoholism. The patient must be informed of his or her rights with respect to the certification review hearing, including the right to the assistance of another person to prepare for the hearing and/or to answer other questions and concerns about the involuntary commitment. Also, the patient must receive an explanation about what judicial review by habeas corpus entails and be informed of his or her right to counsel at these hearings, including counsel appointed by the court under Welfare and Institutions Code Section 5276. [Welfare and Institutions Code Sections 5254 and 5254.1] The processes for certification review hearings and judicial review by writ of habeas corpus are described in "Certification Review Hearings," page 3.20, and "Judicial Review Pursuant to a Writ of Habeas Corpus," page 3.22.

Documentation of Notice to Patient

It is recommended that the person who delivers a copy of the certification notice and advises the patient of his or her rights complete the "Advisement of Rights — Involuntary Patient" form (CHA Form 12-7). This form provides documentation that the requirements of delivery of copies of the certification notice as specified in Welfare and Institutions Code Section 5253 *(see "Delivery of Copies of the Certification Notice," page 3.17)*, and advisement of the right to review as specified in Welfare and Institutions Code Sections 5254 and 5254.1 *(see "Advisement of Rights to Patient," page 3.18)* have been met. The form should be placed in the patient's medical record.

MAXIMUM PERIOD OF DETENTION

After an involuntary commitment is initiated, the total period of detention, including intervening periods of voluntary treatment, must not exceed the total maximum period during which the person could have been detained if the person had been detained continuously on an involuntary basis from the time of the initial involuntary commitment. Thus, if a patient is admitted as a voluntary patient and subsequently detained on an involuntary basis, the maximum period of time is counted from the first date of involuntary commitment rather than from the date the patient was admitted to the hospital. [Welfare and Institutions Code Section 5258]

After the maximum period of involuntary treatment has passed, the patient may receive further treatment if he or she:

1. Agrees to remain voluntarily after the time limit has passed;
2. Is suicidal or is certified for additional intensive treatment *(see "Conditions for Confinement," page 3.23)*;
3. Is a danger to others or is certified for 180 days post-certification treatment *(see E. "Additional Confinement for a Person Dangerous to Others (Post-Certification Procedures)," page 3.28)*; or
4. Is gravely disabled and a conservatorship is initiated *(see F. "Additional Treatment for Gravely Disabled Person (LPS Conservatorship)," page 3.31)*.

After consulting with legal counsel, the facility should adopt a policy regarding procedures to be followed when the total period of detention exceeds the maximum time periods allowed for treatment of a patient who is a danger to self or others or is gravely disabled.

TERMINATION OF CERTIFICATION

Certification may last for no more than 14 days, and may terminate earlier only if the psychiatrist directly responsible for the patient's treatment believes, as a result of his or her personal observations, that the patient no longer is, as a result of a mental disorder or impairment by chronic alcoholism, a danger to self or others or gravely disabled [Welfare and Institutions Code Section 5257].

However, in those situations in which both a psychiatrist and psychologist have personally evaluated or examined a person who is undergoing intensive treatment and there is a collaborative treatment relationship between the psychiatrist and psychologist, either the psychiatrist or psychologist may authorize the release of the person, but only after they have consulted with one another. In the event of a clinical or professional disagreement regarding the early release, the person may not be released unless the facility's medical director overrules the decision of the psychiatrist or psychologist opposing the release. Both the psychiatrist and psychologist must enter their findings, concerns or objections into the patient's medical record.

If any other professional who is authorized to release the person believes the person should be released during the 14-day additional treatment period, and the psychiatrist directly responsible for the person's treatment objects, the matter is to be referred to the medical director of the facility for the final decision. If the medical director is not

a psychiatrist, he or she must appoint a designee who is a psychiatrist to make these decisions. If the matter is referred, the person must be released during the 14-day additional treatment period only if the psychiatrist who makes the final decision believes, as a result of his or her personal observations, that the person certified no longer is, as a result of mental disorder or impairment by chronic alcoholism, a danger to self or others or gravely disabled. A psychologist may not order an early release without potential liability [*Ford v. Norton*, 89 Cal. App. 4th 974 (2001)] except in the narrow instance outlined in the previous paragraph. The person may remain at the facility on a voluntary basis, and the facility may provide the person with appropriate referral information concerning mental health services.

A person who has been certified for 14 days of intensive treatment and to whom Welfare and Institutions Code Section 5226.1 (which involves court-ordered evaluation for persons impaired by chronic alcoholism or drug abuse) does not apply, or with respect to whom the criminal charge has been dismissed under Welfare and Institutions Code Section 5226.1, must be released at the end of the 14 days unless any of the following applies:

1. The patient agrees to receive further treatment on a voluntary basis.
2. A temporary conservator has been appointed for the patient [Welfare and Institutions Code Section 5350 *et seq.*].
3. The patient is suicidal and is certified for additional intensive treatment [Welfare and Institutions Code Section 5260 *et seq.*]. *(See C. "Additional Intensive Treatment for Suicidal Patient," page 3.23.)*
4. The patient is dangerous to others and post-certification procedures are initiated [Welfare and Institutions Code Section 5300 *et seq.*].
5. The patient is certified for an additional 30 days of intensive treatment for grave disability [Welfare and Institutions Code Section 5270.10 *et seq.*].

DAMAGES FOR EXCESSIVE DETENTION

An individual who is knowingly and willfully responsible for detaining a person for more than 14 days in violation of the law is liable to that person in civil damages. [Welfare and Institutions Code Section 5259.1]

FACILITY PREFERENCE

Whenever a county designates two or more facilities to provide intensive treatment and the patient or patient's family, conservator, or guardian expresses a preference for one of the facilities, the professional person who certifies the patient must attempt, if administratively possible, to comply with the preference [Welfare and Institutions Code Section 5259.2].

TEMPORARY RELEASE

The professional in charge of an intensive treatment facility, or a designee, may permit a person certified for intensive treatment to leave the facility for short periods during the person's involuntary intensive treatment. The permission should be in writing and documented in the patient's record [Welfare and Institutions Code Section 5259]. The "Leave of Absence from Psychiatric Service" form (CHA Form 12-8) is suggested for use by the hospital.

IMMUNITY FROM LIABILITY

Provided they have complied with the provisions of Welfare and Institutions Code Sections 5250-5259.3, which are discussed above, the following persons are not civilly or criminally liable for any action by a person released at or before the end of the 14 days:

1. The professional in charge of the facility that provides intensive treatment, or a designee;
2. The professional person designated by the county;
3. The medical director of the facility, or a designee described in Welfare and Institutions Code Section 5257;
4. The psychiatrist directly responsible for the person's treatment; and
5. The psychologist.

[Welfare and Institutions Code Section 5259.3]

NOTIFICATION OF RELEASE TO COUNTY BEHAVIORAL HEALTH DIRECTOR AND PEACE OFFICER

The professional person in charge of a facility that provides 14-day intensive treatment pursuant to Welfare and Institutions Code Section 5250 or 5270.15, or a designee, must notify the county behavioral health director, or a designee, and the peace officer who made the original application for a 72-hour hold, or a person designated by the law enforcement agency that employs the peace officer, when a patient admitted for involuntary treatment has been released unconditionally if:

1. The peace officer requested notification at the time the application for the 72-hour evaluation was made; and

2. The peace officer certified in writing that the person was referred to the facility under circumstances that would support the filing of criminal charges.

The only information that may be released is the person's name, address, date of admission for the 72-hour evaluation period, date of certification for intensive treatment, and the date of release. [Welfare and Institutions Code Section 5250.1; 45 C.F.R. Section 164.512(a) and (f)].

The hospital should examine the paperwork completed by the law enforcement officer to determine if notification upon release is required.

B. Review of Commitment for 14 Additional Days of Intensive Treatment

Each patient who is certified for 14 days of involuntary treatment because he or she is a danger to self or others or gravely disabled has the right to a "certification review hearing," unless he or she has requested judicial review by a writ of habeas corpus. A patient who requests a writ of habeas corpus review does not have the right to a certification review hearing unless he or she withdraws the request for judicial review before it occurs. In such cases, the patient is entitled to a certification review hearing within four days of the withdrawal of the request for writ of habeas corpus review.

The certification review hearing and writ of habeas corpus review procedures are designed to assure that the commitment of all patients beyond 72 hours is reviewed to determine whether probable cause exists to continue the involuntary confinement. These procedures provide the mandatory hearings which the federal Ninth Circuit Court of Appeals, in *Doe v. Gallinot*, 657 F.2d 1017 (9th Cir. 1981), held were necessary to meet constitutional requirements.

A patient should not be certified for involuntary treatment and subsequently released before a writ of habeas corpus hearing or certification review hearing has been held except in those rare situations when the patient's condition changes before the hearing is held.

As described in "Advisement of Rights to Patient," page 3.18, at the time a patient is certified for 14 days of intensive treatment, the patient must be informed that he or she is entitled to:

1. A certification review hearing to determine whether or not probable cause exists to detain him or her for intensive treatment related to a mental disorder or chronic alcoholism; or
2. Judicial review of the involuntary commitment pursuant to a writ of habeas corpus.

The procedures for these reviews are discussed below.

CERTIFICATION REVIEW HEARINGS

County Plans

Although the law outlines the general procedures that must be used for certification review hearings, each county is required to describe, in its Short-Doyle county plan, the specific procedures it will use for certification review hearings. Each county's plan must address the issues of how the patient's representatives and hearing officers will be selected and trained, how these persons will be notified, and who will be responsible for the costs associated with the hearings. The plan also must identify the individuals who will represent treatment facilities at certification review hearings, and the schedule for these hearings at each facility *(see Welfare and Institutions Code Sections 5255-5256.8)*.

If the county has not adopted procedures for certification review hearings, treatment facilities will not be able to fully comply with the law. However, interim procedures should be instituted to assure that patients who are involuntarily detained for 14 days of intensive treatment are given their right of review. In this regard, the best interim procedure is to request judicial review by a writ of habeas corpus. However, if the patient refuses to request this review and the courts in the county in which the facility is located will not conduct such review in the absence of a patient request, the facility may be required either to release the patient after the 72-hour intensive evaluation and treatment period or to continue the involuntary detention without complying with the review procedures. In such cases, the facility should consult its legal counsel regarding appropriate procedures.

Certification Review Hearing Procedures

The procedure for the certification review hearings is as follows.

Meeting Between the Patient and His or Her Representative. As soon after the certification as practicable, an attorney or patient advocate who will advise and represent the patient is required to meet with the certified patient and discuss the commitment process, assist the patient in preparing for the certification review hearing, answer the patient's questions, and otherwise assist the patient as appropriate. Each county must designate persons who will act as patient representatives and adopt procedures for informing these persons when

a certification is initiated. In this regard, although the law does not explicitly designate responsibility for paying for the services of such a representative, it is the opinion of CHA's legal counsel (pending judicial or other clarification of this ambiguity) that the county, rather than the patient or the facility, is responsible for these costs.

Timing. The certification review hearing must be held within four days of the date on which the person is certified for a period of intensive treatment unless the patient, or his or her attorney or advocate, requests postponement of the hearing. Hearings may be postponed for 48 hours. A hearing in a county with a population of 100,000 or less may be postponed by the facility or the patient until the next regularly scheduled hearing date.

If a patient is involuntarily detained for 72 hours but not placed on a 14-day hold until some later date, the facility may not be able to comply with the time limit. In these cases the hearing should be held as soon as possible and, to the extent feasible, on or before the eighth day of involuntary treatment.

Location. The certification review hearing must be held in a location that is compatible with and the least disruptive of the treatment program. If the hearing is conducted by a "certification review hearing officer" rather than a court-appointed commissioner or referee *(see below)*, the hearing should be held at an appropriate place at the facility where the certified patient is receiving treatment.

Certification Review Hearing Officer. The certification review hearing must be conducted by a court-appointed commissioner or referee or a "certification review hearing officer." Each county is responsible for determining who will conduct the hearings and, if certification review hearing officers will be used, the county's board of supervisors must appoint a panel (composed of the local behavioral health director, the county public defender, and the county counsel or district attorney) which will approve (by unanimous vote) a list of persons who may act as certification review hearing officers. Persons eligible to serve as certification review hearing officers include state-qualified administrative law hearing officers, physicians, lawyers, and certified law students. In addition, licensed psychologists, registered nurses, licensed marriage and family therapists or licensed clinical social workers who have had a minimum of five years' experience in mental health may act as certification review hearing officers. However, no employee of the county mental health program or of a facility designated to provide involuntary treatment may serve as a certification review hearing officer. Although the law does not specify the party responsible for paying for the services of the certification review hearing officer, it is the opinion of CHA's legal counsel (pending judicial or other clarification of this ambiguity) that the county, rather than the patient or the facility, is responsible for these costs.

Presentation of Evidence. At the hearing, a person who is designated by the director of the facility in which the patient is being treated must present evidence in support of the certification decision. The hearing is informal in nature and the judicial rules of procedure and evidence do not apply. It is, however, important for the person presenting evidence in support of the certification (who should be the patient's physician or a mental health professional who is familiar with the patient's condition) to be prepared to present facts and information in support of the determination that the patient is a danger to self or others or gravely disabled.

The district attorney or county counsel also may present evidence at the certification review hearing.

Patient's Rights at the Certification Review Hearing. The certified patient has the following rights at the certification review hearing:

1. To be present unless the patient, with his or her representative's assistance, has specifically waived this right;
2. To be assisted by an attorney or advocate;
3. To present evidence on his or her behalf;
4. To question persons presenting evidence in support of the certification decision;
5. To make reasonable requests for the attendance of facility employees who have knowledge of, or participated in, the certification decision; and
6. To have the persons conducting the hearing informed whether the patient received medication within the past 24 hours (or a longer period as the hearing officer may determine), and, if so, the probable effects of the medication.

Decision. The hearing officer is required to decide whether a patient should be involuntarily detained. At the conclusion of the hearing, the patient must be orally notified of the decision. In addition, the hearing officer must provide a written decision that identifies the evidence relied upon and the reasons for the decision, to the patient's attorney or advocate and to the facility director. The patient's representative is responsible for notifying the patient of the decision and of his or her right to a judicial review of the commitment by a writ of habeas corpus proceeding.

A copy of the decision and of the 14-day certification form must also be submitted to the superior court for the county

in which the facility is located. The hospital should assure that the hearing officer does so.

Post-Decision Options. If the hearing officer decides that there is not probable cause to believe that the patient is a danger to self or others or gravely disabled, the patient may not be detained for involuntary treatment and the facility must release him or her. However, in such cases, the patient may choose to remain for treatment on a voluntary basis. Also, the facility is allowed to give the patient appropriate referral information concerning mental health services.

If the hearing officer concludes that as a result of a mental disorder or impairment by chronic alcoholism the patient is a danger to self or others or gravely disabled, the patient may be held for the 14-day certification period subject to his or her right to judicial review by writ of habeas corpus. If, however, during the 14-day period, the person who certified the patient determines that the patient is no longer a danger to self or others or gravely disabled, the involuntary commitment must end and the person must be released (unless the patient accepts continuing treatment on a voluntary basis).

At the end of the 14-day involuntary treatment period, a patient who remains dangerous to self or others or gravely disabled may be detained for additional involuntary treatment in accordance with the procedures applicable to the certification for:

1. 14 additional days of involuntary treatment for suicidal patients *(see C. "Additional Intensive Treatment for Suicidal Patient," page 3.23)*;
2. 30 days for gravely disabled patients *(see D. "Additional Intensive Treatment for Gravely Disabled Person," page 3.25)*;
3. 180 days for patients who are dangerous to others *(see E. "Additional Confinement for a Person Dangerous to Others (Post-Certification Procedures)," page 3.28)*; or
4. A temporary or permanent conservatorship for gravely disabled patients *(see F. "Additional Treatment for Gravely Disabled Person (LPS Conservatorship)," page 3.31)*.

JUDICIAL REVIEW PURSUANT TO A WRIT OF HABEAS CORPUS

Patient Request for Court Hearing or Release Triggers Judicial Review Process

Every person detained by certification for intensive treatment has the right to a hearing pursuant to a writ of habeas corpus for his or her release after he or she, or any person acting on his or her behalf, has made a request for release to:

1. The person who delivers the copy of the certification notice at the time of delivery;
2. A member of the treatment staff of the facility that provides intensive treatment, at any time during the 14 days of intensive treatment; or
3. The attorney or advocate who represented him or her at a certification review hearing at which it was concluded that probable cause existed to detain the patient for 14 days of involuntary treatment.

A person who delivers a copy of the certification notice or a member of the treatment staff to whom a request for release is made must promptly provide the patient or other person making the request with a copy of a form described in Welfare and Institutions Code Section 5275 for his or her signature or mark. The "Request for Release from Involuntary Treatment" form (CHA Form 12-9) has been developed to comply with this requirement.

The person who delivers the copy of the certification notice or the member of the treatment staff, as the case may be, must:

1. Fill in his or her own name and the date,
2. If the patient signs by mark, fill in the patient's name and
3. Deliver the completed copy to the professional in charge of the intensive treatment facility, or a designee.

As soon as possible, the professional in charge of the facility or designee must inform the superior court for the county in which the facility is located of the request for release.

A person who intentionally violates this requirement is guilty of a misdemeanor.

Effect of Judicial Review

Judicial review is provided by the superior court for the county in which the facility that provides the intensive treatment is located or in the county in which the 72-hour evaluation was conducted if the patient, or a person acting on the patient's behalf, informs the professional staff of the evaluation facility in writing that judicial review will be sought.

No patient may be transferred from the county that provides evaluation services to a different county for intensive treatment if the staff of the evaluation facility has been informed in writing that a judicial review will be sought, until the completion of the judicial review.

The patient must be informed of the right to counsel by the member of the treatment staff and by the court. If the patient so elects, the court must immediately appoint the public defender or another attorney to assist the patient to prepare a petition for a writ of habeas corpus and, if he or she so elects, to represent the patient in the proceedings. The patient is required to pay the costs of legal advice if able.

The court must either release the patient or order an evidentiary hearing to be held within two judicial days after the petition is filed. The patient must be released immediately if the court finds that:

1. The patient is not, as a result of a mental disorder or impairment by chronic alcoholism, a danger to self or others or gravely disabled;
2. The patient had not been advised of, or had accepted, voluntary treatment; or
3. The facility that provides intensive treatment is not designated by the county to provide intensive treatment.

[Welfare and Institutions Code Section 5276]

PATIENT'S RIGHT TO DENY RELEASE OF INFORMATION

The patient must be advised by the treating facility that he or she has the right to request that no person be told the time and place of the certification hearing or of the subsequent judicial review. [Welfare and Institutions Code Sections 5256.4(c) and 5276]

C. Additional Intensive Treatment for Suicidal Patient

CONDITIONS FOR CONFINEMENT

At the expiration of the initial 14-day period of intensive treatment a person who, as a result of a mental disorder or impairment by chronic alcoholism, threatened or attempted to take his or her life during the 14-day period or the 72-hour evaluation period, or was detained for evaluation and treatment because he or she threatened or attempted to take his or her life and who continues to present an imminent threat of taking his or her life, may be confined for further intensive treatment for an additional period not to exceed 14 days. [Welfare and Institutions Code Section 5260]

The additional period of intensive treatment may occur only if the following conditions have been met:

1. The professional staff of the agency or the facility that provides intensive treatment services has analyzed the person's condition and found that the person presents an imminent threat of taking his or her life.
2. The person has been advised of, but has not accepted, voluntary treatment.
3. The facility is equipped and staffed to provide intensive treatment, is designated by the county to provide intensive treatment, and agrees to admit the person.
4. The person has, as a result of a mental disorder or impairment by chronic alcoholism, threatened or attempted to take his or her life during the 14-day period of intensive treatment or the 72-hour evaluation period, or was detained for evaluation and treatment because of threats or attempts to take his or her life.

The facility must obtain the patient's medication history, if possible [Welfare and Institutions Code Section 5332].

COMPLETION OF A SECOND NOTICE OF CERTIFICATION

For a person to be certified for an additional period of intensive treatment, a second notice of certification must be completed and signed by:

1. The professional in charge of the facility providing the first 14 days of intensive treatment to the person; and
2. By a physician who is, whenever possible, a board-qualified psychiatrist, or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. The physician or psychologist who signs must have participated in the analysis of the patient's condition and determined that the conditions referred above were met. [Welfare and Institutions Code Section 5261]

If the professional in charge 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 social worker, marriage and family therapist, professional clinical counselor, or registered nurse who participated in the evaluation may sign the notice of certification.

REQUIRED FORM OF SECOND NOTICE OF CERTIFICATION

The "Notice of Certification to Second Involuntary 14-Day Period for Intensive Treatment — Suicidal Patient" form (CHA Form 12-10) complies with the

requirements of Welfare and Institutions Code Section 5262. It is recommended that this form be used for these notification purposes.

DELIVERY OF COPIES OF SECOND NOTICE OF CERTIFICATION

Copies of the second notice of certification of imminently suicidal patients must be filed with the court, and must be given to the patient, the patient's attorney, the district attorney, the public defender, if any, and the facility that provides intensive treatment. Also, the patient must be asked to designate a person to receive a copy of the certification notice. If the patient is unable to make such a designation at the time he or she is certified, the patient must be asked to do so as soon as he or she becomes capable. [Welfare and Institutions Code Section 5263]

A hospital that certifies patients should consult legal counsel regarding the advisability of filing documents with the court under seal and/or obtaining a protective order *(see HIPAA provision at 45 C.F.R. Section 164.512(e))*.

ADVISEMENT OF RIGHTS TO PATIENT

Upon delivery of the second notice of certification to the patient, the patient should be informed of his or her right to a certification review or to judicial review pursuant to a writ of habeas corpus and be given other information as discussed under "Advisement of Rights to Patient," page . [Welfare and Institutions Code Sections 5254 and 5254.1]

REVIEW OF INTENSIVE TREATMENT

The procedures for review pursuant to a request for release made by a patient detained by certification for a second 14-day intensive treatment period are the same as the review procedures of an initial 14-day commitment, discussed under B. "Review of Commitment for 14 Additional Days of Intensive Treatment," page 3.20.

TERMINATION OF CERTIFICATION FOR ADDITIONAL INTENSIVE TREATMENT FOR SUICIDAL PATIENT

A certification for additional treatment for an imminently suicidal person must be for no more than 14 days of intensive treatment, and must terminate only when the psychiatrist directly responsible for the person's treatment believes, as a result of his or her personal observations, that the individual has improved sufficiently to leave, or is prepared to accept voluntary treatment in the facility that provides intensive treatment or in another facility.

However, in those situations in which both a psychiatrist and psychologist have personally evaluated or examined a person who is undergoing intensive treatment and there is a collaborative treatment relationship between the psychiatrist and psychologist, either the psychiatrist or psychologist may authorize the release of the person, but only after they have consulted with one another. In the event of a clinical or professional disagreement regarding the early release, the person may not be released unless the facility's medical director overrules the decision of the psychiatrist or psychologist opposing the release. Both the psychiatrist and psychologist must enter their findings, concerns or objections in to the patient's medical record.

If any other professional who is authorized to release the person believes the person should be released before 14 days have elapsed, and the psychiatrist directly responsible for the person's treatment objects, the matter must be referred to the medical director of the facility for the final decision. However, if the medical director is not a psychiatrist, he or she must appoint a designee who is a psychiatrist to make these decisions. If the matter is referred, the person may be released before 14 days have elapsed only if the psychiatrist believes, as a result of his or her personal observations, that the individual has improved sufficiently to leave, or is prepared to accept voluntary treatment in the facility that provides intensive treatment or in another facility. [Welfare and Institutions Code Section 5264] A psychologist may not order an early release without potential liability [*Ford v. Norton*, 89 Cal. App. 4th 974 (2001)] except in the narrow instance outlined in the previous paragraph.

A person who has been certified for 14 days of intensive treatment and to whom Welfare and Institutions Code Section 5226.1 (which involves court-ordered evaluation for persons impaired by chronic alcoholism or drug abuse) does not apply, or with respect to whom the criminal charge has been dismissed under Welfare and Institutions Code Section 5226.1, must be released at the end of the 14 days unless any of the following applies:

1. The patient agrees to receive further treatment on a voluntary basis.
2. The patient is recommended for conservatorship under Welfare and Institutions Code Section 5350 *et seq.*
3. The patient is dangerous to others [Welfare and Institutions Code Section 5300 *et seq.*].

DAMAGES FOR EXCESSIVE DETENTION

An individual who is knowingly and willfully responsible for detaining a person for more than 14 days in violation of the law is liable to that person in civil damages [Welfare and Institutions Code Section 5265].

FACILITY PREFERENCE

Whenever a county designates two or more facilities to provide intensive treatment and the patient or patient's family, conservator, or guardian expresses a preference for one of the facilities, the professional person who certifies the patient must attempt, if administratively possible, to comply with the preference [Welfare and Institutions Code Section 5266].

TEMPORARY RELEASE

The professional in charge of an intensive treatment facility, or a designee, may permit a person certified for intensive treatment to leave the facility for short periods during the person's involuntary intensive treatment. The permission should be in writing and documented in the patient's record. The "Leave of Absence from Psychiatric Service" form (CHA Form 12-8) is suggested for use by the hospital [Welfare and Institutions Code Section 5268].

IMMUNITY FROM LIABILITY

Provided they have complied with Welfare and Institutions Code Sections 5260-5268, which are discussed above, the following persons are not civilly or criminally liable for any action by a person released at or before the end of the 14 days:

1. The professional person in charge of the facility that provides intensive treatment, or a designee;
2. The medical director of the facility, or a designee described in Welfare and Institutions Code Section 5264;
3. The psychiatrist directly responsible for the person's treatment; and
4. The psychologist.

[Welfare and Institutions Code Section 5267]

D. Additional Intensive Treatment for Gravely Disabled Person

OPTIONAL ADDITIONAL 30-DAY PERIOD OF INTENSIVE TREATMENT

Counties have the option to adopt procedures that allow an additional 30 days of intensive treatment upon the completion of the 14-day period of intensive treatment under Welfare and Institutions Code Section 5250. These provisions [Welfare and Institutions Code Section 5270.10 *et seq.*] are effective only in the counties in which the county board of supervisors, by resolution, authorizes the procedures after assuring that implementation of these procedures will not result in reduction of current mental health services. At least 17 counties have adopted 30-day extensions, including Los Angeles, Orange, Sacramento, and San Diego. DHCS is charged with ensuring the maintenance of current service levels through its review and approval of county Short-Doyle plans.

The provision of an additional intensive treatment period for gravely disabled persons is intended to reduce the number of petitions for temporary conservatorship that are filed on behalf of gravely disabled persons simply to obtain an additional period of treatment and without the belief that a conservator is actually needed and without the intention to go to trial on the petition.

CONDITIONS FOR CONFINEMENT

At the expiration of the initial 14-day period of intensive treatment under Welfare and Institutions Code Section 5250, a person may be certified for an additional period of no more than 30 days of intensive treatment only if the following conditions are met:

1. The professional staff of the agency or facility that treats the person has found that the person remains gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism; and
2. The person remains unwilling or unable to accept treatment voluntarily.

The facility must make reasonable attempts to notify family members or others designated by the patient at least 36 hours prior to the certification review hearing. The notification must include the time and place of the certification hearing. However, the facility must first advise the patient that he or she has the right to request that this information not be provided. If the patient prohibits the facility from notifying family or others, this should be documented.

[Welfare and Institutions Code Section 5270.15]

As mentioned above, a precondition for the additional 30-day period of intensive treatment is the adoption of Welfare and Institutions Code Section 5270.10 *et seq.* by the county board of supervisors.

A person certified for an additional 30 days must be provided with notice as discussed below and with a certification review hearing *(see "Certification Review Hearings," page 3.20)* unless a judicial review is requested *(see "Judicial Review Pursuant to a Writ of Habeas Corpus," page 3.22)*.

The facility must obtain the patient's medication history, if possible [Welfare and Institutions Code Section 5332].

The professional staff that provides intensive treatment must analyze and evaluate the patient's condition at intervals not to exceed 10 days to determine whether the patient continues to meet the certification criteria. Termination of the certification period prior to the 30th day must be made only when the psychiatrist directly responsible for the person's treatment believes, as a result of his or her personal observations, that the individual has improved sufficiently to leave, or is prepared to accept voluntary treatment in the facility that provides intensive treatment or in another facility.

However, in those situations in which both a psychiatrist and psychologist have personally evaluated or examined a person who is undergoing intensive treatment and there is a collaborative treatment relationship between the psychiatrist and psychologist, either the psychiatrist or psychologist may authorize the release of the person, but only after they have consulted with one another. In the event of a clinical or professional disagreement regarding the early release, the person may not be released unless the facility's medical director overrules the decision of the psychiatrist or psychologist opposing the release. Both the psychiatrist and psychologist must enter their findings, concerns or objections into the patient's medical record.

If any other professional who is authorized to release the person believes the person should be released before 30 days have elapsed, and the psychiatrist directly responsible for the person's treatment objects, the matter must be referred to the medical director of the facility for the final decision. However, if the medical director is not a psychiatrist, he or she must appoint a designee who is a psychiatrist to make these decisions. If the matter is referred, the person may be released before 30 days have elapsed only if the psychiatrist believes, as a result of his or her personal observations, that the individual has improved sufficiently to leave, or is prepared to accept voluntary treatment in the facility that provides intensive treatment or in another facility. [Welfare and Institutions Code Section 5270.35] A psychologist may not order an early release without potential liability [*Ford v. Norton*, 89 Cal. App. 4th 974 (2001)] except in the narrow instance outlined in the previous paragraph.

NOTICE REQUIRED

For a person to be certified for an additional period of intensive treatment, a second notice of certification must be completed and signed by:

1. The professional in charge of the facility providing intensive treatment to the person; and
2. A physician who is, whenever possible, a board-qualified psychiatrist, or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. The physician or psychologist who signs must have participated in the evaluation of the patient's condition and determined that the conditions referred to above were met. [Welfare and Institutions Code Section 5270.20]

If the professional in charge of the facility 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 social worker, marriage and family therapist, professional clinical counselor, or registered nurse who participated in the evaluation must sign the notice of certification.

REQUIRED FORM OF SECOND NOTICE OF CERTIFICATION

The "Notice of Certification for Intensive Treatment" form (CHA Form 12-6) is required for all involuntary intensive treatment under this law. The form is the same as that for Welfare and Institutions Code Section 5252. It is recommended that this form be used for these notification purposes [Welfare and Institutions Code Section 5250.25].

DELIVERY OF COPIES OF SECOND NOTICE OF CERTIFICATION

Copies of the second notice of certification of a gravely disabled person for an additional 30-day period of intensive treatment must be filed with the court and personally delivered to the patient. In addition, a copy must be sent to the patient's attorney, the district attorney, the public defender, if any, and the facility that provides the intensive treatment. Also, the patient must be asked to designate a person to receive a copy of the certification notice. If the patient is unable to make such a designation at the time he or she is certified, the patient must be given another opportunity to do so as soon as he or she is able. [Welfare and Institutions Code Section 5270.30]

A hospital that certifies patients should consult legal counsel regarding the advisability of filing documents with the court under seal and/or obtaining a protective order *(see HIPAA provision at 45 C.F.R. Section 164.512(e))*.

JUDICIAL REVIEW OF INTENSIVE TREATMENT

The procedures for judicial review pursuant to a request for release made by a patient detained for certification for a 30-day intensive treatment period are the same as

the procedures for judicial review for an initial 14-day commitment, discussed under "Judicial Review Pursuant to a Writ of Habeas Corpus," page .

A certification for additional treatment for a gravely disabled person must be for no more than 30 days of intensive treatment, or until the *psychiatrist* directly responsible for the patient's treatment believes, as a result of his or her personal observations, that the individual has improved sufficiently to leave, or is prepared to accept voluntary treatment in the facility that provides the intensive treatment or in another facility.

However, in those situations in which both a psychiatrist and psychologist have personally evaluated or examined a person who is undergoing intensive treatment and there is a collaborative treatment relationship between the psychiatrist and psychologist, either the psychiatrist or psychologist may authorize the release of the person, but only after they have consulted with one another. In the event of a clinical or professional disagreement regarding the early release, the person may not be released unless the facility's medical director overrules the decision of the psychiatrist or psychologist opposing the release. Both the psychiatrist and psychologist must enter their findings, concerns or objections into the patient's medical record.

If any other professional who is authorized to release the person believes the person should be released before 30 days have elapsed, and the psychiatrist directly responsible for the person's treatment objects, the matter must be referred to the medical director of the facility for the final decision. However, if the medical director is not a psychiatrist, he or she must appoint a psychiatrist to make the final decision. If the matter is referred, the person must be released before 30 days have elapsed only if the psychiatrist believes, as a result of his or her personal observations, that the individual has improved sufficiently to leave, or is prepared to accept voluntary treatment in the facility that provides the intensive treatment or in another facility. [Welfare and Institutions Code Section 5270.35] A psychologist may not order an early release without potential liability [*Ford v. Norton*, 89 Cal. App. 4th 974 (2001)] except in the narrow instance outlined in the previous paragraph.

A person who has been certified for 30 days of intensive treatment must be released at the end of 30 days unless any of the following applies:

1. The patient agrees to receive further treatment on a voluntary basis.
2. The patient is recommended for conservatorship pursuant to Welfare and Institutions Code Section 5350 *et seq.*
3. The patient is dangerous to others *(see Welfare and Institutions Code Section 5300 et seq.)*.

DAMAGES FOR EXCESSIVE DETENTION

An individual who is knowingly and willfully responsible for detaining a person for more than 30 days in violation of the provisions described under D. "Additional Intensive Treatment for Gravely Disabled Person," page , is liable to that person in civil damages [Welfare and Institutions Code Section 5270.40].

FACILITY PREFERENCE

Whenever a county designates two or more facilities to provide intensive treatment and the patient or patient's family, conservator, or guardian expresses a preference for one of the facilities, the professional person who certifies the patient must attempt, if administratively possible, to comply with the preference. [Welfare and Institutions Code Section 5270.43]

IMMUNITY FROM LIABILITY

Provided they have complied with the provisions of Welfare and Institutions Code Section 5270.35, which are discussed above, the professional in charge of the facility that provides intensive treatment, a designee, and the professional directly responsible for the person's treatment are not civilly or criminally liable for any action by a person released before or at the end of the 30-day intensive treatment period [Welfare and Institutions Code Section 5270.50].

NOTE: The law permits a psychologist, under certain circumstances, to release a patient who is undergoing intensive treatment before the end of his or her hold. However, the immunity statute was not amended in a corresponding manner to provide immunity for these psychologists. This may have been a drafting error.

TEMPORARY RELEASE

The professional in charge of an intensive treatment facility, or a designee, may permit a person certified for 30 days of intensive treatment to leave the facility for short periods during the person's intensive treatment [Welfare and Institutions Code Section 5270.65]. The permission should be in writing and documented in the patient's record. The "Leave of Absence from Psychiatric Service" form (CHA Form 12-8) is suggested for use by the hospital.

EVALUATION OF NEED FOR TEMPORARY CONSERVATORSHIP

Whenever it appears that a gravely disabled person may need to be detained beyond the initial 14-day period of intensive treatment, the professional in charge of the facility must have the person's condition evaluated to determine whether it is likely that the person will need an appointment of a conservator. This evaluation process should be initiated before the end of the 14-day period of intensive treatment and prior to proceeding with an additional 30-day certification. If it appears that, with up to 30 days of additional treatment, the person is likely to improve so that a conservator will not be needed, the person may be certified for the additional 30-day period of treatment. [Welfare and Institutions Code Section 5270.55]

If no conservatorship referral is made during the 14-day period and during the 30-day certification it appears that the person is likely to require the appointment of a conservator, the conservatorship referral procedure should be made to allow sufficient time for conservatorship investigation and other related procedures. The conservatorship hearing must be held by the 30th day of the certification. In addition, if a temporary conservatorship is obtained, it is deemed to run concurrently and not consecutively with the 30-day certification period.

The maximum involuntary detention period for a gravely disabled person under Welfare and Institutions Code Sections 5150, 5250 and 5270.15 is 47 days.

E. Additional Confinement for a Person Dangerous to Others (Post-Certification Procedures)

GROUNDS FOR ADDITIONAL CONFINEMENT

At the expiration of the 14-day period of intensive treatment or an additional 14-day period of intensive treatment for an imminently suicidal patient, a person may be confined for further treatment for an additional period, not to exceed 180 days, if the patient is dangerous to others. A person is dangerous to others only if he or she has:

1. Attempted, inflicted or made a serious threat of substantial physical harm upon another person after having been taken into custody, and while in custody, for evaluation and treatment and, as a result of a mental disorder, the patient presents a demonstrated danger of inflicting substantial physical harm upon others; or
2. Attempted or inflicted physical harm upon another person, which resulted in the patient's being taken into custody and, as a result of a mental disorder, the patient presents a demonstrated danger of inflicting substantial physical harm upon others; or
3. Made a serious threat of substantial physical harm upon another person within seven days before the patient was taken into custody, which at least in part resulted in the patient's being taken into custody, and presents, as a result of a mental disorder, a demonstrated danger of inflicting substantial physical harm upon others.

[Welfare and Institutions Code Section 5300]

The determination that a patient presents a "demonstrated danger" of substantial physical harm to another may be based on an assessment of the patient's present mental condition, including consideration of past behavior of the patient within six years prior to the time the patient attempted, inflicted, or threatened physical harm to another, and other relevant evidence.

Facilities that commit patients under these provisions have affirmative obligations to provide treatment for the underlying causes of the patient's mental disorders. It is not necessary, however, to find that the patient is amenable to treatment, that the treatment will be successful or potentially successful, or that the patient recognizes his or her problem and will willingly participate in the treatment program. Instead, it is only necessary to reach the determinations described above and make a treatment program available.

For purposes of this law, the term **"custody"** means involuntary detention under LPS uninterrupted by a period of unconditional release (i.e., a release in which the patient was not required to return) from a facility that provides involuntary care and treatment.

PETITION BY PROFESSIONAL PERSON

Responsibility

At any time during the initial 14-day intensive treatment period, the professional in charge of the facility, or a designee, may ask the public officer required by Welfare and Institutions Code Section 5114 (i.e., the county's district attorney or county counsel) to petition the superior court in the county in which the facility providing the treatment is located to present evidence in support of an order requiring the patient to undergo an additional period of treatment on the grounds described in paragraphs 1-3 above. The petition must summarize the facts that support

the contention that the patient is dangerous and be supported by affidavits that describe the behavior in detail.

Copies of the petition for post-certification treatment and the supporting affidavits must be served on the patient on the same day they are filed with the clerk of the superior court.

A hospital that files a petition with the court should consult legal counsel regarding the advisability of filing documents with the court under seal and/or obtaining a protective order *(see HIPAA provision at 45 C.F.R. Section 164.512(e))*.

Recommended Form of Petition

Welfare and Institutions Code Section 5301 establishes the form of the petition. The "Petition for Post-certification Treatment of Imminently Dangerous Person" form (CHA Form 12-11) complies with this law and it is recommended that it be used for these purposes. The petition should be properly captioned for filing with the superior court.

COURT PROCEEDINGS

A court-conducted hearing or a jury trial, if the patient so requests, must be held to determine whether one or more of the grounds for additional confinement is present.

Patient's Right to Counsel and to a Jury Trial

At the time a petition for post-certification treatment is filed, the court is required to advise the patient of his or her right to be represented by an attorney and of his or her right to a jury trial. The court must assist in finding an attorney, or, if need be, appoint an attorney if the patient is unable to obtain counsel. If the patient is financially unable to provide his or her own attorney, the court must appoint the public defender or another attorney to represent the patient. The attorney must advise the patient of his or her rights in relation to the proceeding and represent him or her before the court. *(See Welfare and Institutions Code Sections 5302 and 5303.)*

Time Requirements for Proceedings

The hearing on the petition for post-certification treatment must be held within four judicial days of the filing of the petition.

At the time of the hearing, if the patient requests a jury trial, the trial must commence within 10 judicial days of the filing of the petition unless the patient's attorney requests a delay (continuance), which may be for a maximum of 10 additional judicial days.

The patient must be released if no decision has been made within 30 days after the petition is filed. Otherwise, until a final decision on the merits is made by the trial court, the patient must continue to be treated in the intensive treatment facility until released by order of the superior court that has jurisdiction over the action, or unless the petition for post-certification treatment is withdrawn [Welfare and Institutions Code Section 5303].

Required Presence of Professional at the Hearing or Jury Trial

The judge may appoint a psychiatrist or psychologist with forensic skills to examine the patient and testify at the hearing or jury trial about the patient's mental condition and the threat of substantial physical harm that the patient presents. Neither the professional, nor designee, who petitioned for the additional period of treatment, nor the physicians who provide intensive treatment are required to be present at the hearing or jury trial unless the patient subpoenas them.

If a psychiatrist or psychologist with forensic skills is not appointed, the patient, upon advice of counsel, may waive the presence at the hearing or at the jury trial of the professional, or designee, who petitioned for the additional period of treatment and the physician who provides intensive treatment. In the event of a waiver, the professional, designee, or other physicians are not required to be present at the hearing if it is stipulated that the certification, supporting affidavit(s), and records of the physicians concerning the mental condition of the person named in the petition will be received in evidence. [Welfare and Institutions Code Section 5303.1]

Findings Required for 180-Day Additional Confinement

If the court or the jury finds that a patient is dangerous to others pursuant to one of the three criteria listed in "Grounds for Additional Confinement," page 3.28, the court will remand the patient to the custody of DSH or to a facility designated by the county of residence for a further period of intensive treatment not to exceed 180 days from the date of judgment. The county from which the patient is remanded must bear any transportation costs incurred in placing the patient in the appropriate facility. [Welfare and Institutions Code Section 5304]

TERMINATION OF ADDITIONAL INTENSIVE TREATMENT AND PLACEMENT ON OUTPATIENT STATUS

The patient must be released from involuntary treatment at the expiration of 180 days unless the district attorney or county counsel files a new petition for post-certification treatment, and the patient has attempted, inflicted or made a serious threat of substantial physical harm upon another during the post-certification treatment, and he or she, by

reason of mental health disorder, presents a demonstrated danger of inflicting substantial physical harm on others. The new petition for post-certification treatment must be filed in the superior court where the original petition for post-certification treatment was filed. [Welfare and Institutions Code Section 5304]

A patient may be placed on outpatient status prior to the expiration of the 180-day period if:

1. The superintendent or professional in charge of the licensed facility determines that the patient will no longer be a danger to the health and safety of others while on outpatient status and will benefit from outpatient status;
2. The county behavioral health director agrees with this determination, identifies an appropriate program, assumes responsibility for supervising the patient on outpatient status, and submits reports periodically to the court; and
3. The district attorney or county counsel, the patient's attorney, the court, and the county behavioral health director are given notice of the proposed transfer of the patient to outpatient status and do not request a hearing within five days or, if a hearing was requested, the court approves the transfer after the hearing.

[Welfare and Institutions Code Section 5305]

A patient whose transfer to outpatient status is approved may remain on outpatient status for the remaining portion of the 180-day period unless the county behavioral health director believes the patient again requires inpatient treatment. A court hearing is required to determine whether the patient's outpatient status should be revoked, but the county behavioral health director may immediately confine the patient in a hospital pending the court's decision if the director believes that delay in hospitalization would pose a demonstrated danger of harm to the person or to another *(see Welfare and Institutions Code Sections 5306.5, 5307 and 5308 regarding requirements relating to patients on outpatient status)*.

Alternatively, the patient may be released from all treatment prior to the expiration of the 180-day period if the psychiatrist directly responsible for the person's treatment believes, as a result of his or her personal observations, that the person being involuntary treated no longer constitutes a demonstrated danger of substantial physical harm to others. If any other professional who is authorized to release the person believes the person should be released prior to the expiration of the commitment period, and the psychiatrist directly responsible for the person's treatment objects, the matter must be referred to the medical director of the facility for the final decision. However, if the medical director is not a psychiatrist, he or she must appoint a designee who is a psychiatrist to make the final decision. If the matter is referred, the person must be released prior to the expiration of the commitment period only if the psychiatrist believes, as a result of his or her personal observations, that the individual being involuntarily treated no longer constitutes a demonstrated danger of substantial physical harm to others. A psychologist may not order an early release without potential liability [*Ford v. Norton*, 89 Cal. App. 4th 974 (2001)].

NOTE: The law that permits a psychologist, under certain circumstances, to release a patient before the end of the hold does not apply to patients who are detained for additional intensive treatment.

The patient may be released five days after notice is given to the district attorney or county counsel, the patient's attorney, the court and the county behavioral health director, unless one of these parties requests a hearing. If a hearing is requested, the patient may not be released unless the court approves the release after the hearing. [Welfare and Institutions Code Section 5309]

IMMUNITY FROM LIABILITY

Provided they have complied with the provisions of Welfare and Institutions Code Sections 5300-5309, which are discussed above, the following persons are not civilly or criminally liable for any action by a person released at or before the end of a 90-day period:

1. The superintendent;
2. The professional in charge of the hospital that provides the involuntary treatment, or a designee;
3. The medical director of the facility, or a designee, described in Welfare and Institutions Code Section 5309(a); and
4. The psychiatrist directly responsible for the person's treatment.

[Welfare and Institutions Code Section 5306]

NOTE: The law that permits a psychologist, under certain circumstances, to release a patient before the end of his or her hold does not apply to patients who are detained for additional intensive treatment. Thus, there is no immunity for a psychologist who releases such a patient.

F. Additional Treatment for Gravely Disabled Person (LPS Conservatorship)

This portion of the manual is designed to present only a basic overview of the process for establishing a conservatorship under LPS. The facility should consult with the officials responsible for conservatorship investigations and with legal counsel before adopting policies for or initiating conservatorship. [Welfare and Institutions Code Section 5350 *et seq.*]

A discussion of the differences between an LPS conservatorship and a Probate Code conservatorship is found under "Caution: Type of Conservatorship," page 3.3.

CONSERVATORSHIP RECOMMENDATION

When the professional in charge of an agency that provides comprehensive evaluation or a facility that provides intensive treatment determines that a patient is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism and the person is unwilling to accept or incapable of accepting treatment voluntarily, the professional may recommend that a conservatorship be established. This recommendation must be made to the officer that provides conservatorship investigation for the county the person resided in prior to admission to the facility. The responsible officer may have developed an application form which should be completed by the facility. The facility should request these forms from the patient's county of residence.

Inpatient

If the professional in charge of a facility that provides intensive treatment recommends a conservatorship under Welfare and Institutions Code Section 5352 as discussed above, the proposed conservatee may be held in that facility for a period not to exceed three days after the expiration of the initial 14-day certification period if this additional time period is necessary to allow for the filing of the petition for temporary conservatorship and the establishment of the temporary conservatorship by the court.

Other Person

The professional in charge of an agency that provides comprehensive evaluation or a facility that provides intensive treatment may recommend conservatorship for a person without the patient being an inpatient in the facility if the professional, or a designee, has:

1. Examined and evaluated the person and determined that he or she is gravely disabled, and
2. Determined that future examination on an inpatient basis is not necessary to make the determination that the person is gravely disabled.

[Welfare and Institutions Code Section 5352]

INVESTIGATOR ACTION

If the officer who provides the conservatorship investigation concurs with the recommendation, he or she will file a conservatorship petition with the superior court in the patient's county of residence. A temporary conservatorship may be requested by the officer and, if granted, the investigating officer or another person designated by the county will be appointed to serve as the temporary conservator. A temporary conservatorship automatically expires after 30 days unless the court extends the time. A temporary conservator may require the patient to be detained in a facility that provides intensive treatment pending the determination of whether or not a year-long conservatorship will be established. The patient has the right to judicial review during this period, as described in "Judicial Review Pursuant to a Writ of Habeas Corpus," page 3.22.

COURT HEARING

A court hearing will be held and county counsel may be appointed to represent the patient if the county has authorized such appointments. At the conclusion of the hearing, the judge may rule that no conservatorship is appropriate, or the judge may order a year-long conservatorship.

CONSERVATORSHIP ESTABLISHED

If a year-long conservatorship is established, the court will specify the conservator's rights and may authorize the conservator to require the conservatee to receive treatment related specifically to remedying or preventing the recurrence of the conservatee's grave disability, or to require the conservatee to receive routine medical treatment unrelated to the conservatee's grave disability. [Welfare and Institutions Code Section 5357] *(See C. "Adults Under Conservatorship," page 2.15, for more information about an LPS conservator's authority to consent to, or refuse, nonpsychiatric medical treatment.)*

The facility should obtain a copy of the certified conservatorship papers to determine whether the conservator has the right to hospitalize the conservatee. The copy should be placed in the patient's medical record.

EXPIRATION OF CONSERVATORSHIP

A conservatorship will automatically expire at the end of one year unless it is renewed [Welfare and Institutions Code Section 5361]. The period of service of the termporary conservator is not included in the one-year period. The court clerk is required to give the conservator, conservatee, conservatee's attorney and the facility where a conservatee is detained 60 days notice that the year term is about to expire. An application may be submitted to renew the conservatorship at any time during this 60-day period. [Welfare and Institutions Code Section 5362]

VI. DETENTION OF PATIENT IN A NONDESIGNATED FACILITY

A. Immunity for Detaining Patient

Health and Safety Code Section 1799.111 provides that specified general acute care hospitals, acute psychiatric hospitals, licensed professional staff of these hospitals, and any physician providing emergency medical services in any department of these hospitals is not civilly or criminally liable for detaining a patient, if all of the following conditions exist during the detention:

1. The patient cannot be safely released from the hospital because, in the opinion of the treating physician (or a clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Health and Safety Code Section 1316.5, described below), the patient, as a result of a mental health disorder, presents a danger to himself or herself, or others, or is gravely disabled. **"Gravely disabled"** is defined, for the purpose of this law, as the inability to provide for basic personal needs for food, clothing, or shelter.

   NOTE: Health and Safety Code Section 1316.5 states that state owned and operated health facilities that offer services within the scope of practice of a psychologist must establish rules and procedures for consideration of an application for medical staff membership and clinical privileges submitted by a clinical psychologist. Private health facilities may appoint clinical psychologists on any terms and conditions as the facility may establish. However, if a particular service is offered by a health facility that permits clinical psychologists on its medical staff, which service both physicians and clinical psychologists are authorized by law to perform, such service may be performed by either, without discrimination.

2. The hospital staff, treating physician, or appropriate mental health professional has made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the patient. Telephone calls or other contacts required by this paragraph must commence as soon as the treating physician has determined when the patient will be medically stable for transfer. In no case may the contacts required by this paragraph begin after the patient becomes medically stable for transfer. If the hospital starts making the contacts after the patient is medically stable for transfer, the hospital may lose the legal immunity conferred by this law.
3. The patient is not detained beyond 24 hours.
4. There is probable cause for the detention.
5. If the patient is detained beyond eight hours, but less than 24 hours, both of the following additional conditions must be met:
   a. A discharge or transfer for appropriate evaluation or treatment has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.
   b. In the opinion of the treating physician, or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, the patient, as a result of a mental health disorder, is still a danger to himself or herself or others, or is gravely disabled (as defined above).

It appears that minors may be detained under this law, although the law does not expressly mention minor patients.

CHA has developed a form, "Detention of Patient with Psychiatric Emergency in a Nondesignated Health Facility (Health and Safety Code Section 1799.111)" (CHA Form 12-12), that hospitals may use to document compliance with this law.

B. Immunity for Actions of Patient After Release

The facilities and professionals listed above are not civilly or criminally liable for the actions of a patient detained up to 24 hours after release if the following conditions exist during the detention:

1. The patient has not been admitted to a hospital for evaluation and treatment under Welfare and Institutions Code Section 5150.
2. The release from the hospital is authorized by a physician or a clinical psychologist with the medical

staff privileges or professional responsibilities provided for in Health and Safety Code Section 1316.5, who determines, based on a face-to-face examination of the patient, that the patient does not present a danger to self or others and is not gravely disabled. The clinical psychologist may authorize the release only after consulting with the physician. If there is a disagreement, the patient must be detained unless the hospital's medical director overrules the decision of the physician opposing the release. The physician and psychologist must both enter their findings, concerns or objections in the patient's medical record.

C. Hospitals Covered by This Law

The hospital does not need to be designated by the county to hold patients pursuant to this law. In fact, hospitals that are designated by the county under LPS do not enjoy these immunities.

D. Relationship to Other Laws

This law does not affect the responsibility of a hospital to comply with all state laws and regulations pertaining to the use of seclusion and restraint and psychiatric medications for psychiatric patients. In addition, patients detained under this law retain their legal rights regarding consent for medical treatment (i.e., the hospital cannot treat the patient without his or her consent, or the consent of the legal representative if the patient has been determined by a physician to lack capacity to consent to treatment).

E. Credit for Time Detained

A patient detained under Health and Safety Code Section 1799.111 must be credited for the time detained if he or she subsequently is placed on a 72-hour hold under Welfare and Institutions Code Section 5150. A transferring hospital should provide to the receiving hospital documentation regarding the length of time the person was detained, so that the receiving hospital can comply with this requirement.

VII. COURT-ORDERED EVALUATION OF PERSONS WHO MAY HAVE A MENTAL HEALTH DISORDER

LPS specifies the procedures by which an individual may apply to the appropriate county agency for a petition for a court-ordered evaluation of a person alleged to be a danger to self or others or gravely disabled as a result of mental health disorder [Welfare and Institutions Code Section 5200].

This procedure is available when involuntary detention is not or will not be authorized by persons permitted to initiate involuntary detention under Welfare and Institutions Code Section 5150 *(see "Conditions for Detention," page 3.9)*.

VIII. REPORTING PATIENT ESCAPE, DISAPPEARANCE, RELEASE OR TRANSFER

The law requires that hospitals notify law enforcement officers and/or other persons of specified patient escapes, disappearances, releases, or transfers. The relevant laws and their requirements are described in X. "Notifying Law Enforcement Officers of Patient Presence, Release or Disappearance," page 7.36.

IX. INVOLUNTARY OUTPATIENT TREATMENT

California law permits courts to order patients to participate in outpatient mental health treatment [Welfare and Institutions Code Sections 5345-5349.5]. This law is operative only in those counties in which the county board of supervisors, by resolution or through the county budget process, authorizes its application and makes a finding that no voluntary mental health program serving adults, and no children's mental health program, will be reduced as a result of the implementation of this law. A county choosing to implement this law is required to provide a wide range of outpatient services to both voluntary and involuntary patients of every cultural and linguistic background, age, gender, physical disability, etc. A county implementing this law is also required to undertake detailed data collection, evaluation and reporting.

A petition must be filed with the court to initiate the process of involuntary outpatient treatment for a particular patient.

A. Contents of Petition

A court must find by clear and convincing evidence that the following facts stated in a verified petition are true:

1. The patient is 18 years of age or older.
2. The patient is suffering from a mental illness as defined in Welfare and Institutions Code Section 5600.3(b)(2) and (3). This law defines a mental disorder as one that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment for a long or indefinite period of time. These disorders include, but are not limited to, schizophrenia,

bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. Patients must meet additional criteria related to functional impairments.

3. There has been a clinical determination that the patient is unlikely to survive safely in the community without supervision.
4. The patient has a history of lack of compliance with mental health treatment, in that at least one of the following is true:
    a. The patient's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the patient was hospitalized or incarcerated immediately preceding the filing of the petition.
    b. The patient's mental illness has resulted in one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months, not including any period in which the patient was hospitalized or incarcerated immediately preceding the filing of the petition.
5. The patient has been offered an opportunity to participate in a treatment plan provided by the local mental health department and the patient continues to fail to engage in treatment.
6. The patient's condition is substantially deteriorating.
7. Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the patient's recovery and stability.
8. In view of the patient's treatment history and current behavior, the patient needs assisted outpatient treatment to prevent a relapse or deterioration that would likely result in grave disability or serious harm to himself or herself, or to others.

B. Who May Initiate a Petition

A petition may be filed by the county behavioral health director or designee in the superior court in the county in which the patient is present.

Any of the following persons may request the county behavioral health director to file a petition:

1. Any adult cohabitant of the patient;
2. Any adult parent, spouse, sibling or child of the patient;
3. The director of any public or private agency, treatment facility, charitable organization, or licensed residential care facility providing mental health services to the patient in whose institution the patient resides;
4. The director of a hospital in which the patient is hospitalized;
5. A licensed mental health treatment provider who is either supervising the treatment of, or treating the mental illness of, the patient; or
6. A peace officer, parole officer, probation officer assigned to supervise the patient.

Upon request of one of these persons, the county behavioral health director must conduct an investigation into the appropriateness of filing a petition. A hospital or other health care provider should consult its legal counsel about a patient's confidentiality rights prior to disclosing medical information to the county behavioral health director for purposes of petitioning a court for involuntary outpatient treatment.

C. Procedure

The petition must contain specified information *(see A. "Contents of Petition," page 3.33)*, and must be accompanied by an affidavit of a licensed mental health treatment provider designated by the local mental health director. The court will hold a hearing. The patient has the right to be represented by counsel, to be present at the hearing, to present evidence, to call witness, and to cross-examine witness. The patient has the right to judicial review by habeas corpus and to appeal decisions. If the court determines that the patient meets the criteria for assisted outpatient treatment, it may be ordered for an initial period not to exceed six months. (Procedures exist for lengthening this time period.) The court order will state the categories of assisted outpatient treatment that the patient is to receive. Involuntary medication is not allowed without a separate order by the court pursuant to Welfare and Institutions Code Sections 5332-5336, inclusive.

Every 60 days, the director of the outpatient treatment program must file an affidavit with the court that the patient continues to meet the criteria for assisted outpatient treatment. The patient has the right to a hearing if he or she disagrees.

Failure to comply with an order of assisted outpatient treatment alone may not be grounds for involuntary civil commitment or a finding that the patient is in contempt of court.

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FORMS & APPENDICES

13-3[S] Aftercare Plan

Forms and Appendices can be found at the back of the manual and online for CHA members at www.calhospital.org/free-resources.

"S" denotes that the form is provided in English and Spanish.

4 Rights of Mental Health Patients

I. INTRODUCTION

Both state and federal law contain multiple provisions regarding patients' rights. Requirements regarding patient rights in general — that is, rights that apply to all patients, not just mental health patients — are described in chapter 1 of CHA's *Consent Manual*. Patients' rights that are specific to restraint and seclusion are described in chapter 5 of this manual.

This chapter discusses the rights afforded under state and federal law to persons who are involuntarily or voluntarily admitted to a facility for mental health services, including evaluation and treatment of a mental disorder, inebriation, or drug use. These rights are codified primarily in the Lanterman-Petris-Short (LPS) Act [Welfare and Institutions Code Section 5000 *et seq.*]. Other relevant principles that apply to these patients are found in Welfare and Institutions Code Section 6000 *et seq.* and in state and federal judicial decisions interpreting these statutes.

II. PATIENT RIGHTS UNDER STATE LAW

The Lanterman-Petris-Short Act contains two provisions that discuss the rights of mental health patients:

1. **Welfare and Institutions Code Section 5325.** A list of these rights must be prominently posted in the facility in English, Spanish, and the predominant language of the community, and explained to patients in a language or modality accesible to the patient. These rights may be denied for good cause (with some exceptions). Details about these rights and denial of rights are described in this chapter.
2. **Welfare and Institutions Code Section 5325.1.** This statute states that persons with mental illness have the same legal rights and responsibilities guaranteed to all other persons by the constitutions and laws of the United States and California. The statute also states that persons who have been treated for mental illness may not be subject to discrimination under any program or activity that receives public funds. Finally, this statute states the "intent of the legislature" that persons with mental illness have certain rights. This list of patient rights differs from the list found in Welfare and Institutions Code Section 5325. These rights are not subject to denial. It is not clear why the legislature enacted a second list of patient rights. Details about these rights are described in this chapter.

NOTE: As a legal matter, the "intent of the legislature" is sometimes considered by a judge who is trying to interpret an ambiguous provision of law. If a law is clear and unambiguous, the judge will not consider legislative intent. It is only when a statute can be interpreted in more than one way that the judge will consider legislative intent to resolve the ambiguity. It is not clear why the legislature enacted a list of patient rights as "legislative intent."

A. Notifying Patients of Their Rights

POSTERS AND BOOKLETS

A facility that treats patients listed in "Patients Covered by the Law," page 4.2, must post a list of patient rights in English, Spanish, and the predominant languages of the community, in all wards and common living areas.

In addition, the facility must notify each patient personally of his or her rights, both orally and in writing, in a language the patient can understand. The patient's rights must be brought to the patient's attention by other means if he or she is unable to read or understand the information provided.

The California Department of Health Care Services (DHCS) has developed posters and booklets that facilities may use to notify patients of their rights. The booklet, "Rights for Individuals in Mental Health Facilities," and posters are available in many languages at www.dhcs.ca.gov/services/pages/office-of-patients-rights.aspx.

These posters and booklets do not fulfill the following requirements:

1. Notifying voluntary patients that they can discharge themselves *(see "Right to Discharge," page 4.3).*
2. Notifying patients that nobody may be presumed incompetent due to evaluation or treatment for a mental disorder or chronic alcoholism *(see "Required Statement of California Law," page 4.3).*

3. Notifying patients about how to file a complaint with the hospital *(see "Complaint to Hospital," page 4.4).*

Hospitals should adopt a procedure to ensure that these requirements are met.

[Welfare and Institutions Code Section 5325; Title 9, California Code of Regulation, Sections 862; Title 22, California Code of Regulations, Section 71507]

DOCUMENTATION

A note that the hospital notified, or attempted to notify, the patient of his or her rights must be entered in the patient's medical record within 24 hours of admission. This may be accomplished by having the patient sign a form that lists the patients' rights, or another form acknowledging receipt of the DHCS booklet. One copy of the signed form should be given to the patient and the original placed in the medical record.

If the patient cannot be notified of patients' rights within 24 hours of admission, a note about the reason should be entered in the patient's medical record and the advisement of rights should occur as soon as the patient is capable of understanding [Title 9, California Code of Regulations, Section 862].

B. Patient Rights Under Welfare and Institutions Code Section 5325

PATIENTS COVERED BY THE LAW

Welfare and Institutions Code Section 5325 lists certain rights enjoyed by all mental health patients, including:

1. Each person involuntarily detained for evaluation or treatment under the LPS Act;
2. Each person admitted as a voluntary patient for psychiatric evaluation or treatment to any facility (as defined in Health and Safety Code Section 1250), including a general acute care hospital, acute psychiatric hospital, skilled nursing facility, or intermediate care facility in which psychiatric evaluation or treatment is offered; and
3. Each person committed to a state hospital.

LIST OF RIGHTS

The patients' rights are:

1. To wear one's own clothes, to keep and use personal possessions including toilet articles, and to keep and spend a reasonable sum of one's own money for canteen expenses and small purchases.
2. To have access to individual storage space for private use.
3. To see visitors each day.
4. To have reasonable access to telephones, both to make and to receive confidential calls, or to have calls made for them.
5. To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.
6. To refuse convulsive treatment including, but not limited to, electroconvulsive treatment, any treatment for a mental condition that depends on the induction of a convulsion by any means, and insulin coma treatment. **NOTE:** This right may be denied only under the conditions specified in Welfare and Institutions Code Section 5326.7 *(see D. "Convulsive Therapy and Insulin Coma Treatment," page 2.49)*.
7. To refuse psychosurgery. (**NOTE:** This right may not be denied.) **"Psychosurgery"** is defined as those operations referred to as lobotomy, psychiatric surgery, behavioral surgery, and all other forms of brain surgery if the surgery is performed for the purpose of any of the following:
   a. Modification or control of thoughts, feelings, actions, or behavior rather than the treatment of a known and diagnosed physical disease of the brain.
   b. Modification of normal brain function or normal brain tissue in order to control thoughts, feelings, actions, or behavior.
   c. Treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions, or behavior when the abnormality is not an established cause for those thoughts, feelings, actions, or behavior.

   Psychosurgery includes prefrontal sonic treatment if there is any possibility of destruction of brain tissue or brain cells. [Title 9, California Code of Regulations, Section 857]
8. To see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the patient. (**NOTE:** This right may not be denied.)
9. Other rights as specified by regulation. (There are no additional rights specified by regulation at this time.)

WAIVER OF RIGHTS

The rights listed above may not be waived by the patient's parent, guardian, or conservator. However, these rights may be denied when "good cause" exists (except as noted in the list above). The procedure for denying these rights when good cause exists is discussed in F. "Denial of Patient Rights," page 4.4.

C. Patient Rights Under Welfare and Institutions Code Section 5325.1

Welfare and Institutions Code Section 5325.1 expressly states that persons with mental illness have the same legal rights and responsibilities guaranteed to all other persons by the U.S. Constitution and the laws of the state of California, unless specifically limited by federal or state law. If an otherwise qualified person is involuntarily detained for evaluation or treatment, or is admitted as a voluntary patient to a health facility in which psychiatric evaluation or treatment is offered, he or she may not be excluded from participation in, denied the benefits of, or subjected to discrimination under, any program or activity that receives public funds.

In addition, Welfare and Institutions Code Section 5325.1 declares the legislative intent that persons with mental illness shall have rights including, but not limited to, the following:

1. A right to treatment services which promote the potential of the person to function independently. Treatment should be provided in ways that are least restrictive of the personal liberty of the individual.
2. A right to dignity, privacy, and humane care.
3. A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect. Medication may not be used as punishment, for the convenience of staff, as a substitute for a program, or in quantities that interfere with the treatment program.
4. A right to prompt medical care and treatment.
5. A right to religious freedom and practice.
6. A right to participate in appropriate programs of publicly supported education.
7. A right to social interaction and participation in community activities.
8. A right to physical exercise and recreational opportunities.
9. A right to be free from hazardous procedures.

D. Rights Noted in Other Laws

RIGHT TO DISCHARGE

A person who has the lawful right to discharge himself or herself from a facility must be informed of that right at the time of admission to the facility. This information is not expressly included in the DHCS posters and booklets. Hospitals should adopt a procedure to ensure that patients are given this information. If the person decides to discharge himself or herself from the facility rather than voluntarily accepting a denial of patients' rights, that decision must be documented in the medical record and the person must be permitted to leave the facility.

REQUIRED STATEMENT OF CALIFORNIA LAW

Welfare and Institutions Code Section 5331 states that a person who leaves a mental health facility after evaluation or treatment for a mental disorder or chronic alcoholism, regardless of whether that evaluation or treatment was voluntarily or involuntarily received, must be given the following statement of California law:

> No person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether such evaluation or treatment was voluntarily or involuntarily received.

This information is not expressly included in the DHCS posters and booklets. Hospitals should adopt a procedure to ensure that patients are given this statement. The law does not specify when this information must be given to the patient.

E. Complaint Procedures

A patient may complain to a patients' rights advocate, CDPH, or to the hospital. Patients must be given information about these procedures, as described below. This information is not expressly included in the DHCS posters and booklets. Hospitals should adopt a procedure to ensure that patients are given this information.

COMPLAINT TO ADVOCATES

A patient who believes a right has been abused, punitively withheld, or unreasonably denied may file a complaint with a patients' rights advocate. The patients' rights advocates are assigned by each county behavioral health

director to handle complaints of mental health patients *(see B. "County Patients' Rights Advocates," page 4.11)*. Residents' rights advocates are assigned to handle complaints from patients with developmental disabilities.

The posted complaint procedure must contain the following:

1. Notification that a patient who believes a right of his/hers has been abused, punitively withheld, or unreasonably denied may file a complaint with the patients' rights advocate.
2. The name of the patients' rights advocates assigned to handle complaints, their telephone number(s), and times they may be contacted.

[Title 9, California Code of Regulations, Section 864]

The patients' rights advocate must take action to investigate and resolve a complaint within two working days of receipt. A complainant who is dissatisfied with the patients' rights advocate's resolution of the complaint may appeal. The appeals procedure is described in Title 9, California Code of Regulations, Section 864.

The DHCS poster and booklet have a space on them for the name and contact information of the local patients' rights advocate. The booklet also gives the names and contact information of two statewide organizations. However, the statement included in paragraph 1. above is not expressly included. Hospitals should adopt a procedure to ensure that patients are given this information.

COMPLAINT TO CDPH

Information about how to submit complaints to CDPH must be posted [Title 22, California Code of Regulations, Section 71507]. The DHCS posters do not contain language that fulfills this requirement. Therefore, the hospital must post an additional poster informing patients how to file a complaint as well as the address and phone number of the CDPH local district office.

COMPLAINT TO HOSPITAL

Information about how a patient may file a complaint with the hospital must be provided to the patient [Title 22, California Code of Regulations, Section 71507(d)]. The DHCS posters and booklets do not contain language that fulfills this requirement. Therefore, the hospital must post another poster or handout informing patients of the hospital's complaint procedure must be used. Hospitals that participate in the Medicare program are required to have a specified grievance policy *(see "Complaint to Hospital," page 4.4, for details)*.

F. Denial of Patient Rights

DENIAL FOR GOOD CAUSE

The professional person in charge of the facility or a designee may, for good cause, deny a person a right specified under Welfare and Institutions Code Section 5325 *(see B. "Patient Rights Under Welfare and Institutions Code Section 5325," page 4.2)*.

EXCEPTIONS

The rights to refuse psychosurgery or to see and receive the services of a patient advocate may not be denied, and the right to refuse convulsive treatment may be denied only under the conditions specified in Welfare and Institutions Code Section 5326.7 *(see D. "Convulsive Therapy and Insulin Coma Treatment," page 2.49)*.

Definition

The term **"professional person in charge of a facility"** means a person as defined in Title 9, California Code of Regulations, Section 623 (psychiatrist), 624 (psychologist), 625 (social worker), 626 (marriage and family therapist), or 627 (registered nurse with a master's degree in psychiatric or public health nursing) who is designated by the governing board of the facility or person having control of the facility as the professional person clinically in charge of the facility for purposes of LPS. The designation must be in writing. [Title 9, California Code of Regulations, Section 822]

Good Cause

Good cause must be established to justify a denial of rights [Title 9, California Code of Regulations, Section 862 *et seq.*].

Good cause for denying a patient the exercise of a right exists when the professional person in charge of a facility or a designee has good reason to believe:

1. That the exercise of the specific right would be injurious to the patient; or
2. That there is evidence that the specific right, if exercised, would seriously infringe upon the rights of others; or
3. That the institution or facility would suffer serious damage if the specific right is not denied; and
4. That there is no less restrictive way of protecting the interests specified above.

[Title 9, California Code of Regulations, Section 865.2]

The reason used to justify the denial of a patient right must be related to the specific right denied. A right must not be withheld or denied as a punitive measure. A right may not be considered a privilege to be earned.

Treatment modalities must not include the denial of any right specified in Welfare and Institutions Code Section 5325. Waivers signed by the patient or by the responsible relative, guardian, or conservator must not be used as a basis for denying these rights.

When a right has been denied, staff must use the least restrictive means of managing the problem that led to the denial.

Restraint and Seclusion

When a patient is restrained or secluded, a denial of rights is deemed to have occurred, even though "restraint" and "seclusion" are not mentioned in the list of patients' rights under Welfare and Institutions Code Section 5325. This is because when a patient is restrained or secluded, the situation implies the denial of other patients' rights that are listed, such as the right of reasonable access to telephones and the right to have ready access to letter writing materials.

If a patient is restrained or secluded and does not specifically request to exercise any listed right, then only the restraint or seclusion must be documented. If the patient is restrained or secluded and requests to exercise a listed right (for example, the patient asks to make a phone call), then both the restraint (or seclusion) and the other specifically denied right (in the example, the right to make a phone call) must be documented. *(See chapter 5 for more information about restraint and seclusion.)*

DOCUMENTATION OF DENIAL OF RIGHTS

Each denial of a patient's rights must be noted in the medical record [Welfare and Institutions Code Section 5326; Title 9, California Code of Regulations, Sections 865.3 and 865.4]. Documentation must take place immediately whenever a right is denied, and each denial of a right must be documented regardless of the gravity of the reason for the denial or the frequency with which a specific right is denied in a particular facility or to a particular individual. As mentioned above, if a patient in seclusion or restraints is denied any right, the denial must also be documented. The documentation must include:

1. The specific right denied.
2. The date and time the right was denied.
3. The reason (good cause) for denial of the right.
4. The date of review if the denial of the right extended beyond 30 days.
5. The signature of the professional person in charge of the facility or a designee.

The patient must be told the contents of the documentation.

Forms

The former DMH has developed two forms for providers to use, "Patients' Rights Denial — Monthly Tally" and "Denial of Rights/Seclusion and Restraint Monthly Report." Both forms may be found at www.dhcs.ca.gov/formsandpubs/forms/pages/mental_health-Forms.aspx.

The "Patients' Rights Denial — Monthly Tally" form should be completed for each patient each month. The form has a chart showing each day of the month. A number has been assigned to each right (for example, "5" represents the right to see visitors each day). If a denial of rights occurs, the number assigned to the right that was denied is entered into the box underneath the day of the month the denial occurred. This form must be filed in the patient's medical record.

The "Denial of Rights/Seclusion and Restraint Monthly Report" form must be completed monthly. This form captures all patients and all denials of rights in a facility in a particular month. The form must be submitted to the local behavioral health director or the county or state hospital executive director by the 10th day of the following month. The Monthly Tally must be attached to the Denial of Rights form.

Quarterly reports of the number of persons, by facility, whose rights were denied and the specific right or rights denied must be submitted to the local mental health director, who must report to DHCS [Welfare and Institutions Code Section 5326.1, Title 9, California Code of Regulations, Section 866].

DISCLOSURE OF DENIAL OF RIGHTS

Information in a patient's medical record about denial of rights must be available, upon request, to the patient, patient's attorney, conservator and/or guardian, the local mental health director or a designee, or the patients' rights program *(see chapter 9 regarding HIPAA and the disclosure of mental health information)*. The information that must be made available includes consent forms, the required documentation for convulsive treatment, documentation regarding the use of restraints and seclusion, physicians' orders, nursing notes, and involuntary detention and conservatorship papers.

State law calls for this information, except for the identity of the patient whose rights are denied, to also be made available upon request to a member of the California State Legislature or a member of a county board of supervisors [Welfare and Institutions Code Section 5326.1; Title 9, California Code of Regulations, Section 867]. However, legal counsel should be consulted prior to any release to legislators or supervisors to be sure the facility complies with HIPAA.

RESTORATION OF RIGHTS

A right may not be denied to a patient when good cause for its denial no longer exists. Also, as noted above, when a right has been denied, staff must employ the least restrictive means of managing the problem that led to the denial. The date a specific right is restored must be documented in the patient's medical record. [Title 9, California Code of Regulations, Section 865.5]

III. SEXUAL ORIENTATION CHANGE THERAPY FOR MINORS

California law states that "under no circumstances shall a mental health provider engage in sexual orientation change efforts with a patient under 18 years of age."

"Sexual orientation change efforts," also known as reparative therapy or conversion therapy, means any practices by mental health providers that seek to change an individual's sexual orientation. This includes efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.

However, sexual orientation change efforts does not include psychotherapies that:

1. Provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices; and
2. Do not seek to change sexual orientation.

"Mental health provider" means:

1. A physician and surgeon specializing in the practice of psychiatry;
2. A psychologist;
3. A psychological assistant, intern, or trainee;
4. A licensed marriage and family therapist, a registered associate marriage and family therapist, or marriage and family therapist trainee;
5. A licensed educational psychologist;
6. A credentialed school psychologist;
7. A licensed clinical social worker;
8. An associate clinical social worker;
9. A licensed professional clinical counselor, a registered associate clinical counselor, or professional clinical counselor trainee; or
10. Any other person designated as a mental health professional under California law or regulation.

Any sexual orientation change efforts attempted on a patient under 18 years of age by a mental health provider are considered unprofessional conduct and subject the provider to discipline by the licensing board.

[Business and Professions Code Sections 865-865.2]

IV. AFTERCARE PLAN

All psychiatric inpatient care providers must furnish each mental health patient and specified other persons a written aftercare plan upon the patient's discharge from the facility [Health and Safety Code Section 1262; Welfare and Institutions Code Sections 5622 and 5768.5]. CHA has developed the "Aftercare Plan" form (CHA Form 13-3) which facilities may use to document compliance with this law. Facilities are not required to use this particular form; any form meeting the requirements described in this section of the manual will work.

"Mental health patient," for the purposes of this law, means a person who is admitted to a facility primarily for the diagnosis or treatment of a mental disorder.

A. Facilities Subject to This Law

The following facilities, both public and private, are subject to this law:

1. State mental hospitals.
2. General acute care hospitals as defined in Health and Safety Code Section 1250(a).
3. Acute psychiatric hospitals as defined in Health and Safety Code Section 1250(b).
4. Psychiatric health facilities as defined in Health and Safety Code Section 1250.2.

5. Mental health rehabilitation centers as defined in Welfare and Institutions Code Section 5675.
6. Skilled nursing facilities with a special treatment program service unit for patients with chronic psychiatric impairments *(see Title 22, California Code of Regulations, Sections 51335 and 72443-72475 about special treatment programs).*
7. Facilities authorized under Welfare and Institutions Code Section 5675 or 5768 (mental health rehabilitation center pilot projects and other new programs approved by the California Department of Social Services (DSS)).

B. Contents of the Aftercare Plan

The aftercare plan must be written and must, to the extent known, include the following components:

1. The nature of the illness and follow-up required.
2. Medications prescribed and their side effects and dosage schedules. A signed informed consent form for medications, when attached to the aftercare plan, may satisfy this requirement if the consent form includes the specified information.
3. The patient's expected course of recovery.
4. Recommendations regarding treatment that are relevant to the patient's care.
5. Referral to providers of medical and mental health services.
6. Other relevant information.

If any item above is not known at the time of discharge, this should be noted on the aftercare plan.

The aftercare plan for a minor being released from involuntary treatment must also include "education or training needs, provided these are necessary for the minor's well-being" [Welfare and Institutions Code Section 5585.57].

CHA Form 13-3, "Aftercare Plan," has space to document compliance with this requirement.

C. Persons Who Must Be Given an Aftercare Plan

The law states that when a mental health patient is being *discharged* from one of the facilities subject to the law, the patient and the patient's conservator, guardian, or other legally authorized representative must be given a written aftercare plan. As mentioned above, for purposes of this law, a **"mental health patient"** is defined as a person who is *admitted* to a facility primarily for the diagnosis or treatment of a mental disorder. This law does not appear to require that a mental health patient seen in the emergency room, but never admitted, be given a written aftercare plan; however, a hospital may wish to provide one.

The law is unclear about when a legally authorized representative must be given an aftercare plan. In general, a "legally authorized representative" exists only if the patient lacks the capacity to make medical decisions for himself or herself, in the opinion of the attending physician or psychologist. In such a situation, the legally authorized representative might be a guardian, conservator, or parent. *(See chapter 2 for a detailed discussion of capacity and legally authorized representatives.)*

In addition, facility personnel must advise the patient that he or she may designate another person to receive a copy of the aftercare plan. If the patient designates such a person, the facility must give that person a copy of the aftercare plan also.

V. MENTAL HEALTH ADVOCACY PROGRAMS

Advocacy programs, including the county patients' rights advocate program and the California Department of State Hospitals (DSH), DHCS, and the California Department of Social Services (DSS) advocacy program (contracted to the statewide protection and advocacy agency), and the Patients' Rights Committee of the California Mental Health Planning Council, are described in Welfare and Institutions Code Sections 4900-4906 and 5500 *et seq. (see also 42 U.S.C. Sections 10805 and 10806)*.

The county program pertains mainly to mental health patients. The statewide program's reach is much broader, as described below.

State law specifies various circumstances under which a health care facility must provide individually-identifiable health information to patient advocates. This portion of the manual describes the different types of patient advocacy programs and when information must be disclosed to them.

A. Statewide Protection and Advocacy Organization

The advocacy responsibilities of DHCS and DSH have been transferred to a nongovernmental, nonprofit corporation that acts as a statewide protection and advocacy agency. The corporation that currently has the contract to act as the statewide protection and advocacy agency is Disability Rights California (DRC). [Welfare and Institutions Code Section 5510]

This organization is responsible for ensuring that mental health laws, regulations, and policies regarding the rights of recipients of mental health services are observed in state hospitals as well as health and community care facilities [Welfare and Institutions Code Section 5510]. In addition, this organization is responsible for ensuring that laws related to abuse and neglect of disabled persons are observed in state hospitals and health and community care facilities.

DRC may also investigate any incident of abuse or neglect of a disabled person if the incident is reported to DRC or if DRC, determines there is probable cause to believe abuse or neglect occurred. The definition of a "person with a disability" is extremely broad and encompasses persons with physical disabilities as well as persons with mental illness and developmentally disabled persons. [Welfare and Institutions Code Section 4902]

DRC's authority includes reasonable access to a facility or program, and authority to examine relevant records. What is considered "reasonable" differs depending upon the purpose of DRC's visit. [Welfare and Institutions Code Section 4902(b)] DRC may also interview any facility or program service recipient, employee, or other person who might have knowledge of the alleged abuse or neglect.

INVESTIGATIONS

DRC must be given reasonable unaccompanied access to public or private facilities, programs, and services, and to recipients of services therein, at all times necessary to investigate incidents of abuse and neglect. Access must be given to DRC, upon request, when any of the following has occurred:

1. An incident is reported or a complaint is made to DRC.
2. DRC determines there is probable cause to believe that an incident has or may have occurred.
3. DRC determines that there is or may be imminent danger of serious abuse or neglect of an individual with a disability.

"Reasonable unaccompanied access" means access that permits DRC, without undue interference, to:

1. Monitor, inspect, and observe conditions in facilities and programs, and
2. Meet and communicate with residents and service recipients privately and confidentially on a regular basis, formally or informally, by telephone, mail, email, and in person.

Reasonable unaccompanied access also includes the review of records privately and confidentially, in a manner that minimizes interference with the activities of the program or service; that respects patients' privacy interests and honors a patient's request to terminate an interview; and that does not jeopardize the physical health or safety of facility or program staff, patients, service recipients, or DRC staff.

NONINVESTIGATIVE PURPOSES

DRC must be given reasonable unaccompanied access to public or private facilities, programs and services, and to recipients of services therein, during normal working hours and visiting hours for other advocacy services (that is, noninvestigative purposes).

Access must be provided at times mutually agreeable to DRC and facility management for the following:

1. Providing information and training on (and referral to programs addressing the needs of) individuals with disabilities, and information and training on individual rights and the protection and advocacy services available from DRC, including, but not limited to, the name, address, and telephone number of DRC.
2. Monitoring compliance with respect to the rights and safety of patients or service recipients.
3. Inspecting, viewing, and photographing all areas of the facility or program that are used by patients or service recipients, or that are accessible to them.

DELAY OR DENIAL OF ACCESS

If DRC's access to facilities, programs, service recipients, patients, or records is wrongfully delayed or denied, the facility must promptly provide DRC with a written statement of reasons. If denial of access results from an alleged lack of patient authorization, the facility must promptly provide DRC with the name, address, and telephone number of the patient's legal guardian, conservator, or other legal representative. Access to a facility, program, service recipient, patient, or records may not be delayed or denied without the prompt provision of a written statement of the reasons for the denial. [Welfare and Institutions Code Section 4902(c)]

COPYING COSTS

A health care provider may charge a reasonable fee to cover the cost of copying records. This fee may take into account the costs incurred in locating, identifying, and making the records available. Charges for copying records

that would be available to DRC or the patient under other laws may not exceed any rates for obtaining copies of the records specified in the other laws. [Welfare and Institutions Code Section 4902(e)] *(See CHA's* California Health Information Privacy Manual *regarding records that must be made available to the patient and the photocopying rates that may be charged.)*

ACCESS TO RECORDS OF SPECIFIED PERSONS

DRC must be given access to the records of the following people with disabilities:

1. A person with a disability alleged to be a victim of abuse or neglect if the incident is reported to DRC or DRC determines there is probable cause to believe the incident occurred.
2. A person who is a client of DRC or who has requested assistance from DRC, if that person, his or her agent, legal guardian, conservator, or other legal representative, has authorized DRC to have access to the records. If a person with a disability who is able to authorize DRC to access his or her records expressly denies this access after being informed by DRC of his or her right to authorize or deny access, DRC may not have access to the records [Welfare and Institutions Code Section 4903(a)(1)].
3. A person, including an individual who cannot be located, to whom all of the following conditions apply:
    a. The individual, due to his or her mental or physical condition, is unable to authorize DRC to have access to his or her records.
    b. The individual does not have a legal guardian, conservator, or other legal representative, or the individual's representative is a public entity, including the state or one of its political subdivisions.
    c. DRC has received a complaint that the individual has been subject to abuse or neglect, or has determined that probable cause exists to believe that the individual has been subject to abuse or neglect.

    [Welfare and Institutions Code Section 4903(a)(2)]
4. A person who is deceased, and for whom DRC has received a complaint that the individual had been subjected to abuse or neglect, or for whom DRC has determined that probable cause exists to believe that the individual had been subjected to abuse or neglect [Welfare and Institutions Code Section 4903(a)(3)].
5. A person who has a legal guardian, conservator, or other legal representative with respect to whom a complaint has been received by DRC, or with respect to whom DRC has determined that probable cause exists to believe that the person has been subjected to abuse or neglect, whenever all of the following conditions exist:
    a. The representative has been contacted by DRC upon receipt of the representative's name and address.
    b. DRC has offered assistance to the representative to resolve the situation.
    c. The representative has failed or refused to act on behalf of the person.

    [Welfare and Institutions Code Section 4903(a)(4)]

(See also Welfare and Institutions Code Section 5328.06.)

TYPES OF RECORDS AVAILABLE TO DRC

All of the following individual records must be made available to DRC.

1. Information and records prepared or received in the course of providing intake, assessment, evaluation, education, training, or other supportive services, including, but not limited to, medical records, financial records, monitoring reports, or other reports, prepared or received by a member of the staff of a facility, program, or service that is providing care, treatment, or services.
2. Reports prepared by an agency charged with investigating reports of incidents of abuse, neglect, injury, or death occurring at the program, facility, or service while the individual with a disability is under the care of a member of the staff of a program, facility, or service, or by or for a program, facility, or service, that describe any or all of the following:
    a. Abuse, neglect, injury, or death.
    b. The steps taken to investigate the incidents.
    c. Reports and records, including, but not limited to, personnel records prepared or maintained by the facility in connection with reports of incidents, subject to the following:
        - If a state statute specifies procedures with respect to personnel records, DRC must follow those procedures.

- Personnel records are protected from disclosure in compliance with the state constitutional right of privacy. The custodian of personnel records has a right and a duty to resist attempts to allow the unauthorized disclosure of personnel records, and may not waive the privacy rights that are guaranteed pursuant to the state constitutional right to privacy.
- Supporting information that was relied upon in creating a report including, but not limited to, all information and records that document interviews with persons who were interviewed, physical and documentary evidence that was reviewed, or related investigative findings.

d. Discharge planning records.

[Welfare and Institutions Code Section 4903(b) and (c)]

This information must be provided, whether written or in another medium, and whether draft or final. This information may include, but is not limited to, handwritten notes, electronic files, photographs, videotapes, audiotapes or records.

Information About Abuse or Neglect Investigations

A facility must make the following available to DRC when investigating instances of abuse or neglect:

1. Information in reports prepared by individuals and entities performing certification or licensure reviews, or by professional accreditation organizations, as well as related assessments prepared for a program, facility, or service by its staff, contractors, or related entities. However, information subject to any other provision of state law protecting records produced by medical care evaluation or peer review committees need not be disclosed. *(See "Limitations on DRC Access," page 4.10.)*
2. Information in professional, performance, building, or other safety standards, or demographic and statistical information, relating to the facility.

[Welfare and Institutions Code Section 4903(c)]

This information must be provided, whether written or in another medium, and whether draft or final. This information may include, but is not limited to, handwritten notes, electronic files, photographs, videotapes, audiotapes or records.

Documents Prepared by State Agencies

DRC must be given access to the following documents:

1. Unredacted facility evaluation or complaint investigation report forms of the California Department of Social Services.
2. Unredacted citation, licensing or survey reports, plans of correction, or statements of deficiency of the California Department of Public Health, prepared by authorized licensing personnel or authorized representatives of those departments who are licensed or registered health personnel.

[Welfare and Institutions Code Sections 4903(h) and 5328.15(a)]

It should be noted that plans of correction are not prepared by authorized licensing personnel or authorized representatives of the state *(see also Welfare and Institutions Code Section 5328.15(c))*.

Psychotherapy Notes

Psychotherapy notes may be disclosed to DRC without a patient authorization to the extent required by law. If information is disclosed to DRC pursuant to an authorization from the patient or the patient's legal representative, a separate authorization form is required for the disclosure of the psychotherapy notes.

LIMITATIONS ON DRC ACCESS

Under state law, DRC has no right to access records protected from discovery as specified in Evidence Code Sections 1157 and 1157.6, or records protected from disclosure by the physician-patient privilege or the psychotherapist-patient privilege [Welfare and Institutions Code Section 4903(d)]. However, federal judicial decisions have created some doubt about this legal issue. Legal counsel should be consulted if such records are requested.

DRC has no right to access records that qualify as "patient safety work product" as defined in the Patient Safety and Quality Improvement Act of 2005.

TIMELINES FOR COMPLIANCE

DRC must be given access to medical records and other records that are relevant to conducting an investigation not later than three business days after DRC makes a written request.

However, if DRC determines there is probable cause to believe that the health or safety of the individual is in serious and immediate jeopardy, or in a case of death of an individual with a disability, DRC must be given immediate

access to the records, not later than 24 hours after DRC makes a request. No consent from another party is required. [Welfare and Institutions Code Section 4903(e)]

PROHIBITIONS ON REDISCLOSURE OF INFORMATION BY DRC

Confidential information kept or obtained by DRC remains confidential and may not be subject to disclosure by DRC. However, DRC may do the following:

1. Share the information with the individual client who is the subject of the record, report or other document, or with his or her legally authorized representative, subject to any limitation on disclosure to recipients of mental health services under federal law [42 U.S.C. Section 10806]. Federal law contains a provision authorizing the mental health professional responsible for the patient to provide to the advocacy agency a written determination that disclosure of the information to the patient would be detrimental to the patient's health. The advocacy agency may obtain a second opinion and rely on it instead. [42 U.S.C. Section 10806]
2. Issue a public report of the results of an investigation that maintains the confidentiality of individual service recipients.
3. Report the results of an investigation to responsible investigative or enforcement agencies if an investigation reveals information about the facility, its staff, or employees warranting possible sanctions or corrective action. This information may be reported to agencies that are responsible for facility licensing or accreditation, employee discipline, employee licensing or certification suspension or revocation, or criminal prosecution.
4. Pursue alternative remedies, including the initiation of legal action.
5. Report suspected elder or dependent adult abuse.

[Welfare and Institutions Code Section 4903(f)]

B. County Patients' Rights Advocates

In general, the law states that each county behavioral health director must appoint, or contract for the services of, a county patients' rights advocate to undertake the duties described below.

For the purposes of the following discussion, the term "advocate" refers to a "county patients' rights advocate."

The provisions regarding the county patients' rights advocate program apply to licensed health and community care facilities and may apply to state hospitals.

DUTIES OF COUNTY PATIENTS' RIGHTS ADVOCATES

The advocates' duties include, but are not limited to, the following:

1. To receive and investigate complaints from or about recipients of mental health services who reside in licensed health or community care facilities involving abuse, unreasonable denial or punitive withholding of the rights guaranteed by Welfare and Institutions Code Section 5000 *et seq.* (including the Lanterman-Petris-Short Act and the Short-Doyle Act).
2. To monitor mental health facilities, services, and programs for compliance with patients' rights laws.
3. To train and educate mental health providers about mental health law and patients' rights.
4. To assure that recipients of mental health services in licensed health and community care facilities are notified of their rights.
5. To exchange information and cooperate with the patients' rights program.

[Welfare and Institutions Code Section 5520]

AUTHORITY OF COUNTY PATIENTS' RIGHTS ADVOCATE

An advocate's rights of access to a patient or records differ depending upon whether the advocate is acting on behalf of a client or pursuant to the advocate's duties to monitor patients' rights compliance or to conduct an investigation *(see "Access to Persons and Facilities," page 4.12, and "Access to Records and Information," page 4.13)*. This portion of the manual describes the advocate's access rights.

AGREEMENT FOR ADVOCACY SERVICES FOR CLIENT

An advocate may enter into an agreement with a client to provide advocacy services, which include "activities undertaken on behalf of persons who are receiving or have received mental health services to protect their rights or to secure or upgrade treatment or other services to which they are entitled" [Welfare and Institutions Code Section 5500(a)].

"Mental health client" or **"client"** is defined as:

> a person who is receiving or has received services from a mental health facility, service, or program and who has

> personally or through a guardian *ad litem*, entered into an agreement with a county patients' rights advocate for the provision of advocacy services.

[Welfare and Institutions Code Section 5500(b)]

Agreement Requirements

Generally, the client must be competent to enter into a binding agreement. The law states that a recipient of mental health services is presumed competent for the purpose of entering into an agreement with an advocate for advocacy services unless the recipient is found by a superior court to be incompetent to enter into an agreement with an advocate and a guardian *ad litem* is appointed for this purpose [Welfare and Institutions Code Section 5523(a)]. This is true even if the patient has had a guardian or conservator appointed.

The mental health client or guardian *ad litem* must knowingly and voluntarily enter into the agreement with the advocate [Welfare and Institutions Code Section 5523(c)].

The agreement must be in a language and modality that the client understands [Welfare and Institutions Code Section 5523(c)].

The agreement may be revoked at any time by the person who entered into the agreement (i.e., the client or the guardian *ad litem*), either in writing or by an oral declaration to the advocate [Welfare and Institutions Code Section 5523(c)].

The law does not expressly require the advocate to inform the mental health facility or professional when an agreement for advocacy services is either reached or revoked. However, it is important for health providers to know whether such an agreement has been entered into or revoked, as it affects the advocate's rights of access to the patient and the patient's records, and in effect authorizes the advocate to interview all persons who care for the patient.

INVESTIGATION BASED UPON PROBABLE CAUSE

An advocate may conduct an investigation if there is probable cause to believe that the rights of a past or present recipient of mental health services have been or may be violated [Welfare and Institutions Code Section 5522].

Investigations that concern violations of a past recipient's rights are limited to cases that involve discrimination, indicate the need for education or training, or have a direct bearing on violations of the rights of a current recipient [Welfare and Institutions Code Section 5523(f)]. Any such investigation of a past patient's rights are in addition to routine monitoring functions of the advocate.

Welfare and Institutions Code Section 5326.1 requires that a county-designated facility file quarterly reports with the director of DHCS showing the number of patients whose rights were denied and the right(s) which were denied. An advocate may access, without patient authorization, the treatment records of patients reported under Section 5326.1 if those records are pertinent to the investigation concerning the denial of rights [Welfare and Institutions Code Section 5328(a)(13)]. This provision does not permit the advocate to see records of other patients. The records may be inspected by the advocate even after the patient's discharge from the facility. [62 Ops.Cal.Atty.Gen.57, 59 (1979)]

ACCESS TO PERSONS AND FACILITIES

An advocate may distribute educational materials and hold discussions in groups and with individual patients in order to notify patients and others of the availability of advocacy services and to give information about patient rights.

When the advocate seeks access in order to investigate or resolve a specific complaint or to monitor compliance with patients' rights laws, the advocate must be permitted access to all recipients of mental health services in any mental health facility, program, or service at all times as necessary.

For other advocacy purposes, the advocate must be permitted access to mental health facilities, programs, services, and recipients of services, but only during usual working hours and visiting hours [Welfare and Institutions Code Section 5530(a)].

Upon request, the mental health facility must provide, when available, reasonable space for the county advocate to interview clients in privacy [Welfare and Institutions Code Section 5530(c)]. It is generally advisable to provide space when an advocate requests privacy to interview patients who are not clients, as well.

LIMITATIONS ON ACCESS TO PATIENTS

Patients Who Have Not Requested Advocacy Services

The law imposes certain requirements on an advocate investigating a case involving a recipient of mental health services who is not a client. In such a case, the advocate must:

1. Notify the treating professional who is responsible for the care of a recipient of services whom the advocate wishes to interview;
2. Notify the facility, service, or program administrator of the intention to conduct the interview; and

3. Consult the treating professional whenever he or she is reasonably available for consultation to determine the appropriate time to conduct the interview.

[Welfare and Institutions Code Section 5523(b)]

Patient's Right to Refuse Access

Each patient has a right to privacy which includes the right to terminate a visit by an advocate, and the right to refuse to see a patient advocate [Welfare and Institutions Code Section 5530(d)].

Persons Rendering Services to the Advocate's Client

An advocate has the right to interview all persons who provide diagnostic or treatment services to the advocate's client [Welfare and Institutions Code Section 5530(b)].

ACCESS TO RECORDS AND INFORMATION

Under LPS, information must be disclosed to county patients' rights advocates when the patient or guardian *ad litem* has knowingly and voluntarily authorized the disclosure [Welfare and Institutions Code Section 5328(a)(13); 45 C.F.R. Section 164.512(a)(1)]. In addition, the records must be disclosed when an advocate is investigating the denial of a patient's right(s). The details of these LPS provisions are described below.

HIPAA also allows these disclosures. Under HIPAA, a covered entity may use or disclose PHI with a valid authorization, or to the extent that the use or disclosure is required by law [45 C.F.R. Section 164.502(g)(2)]. A separate authorization is required for psychotherapy notes if access is pursuant to an authorization; psychotherapy notes may be disclosed to the extent required by law if access is pursuant to a valid investigation of a denial of a patient's right(s).

Confidential Client Information and Records

The advocate must obtain authorization from the client to have access to, copy, or use confidential records and information about the client. The law imposes the following requirements:

1. The client or guardian *ad litem* must specifically authorize the advocate to have access to, copy, or otherwise use confidential records or information about the client.
2. The authorization must be given knowingly and voluntarily and must be in writing.
3. The client or guardian *ad litem* who has entered into the advocate client agreement may revoke the authorization at any time, either in writing or by oral declaration to the advocate [Welfare and Institutions Code Section 5541(a)].
4. Before confidential patient information is released to an advocate, the mental health facility should obtain a copy of the written authorization and place it in the patient's medical record.

If the client provides authorization, an advocate may discuss information contained in the client's records with the client to the extent necessary for effective advocacy. However, information provided in confidence by members of a client's family may be removed from the record before it is given to the advocate. It is recommended that the patient's physician determine whether such information should be removed. [Welfare and Institutions Code Section 5543(a)]

Any written client information obtained by a county patients' rights advocate may be used and disseminated in court or administrative proceedings, and to public agencies or their authorized officials. However, the information may be used or disseminated only to the extent required in the provision of advocacy services and to the extent authorized by the client [Welfare and Institutions Code Section 5544].

Patient Records in Investigation

An advocate may access, without patient authorization, the treatment records of patients reported under Section 5326.1 (a patient whose rights have been denied) if those records are pertinent to the investigation about the denial of rights. This provision does not permit the advocate to see records of other patients. The records may be inspected by the advocate even after the patient's discharge from the facility. [Welfare and Institutions Code Section 5326.1; 62 Ops.Cal.Atty.Gen.57, 59 (1979)]

Records of Mental Health Facilities and Programs

An advocate has the right to inspect and/or copy records or other materials not subject to confidentiality under Welfare and Institutions Code Section 5328, HIPAA, or other provisions of law. This right applies to records possessed by a mental health program, service, or facility; or city, county, or state agency that relate to an investigation on behalf of a client or that indicate compliance or lack of compliance with laws governing patients' rights. These records include, but are not limited to, reports on the use of restraints or seclusion, and autopsy reports [Welfare and Institutions Code Section 5542]. However, these reports must not be patient-identifiable or they are subject to confidentiality laws.

2003 Memo from Protection & Advocacy, Inc.

In August, 2003, a lawyer working for Protection & Advocacy, Inc. distributed a memo to county patients' rights advocates about the advocates' authority to access patient health information. The overall point of the memo was to reassure interested parties in 2003 that the (then) brand-new HIPAA law did not change advocates' authority under state law to access patient records. This conclusion is correct.

However, the memo did not correctly interpret the advocates' authority under state law to access patient records.

The gist of the memo is on the bottom of page 6 of the memo. It correctly states that:

1. County patients' rights advocates may have access to the facility at all times necessary to investigate specific complaints.
2. County patients' rights advocates may interview staff.
3. County patients' rights advocates may access records if:
    a. They have client authorization;
    b. The records aren't confidential (which would not include patient medical records) and they relate to an investigation on behalf of a client, or they indicate compliance/noncompliance with patients' rights laws; or
    c. The record relates to a denial of patients' rights that the facility reported to the local behavioral health director.

County patients' rights advocates are not entitled to review any medical records they want. The California Legislature has evidenced its intent to protect the privacy of patient records — it has shown this by its wording of various statutes:

Welfare and Institutions Code Section 5328(a)(13)) states that, "[Disclosure may be made] To county patients' rights advocates who have been given knowing voluntary authorization by a client or a guardian *ad litem*. The client or guardian *ad litem*, whoever entered into the agreement, may revoke the authorization at any time, either in writing or by oral declaration to an approved advocate." If the California Legislature wanted county patients' rights advocates to have access to all patients' records, it could easily have said so. It did not.

Welfare and Institutions Code Section states that, "Individual patients shall have a right to privacy which shall include the right to terminate any visit by [patients' rights advocates] and the right to refuse to see any patient advocate."

Welfare and Institutions Code Section 5540 states that, "Except as otherwise provided in this chapter or in other provisions of law, information about and records of recipients of mental health services shall be confidential in accordance with the provisions of Section 5328."

Welfare and Institutions Code Section 5541 states that a specific client authorization is required for a county patients' rights advocate to have access to confidential records of the client.

Welfare and Institutions Code Section 5542 states that county patients' rights advocates have the right to inspect any nonconfidential information.

Welfare and Institutions Code Section 5545 states that, "Nothing in this chapter [Chapter 6.2] shall be construed to limit access to recipients of mental health services in any mental health facility, program, or service or to information or records of recipients of mental health services for the purposes of subdivision (b) of Section 5520 or when otherwise authorized by law to county patients' rights advocates or other individuals who are not county patients' rights advocates." This law does not expand any entities' authority to access patient records. It merely states that it does not limit other authority. Note that the main patient privacy protection statute, Welfare and Institutions Code Section 5328, is in chapter 2. That is the primary statute limiting patients' rights advocates' authority to access records of mental health patients who are not their clients and who have not been the subject of a rights denied by the facility.

The portion of the memo that relates to the facility directory is a correct statement of the Confidentiality of Medical Information Act, but that Act does not apply to patients in an acute psychiatric hospital or the psychiatric unit of a general acute care hospital. Instead, the Lanterman-Petris-Short Act applies. No information may be disclosed about these patients.

Costs Charged to the Advocate

Costs of copying or making records available must be borne by the advocate [Welfare and Institutions Code Section 5546]. Charges may include:

1. Actual costs of copying the records or other material; and
2. Additional reasonable clerical costs incurred in locating and making the records and materials available. These costs must be based on a computation of the time

spent locating and making the records available multiplied by the employee's hourly wage.

The law does not address when payment must be made. It is recommended that payment be received before copies are released.

C. Retaliation and Discrimination Prohibited

It is illegal to discriminate or retaliate in any manner against a patient or employee for initiating or participating in an advocacy proceeding. If a facility attempts to expel a patient or engages in any discriminatory treatment of a patient who submits a complaint to a county patients' rights advocate (or upon whose behalf a complaint is submitted) within 120 days of the filing of the complaint, then a rebuttable presumption is raised that the facility took the action in retaliation for the filing of the complaint. [Welfare and Institutions Code Section 5550(c)]

D. Penalties

A person or facility is subject to a civil fine of between $100 and $1,000, as determined by a court for knowingly obstructing an advocate in the performance of his or her duties as authorized by law including, but not limited to, interference with access to:

1. Clients or potential clients;
2. Records of clients or potential clients, whether financial, medical, or otherwise;
3. Other information, materials, or records; or
4. Anything which otherwise violates the statutory provisions regarding the county patients' rights advocates.

[Welfare and Institutions Code Section 5550(b) and (e)]

In addition, a person aggrieved by a violation of the statute may pursue any other available legal remedies [Welfare and Institutions Code Section 5523(e)].

E. Immunity From Liability

A person who files a complaint, provides information to an advocate pursuant to the law or participates in a judicial proceeding resulting therefrom is presumed to be acting in good faith and, unless the presumption is rebutted, is immune from civil, criminal or administrative penalty [Welfare and Institutions Code Section 5550(a)].

VI. PSYCHIATRIC ADVANCE DIRECTIVES

A psychiatric advance directive is an instrument that mental health patients may use to document their preferences regarding future mental health treatment, in preparation for the possibility of losing capacity to give or withhold consent to treatment in the future. The mental health advocacy community advocates the use of such documents, particularly with respect to involuntary treatment, psychiatric medications, restraint and seclusion.

Neither California nor federal law recognizes a special document called a "psychiatric advance directive." The California advance health care directive laws and statutory form were created with end-of-life issues in mind, not mental health matters. However, the law does not prohibit a person who executes an advance health care directive from including instructions regarding mental health treatment. Whether such wishes are required to be followed by a health care provider if the patient loses capacity depends upon several factors, including:

1. Whether the patient would have the legal ability to consent or withhold consent to the recommended treatment if he or she were competent. For example, a patient who is detained pursuant to Welfare and Institutions Code Section 5150 *et seq.* is, by law, unable to withhold consent to be evaluated for a mental disorder and may not leave the facility. Therefore, if such a patient has executed an advance directive denying consent to such care, a hospital need not comply with this instruction.
2. Whether the wishes stated in the advance directive are medically ineffective or contrary to generally accepted health standards. In such a case, the facility need not comply with the patient's instructions. However, a provider that declines to comply must follow certain procedures *(see Probate Code Sections 4735 and 4736)*.

There are no statutes, regulations, or judicial decisions regarding "psychiatric" advance directives in California. However, California law does contain one reference to advance directives in the context of mental health care. Health and Safety Code Section 1180.4(a) requires psychiatric units of general acute care hospitals, acute psychiatric hospitals, skilled nursing facilities, and other specified facilities to conduct an assessment of each patient prior to a placement decision or upon admission, or as soon thereafter as possible. This assessment must include, based on the information available at the time, the patient's advance directive regarding de-escalation or the use of seclusion or behavioral restraints. This statute does not authorize "psychiatric advance directives," nor

does it require a provider to comply with a patient's stated preferences. It merely requires the specified providers to assess a patient's advance directive, if any. *(See chapter 5 regarding restraint and seclusion.)*

A hospital should consult legal counsel if a situation arises regarding a psychiatric advance directive. *(See chapter 3 of CHA's* Consent Manual *for a complete discussion of the law regarding advance directives.)*

VII. SEXUAL ACTIVITY BETWEEN PATIENT AND PROVIDER

A. Sexual Activity Between Involuntarily Confined Patient and Hospital Employee is a Crime

Penal Code Section 289.6 prohibits an employee, officer or agent of a health facility that contracts with a public entity (including the state or federal government) from engaging in sexual activity with an adult who has been involuntarily confined, even if that adult purportedly "consents" to the sexual activity. Health facilities included in this law are:

1. An acute psychiatric hospital as defined in Health and Safety Code Section 1250(b).
2. An intermediate care facility/developmentally disabled habilitative as defined in Health and Safety Code Section 1250(e).
3. An intermediate care facility/developmentally disabled as defined in Health and Safety Code Section 1250(g).
4. An intermediate care facility/developmentally disabled — nursing as defined in Health and Safety Code Section 1250(h).
5. A congregate living health facility — persons who are catastrophically and severely disabled — as defined in Health and Safety Code Section 1250(i)(2)(C).
6. A correctional treatment center as defined in Health and Safety Code Section 1250(j).

"Sexual activity" means sexual intercourse, sodomy, oral copulation, or penetration, however slight, of the genital or anal openings of another person by a foreign object, substance, instrument, or device, for the purpose of sexual arousal, gratification, or abuse.

The first violation of this law constitutes a misdemeanor. A subsequent violation constitutes a felony.

B. Unprofessional Conduct

The commission of any act of sexual relations, abuse, or misconduct with a patient or client constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under the healing arts licensure provisions of the Business and Professions Code. This includes doctors, nurses, pharmacists, dentists, psychologists, physical therapists, dietitians, clinical laboratory technologists, speech-language pathologists, etc. This activity may also be a crime, punishable by a fine or imprisonment or both.

This law does not apply to consensual sexual contact between a licensee and his or her spouse (or other person in an equivalent domestic relationship) when the licensee provides medical treatment other than psychotherapeutic treatment to the spouse or other person. [Business and Professions Code Sections 726 and 729]

C. Patient Alleges Prior Psychotherapist Sexual Activity

If a psychotherapist or employer of a psychotherapist becomes aware through a client that the client has alleged sexual intercourse, sexual behavior or sexual contact with a previous psychotherapist during the course of a prior treatment, the psychotherapist or employer must give the client a brochure about the patient's rights and remedies [Business and Professions Code Section 728]. The California Department of Consumer Affairs has published a booklet, "Professional Therapy Never Includes Sex," for psychotherapists to use to fulfill this requirement. The booklet is available in English and Spanish at www.mbc.ca.gov/publications. To purchase copies in quantity, contact the Office of State Printing at (916) 445-5357.

In addition, the psychotherapist or employer must discuss the brochure with the client.

For purposes of this law, the following definitions apply.

"Psychotherapist" means:

1. A physician specializing in the practice of psychiatry or practicing psychotherapy,
2. A psychologist, psychological assistant, or trainee under the supervision of a psychologist,
3. A marriage and family therapist, associate marriage and family therapist, or marriage and family therapist trainee,
4. A clinical social worker or associate clinical social worker,

5. A licensed professional clinical counselor, associate professional clinical counselor, or clinical counselor trainee (as specified in Business and Professions Code Section 4999.10 *et seq.*).

"Sexual behavior" means inappropriate contact or communication of a sexual nature, but does not include providing appropriate therapeutic interventions relating to sexual issues.

"Sexual contact" means the touching of an intimate part of another person.

Section 728 states that **"intimate part"** and **"touching"** have the same meanings as those terms are defined in subdivisions (g) and (e), respectively, of Section 243.4 of the Penal Code:

1. **"Intimate part"** means the sexual organ, anus, groin, or buttocks of any person, and the breast of a female [Penal Code Section 243.4(g)(1)].
2. Despite what Section 728 says, **"touching"** is not defined in Penal Code Section 243.4. However, **"touches"** is defined to mean physical contact with another person, whether accomplished directly, through the clothing of the person committing the offense, or through the clothing of the victim [Penal Code Section 243.4(e)(2)].

"The course of a prior treatment" means the period of time during which a client first commences treatment for services that a psychotherapist is authorized to provide under his or her scope of practice, or that the psychotherapist represents to the client as being within his or her scope of practice, until the psychotherapist-client relationship is terminated.

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5 Restraints and Seclusion

I. INTRODUCTION

The use of restraint and seclusion in health care facilities is highly regulated by both the state and federal governments. In the year prior to the publication of the Centers for Medicare & Medicaid Services (CMS) interim final rule regarding patient rights in 1999, the public, patient advocacy groups, the media and Congress became increasingly concerned about the need to ensure basic protections for patient health and safety in hospitals with regard to the use of restraint and seclusion. The *Hartford Courant*, a Connecticut newspaper, heightened public awareness of this issue with a series of articles in October 1998 citing the results of a study that identified 142 deaths from seclusion or restraint use in mental health treatment facilities in the previous 10 years. The majority of the deaths were adolescent patients. The *Hartford Courant* articles were reprinted around the country, receiving widespread attention and leading to broad criticism of both private hospital accreditation organizations and government agencies charged with oversight of patient protection and safety.

The goal of the laws regarding restraint and seclusion is to protect patients' rights to be free from the inappropriate use of restraint and seclusion; to protect the patient, hospital staff, and others from violent or self-destructive behavior; and to promote patient safety when the use of either intervention is necessary.

A. Scope of Chapter

This chapter addresses all state and federal laws regarding restraint and seclusion applicable to general acute care hospitals (GACHs) and acute psychiatric hospitals (APHs) with respect to mental health patients.

This chapter does not discuss all laws regarding restraint and seclusion applicable to skilled nursing facilities, intermediate care facilities, psychiatric health facilities or psychiatric residential treatment facilities. In addition, hospitals operated by the state of California or the United States government may be subject to additional requirements not described in this chapter.

B. Restraint and Seclusion Laws

FEDERAL LAW

CMS Conditions of Participation and Interpretive Guidelines

The primary federal law regarding restraint and seclusion is found in the regulation published by CMS as part of the Patients' Rights Condition of Participation (CoP) [42 C.F.R. Section 482.13]. All hospitals (acute care, long-term care, psychiatric, children's, and cancer) must comply with the regulation to participate in the Medicare and Medicaid programs. The requirements of the regulation apply to all patients in a Medicare- or Medicaid-participating hospital, not just Medicare or Medicaid beneficiaries. The requirements apply to inpatients and outpatients in all locations within the hospital (including medical/surgical units, critical care units, emergency department, psychiatric units, etc.). However, critical access hospitals must comply only if they have a distinct-part psychiatric or rehabilitative unit.

CMS contracts with "State Survey Agencies" (SAs) to survey hospitals to assess their compliance with the CoPs. In California, the SA is the California Department of Public Health (CDPH). The SAs conduct these surveys using the *State Operations Manual* published by CMS. The *State Operations Manual* may be found at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html (click on Publication 100-07). The *State Operations Manual* has several appendices that apply to hospitals, for example, A (hospitals), AA (psychiatric hospitals), V (EMTALA), and W (critical access hospitals). Each appendix contains the actual language of a CoP (the regulation) as well as *Interpretive Guidelines* and survey probes that elaborate on regulatory intent and give in-depth detail to surveyors and hospitals about how to determine compliance with the CoPs. The SAs recommend to CMS whether hospitals meet the CoPs. The appendix that contains the *Interpretive Guidelines* for restraint and seclusion, referred to throughout this chapter, is Appendix A (hospitals). Restraint and seclusion guidelines are found in Tags A-0154 through A-0214.

This chapter discusses the requirements of the CMS CoP regulation related to restraint and seclusion, and describes the *Interpretive Guidelines*, including survey probes to describe what surveyors will look for during surveys. The *Interpretive Guidelines* sometimes distinguish between restraints used to manage nonviolent, non-self-destructive behavior and restraints used to manage violent or self-destructive behavior. The reason for this distinction is that the *Interpretive Guidelines* apply to the use of restraints in the medical/surgical and skilled nursing settings — for example, positioning devices, side rails, Geri-chairs, etc. This chapter focuses on restraints used in the mental health setting, which are primarily used to manage violent or self-destructive behavior. However, requirements related to both types of restraint use are described at times when useful to facilitate understanding of the requirements.

Children's Health Act of 2000

A federal statute, the Children's Health Act of 2000 (Pub.L. 106-310), was enacted on Oct. 17, 2000 — after the publication by CMS of its interim final rule regarding restraint and seclusion, but before publication of the final rule.

The Children's Health Act contained several provisions not specific to children's health, including some related to restraint and seclusion [42 U.S.C. Sections 290ii to 290ii-2]. CMS incorporated these statutory requirements into its final rule, which amended the hospital CoPs, regarding restraint and seclusion. Therefore, hospitals in compliance with the CoPs are also in compliance with the Children's Health Act requirements related to restraint and seclusion.

CALIFORNIA LAW

The primary law in California regarding restraint and seclusion is found in Health and Safety Code Sections 1180.1 to 1180.5. This statute applies to patients admitted to acute psychiatric hospitals and to psychiatric units of general acute care hospitals (and other facilities as well). It does not apply to patients in a medical/surgical unit, an ICU, or the emergency department of a general acute care hospital.

Hospital licensing regulations (Title 22) also contain several requirements regarding the use of restraint and seclusion. They are discussed in this chapter.

MUST COMPLY WITH ALL LAWS

California hospitals that participate in Medicare or Medicaid programs must comply with all of the federal requirements and all of the state requirements described in this chapter. There is no federal preemption of state law.

C. Accreditation Organization Standards

California hospitals that are accredited by The Joint Commission (TJC) or other accreditation organizations must comply with the standards established by those organizations. TJC standards regarding restraint and seclusion are substantially similar to the federal law requirements described in this chapter. (The relevant TJC standards are PC.03.05.01 through PC.03.05.19.)

Other accrediting organizations may have adopted different requirements regarding the use of seclusion or restraint. Hospitals accredited by organizations other than TJC should carefully check those requirements in addition to complying with the requirements described in this chapter.

II. PATIENTS' RIGHTS REGARDING RESTRAINT AND SECLUSION

Both state and federal law contain multiple provisions regarding patients' rights. Requirements regarding patient rights in general — that is, rights that apply to all patients, not just mental health patients — are described in chapter 1 of CHA's *Consent Manual*. Requirements regarding the general rights of mental health patients are described in chapter 4 of this manual. This chapter describes only those patients' rights that are specific to restraint and seclusion.

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

Federal law states that all patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may be imposed only to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. The patient also has the right to safe implementation of restraint or seclusion by trained staff. [42 C.F.R. Section 482.13(e) and (f)]

The *Interpretive Guidelines* state that hospital leadership is responsible for creating a culture that supports a patient's right to be free from restraint or seclusion. Leadership must ensure that systems and processes are developed, implemented, and evaluated that support patients' rights and that eliminate the inappropriate use of restraint or seclusion. Through its Quality Assurance/Performance Improvement (QAPI) program, hospital leadership should:

1. Assess and monitor the use of restraint or seclusion in the facility;

2. Implement actions to ensure that restraint or seclusion is used only to ensure the physical safety of the patient, staff and others; and
3. Ensure that the hospital complies with the requirements set forth in the federal regulation as well as those set forth by state law and hospital policy when the use of restraint or seclusion is necessary.

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Review a sample of medical records of patients for whom restraints were used to manage nonviolent, non-self-destructive behavior, as well as a sample of medical records of patients for whom restraint or seclusion was used to manage violent or self-destructive behavior.
2. Include in the review patients who are currently in restraint or seclusion, as well as those who have been in restraint or seclusion during their hospital stay (include both violent or self-destructive patients, as well as nonviolent, non-self-destructive patients).
3. What evidence is there that hospital staff identified the reason for the restraint or seclusion, and determined that other less restrictive measures would not be effective before applying the restraint?
4. Interview staff who work directly with patients to determine their understanding of the restraint and seclusion policies. If any patients are currently in restraint or seclusion, ascertain the rationale for use and when the patient was last monitored and assessed.
5. Is the actual use of restraints or seclusion consistent with hospital restraint and seclusion policies and procedures, as well as CMS requirements?
6. Review incident and accident reports to determine whether patient injuries occurred proximal to or during a restraint or seclusion intervention. Are incidents and accidents occurring more frequently with restrained or secluded patients?
7. If record review indicates that restrained or secluded patients sustained injuries, determine what the hospital did to prevent additional injury. Determine if the hospital investigated possible changes to its restraint or seclusion policies.
8. Obtain data on the use of restraint and seclusion for a specified time period (e.g., three months) to determine any patterns in their use for specific units, shifts, days of the week, etc.
9. Does the number of patients who are restrained or secluded increase on weekends, on holidays, at night, on certain shifts; where contract nurses are used; in one unit more than other units? Such patterns of restraint or seclusion use may suggest that the intervention is not based on the patient's need, but on issues such as convenience, inadequate staffing or lack of staff training. Obtain nursing staffing schedules during time periods in question to determine if staffing levels impact the use of restraint or seclusion.
10. Interview a random sample of patients who were restrained to manage nonviolent, non-self-destructive behavior. Were the reasons for the use of a restraint to manage nonviolent, non-self-destructive behavior explained to the patient in understandable terms? Could the patient articulate his/her understanding?

NOTE: The instructions to surveyors regarding restraints to manage nonviolent, non-self-destructive behavior may be more applicable in a medical/surgical or skilled nursing setting than a mental health setting.

B. California Law

California law is virtually identical to federal law with respect to the rights of patients who are restrained or secluded. California law states that:

> A patient has the right to be free from the use of seclusion and behavioral restraints of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff. This right includes, but is not limited to, 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.

[Health and Safety Code Section 1180.4(k); Title 9, California Code of Regulations, Section 865.4] (Although the last sentence in the state law is not included in the patients' rights portion of the federal law, it is included elsewhere in the federal law.) *(See "Drug Used as a Restraint," page 5.6.)*

III. GENERAL INFORMATION REGARDING RESTRAINT AND SECLUSION

A. Quick Summary of Restraint and Seclusion Laws

If a hospital uses restraint or seclusion, the use must be:

1. In accordance with the order of a licensed health care practitioner acting within the scope of his or her professional licensure;
2. In accordance with a written modification to the patient's plan of care;
3. Used in the least restrictive manner possible;
4. Used in accordance with safe and appropriate restraining techniques;
5. Selected only when other less restrictive measures have been found ineffective to protect the patient or others from harm; and
6. Ended at the earliest possible time.

The patient's attending physician must be consulted as soon as possible, if the attending physician did not order the restraint *(see IX. "Notification of Attending Physician," page 5.16)*. In addition, the condition of the restrained or secluded patient must be continually assessed, monitored, and reevaluated. All staff involved in the care of restrained or secluded patients must have ongoing education and training in the proper and safe use of restraint and seclusion. A debriefing must follow each episode of restraint or seclusion.

Details of these requirements are discussed in this chapter.

B. Techniques

The use of restraint or seclusion must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with state law [42 C.F.R. Section 482.13(e)(4)(ii)]. State law does not contain specific requirements regarding restraint technique, except to describe certain prohibited techniques *(see XV. "Prohibited Techniques," page 5.21)*.

Title 22 regulations applicable to acute psychiatric hospitals require that restraints be easily removable in the event of fire or other emergency [Title 22, California Code of Regulations, Section 71545(d)]. In addition, if seclusion rooms are provided, they must be designed and equipped to ensure the safety of the patient [Title 22, California Code of Regulations, Section 71625].

The *Interpretive Guidelines* state that the use of restraint or seclusion must never act as a barrier to the provision of other interventions to meet the patients' needs.

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Review the hospital's policies and procedures to determine if they reflect current standards of practice regarding safe and appropriate restraint and seclusion techniques. Are there any references to state law statutes or any indication that state laws were reviewed and incorporated?
2. Review a sample of patient medical records that include patients who required the use of restraint or seclusion for the management of both violent, self-destructive behaviors, and nonviolent, non-self-destructive behaviors.
3. After restraints were applied, was an assessment immediately made to ensure that restraints were properly and safely applied?
4. Were the hospital policies and procedures followed?
5. Was the use of restraint or seclusion effective in achieving the purpose for which it was ordered? If not, were timely changes made?
6. Was there any evidence of injury to the patient?

C. Restraints are Medical Devices Regulated by the FDA

The Food and Drug Administration (FDA) regulates restraint devices as it regulates other medical devices. Any restraint used by a hospital should be FDA-approved, and used according to the manufacturer's instructions.

Under the Safe Medical Devices Act of 1990, hospitals and other device user facilities must report incidents involving medical devices (including restraints) that have or may have caused or contributed to the serious injury or death of a patient. Details of this reporting requirement are found in XVII. "Reporting Requirements Related to Restraint or Seclusion," page 5.24.

IV. DEFINITIONS

Both federal and state law contain definitions of various terms related to restraint and seclusion. The definition of "seclusion" is identical under both; however, other terms are defined differently. As a practical matter, the difference in definitions is not significant in the mental health setting.

The definitions and requirements in federal law apply to medical/surgical patients as well as mental health patients. Although this manual focuses on mental health law, some discussion of the definitions as applied to medical/surgical patients is included as helpful to understanding their meaning as applied to mental health patients.

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

RESTRAINT

Federal law defines a **"restraint"** as:

1. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely; or
2. A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

[42 C.F.R. Section 482.13(e)(1)]

General Rule

The CMS definition is a functional definition. That is, if a patient is functionally restrained, regardless of the method used, then the restraint requirements apply. Similarly, if a patient can easily remove a device, the device would not be considered a restraint. **"Easily remove"** means that the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff, considering the patient's physical condition and ability to accomplish the objective, such as transfer to a chair, get to the bathroom in time, etc. (e.g., side rails can be put down, not climbed over; buckles can be intentionally unbuckled; ties or knots can be intentionally untied; etc.). It is important to document that the patient can unsnap the belt in the wheelchair, or that the patient can lower the side rails when she wants to, etc. so that it is clear that such devices do not constitute restraints.

Examples

The use of an FDA-approved protective restraint would constitute the restraint of a patient as defined in the federal regulation. Other devices and practices that could meet the CMS definition of a restraint include:

1. Tucking a patient's sheets in so tightly that the patient cannot move.
2. Use of a "net bed" or an "enclosed bed" that prevents the patient from freely exiting the bed. However, placement of a toddler in an "enclosed" or "domed" crib is not a restraint.
3. Use of "Freedom" splints that immobilize a patient's limb.
4. Using side rails that prevent a patient from voluntarily getting out of bed.
5. Geri-chairs or recliners, but only if the patient cannot easily remove the restraint appliance and get out of the chair on his or her own.

These types of "restraints" are more commonly used in medical/surgical and skilled nursing settings rather than mental health settings; they are included in this manual as illustrative.

Positioning Devices

A medically-necessary positioning or securing device used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures is not considered a restraint. Thus, an IV arm board or a hand mitt would generally not be considered a restraint. However, if the board or mitt is attached to the bed, this would meet the definition of a restraint. In addition, if the mitts are applied so tightly that the hand or fingers are immobilized — or if the mitts are so bulky that the patient's ability to use his or her hands is significantly reduced — this would be considered a restraint.

Physical Escort

A physical escort may include a light grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp, this is not a restraint. However, if the patient cannot easily remove or escape the grasp, this is a restraint.

Physical Holding

The *Interpretive Guidelines* permit the physical holding of a patient to conduct routine physical exams or tests. However, patients have the right to refuse physical exams or tests. Holding a patient in a manner that restricts the patient's movement against the patient's will is considered a restraint. This includes "therapeutic holds." CMS states that physically holding a patient can be just as restrictive, and just as dangerous, as restraining methods that involve devices.

The application of force to physically hold a patient, in order to administer a medication against the patient's wishes,

is considered restraint. The patient has a right to be free of restraint and, in accordance with the patients' rights CoP (42 C.F.R. Section 482.13(b)(2)), also has a right to refuse medications, unless a court has ordered medication treatment. Additionally, some patients may be medicated against their will in certain emergency circumstances. However, in both of these circumstances, health care staff is expected to use the least restrictive method of administering the medication to avoid or reduce the use of force, when possible. The use of force in order to medicate a patient, as with other restraint, must have a physician's order prior to the application of the restraint (use of force). If physical holding for forced medication is necessary with a violent patient, the one-hour face-to-face evaluation requirement would also apply.

In certain circumstances, a patient may consent to an injection or procedure, but may not be able to hold still for an injection, or cooperate with a procedure. In such circumstances, and at the patient's request, staff may "hold" the patient in order to safely administer an injection (or obtain a blood sample, or insert an intravenous line, if applicable) or to conduct a procedure. This is not considered restraint.

A staff member picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient is not considered restraint.

Side Rails

A restraint does not include methods that protect the patient from falling out of bed. However, side rails are sometimes used instead to restrict the patient's freedom to exit the bed (this is usually not an issue in the mental health setting). Such use of side rails would be considered a restraint.

Disoriented patients may view a raised side rail as a barrier to climb over, may slide between raised, segmented side rails, or may scoot to the end of the bed to get around a raised side rail and exit the bed. When attempting to leave the bed by any of these routes, the patient is at risk for entrapment, entanglement, or falling from a greater height posed by the raised side rail, with a possibility for sustaining greater injury or death than if the patient had fallen from the height of a lowered bed without raised side rails. In short, the patient may have an increased risk for a fall or other injury by attempting to exit the bed with the side rails raised. The risk presented by side rail use should be weighed against the risk presented by the patient's behavior as ascertained through individualized assessment.

When the clinician raises all four side rails in order to restrain a patient (that is, to immobilize or reduce the ability of a patient to move his or her arms, legs, body, or head freely) to ensure the immediate physical safety of the patient, then the requirements of the restraint regulation apply. Raising fewer than four side rails when the bed has segmented side rails would not necessarily immobilize or reduce the ability of a patient to move freely as defined in the regulation. For example, if the side rails are segmented and all but one segment are raised to allow the patient to freely exit the bed, the side rail is not acting as a restraint. Conversely, if a patient is not physically able to get out of bed regardless of whether the side rails are raised or not, raising all four side rails for this patient would not be considered restraint because the side rails have no impact on the patient's freedom of movement. In this example, the use of all four side rails would not be considered restraint.

The use of side rails on stretchers is not considered a restraint. Neither is the use of a seat belt when transporting a patient in a wheelchair.

Drug Used as a Restraint

Drugs or medications that are used as part of a patient's standard medical or psychiatric treatment, and are administered within the standard dosage for the patient's condition, are not considered restraints [42 C.F.R. Section 482.13(e)(1)(i)(B)].

The *Interpretive Guidelines* state that the restraint and seclusion regulations are not intended to interfere with the clinical treatment of patients who are suffering from serious mental illness and who need therapeutic doses of medication to improve their level of functioning so that they can more actively participate in their treatment. Similarly, the regulations are not intended to interfere with appropriate doses of sleeping medication prescribed for patients with insomnia, anti-anxiety medication prescribed to calm a patient who is anxious, or analgesics prescribed for pain management. The regulatory language is intended to provide flexibility and recognize the variations in patient conditions.

Whether or not an order for a medication is PRN or a standing order does not determine whether or not the use of that drug is considered a restraint. The use of PRN or standing order medications is prohibited only if the medication is a drug used as a restraint. Similarly, whether or not the use of a medication is voluntary, or even whether the drug is administered as a one-time dose or PRN are not factors in determining if a drug is being used as a standard treatment. [71 Fed. Reg. 71378, 71391 (Dec. 8, 2006)]

If a drug is used as a restraint, all restraint requirements must be followed, including the time-limited orders and the assessment, documentation, and monitoring requirements.

Criteria used to determine whether the use of a drug or combination of drugs is a standard treatment or dosage for the patient's condition includes all of the following:

1. The drug is used within the pharmaceutical parameters approved by the FDA and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage parameters;
2. The use of the drug follows national practice standards established or recognized by the medical community, or professional medical associations or organizations; and
3. The use of the drug to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's knowledge of that patient's expected and actual response to the medication.

Another component of "standard treatment or dosage" for a drug is the expectation that the standard use of a drug to treat the patient's condition enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of the medication. If the overall effect of a drug or combination of drugs is to reduce the patient's ability to effectively or appropriately interact with the world around the patient, then the drug is not being used as a standard treatment or dosage for the patient's condition.

As with any use of restraint or seclusion, staff must conduct a comprehensive patient assessment to determine the need for other types of interventions before using a drug as a restraint. For example, a patient may be agitated due to pain, an adverse reaction to an existing drug or medication, or other unmet care need or concern.

There are situations where the use of a drug is clearly outside the standard for a patient or a situation, or a medication is not medically necessary but is used for patient discipline or staff convenience (neither of which is allowed by law).

CMS has provided the following two examples.

Example 1. A patient has Sundowner's Syndrome, a syndrome in which a patient's dementia becomes more apparent at the end of the day rather than at the beginning of the day. The patient may become agitated, angry, or anxious at sundown. This may lead to wandering, pacing the floors, or other nervous behaviors. The staff finds the patient's behavior bothersome, and asks the physician to order a high dose of a sedative to "knock out" the patient and keep him in bed. The patient has no medical symptoms or condition that indicates the need for a sedative. In this case, for this patient, the sedative is being used inappropriately as a restraint for staff convenience. Such use is not permitted.

Example 2. A patient is in a detoxification program. The patient becomes violent and aggressive. Staff administers a PRN medication ordered by the patient's physician to address these types of outbursts. The use of the medication enables the patient to better interact with others or function more effectively. In this case, the medication used for this patient is not considered a "drug used as a restraint." The availability of a PRN medication to manage outbursts of specific behaviors, such as aggressive, violent behavior is standard for this patient's medical condition (i.e., drug or alcohol withdrawal). Therefore, this patient's medication does not meet the definition of "drug used as a restraint" since it is a standard treatment or dosage for the patient's medical or psychiatric condition.

If a drug or medication is used as a standard treatment (as previously defined) to address the assessed symptoms and needs of a patient with a particular medical or psychiatric condition, its use is not subject to the requirements of the federal regulation. However, the patient would still need to receive any assessments, monitoring, interventions, and care that are appropriate for that patient's needs.

SECLUSION

"Seclusion" is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

Seclusion is not just confining a patient to an area, but involuntarily confining the patient alone in a room or area where the patient is physically prevented from leaving. If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room, the room is considered locked, whether the door is actually locked or not. In this situation, the patient is being secluded.

A patient physically restrained alone in an unlocked room does not constitute seclusion. Confinement on a locked unit or ward where the patient is with others does not constitute seclusion.

Timeout is not considered seclusion. The *Interpretive Guidelines* state that a **"timeout"** is an intervention in which the patient consents to being alone in a designated area

for an agreed upon time frame from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses.

The Children's Health Act defines **"time out"** to mean a "behavior management technique that is part of an approved treatment program and may involve the separation of the resident from the group, in a nonlocked setting, for the purpose of calming" [42 U.S.C. Section 290ii].

Quarantining a patient for public health reasons, as governed by state law, is not considered "seclusion" under federal law [71 Fed. Reg. 71378, 71404 (Dec. 8, 2006)].

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Determine whether the hospital's policies and procedures employ a definition or description of what constitutes "restraint" and "seclusion" that is consistent with the federal regulation.
2. Determine whether the hospital's policies and procedures employ a definition or description of what constitutes the use of a drug as a restraint that is consistent with the federal regulation.
3. While touring hospital units look for restraints in use. Where a restraint is in use, check the medical record for appropriate documentation.
4. While touring hospital units look for bed side rail use to determine whether it is consistent with the definition of a restraint. Where bed side rails are being used as a restraint, check the medical record for appropriate documentation. (This direction to surveyors is more applicable to the medical/surgical or skilled nursing setting rather than the mental health setting.)
5. Interview hospital staff to determine whether they know the definition of a "restraint" (particularly with respect to use of bed side rails) and "seclusion."
6. Interview hospital staff to determine whether they can identify when the use of a drug or medication is considered a chemical restraint.

B. California Law

For purposes of this chapter, the following definitions apply.

"Behavioral restraint" means "mechanical restraint" or "physical restraint" used as an intervention when a patient presents an immediate danger to self or others. It does not include restraints used for medical purposes, including, but not limited to, securing an intravenous needle or immobilizing a person for a surgical procedure, or postural restraints, or devices used to prevent injury or to improve a patient's mobility and independent functioning rather than to restrict movement.

"Containment" means a brief physical restraint of a patient for the purpose of effectively gaining quick control of a patient who is aggressive or agitated or who is a danger to self or others.

"Mechanical restraint" means the use of a mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove and that restricts the freedom of movement of all or part of a person's body or restricts normal access to the person's body, and that is used as a behavioral restraint.

"Physical restraint" means the use of a manual hold to restrict freedom of movement of all or part of a patient's body, or to restrict normal access to the patient's body, and that is used as a behavioral restraint. "Physical restraint" is staff-to-patient physical contact in which the patient unwillingly participates. "Physical restraint" does not include briefly holding a patient without undue force in order to calm or comfort, or physical contact intended to gently assist a patient in performing tasks or to guide or assist a patient from one area to another.

"Seclusion" means the involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving. "Seclusion" does not include a "timeout," as defined in regulations relating to facilities operated by the State Department of Developmental Services.

"Time out" is defined as the "removal of a client from specified activities for a specific period of time."

[Health and Safety Code Section 1180.1; Title 9, California Code of Regulations, Section 865.4; Title 22, California Code of Regulations, Section 76331]

V. INTAKE ASSESSMENT/CARE PLAN

State and federal laws require that a patient receive an overall physical and psychiatric exam around the time of admission and that a plan of care be developed [42 C.F.R. Sections 482.24(c)(2) and 482.61; Title 22, California Code of Regulations, Sections 70717(d), 71517(c) and 71549]. This portion of the manual describes only the requirements related to restraint and seclusion — it is not intended to describe everything a hospital must consider and document in its evaluation, assessment, and overall care planning for a mental health patient.

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

CMS requires that the use of restraint or seclusion be in accordance with a written modification to the patient's plan of care [42 C.F.R. Section 482.13(e)(4)(i)].

CMS notes that it refers to the "modified" plan of care to reinforce its expectation that restraint or seclusion should not be a standard response to a particular behavior or situation [64 Fed. Reg. 36070, 36083 (July 2, 1999)]. CMS also states that the regulation does not require that a modification to the patient's plan of care be made before initiating or obtaining an order for the use of restraint or seclusion. The plan of care should be reviewed and updated in writing to reflect the use of restraint or seclusion within a time frame specified by hospital policy. The use of restraint or seclusion should be reflected in the patient's plan of care based on an assessment and evaluation of the patient.

The Patients' Rights CoP promotes the patient's right to be involved in and make decisions about his or her health care. This includes being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This standard applies to all health care, and is not specific to mental health care or to the use of restraint or seclusion. The patient should be informed of changes to the plan of care, including the use of restraint or seclusion.

Although in general a competent patient may refuse recommended treatment, in the preamble to the final Patients' Rights rule, CMS stated that:

> If the patient's violent or self-destructive behavior jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient does not have the right to refuse the use of restraint or seclusion. In this situation, the use of restraint or seclusion is an emergency measure to protect the safety of the patient, staff, or others. [71 Fed. Reg. 71378, 71392 (Dec. 8, 2006)]

SURVEY PROCEDURES

CMS emphasizes the individualized assessment and evaluation of the patient in its survey probes. The *Interpretive Guidelines* direct surveyors to consider the following:

1. Determine whether the hospital's procedures are consistent with the requirements of the regulation. Does the plan of care reflect a process of assessment, intervention, and evaluation when restraint or seclusion is used?
2. Is there evidence of assessment of the identified problem or of an individual patient assessment? Does the patient's plan of care reflect that assessment?
3. What was the goal of the intervention?
4. What was the described intervention?
5. Who is responsible for implementation?
6. Was the patient informed of the changes in his or her plan of care?
7. Did the physician or other licensed independent practitioner (LIP) write orders that included a time limit? Were these orders incorporated into the plan of care? *(See VII. "Order for Restraint or Seclusion," page 5.12.)*
8. After the discontinuation of the restraint or seclusion, was this information documented in an update of the plan of care?

B. California Law

California law requires that each facility conduct an initial assessment of each patient prior to a placement decision or upon admission, or as soon thereafter as possible.

The assessment must include input from the patient and someone the patient desires to be present, such as a family member or other person designated by the patient, if the desired family member or other person can be present at the time of admission.

The initial assessment must include all of the following, to the extent the information is available at the time of the initial assessment:

1. Identification of early warning signs, triggers, and precipitants that cause the patient to escalate.
2. Identification of the earliest precipitant of aggression for patients with a known or suspected history of aggressiveness, or patients who are currently aggressive.
3. Techniques, methods, or tools that would help the patient control his or her behavior.
4. Preexisting medical conditions or any physical disabilities or limitations that would place the patient at greater risk during restraint or seclusion.
5. Any trauma history, including any history of sexual or physical abuse that the patient feels is relevant.

6. The patient's advance directive regarding de-escalation or the use of seclusion or behavioral restraints. *(See discussion below regarding psychiatric advance directives.)*

For general acute care hospitals, this California requirement applies only to patients admitted to the psychiatric unit, if the hospital has one. It does not apply to mental health patients in the emergency department, an intensive care unit, or other locations within the hospital [Health and Safety Code Sections 1180.3 and 1180.4].

PSYCHIATRIC ADVANCE DIRECTIVES

A psychiatric advance directive is an instrument that mental health patients may use to document their preferences regarding future mental health treatment, in preparation for the possibility of losing capacity to give or withhold consent to treatment in the future. The mental health advocacy community advocates the use of such documents, particularly with respect to involuntary treatment, psychiatric medications, restraint and seclusion.

Neither California nor federal law recognizes a special document called a "psychiatric advance directive." The California advance health care directive laws and statutory form were created with end-of-life issues in mind, not mental health matters. However, the law does not prohibit a person who executes an advance health care directive from including instructions regarding mental health treatment. Whether such wishes are required to be followed by a health care provider if the patient loses capacity depends upon several factors, including:

1. Whether the patient would have the legal ability to consent or withhold consent to the recommended treatment if he or she were competent. For example, a patient who is detained pursuant to Welfare and Institutions Code Section 5150 *et seq.* is, by law, unable to withhold consent to be evaluated for a mental disorder and may not leave the facility. Therefore, if such a patient has executed an advance directive denying consent to such care, a hospital need not comply with this instruction.
2. Whether the wishes stated in the advance directive are medically ineffective or contrary to generally accepted health standards. In such a case, the facility need not comply with the patient's instructions.

There are no statutes, regulations, or judicial decisions regarding "psychiatric" advance directives in California, except for the reference in the intake assessment requirement. It should be noted that this statute does not authorize "psychiatric advance directives," nor does it require a provider to comply with a patient's stated preferences. It merely requires the provider to assess a patient's advance directive, if any.

A hospital should consult legal counsel if a situation arises regarding a psychiatric advance directive. *(See chapter 3 of CHA's* Consent Manual *for a complete discussion of the law regarding advance directives.)*

VI. LEAST RESTRICTIVE ALTERNATIVE

Both state and federal law require that the restraint or seclusion be used only when less restrictive interventions are ineffective to protect the patient, staff or others from harm.

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

Restraint or seclusion may be used only when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm [42 C.F.R. Section 482.13(e)(3)]. In addition, the type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm. This determination may be made by nursing staff or other trained clinical staff [71 Fed. Reg. 71378, 71393 (Dec. 8, 2006)].

CMS states that less restrictive interventions do not always need to be attempted, but less restrictive interventions must be considered and determined by staff to be ineffective to protect the patient or others from harm prior to the introduction of more restrictive measures. Alternatives attempted, or the rationale for not using alternatives, must be documented.

CMS states that the underpinning of this regulation is the concept that safe patient care hinges on looking at the patient as an individual and assessing his or her condition, needs, strengths, weaknesses, and preferences. Such an approach relies on caregivers who are skilled in individualized assessment and in tailoring interventions to the patient's needs after weighing factors such as the patient's condition, behaviors, history, and environmental factors.

Prior to the use of restraint or seclusion, a comprehensive assessment of the patient must determine that the risks associated with the use of restraint or seclusion are outweighed by the risk of not using the restraint or seclusion. CMS recommends a document entitled,

"Learning from Each Other – Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health," sponsored by the American Psychiatric Association, American Psychiatric Nurses Association, the National Association of Psychiatric Health Systems, and the American Hospital Association. This document may be found at www.nabh.org/nabh-resources. This website also includes useful forms, assessment tools, and checklists.

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Do the physician's or other LIP's orders specify the reason for restraint or seclusion, the type of restraint, and the duration of restraint or seclusion? *(See VII. "Order for Restraint or Seclusion," page 5.12.)*
2. Does the severity of the behavior justify seclusion or restraint usage by identifying an immediate and serious danger to the physical safety of the patient or others?
3. Is there evidence that the hospital considers factors other than the individual patient in determining causes for the need for restraints or seclusion (i.e., environmental factors)?
4. Does the medical record include documentation of an individual patient assessment and a revision of the plan of care?
5. Does the medical record reflect changes in behavior and staff concerns regarding safety risks to the patient, staff, or others prompting use of seclusion or restraints?
6. Did the patient's behavior place the patient or others at risk for harm? Was the patient's behavior violent or self-destructive?
7. Were other, less restrictive interventions tried and documented, or is there evidence that alternatives were considered and determined to be insufficient?
8. Is there clear documentation in the patient's medical record describing the steps or interventions used prior to the use of the needed restraint or seclusion? That is, what documentation is in the medical record to explain the rationale for the use of restraint or seclusion?
9. Is the restraint or seclusion intervention the least restrictive intervention that meets the patient's clinical needs and protects the safety of the patient, staff, or others?
10. Did the staff determine that less restrictive alternatives would not meet the patient's clinical needs, or protect the patient's safety or the safety of others?
11. Do ongoing documented assessments demonstrate that the restraint or seclusion intervention is needed at this time (or at a time in the past) and that the restraint or seclusion intervention remains the least restrictive way to protect the patient's safety?
12. If the time of restraint or seclusion use is lengthy, look for evidence that the symptoms necessitating the use of restraint or seclusion have persisted. Is there evidence to indicate that the staff have evaluated whether or not the restraint or seclusion can be safely discontinued?

B. California Law

California law contains several provisions regarding seclusion and restraint that require the least restrictive alternative form of treatment be provided to mental health patients.

Title 9, California Code of Regulations, Section 865.4 states that "seclusion and/or restraints shall never be used as punishment or as a substitute for a less restrictive alternative form of treatment."

Similarly, the Health and Safety Code states that a health facility must afford patients who are restrained the least restrictive alternative and the maximum freedom of movement, while ensuring the physical safety of the patient and others. The facility must use the least number of restraint points. [Health and Safety Code Section 1180.4(j)] This requirement applies to all facilities. However, for general acute care hospitals, this requirement applies only to patients admitted to the psychiatric unit, if the hospital has one. It does not apply to mental health patients in the emergency department, an intensive care unit, or other locations within the hospital [Health and Safety Code Sections 1180.3 and 1180.4].

Title 22 regulations applicable to the psychiatric unit of general acute care hospitals and to acute psychiatric hospitals state that "restraint shall be used only when alternative methods are not sufficient to protect the patient or others from injury" [Title 22, California Code of Regulations, Sections 70577(j)(1) and 71545(a)].

VII. ORDER FOR RESTRAINT OR SECLUSION

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

Federal law states that the use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner (LIP) who is responsible for the care of the patient as specified under 42 C.F.R. Section 482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with state law.

Section 482.12(c) states:

> (c) Standard: Care of patients. In accordance with hospital policy, the governing body must ensure that the following requirements are met:
>
> (1) Every Medicare patient is under the care of:
>
> (a) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under state law or a state's regulatory mechanism.);
>
> (b) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the state and who is acting within the scope of his or her license;
>
> (c) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the state to perform;
>
> (d) A doctor of optometry who is legally authorized to practice optometry by the state in which he or she practices;
>
> (e) A chiropractor who is licensed by the state or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist; and
>
> (f) A clinical psychologist as defined in 42 C.F.R. Section 410.71, but only with respect to clinical psychologist services as defined in 42 C.F.R. Section 410.71 and only to the extent permitted by state law.
>
> (2) Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the state to admit patients to a hospital. If a Medicare patient is admitted by a practitioner not specified in paragraph (c)(1) above, that patient is under the care of a doctor of medicine or osteopathy.
>
> (3) A doctor of medicine or osteopathy is on duty or on call at all times.
>
> (4) A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that —
>
> (a) is present on admission or develops during hospitalization; and
>
> (b) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is —
>
> (i) Defined by the medical staff;
>
> (ii) Permitted by state law; and
>
> (iii) Limited, under paragraph (c)(1)(e) above, with respect to chiropractors.

PRN ORDERS

Orders for the use of restraint or seclusion must never be written as a standing order or on an as-needed "PRN" basis.

WHO MAY ORDER RESTRAINT OR SECLUSION

Hospitals must have policies and procedures for the initiation of restraint or seclusion that identify the categories of LIPs that are permitted to order restraint or seclusion in that hospital, consistent with state law. (California law is described in B. "California Law," page 5.3.)

CMS states that, for the purposes of the use of restraint or seclusion, the attending practitioner must be able to conduct both a physical and psychological assessment of the patient in accordance with state law, their scope of practice, and hospital policy [71 Fed. Reg. 71378, 71398 (Dec. 8, 2006)].

A resident physician who is authorized by state law and the hospital's residency program to practice as a physician can carry out functions reserved for a physician or LIP by the CMS regulation. A medical student is not an LIP.

Patient or Family Request

A request from a patient or family member for the application of a restraint is not a sufficient basis for the use of a restraint intervention. A patient or family member request for a restraint intervention should prompt an assessment to determine whether such a restraint intervention is needed.

WHEN ORDER MUST BE OBTAINED

If possible, the physician or other LIP responsible for the care of the patient should order the restraint or seclusion prior to its application. In some situations, however, the

need for restraint or seclusion may occur so quickly that an order cannot be obtained prior to the application of restraint or seclusion. In these emergency situations, the *Interpretive Guidelines* state that the order must be obtained either during the emergency application of the restraint or seclusion, or immediately (within a few minutes) after the restraint or seclusion has been applied. The failure to immediately obtain an order is viewed by CMS as the application of restraint or seclusion without an order. The hospital should address this process in its restraint and seclusion policies and procedures. The policies and procedures should specify who can initiate the emergency application of restraint or seclusion prior to obtaining an order from a physician or other LIP.

PROTOCOL, STANDING ORDERS, AND PRN ORDERS

Protocol

A protocol cannot serve as a substitute for obtaining a physician's or other LIP's order prior to restraint or seclusion. If a hospital uses protocols that include the use of restraint or seclusion, a specific physician or LIP order is still required for each episode of restraint or seclusion. CMS states that the philosophy that serves as a foundation for its regulation is that restraint or seclusion use is an exceptional event, not a routine response to a certain patient condition or behavior. Each patient must be assessed, and interventions should be tailored to meet the individual patient's needs. The creation of a protocol can run counter to this philosophy if it sets up the expectation that restraint or seclusion will be used as a routine part of care. The use of restraint or seclusion is a last resort when less restrictive measures have been determined ineffective to ensure the safety of the patient, staff or others; it should not be a standard response to a behavior or patient need.

However, protocols are not banned by the regulation. A protocol may contain information that is helpful for staff, such as how a restraint is to be applied and monitored. Typically, a hospital will develop an emergency protocol approved by the medical staff to be used in emergency situations in a manner consistent with the regulations. As mentioned above, however, a protocol cannot serve as a substitute for obtaining a physician or LIP order before initiating each episode of restraint or seclusion. [64 Fed. Reg. 36070, 36083 (July 2, 1999); 71 Fed. Reg. 71378, 71395 (Dec. 8, 2006)]

When implementing a protocol that includes restraint or seclusion, the patient's medical record must include documentation of an individualized patient assessment indicating that the patient's symptoms and diagnosis meet the use-triggering criteria listed in the protocol. Hospitals that utilize protocols involving restraint or seclusion are expected to provide evidence that the medical staff has been involved in the development, review, and quality monitoring of their use. [71 Fed. Reg. 71378, 71396 (Dec. 8, 2006)]

Standing or PRN Orders

Standing orders or PRN orders are not permitted. Each episode of restraint or seclusion must be initiated in accordance with the order of a physician or other LIP. If a patient was recently released from restraint or seclusion, and exhibits behavior that can be handled only through the reapplication of restraint or seclusion, a new order is required. Staff cannot discontinue a restraint or seclusion, and then re-start it under the same order. This would constitute a PRN order. A "trial release" constitutes a PRN use, and therefore is not permitted.

A temporary, directly-supervised release that occurs for the purpose of caring for a patient's needs (such as toileting, feeding, or range-of-motion exercises) is not considered a discontinuation of the restraint or seclusion. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and serving the same purpose as the restraint or seclusion.

The use of PRN orders for drugs is prohibited only when a drug is being used as a restraint.

Exceptions

1. **Geri-chair.** If a patient requires a Geri-chair with the tray locked to be safely out of bed, a standing or PRN order is permitted.
2. **Raised side rails.** If a patient requires that all bedrails be raised (restraint) while in bed, a standing or PRN order is permitted.
3. **Repetitive self-mutilating behavior.** If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyham Syndrome, and the patient engages in repetitive self-mutilating behavior, a standing or PRN order for restraint to be applied in accordance with specific parameters established in the treatment plan is permitted.

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Review hospital policies and medical staff bylaws to ascertain clinical practice guidelines that describe the responsibilities of medical staff and clinicians who are privileged to order restraint and seclusion.

2. Do the hospital's written policies identify what categories of practitioners the state recognizes as an LIP or as having the authority to order restraint and seclusion?
3. Does the hospital have written policies indicating which practitioners are permitted to order restraint or seclusion in the facility?
4. Do the hospital's written policies conform to state law?
5. Does the hospital have established policies for who can initiate restraint or seclusion?
6. Does the hospital utilize protocols for the use of restraint or seclusion? If so, is the use of protocols consistent with the requirements of the regulation?
7. Do the medical records reviewed identify the physician or LIP who ordered each use of restraint or seclusion?
8. During the medical record review, verify that a physician or LIP order was obtained prior to the initiation of restraint or seclusion. When emergency application of restraint or seclusion was necessary, verify that a physician or LIP order was obtained immediately (within a few minutes) after application of the restraint or seclusion.
9. Review a random sample of medical records for patients that have been restrained or secluded. Review orders, progress notes, flow sheets, and nursing notes to:
    a. Verify that there is a physician or other LIP order for each episode of restraint or seclusion;
    b. Evaluate patterns of use and verify that orders were obtained when necessary;
    c. Verify that the documentation specifically addresses the patients' behaviors or symptoms; and
    d. Determine if restraint or seclusion is being improperly implemented on a PRN basis.
10. Interview staff to determine if actual practice is consistent with written hospital policies and procedures.

B. California Law

Title 22 regulations applicable to psychiatric units of general acute care hospitals and to acute psychiatric hospitals state that patients may be placed in restraint "only on the written order of a licensed health care practitioner acting within the scope of his or her professional licensure." This order must include the reason for the restraint and the type of restraint to be used. Because the Title 22 definitions of a restraint include seclusion, an order from the LIP is also required for seclusion.

However, "in a clear case of emergency," a patient may be placed in restraint at the discretion of a registered nurse and a verbal or written order obtained thereafter. A verbal order must be recorded in the patient's medical record and signed by the LIP on his or her next visit.

[Title 22, California Code of Regulations, Sections 70059, 70577(j)(2), 71055 and 71545(b)]

A drug used as a restraint requires a physician order.

Whereas California law clearly permits physicians to order restraint and seclusion, the law regarding the ability of licensed psychologists to order restraint and seclusion in general acute care hospitals and in acute psychiatric hospitals was less clear until recently. Prior to April 2, 2010, Title 22 regulations applicable to psychiatric units of general acute care hospitals and to acute psychiatric hospitals required that patients be placed in restraint only on the written order of a physician [Title 22, California Code of Regulations, Sections 70577(j)(2) and 71545]. However, effective April 2, 2010, the California Department of Public Health (CDPH) replaced the word "physician" with "licensed health care practitioner acting within the scope of his or her professional licensure" in approximately 99 places throughout the Title 22 health facility licensing regulations. CDPH made these changes as an acknowledgment that it is not CDPH's role to determine scope of practice — this is the role of professional licensing boards.

In an issue paper adopted on Jan. 6, 1994, the California Board of Psychology stated:

> The ordering of restraints and seclusion is within the authorized scope of practice of a licensed psychologist, provided such order is performed within the field of competence of the psychologist as established by his or her education, training and experience.

Hospitals with questions or concerns about the scope of practice of psychologists should consider the nondiscrimination requirements of Health and Safety Code Section 1316.5(b)(2), and consult their legal counsel.

VIII. FACE-TO-FACE EVALUATION

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the

immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within one hour after the initiation of the intervention:

1. By a physician or other LIP; or
2. By a registered nurse or physician assistant who has been trained in accordance with the requirements described in XVIII. "Staff Training Requirements," page 5.27.

[42 C.F.R. Section 482.13(e)(12)]

This requirement also applies when a drug is used as a restraint to manage violent or self-destructive behavior.

The one-hour face-to-face evaluation must be conducted by a physician, other LIP, registered nurse or physician assistant. CMS states that the practitioner who conducts this evaluation must be able to complete both a physical and behavioral assessment of the patient in accordance with state law, his or her scope of practice, and hospital policy. Generally, practitioners such as social workers, psychologists and other mental health workers are not qualified to conduct a physical assessment, nor is it in their scope of practice. [71 Fed. Reg. 71378, 71411 (Dec. 8, 2006)]

The evaluation must be conducted in person. A telephone call or telemedicine methodology is not permitted.

If a patient's violent or self-destructive behavior resolves and the restraint or seclusion intervention is discontinued before the practitioner arrives to perform the one-hour face-to-face evaluation, the practitioner is still required to see the patient face-to-face and conduct the evaluation within one hour after the initiation of this intervention. The fact that the patient's behavior warranted the use of a restraint or seclusion indicates a serious medical or psychological need for prompt evaluation of the patient behavior that led to the intervention. The evaluation would also determine whether there is a continued need for the intervention, factors that may have contributed to the violent or self-destructive behavior, and whether the intervention was appropriate to address the violent or self-destructive behavior.

EXCEPTION

If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyham Syndrome, and the patient engages in repetitive self-mutilating behavior, a one-hour face-to-face evaluation is not required.

CONTENT OF THE EVALUATION

The physician, LIP, registered nurse, or physician assistant must evaluate:

1. The patient's immediate situation;
2. The patient's reaction to the intervention;
3. The patient's medical and behavioral condition; and
4. The need to continue or terminate the restraint or seclusion.

The one-hour face-to-face evaluation includes both a physical and behavioral assessment of the patient that must be conducted by a qualified practitioner within the scope of their practice. An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, drugs and medications, most recent lab results, etc. The purpose is to complete a comprehensive review of the patient's condition to determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior.

Training for a registered nurse (RN) or physician assistant (PA) to conduct the one-hour face-to-face evaluation would include all of the training requirements described in XVIII. "Staff Training Requirements," page 5.27, including content to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition (documented training in conducting physical and behavioral assessment); and the need to continue or terminate the restraint or seclusion.

CONSULTATION WITH ATTENDING PHYSICIAN OR OTHER LIP

If the face-to-face evaluation is conducted by a registered nurse or physician assistant, the registered nurse or physician assistant must consult the attending physician or other LIP who is responsible for the care of the patient under 42 C.F.R. Section 482.12 as soon as possible after completing the evaluation. Hospital policy should address the expected time frame for, and the components of, the consultation.

This consultation should include, at a minimum, the following:

1. A discussion of the findings of the one-hour face-to-face evaluation.
2. The need for other interventions or treatments.

3. The need to continue or discontinue the use of restraint or seclusion.

The consultation must be conducted prior to a renewal of the order. Otherwise, CMS considers that the timing of the consultation is not consistent with the "as soon as possible" requirements.

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Review the hospital policy regarding the one-hour face-to-face evaluation.
2. What categories of practitioners does the hospital policy authorize to conduct the one-hour face-to-face evaluation?
3. Interview staff to determine if practice is consistent with hospital policy.
4. Was the one-hour face-to-face evaluation conducted by a practitioner authorized by hospital policy in accordance with state law to conduct this evaluation?
5. If the one-hour face-to-face evaluations are conducted by RNs who are not advanced practice nurses (APN), verify that those RNs have documented training that demonstrates they are qualified to conduct a physical and behavioral assessment of the patient that addresses: the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint or seclusion.
6. Does documentation of the one-hour face-to-face evaluation in the patient's medical record include all the listed elements of this requirement?
7. Did the evaluation indicate whether changes in the patient's care were required, and, if so, were the changes made?
8. Review the hospital restraint and seclusion policy regarding consultation with the physician or other LIP after a face-to-face evaluation conducted by a registered nurse or physician assistant.
9. Does the hospital policy clarify expectations regarding the requirement, "as soon as possible?"
10. Does documentation in the patient's medical record indicate consultation with the attending physician or other LIP when the one-hour face-to-face evaluation was conducted by a trained RN or PA?
11. Is practice consistent with hospital policy and state law?

B. California Law

California law contains no specific requirements regarding a face-to-face evaluation. Hospitals should follow federal law.

IX. NOTIFICATION OF ATTENDING PHYSICIAN

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion. This consultation may occur via telephone.

Hospital medical staff policies determine who is considered the attending physician. Medicare permits the attending "physician" to be an LIP (physician, dentist, podiatrist, chiropractor, or clinical psychologist), if permitted by state law and hospital policy. The intent of this requirement is to ensure that the practitioner who has overall responsibility and authority for the management and care of the patient is aware of the patient's condition and is aware of the restraint or seclusion intervention. When the attending physician is unavailable, responsibility for the patient must be delegated to another practitioner, who would then be considered the attending physician. [*Interpretive Guidelines*, Tag A-0170]

Hospital policies should address the definition of "as soon as possible" based on the needs of their particular patient population.

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Review the patient's medical record for documentation that the attending physician was notified immediately if the attending physician did not order the restraint or seclusion. Was the attending physician notified "as soon as possible?"
2. Review the hospital's policies and procedures regarding consultation with the attending physician if the attending physician did not order the restraint or seclusion.

B. California Law

California law contains no specific requirements regarding notification of the attending physician. Hospitals should follow federal law.

X. LIMITS ON LENGTH OF TIME THAT ORDERS FOR RESTRAINT/SECLUSION ARE VALID

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

ORIGINAL ORDER

Restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may be ordered only in accordance with the following limits, for up to a total of 24 hours:

1. Adults 18 years of age or older: 4 hours
2. Children and adolescents 9 to 17 years of age: 2 hours
3. Children under 9 years of age: 1 hour

[42 C.F.R. Section 482.13(e)(8)]

The physician or other LIP may write the order for a shorter length of time. The requirement that restraint use be ended at the earliest possible time applies to all uses of restraint *(see XI. "Discontinuation of Restraint or Seclusion," page 5.18)*.

These limited time frames apply regardless of whether each order is considered a separate, distinct, original order, or whether an order is considered a continuation or renewal of the original order. [71 Fed. Reg. 71378, 71413 (Dec. 8, 2006)]

RENEWAL OF ORDER

At the end of the time frame, if the continued use of restraint or seclusion to manage violent or self-destructive behavior is necessary based on an individualized patient assessment, another order is required. When the original order is about to expire, the RN must contact the physician or other LIP, report the results of the most recent patient assessment and request that the original order be renewed (not to exceed the time limits described above). Whether or not an onsite assessment is necessary prior to renewing the order is left to the discretion of the physician or other LIP in conjunction with a discussion with the RN who is overseeing the care of the patient. Another one-hour face-to-face patient evaluation is not required when the original order is renewed.

When the physician or other LIP renews an order or writes a new order authorizing the continued use of restraint or seclusion, there must be documentation in the patient's medical record that describes the findings of the physician's or other LIP's re-evaluation supporting the continued use of restraint or seclusion.

RENEWAL OF ORDER 24 HOURS AFTER ORIGINAL ORDER

If a patient remains in restraint or seclusion for the management of violent or self-destructive behavior 24 hours after the original order, the physician or other LIP who is responsible for the care of the patient must see and assess the patient before writing a new order for the continued use of restraint or seclusion [42 C.F.R. Section 482.13(e)(8)]. This assessment must be done in person. CMS views 24 hours of restraint or seclusion for the management of violent or self-destructive behavior to be an extreme measure with potential for serious harm to the patient, and so requires the patient to be seen in person at least every 24 hours.

EXCEPTIONS

Repetitive Self-Mutilating Behavior

If a patient is diagnosed with a chronic medical or psychiatric condition, such as Lesch-Nyham Syndrome, and the patient engages in repetitive self-mutilating behavior, a standing or PRN order for restraint to be applied in accordance with specific parameters established in the treatment plan is permitted. Since the use of restraints to prevent self-injury is needed for these types of rare, severe, medical and psychiatric conditions, the requirements regarding time-limited orders and evaluation every 24 hours before renewal of the order for the management of violent or self-destructive behavior do not apply.

Nonviolent or Non-Self-Destructive Patient

Renewal of an order for restraint used to ensure the physical safety of a nonviolent or non-self-destructive patient does not need to meet the above requirements. (This use of restraints is more typically found in medical/surgical and skilled nursing settings than in the mental health setting.) These orders may be renewed as authorized by hospital policy. Hospitals have the flexibility to determine time frames for the renewal of orders for restraint of nonviolent, non-self-destructive patients. These time frames should be addressed in hospital policies and procedures. (However, the requirement that restraint use be ended at the earliest possible time applies to all uses of restraint.)

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. When restraint or seclusion is used to manage violent or self-destructive behavior, do orders contain the appropriate time frames based on the patient's age? Does the total number of hours covered by an order or its renewal exceed 24 hours?
2. If more restrictive state laws apply, are they being followed? (**NOTE:** California does not have more restrictive laws.)
3. Is the renewal order for restraint or seclusion based on a comprehensive individual patient assessment?
4. Is there evidence in the patient's medical record that the symptoms necessitating the continued use of restraint or seclusion have persisted?
5. If restraint or seclusion is used to manage violent or self-destructive behavior for longer than 24 hours, is there documentation of a new written order, patient assessments, and a re-evaluation by a physician or other LIP in the medical record? Does the documentation provide sufficient evidence to support the need to continue the use of restraint or seclusion? Is there evidence in the medical record that the symptoms necessitating the continued use of restraint or seclusion have persisted?
6. Does the patient's plan of care address the use of restraint or seclusion?
7. What is the patient's documented clinical response to the continued need for restraint or seclusion?
8. Review the hospital policy on renewal of restraint orders for the management of nonviolent, non-self-destructive patient behavior.
9. Interview staff and review the medical record documentation to ensure that practice is consistent with the hospital policy.

B. California Law

California law contains no specific requirements regarding time limitations of orders for restraint and seclusion. Hospitals should follow federal law.

XI. DISCONTINUATION OF RESTRAINT OR SECLUSION

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order [42 C.F.R. Section 482.13(e)(9)].

Restraint or seclusion may be employed only while the unsafe situation continues. Once it ends, the restraint or seclusion must be discontinued. Staff members are expected to assess and monitor the patient's condition on an ongoing basis to determine whether restraint or seclusion can safely be discontinued to ensure that the patient is released from restraint or seclusion at the earliest possible time. The decision to discontinue the intervention should be based on the determination that the need for restraint or seclusion is no longer present, or that the patient's needs may be addressed using less restrictive methods.

A hospital's policies and procedures should address, at a minimum:

1. Categories of staff that the hospital authorizes to discontinue restraint or seclusion in accordance with state law (described below); and
2. The circumstances under which restraint or seclusion is to be discontinued.

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Does the hospital have policies and procedures for ending restraint or seclusion? Do they address, at a minimum:
    a. Who has the authority to discontinue the use of restraint or seclusion (based on state law and hospital policies); and
    b. Circumstances under which restraint or seclusion should be discontinued?
2. Do the policies include a requirement to end the restraint or seclusion as soon as is safely possible?
3. Does the medical record contain evidence that the decision to continue or discontinue the use of restraint or seclusion was based on an assessment and re-evaluation of the patient's condition?

4. Interview staff to determine whether they are aware that use of a restraint or seclusion must be discontinued as soon as is safely possible.

B. California Law

California law does not contain an explicit statement that restraint or seclusion must be discontinued at the earliest possible time. However, the California requirement that the least restrictive alternative be employed, and the totality of California requirements in general, capture the same sentiment.

Registered nurses are permitted by California law to discontinue restraint or seclusion.

XII. PATIENT MONITORING

Both state and federal law require that a patient in restraint or seclusion be carefully monitored. Whereas the CoPs permit the hospital some flexibility in determining the time intervals between assessments, California law is much stricter — patients must be observed every 15 minutes. The federal law is described below, but California hospitals are cautioned to follow the stricter state time frames (described in B. "California Law," page 5.20).

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

The condition of the patient who is restrained or secluded must be monitored by a physician, other LIP, or trained staff at an interval determined by hospital policy in accordance with state law.

CMS states that ongoing assessment and monitoring of the patient's condition by a physician, other LIP or trained staff is crucial for prevention of patient injury or death, as well as ensuring that the use of restraint or seclusion is discontinued at the earliest possible time. Hospital policies are expected to guide staff in determining appropriate intervals for assessment and monitoring based on the individual needs of the patient, the patient's condition, and the type of restraint or seclusion used. The selection of an intervention and determination of the necessary frequency of assessment and monitoring should be individualized, taking into consideration variables such as the patient's condition, cognitive status, risks associated with the use of the chosen intervention, and other relevant factors. In some cases, checks every 15 minutes or vital signs taken every 2 hours may not be sufficient to ensure the patient's safety. In others, it may be excessive or disruptive to patient care (e.g., it may be unnecessary to mandate that a patient with wrist restraints, and who is asleep, be checked every 15 minutes and awakened every 2 hours to take the patient's vital signs). Similarly, depending on the patient's needs and situational factors, the use of restraint or seclusion may require either periodic (e.g., every 15 minutes, every 30 minutes, etc.) or continual (i.e., moment-to-moment) monitoring and assessment.

Hospital policies should address:

1. Frequencies of monitoring and assessment;
2. Assessment content (e.g., vital signs, circulation checks, hydration needs, elimination needs, level of distress and agitation, mental status, cognitive functioning, skin integrity, etc.);
3. Providing for nutritional needs, range of motion exercises, and elimination needs; and
4. Mental status and neurological evaluations.

With the exception of the simultaneous use of restraint and seclusion, one-to-one observation with a staff member in constant attendance is not required unless deemed necessary based on a practitioner's clinical judgment. *(See XIV. "Simultaneous Restraint and Seclusion," page 5.20.)* For example, placing staff at the bedside of a patient with wrist restraints may be unnecessary. However, for a more restrictive or risky intervention and/or a patient who is suicidal, self injurious, or combative, staff may determine that continual face-to-face monitoring is needed. The hospital is responsible for providing the level of monitoring and frequency of reassessment that will protect the patient's safety.

Hospitals have flexibility in determining which staff performs the patient assessment and monitoring. This determination must be in accordance with the practitioner's scope of clinical practice and state law. For example, assessment and monitoring are activities within a registered nurse's scope of practice. However, some trained, unlicensed staff with demonstrated competency may perform components of monitoring (e.g., checking the patient's vital signs, hydration and circulation; the patient's level of distress and agitation; or skin integrity), and may also provide for general care needs (e.g., eating, hydration, toileting, and range of motion exercises).

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Review hospital policies regarding assessment and monitoring of a patient in restraint or seclusion.

a. What evidence do you find that the hospital's monitoring policies are put into practice for all restrained or secluded patients?

b. Do hospital policies identify which categories of staff are responsible for assessing and monitoring the patient?

c. Do hospital policies include time frames for offering fluids and nourishment, toileting/elimination, range of motion, exercise of limbs and systematic release of restrained limbs? Is this documented in the patient's medical record?

2. Review patient medical records.

a. Was there a valid rationale for the decision regarding the frequency of patient assessment and monitoring documented in the medical record?

b. Was documentation consistent, relevant, and reflective of the patient's condition?

c. Are time frames described for how often a patient is monitored for vital signs, respiratory and cardiac status, and skin integrity checks?

d. Is there documentation of ongoing patient monitoring and assessment (e.g., skin integrity, circulation, respiration, intake and output, hygiene, injury, etc.)?

e. Is the patient's mental status assessed? Is this documented in the medical record?

f. Is the patient assessed regarding continued need for the use of seclusion or restraint?

g. Is there adequate justification for continued use and is this documented?

h. Is the level of supervision appropriate to meet the safety needs of the patient who is at a higher risk for injury (e.g., self-injurious, suicidal)?

B. California Law

Title 22 regulations applicable to psychiatric units of general acute care hospitals and to acute psychiatric hospitals require that "patients in restraint by seclusion or mechanical means shall be observed at intervals not greater than 15 minutes" [Title 22, California Code of Regulations, Sections 70577(j)(3) and 71545(c)]. State law does not specify any particular actions a hospital must take when making the required observations.

XIII. EMERGENCY SITUATIONS

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

Federal law does not contain any special language regarding emergency situations. All of the federal requirements should be complied with regardless of whether the situation is considered an "emergency" or not.

B. California Law

A health facility may use seclusion or behavioral restraints for behavioral emergencies only when a patient's behavior presents an imminent danger of serious harm to self or others [Health and Safety Code Section 1180.4(b)].

There is no definition in this law for "behavioral emergencies," "imminent danger," or "serious harm."

This requirement applies to all facilities. For general acute care hospitals, this requirement applies only to patients admitted to the psychiatric unit, if the hospital has one. It does not apply to mental health patients in the emergency department, an intensive care unit, or other locations within the hospital [Health and Safety Code Sections 1180.3 and 1180.4]. However, the federal regulation requires that restraint or seclusion be used only when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. Therefore, as a matter of practicality, hospitals in compliance with the federal regulation will be in compliance with this state requirement throughout the facility.

XIV. SIMULTANEOUS RESTRAINT AND SECLUSION

At times a patient may be in restraint and in seclusion at the same time. If so, all requirements applicable to restraints and all requirements applicable to seclusion must be followed. In addition, the requirements described below must be met.

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

Simultaneous restraint and seclusion is permitted only if the patient is continually monitored:

1. Face-to-face by an assigned, trained staff member; or

2. By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

[42 C.F.R. Section 482.13(e)(15)]

For the purposes of this requirement, **"continually"** means ongoing without interruption.

A patient who is physically restrained alone in his or her room is not necessarily being simultaneously secluded. The question to ask is whether the patient would be able to leave the room if he or she were not being physically restrained. If so, then the patient is not also being secluded. However, if the physical restraint was removed and the patient was still unable to leave the room because the door was locked or staff otherwise physically preventing the patient from leaving, then the patient is also being secluded.

DOCUMENTATION

When the simultaneous use of restraint and seclusion is employed, there must be adequate documentation that justifies the decision for simultaneous use.

PATIENT MONITORING AND ASSESSMENT

The use of video and audio equipment does not eliminate the need for frequent monitoring and assessment of the patient.

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Review the hospital's policy regarding simultaneous use of restraint and seclusion to determine whether it provides for continual monitoring and complies with all other requirements regarding restraint and seclusion.
2. Conduct document review and staff interviews to determine if practice is consistent with the hospital policy and required uninterrupted audio and visual monitoring is provided as required.
3. Is the staff member monitoring the patient with video and audio equipment trained and in close proximity to ensure prompt emergency intervention if a problem arises?
4. Does the video equipment cover all areas of the room or location where the patient is restrained or secluded?
5. Is the audio and video equipment located in an area that assures patient privacy?
6. Is the equipment appropriately maintained and in working condition?

B. California Law

California law is somewhat stricter than federal law with respect to patient observation requirements when a patient is simultaneously restrained and secluded.

FACE-TO-FACE OBSERVATION

California law requires that a patient who is in seclusion and in any type of behavioral restraint at the same time must be kept under constant, face-to-face human observation.

Observation by means of video camera may be used only in facilities that were permitted to use video monitoring under federal regulations specific to that facility when this law became effective (Jan. 1, 2004). Facilities should consult their legal counsel if in doubt as to whether this provision applies to them.

[Health and Safety Code Section 1180.4(i)]

This California requirement applies to all health facilities. However, for general acute care hospitals, this requirement applies only to patients admitted to the psychiatric unit, if the hospital has one. It does not apply to mental health patients in the emergency department, an intensive care unit, or other locations within the hospital [Health and Safety Code Sections 1180.3 and 1180.4]. However, a hospital may wish to consider following this requirement with respect to all patients who are in simultaneous restraint and seclusion.

XV. PROHIBITED TECHNIQUES

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

The CMS CoP and *Interpretive Guidelines* do not specify any prohibited techniques. However, CMS requires that the use of restraint or seclusion be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with state law. California law does prohibit some techniques.

B. California Law

California law prohibits specific restraint techniques. Some of these techniques are prohibited for all patients. Other techniques are prohibited only for specified types of patients. These prohibitions are described in the following sections.

TECHNIQUES THAT ARE PROHIBITED FOR ALL PATIENTS

A health facility may not do any of the following:

1. Use a physical restraint or containment technique that obstructs a patient's respiratory airway or impairs the patient's breathing or respiratory capacity, including a technique in which a staff member places pressure on a patient's back or places his or her body weight against the patient's torso or back [Health and Safety Code Section 1180.4(c)(1)].
2. Use a pillow, blanket, or other item to cover a patient's face as part of a physical or mechanical restraint or containment process [Health and Safety Code Section 1180.4(c)(2)].
3. Place a patient in a facedown "prone" position with the patient's hands held or restrained behind the patient's back [Health and Safety Code Section 1180.4(g)].
4. Use physical or mechanical restraint or containment on a patient who has a known medical or physical condition and there is reason to believe that the use would endanger the patient's life or seriously exacerbate the patient's medical condition [Health and Safety Code Section 1180.4(d)].
5. Use physical restraint or containment as an extended procedure [Health and Safety Code Section 1180.4(h)].

TECHNIQUES THAT ARE PROHIBITED FOR SPECIFIED PATIENTS

A health facility may not use prone (facedown) mechanical restraint on a person at risk for positional asphyxiation as a result of one of the following risk factors, if the risk factor(s) is known to the health care provider:

1. Obesity
2. Pregnancy
3. Agitated delirium or excited delirium syndromes
4. Cocaine, methamphetamine, or alcohol intoxication
5. Exposure to pepper spray
6. Preexisting heart disease, including, but not limited to, an enlarged heart or other cardiovascular disorders
7. Respiratory conditions, including emphysema, bronchitis, or asthma

[Health and Safety Code Section 1180.4(e)(1)]

However, this prohibition regarding prone mechanical restraint does not apply in the following situations:

1. When the patient has stated a preference for the prone position. The patient might have stated this preference during the initial intake assessment (in which case it should be carefully documented) or later when the use of restraint is taking place.
2. When the physician judges other clinical risks to take precedence.

In both of the above situations, a physician must provide "written authorization." This written authorization — presumably a physician order — may not be a standing order, and must be evaluated on a case-by-case basis by the physician. [Health and Safety Code Section 1180.4(e)(2)]

PRONE CONTAINMENT TECHNIQUES

A health facility must avoid the deliberate use of prone containment techniques whenever possible, using the best practices in early intervention techniques, such as de-escalation. If prone containment techniques are used in an emergency situation, a staff member must observe the patient for any signs of physical duress throughout the use of prone containment. Whenever possible, the staff member observing the patient should not be involved in restraining the patient. [Health and Safety Code Section 1180.4(f)]

APPLICABILITY

The prohibitions described above apply to all facilities. However, for general acute care hospitals, the prohibitions apply only to patients admitted to the psychiatric unit, if the hospital has one. They do not apply to mental health patients in the emergency department, an intensive care unit, or other locations within the hospital [Health and Safety Code Sections 1180.3 and 1180.4]. However, a hospital may wish to adopt these prohibitions throughout its facility.

XVI. POST-RESTRAINT OR SECLUSION REVIEW (CLINICAL/QUALITY REVIEW AND DEBRIEFING)

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

The CMS CoP and *Interpretive Guidelines* do not specify any required clinical/quality reviews or debriefings after the use of restraint or seclusion. However, California law does contain such requirements.

B. California Law

A health facility must conduct two reviews for each episode of the use of seclusion or behavioral restraint: a clinical/quality review and a debriefing. The requirements for each type of review are discussed below.

The review requirements apply to all facilities. However, for general acute care hospitals, they apply only to patients admitted to the psychiatric unit, if the hospital has one. They do not apply to mental health patients in the emergency department, an intensive care unit, or other locations within the hospital [Health and Safety Code Sections 1180.3 and 1180.5]. However, a facility may wish to conduct these reviews on all mental health patients who experience an episode of the use of seclusion or behavioral restraint.

If an adverse event or adverse outcome occurs while a patient is in seclusion or restraint, the hospital should follow its adverse event/sentinel event/root cause analysis policy in addition to conducting the two types of reviews described in this section.

CLINICAL AND QUALITY REVIEW

A health facility must conduct a clinical and quality review for each episode of the use of seclusion or behavioral restraints [Health and Safety Code Section 1180.5(a)]. The law does not specify which types of professionals in the facility must conduct this review nor what information must be considered. A health facility may choose to have a special committee to review restraint and seclusion use, or may assign this function to a more general medical staff quality assurance committee. In order to protect the documents and deliberations of the committee from discovery (including subpoena) under the "peer review" confidentiality provision of Evidence Code Section 1157, the committee should be formed under the auspices of the medical staff quality assurance program. *(See chapter 8 for more information about protecting peer review and quality assurance information from discovery.)*

DEBRIEFING

In addition, a health facility must conduct a debriefing regarding each episode of the use of seclusion or behavioral restraints. This debriefing must take place as quickly as possible, but no later than 24 hours after the use of seclusion or behavioral restraints.

Who Must be Included in the Debriefing

1. The patient's participation is voluntary. The facility should encourage the patient to participate in the debriefing, but may not require the patient to do so. If the patient chooses not to participate, the hospital should document both its encouragement and the refusal.
2. The staff members involved in the incident, if reasonably available.
3. A supervisor.
4. If the patient requests it, someone the patient desires to be present, such as a family member or other person designated by the patient, should be included (if the desired family member or other person can be present at the time of the debriefing at no cost to the facility).

The Purpose and Elements of the Debriefing

The purpose of the debriefing is to do all of the following:

1. Assist the patient to identify the precipitant of the incident, and suggest methods of more safely and constructively responding to the incident.
2. Assist the staff to understand the precipitants to the incident, and to develop alternative methods of helping the patient avoid or cope with those incidents.
3. Help treatment team staff devise treatment interventions to address the root cause of the incident and its consequences, and to modify the treatment plan.
4. Help assess whether the intervention was necessary and whether it was implemented in a manner consistent with staff training and facility policies.

In the debriefing, the health facility must provide the patient and the staff the opportunity to discuss the following:

1. The circumstances resulting in the use of seclusion or behavioral restraints; and
2. Strategies to be used by the staff, the patient, or others that could prevent the future use of seclusion or behavioral restraints.

[Health and Safety Code Section 1180.5(b) and (c)]

Documentation Requirements Regarding the Debriefing

The law explicitly requires that the health facility document in the patient's medical records that the debriefing session took place and any changes to the patient's treatment plan that resulted from the debriefing [Health and Safety

Code Section 1180.5(d)]. In addition, health facilities should consider documenting the date and time of the debriefing, the participants in the debriefing, whether the patient wanted to participate, whether the patient wanted a third party to participate, and the fact that each element described under "The Purpose and Elements of the Debriefing," page 5.23, was addressed.

XVII. REPORTING REQUIREMENTS RELATED TO RESTRAINT OR SECLUSION

There are several state and federal reporting requirements potentially implicated when a patient is restrained or secluded. These reporting requirements are described below. One incident can easily lead to multiple reports being required. The reporting requirements related to the Safe Medical Devices Act, adverse event reporting, and unusual occurrences should be reviewed and all necessary reports should be made in the event of an adverse event involving restraints or seclusion. In addition, the requirements regarding sentinel events should be reviewed. All of these requirements are described in chapter 8.

A. CMS Death Reporting and Documentation Requirements

REPORTING REQUIREMENT

Hospitals must report the following deaths associated with the use of seclusion or restraint to CMS by fax no later than the close of business on the next business day following knowledge of the patient's death. (The CMS Regional Office in California does not accept reports by email.) The following events must be reported:

1. Each death that occurs while a patient is in restraint or seclusion, except for deaths subject to the "Documentation Requirement," page 5.24.
2. Each death that occurs within 24 hours after the patient was removed from restraint or seclusion (whether or not the hospital believes that the use of restraint or seclusion contributed to the patient's death), except for deaths subject to the "Documentation Requirement," page 5.24.
3. Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used. **"Reasonable to assume"** in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

This requirement applies to deaths that occur in any unit of the hospital, including an ICU or critical care unit. However, critical access hospitals are required to report to CMS only if they have a psychiatric or rehabilitative distinct part unit. (Critical access hospitals may be required to report an adverse event related to restraints or seclusion under another reporting requirement described in this chapter.)

The date and time of the report to CMS must be documented in the patient's medical record.

[42 C.F.R. Section 482.13(g)]

REGIONAL OFFICE PHONE NUMBER/WORKSHEET

Hospitals must fax a report to CMS at the Regional Office for Region IX at (443) 380-8909 to report deaths associated with the use of seclusion or restraint. The hospital must use Form CMS-10455, which is included at the end of this manual as CHA Appendix MH 5-A. Reporting by email is not acceptable to CMS.

Hospitals with questions about the reporting requirement may contact Alex Garza or Rosanna Dominguez at:

Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103
(415) 744-3735

DOCUMENTATION REQUIREMENT

When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff does not need to notify CMS of a patient death by the next business day. Instead, hospital staff must record the following information in an internal log or other system:

1. The patient's name,
2. The patient's date of birth,
3. The patient's date of death,
4. The name of attending physician or other LIP who is responsible for the care of the patient,
5. The patient's medical records number, and
6. The patient's primary diagnosis(es).

Each entry must be made not later than seven days after the date of death. An entry must be made for:

1. Any death that occurs while a patient is in restraints as described above.
2. Any death that occurs within 24 hours after a patient has been removed from restraints as described above.

The log or other system must be made available in either written or electronic form to CMS immediately upon request.

The date and time of the log entry must be documented in the patient's medical record.

CMS RESPONSE

CMS will use the information reported by the hospital to:

1. Authorize an onsite investigation (complaint survey) of the hospital by CDPH, which is the state survey agency for CMS, and
2. Inform the federally-mandated protection and advocacy entity, which in California is Disability Rights California (DRC). DRC's role and responsibilities are described in V. "Mental Health Advocacy Programs," page 4.7.

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Does the hospital have a death reporting policy that addresses the requirements of the regulation?
2. Review data related to patient deaths while the patients were in restraint or seclusion to determine if the hospital followed the requirements related to death reporting for:
    a. Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint) or seclusion;
    b. Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion; and
    c. Each death that occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death.
3. Interview staff to determine their knowledge of the hospital's death reporting policy.
4. Is there evidence that deaths associated with the use of restraints or seclusion are reported to CMS? Review medical records of patients who died associated with the use of restraint or seclusion to determine if the documentation included the date and time the death was reported to CMS.

B. FDA: Safe Medical Devices Act Reporting Requirement

The Food and Drug Administration (FDA) regulates restraint devices as it regulates other medical devices. Under the Safe Medical Devices Act of 1990, hospitals and other device user facilities must report incidents involving medical devices (including restraints) that may have caused or contributed to the serious injury or death of a patient.

For purposes of this reporting law, it should be noted that the FDA uses a different definition of restraint than does the CMS CoP or California law. The FDA defines a protective restraint as:

> a device, including but not limited to a wristlet, anklet, vest, mitt, straight jacket, body/limb holder, or other type of strap, that is intended for medical purposes and that limits the patient's movements to the extent necessary for treatment, examination, or protection of the patient or others. [21 C.F.R. Section 880.6760]

Whereas the CMS definition of restraint could include a Geri-chair, a tray table, a side rail, a sheet, or even a staff member holding a patient, the FDA definition does not. Therefore, this reporting requirement is somewhat more narrow than the other reporting requirements discussed throughout XVII. "Reporting Requirements Related to Restraint or Seclusion," page 5.24.

Detailed information regarding the Safe Medical Devices Act of 1990 is found in IX. "Reports Under the Safe Medical Devices Act of 1990," page 8.11.

C. Reporting Restraint and Seclusion to Local Behavioral Health Director

When a patient is restrained or secluded, a denial of rights is deemed to have occurred. *(See F. "Denial of Patient Rights," page 4.4, regarding required monthly and quarterly reporting to the Department of Health Care Services.)*

D. California Adverse Event Reporting Requirement

California law requires that 27 specified adverse events be reported to CDPH within five days of detection. Most of these events are unlikely to occur in the context of restraint

or seclusion. However, one of the specified adverse events that must be reported is "a patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility."

In addition, the following adverse events could happen while a patient is being restrained or secluded and would be reportable:

1. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose. This adverse event could take place in the context of a drug used as a restraint.
2. A patient death associated with a fall while the patient is being cared for in a health facility. If a patient were to die as the result of a fall while in seclusion or while being restrained, this adverse event would be reportable under the adverse event reporting requirement.

The details of the adverse event reporting requirement are described in VII. "CDPH Adverse Events Reporting," page 8.7.

E. Regional Centers for Persons with Developmental Disabilities

State law requires specified facilities to report the use of restraint and seclusion for clients of California regional centers. Regional centers serve individuals with developmental disabilities. The facilities that must report are:

1. Acute psychiatric hospitals that are regional center vendors (that is, the hospital contracts with one or more California regional centers for persons with developmental disabilities). Acute psychiatric hospitals may wish to check with their contracts department to determine whether the hospital is a regional center vendor.
2. Long-term health care facilities that are required to report to a regional center under Title 17, California Code of Regulations, Section 54327. "Long-term health care facilities include:
    a. Skilled nursing facility.
    b. Intermediate care facility.
    c. Intermediate care facility/developmentally disabled.
    d. Intermediate care facility/developmentally disabled habilitative.
    e. Intermediate care facility/developmentally disabled-nursing.
    f. Congregate living health facility.
    g. Nursing facility.
    h. Intermediate care facility/developmentally disabled-continuous nursing.
    i. Pediatric day health and respite care facility.
    j. "Long-term health care facility" does not include a general acute care hospital or an acute psychiatric hospital, except for that distinct part of the hospital that provides skilled nursing facility, intermediate care facility, intermediate care facility/developmentally disabled, or pediatric day health and respite care facility services.
3. Regional center vendors that provide crisis or residential services or supported living services. General acute care hospitals may wish to check with their contracts department to determine whether the hospital is a regional center vendor of crisis services.

MONTHLY REPORTING

Each month, the facilities listed above must report to the state-contracted protection and advocacy agency, Disability Rights California, the following:

1. The number of incidents of seclusion and the duration of time spent per incident in seclusion;
2. The number of incidents of the use of behavioral restraints and the duration of time spent per incident of restraint; and
3. The number of times an involuntary emergency medication is used to control behavior.

These reports must include the name, street address, and telephone number of the facility.

INCIDENT REPORTING

If a client of a California regional center dies or suffers a serious injury during, or related to, the use of seclusion, physical restraint, or chemical restraint, or any combination thereof, a report must be made to the state-contracted protection and advocacy agency, Disability Rights California. The report must be made no later than the close of the business day following the death or serious injury. The report must include the encrypted identifier of the person involved, and the name, street address, and telephone number of the facility.

DEFINITIONS

For purposes of this law, the following definitions apply.

"Physical restraint" means any behavioral or mechanical restraint, as defined in B. "California Law," page 5.3.

"Chemical restraint" means a drug that is used to control behavior and that is used in a manner not required to treat the patient's medical conditions.

"Seclusion" means involuntary confinement of a person alone in a room or an area as defined in B. "California Law," page 5.3.

F. Medication Error

The Board of Pharmacy has adopted regulations requiring specified reports to be made if a medication error occurs (including errors involving a drug used as a restraint). The details of these reporting requirements are described in VIII. "Medication Errors," page 8.11.

G. California Unusual Occurrence Reporting Requirement

Title 22 requires general acute care hospitals and acute psychiatric hospitals to report an unusual occurrence which threatens the welfare, safety, or health of patients, personnel, or visitors. In a letter to general acute care hospitals and acute psychiatric hospitals (and others) dated May 29, 2002, the California Department of Health Services (DHS; now called the California Department of Public Health (CDPH)) stated that a patient death that occurs while a patient is restrained or in seclusion for behavior management is a reportable unusual occurrence. DHS stated that it is also a reportable unusual occurrence when the use of restraint or seclusion for either behavior management or for medical and surgical care may be a cause or a contributing factor to a patient death or injury.

This report must be made to CDPH and to the local health officer as soon as reasonably practicable by telephone. The details of the unusual occurrence reporting requirement are described in XI. "Reportable "Unusual Occurrences"," page 8.14.

H. Staff Injury

If an employee is injured during the application of restraint or seclusion, one or more reports may be required. CHA has published a guidebook that details all reporting requirements — to local law enforcement, to CDPH, and to Cal/OSHA — that may be triggered when an employee is injured by a patient. For more information about the *Healthcare Workplace Violence Prevention* guidebook, or to order, visit www.calhospital.org/wvp-guidebook.

I. TJC Sentinel Event Requirement

Under its policy on "sentinel events," The Joint Commission (TJC) asks hospitals to review all incidents that constitute a sentinel event and, with some exceptions, to share with TJC the results of this review (called a "root cause analysis"). Hospitals are also expected to prepare action plans to address any issues identified in the root cause analysis. Information about TJC's sentinel even requirement is found under A. "Sentinel Events," page 8.5.

XVIII. STAFF TRAINING REQUIREMENTS

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

Federal law requires that staff be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion.

TRAINING INTERVALS

All staff, including contract or agency personnel, must be trained and must demonstrate competency *before* applying restraints; implementing seclusion; or monitoring, assessing, or providing care for a patient in restraint or seclusion.

Training must be included as part of orientation. The required competencies must be demonstrated initially as part of orientation and subsequently on a periodic basis consistent with hospital policy. Hospitals have the flexibility to identify a time frame for ongoing training based on the level of staff competency, and the needs of the patient population served. The results of skills and knowledge assessments, new equipment or policies, or QAPI data may indicate a need for targeted training or more frequent or revised training.

Hospitals may develop and implement their own training programs or use an outside training program.

TRAINING CONTENT

Appropriate staff must have education, training, and demonstrated knowledge based on the specific needs of the patient population in the following:

1. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

2. The use of nonphysical intervention skills.

   CMS states that staff may prevent a patient situation from escalating to the point of needing restraint or seclusion by using alternative techniques to redirect a patient, engage the patient in constructive discussion or activity, or otherwise help the patient maintain self-control and avert escalation. CMS states that the use of nonphysical intervention skills does not mean attempting a complex series of interventions or a lengthy checklist of steps before restraining or secluding a patient. "Rather, a whole toolbox of possible interventions can be implemented during the course of a patient's treatment based upon the assessment of an individual patient's responses" *(see Interpretive Guidelines, Tag A-0200)*. CMS does not provide any information about this "toolbox."

3. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.

   CMS states that the underpinning of this regulation is the concept that safe patient care hinges on looking at the patient as an individual and assessing his or her condition, needs, strengths, weaknesses, and preferences. Such an approach relies on caregivers who are skilled in individualized assessment and in tailoring interventions to the patient's needs after weighing factors such as the patient's condition, behaviors, history, and environmental factors. CMS recommends a document entitled, "Learning from Each Other — Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health," sponsored by the American Psychiatric Association, American Psychiatric Nurses Association, the National Association of Psychiatric Health Systems, and the American Hospital Association. This document may be found at www.nabh.org/nabh-resources. This website also includes useful forms, assessment tools, and checklists.

4. CMS requires that appropriate staff be trained, and demonstrate competency, in the safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia) in a timely manner.

5. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

   CMS states that the use of restraint or seclusion must end at the earliest possible time regardless of the length of time identified in the order. Staff must be trained and demonstrate competency in their ability to identify specific patient behavioral changes that may indicate that restraint or seclusion is no longer necessary and can be safely discontinued.

6. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the one-hour face-to-face evaluation.

7. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

CMS notes that typical "first aid" courses may not adequately address the immediate interventions that need to be rendered to a restrained or secluded patient who is in distress or injured. Training should include information that pertains to restrained or secluded patients in distress or injured — for example, a patient found hanging in a vest restraint, a restrained patient choking on food, a secluded suicidal patient found hanging, a secluded suicidal patient who has cut himself, etc. Staff need to assess their patient population and identify likely scenarios, develop a first aid training that addresses those scenarios, and provide that training to all staff who care for restrained or secluded patients.

In addition, appropriate staff should be certified in cardiopulmonary resuscitation.

Special Training for RN or PA to Conduct One-Hour Face-to-Face Evaluation

Training for an RN or PA to conduct the one-hour face-to-face evaluation would also include content to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint or seclusion. An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, medications, most recent lab results, etc. The purpose of the one-hour face-to-face evaluation is to complete a comprehensive review of the patient's condition and determine if other

factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior. *(See VIII. "Face-to-Face Evaluation," page 5.14.)*

WHO MUST BE TRAINED

The regulation states that "appropriate staff" must be trained. **"Appropriate staff"** includes all staff, including contract or agency personnel, that apply restraint or seclusion, monitor, assess, or otherwise provide care for patients in restraint or seclusion. If hospital security guards or other nonclinical staff, as part of hospital policy, may assist clinical staff when requested, they are also expected to be trained and able to demonstrate competency in the safe application of restraint and seclusion.

Physician and other LIP training requirements must also be specified in hospital policy. At a minimum, physicians and other LIPs who may order restraint or seclusion must have a working knowledge of hospital policy regarding the use of restraint and seclusion.

Hospitals have the flexibility to identify training requirements above this minimum requirement based on the competency level of their physicians and other LIPs and the needs of the patient population(s) that they serve. Physicians receive training in the assessment, monitoring, and evaluation of a patient's condition as part of their medical school education. However, physicians generally do not receive training regarding application of restraint or implementation of seclusion as part of their basic education. Depending on the level and frequency of involvement that a physician has in the performance of these activities, additional training may or may not be necessary to ensure the competency of these individuals in this area.

TRAINER REQUIREMENTS

CMS states that individuals providing staff training "must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors for the patient populations being served." Trainers should demonstrate a high level of knowledge regarding all of the requirements of the CMS regulations as well as the hospital's policies and procedures.

TRAINING DOCUMENTATION

Hospitals must document in staff personnel records that both training and demonstration of competency were successfully completed initially during orientation and on a periodic basis consistent with hospital policy.

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Does the hospital have a documented training program for the use of restraint and seclusion interventions employed by the hospital?
2. Does the hospital have documented evidence that all levels of staff, including agency or contract staff, that have direct patient care responsibilities and any other individuals who may be involved in the application of restraints (e.g., security guards) have been trained and are able to demonstrate competency in the safe use of seclusion and the safe application and use of restraints?
3. Review and verify restraint and seclusion education staff training documentation for all new employees and contract staff.
4. Does the training include demonstration of required competencies?
5. Does the hospital educational program include techniques related to the specific patient populations being served?
6. Does the hospital educational program address each topic discussed in "Training Content," page 5.27?
7. Does the hospital educational program provide more in-depth training in the areas included in the regulation for staff members who routinely provide care to patients who exhibit violent or self-destructive behavior (e.g., staff who work in the emergency department or psychiatric unit)?
8. Does the hospital educational program address the specific requirements for the training of RNs and PAs that the hospital authorizes to conduct the one-hour face-to-face evaluation?
9. Observe patients in restraint or seclusion to verify safe application of the restraint or seclusion.
10. Interview staff to assess their knowledge and skills in each of the topics discussed in "Training Content," page 5.27.
11. Review hospital data (i.e., incident reports, patient injury or death reports, etc.) to identify any patterns of patient injuries or death that may indicate that staff are not adequately trained to recognize and respond to patient signs of physical and psychological distress.
12. Review personnel files of individuals responsible for providing staff education and training. Do these

individuals possess education, training, and experience to qualify them to teach the staff? Are they qualified to identify and meet the needs of the patient population(s) being served?

13. Does the hospital have a system for documenting and ensuring that the individuals providing education and training have the appropriate qualifications required by this regulation?
14. Review a sample of staff personnel records, including contract or agency staff, to determine if the training and demonstration of competency have been completed during orientation and on a periodic basis consistent with hospital policy.
15. Review the hospital policy regarding restraint and seclusion training requirements for physicians and other LIPs. Are the minimum training requirements addressed?
16. Review medical staff credentialing and privileging files to determine if physicians or other LIPs involved in restraint and seclusion activities have completed the required training.

B. California Law

California law contains no requirements regarding staff training. However, the law does mention some desirable (not mandatory) topics for training programs. These include:

1. Conducting the intake assessment.
2. Utilizing strategies to engage patients collaboratively in avoidance and management of crisis situations to minimize the use of seclusion and restraint.
3. Using conflict resolution, effective communication, de-escalation, and patient-centered problem solving strategies to diffuse and safely resolve emerging crisis situations.
4. Using individual treatment planning that identifies risk factors, positive early intervention strategies, and strategies to minimize time spent in seclusion and restraint. Include patient input.
5. Using strategies to mitigate the emotional and physical discomfort of patients in seclusion and restraint and ensure the safety of the patient in seclusion and restraint. Get patient input regarding what would alleviate his or her distress.
6. Conducting an effective debriefing. Include strategies that result in maximum participation and comfort for all participants to identify factors that lead to the use of seclusion and restraint and factors that would reduce the likelihood of future incidents.

(See Health and Safety Code Section 1180.2.)

XIX. LAW ENFORCEMENT RESTRAINT OR SECLUSION

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by nonhospital employed or contracted law enforcement officials for custody, detention, and public safety reasons is not governed by the federal regulation regarding restraint and seclusion. Such devices are considered law enforcement restraint devices and are not considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients. The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital's patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with state and federal law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer's prisoner).

CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of the federal regulation, the term **"weapon"** includes, but is not limited to, pepper spray, mace, nightsticks, tazers, cattle prods, stun guns, and pistols. Security staff may carry weapons as allowed by hospital policy, and state and federal law. However, the use of weapons by security staff is considered a law enforcement action, not a health care intervention. CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion. If a weapon is used by security or law enforcement personnel on a person in a hospital (patient, staff, or visitor) to protect people or hospital property from harm, CMS expects the situation to be handled as a criminal activity and the perpetrator be placed in the custody of local law enforcement.

CMS states that it is not appropriate for a hospital to routinely call upon a law enforcement agency as a means of applying restraint or seclusion. Hospitals must have appropriately trained clinical staff. If hospital security guards or other nonclinical staff, as part of hospital policy, may assist clinical staff when requested, they are also expected to be trained and able to demonstrate competency in the safe application of restraint and seclusion.

B. California Law

California law is silent regarding the use of restraint or seclusion by law enforcement officers with respect to hospitalized patients (with the exception of inmates in labor, who may not be shackled; *see Penal Code Sections 3407, 3423 and 6030; Welfare and Institutions Code Sections 222 and 1774*).

In early 2009, the news media reported that the U.S. Immigration and Customs Enforcement Agency (ICE) contracted with a private California hospital to care for mentally ill detainees. It was reported that the detainees were kept shackled pursuant to ICE requirements, and were denied many of their rights, such as sending and receiving mail or having access to a phone. It was suggested that the hospital was violating state law regarding seclusion and restraint and denial of rights. The argument was made that although patient's rights can be denied for good cause (and must be properly documented and reported), good cause for denial of rights must be based on an individual patient assessment, not on a blanket policy regarding a group of patients, such as ICE detainees.

Most of the California laws regarding restraint and seclusion apply only to patients in acute psychiatric hospitals or in psychiatric units of general acute care hospitals. As a general rule, inmates and detainees who are restrained or secluded by law enforcement officials are not admitted to these settings. If, however, this situation arises, legal counsel should be consulted.

XX. DOCUMENTATION REQUIREMENTS

Hospitals should document compliance with every state and federal requirement regarding restraint and seclusion discussed in this chapter. This portion of the chapter describes the documentation requirements that CMS and CDPH have listed in the "documentation" or "medical records" portions of their regulations. However, it cannot be emphasized enough that compliance with all of the requirements discussed throughout this chapter should be documented — not just compliance with the "medical records" or "documentation" portions of the regulations.

A. Federal Law: CMS Conditions of Participation and Interpretive Guidelines

The CMS CoP states that when restraint or seclusion is used, there must be documentation in the patient's medical records of the following:

1. The one-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;
2. A description of the patient's behavior and the intervention used;
3. Alternatives or other less restrictive interventions attempted (as applicable);
4. The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and
5. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

[42 C.F.R. Section 482.13(e)(16)]

The *Interpretive Guidelines* state that the patient's behavior should be documented in descriptive terms to evaluate the appropriateness of the interventions used. The documentation should include a detailed description of the patient's physical and mental status assessments and of any environmental factors (e.g., physical, milieu, activities, etc.) that may have contributed to the situation at the time of the intervention. The patient's condition or symptom(s) must be identified and documented in the patient's medical record.

SURVEY PROCEDURES

The *Interpretive Guidelines* direct surveyors to consider the following:

1. Does the patient's medical record include documentation of the one-hour face-to-face medical and behavioral evaluation when restraint or seclusion is used to manage violent or self-destructive behavior?
2. Does the patient's medical record include a clear description of the patient's behavior that warranted the use of restraint or seclusion?
3. Was the intervention employed appropriate for the identified behavior?
4. What was the patient's clinical response to the intervention(s)?
5. Does the patient's medical record document any alternatives or less restrictive interventions attempted by staff, if appropriate?
6. What was the effect of less restrictive interventions, if attempted by staff?
7. Were the interventions selected appropriate to the targeted patient behaviors?

8. When an immediate and serious danger to the patient or others occurred, was the more restrictive intervention(s) effective? Could a less restrictive intervention have been used to ensure the safety of the patient, staff or others?
9. Does the patient's medical record include descriptions of the patient's condition or symptom(s) that warranted the use of restraint or seclusion?
10. Does the patient's medical record include descriptions of the impact of the intervention on the patient behavior that resulted in the use of restraint or seclusion?
11. Does the patient's medical record include a detailed assessment of the patient's response to the intervention and a well-reasoned plan for the continued use of restraint or seclusion?

B. California Law

Each instance of seclusion or restraint must be noted in the patient's medical record in accordance with the documentation requirements regarding denials of rights *(see F. "Denial of Patient Rights," page 4.4, for more information about documentation of denial of rights)* [Title 9, California Code of Regulations, Section 865.4].

Psychiatric units of general acute care hospitals must record the type of restraint and the time of application and removal [Title 22, California Code of Regulations, Section 70577(j)(5)].

General acute care hospitals must record the type of restraint and the time of application and removal [Title 22, California Code of Regulations, Section 70749(a)(6)]. This regulation specifies that this information does not need to be recorded for soft-tie restraints used for the support and protection of the patient. The exception likely applies to medical/surgical uses of restraints, not restraints for mental health patients.

In addition, state licensing regulations applicable to general acute care hospitals state that "policies and procedures which contain competency standards for staff performance in the delivery of patient care shall be established, implemented, and updated as needed for each nursing unit, including standards for the application of restraints." The employees' annual evaluation must include measuring individual performance against established competency standards. [Title 22, California Code of Regulations, Section 70213]

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Forms and Appendices can be found at the back of the manual and online for CHA members at www.calhospital.org/free-resources.

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6 Health Information Privacy Basics

I. INTRODUCTION

Health information privacy law is complicated. California health care providers must comply with many state and federal statutes and regulations governing patient privacy. Understanding all of them, and how they interact with each other, is challenging and the answers aren't always clear, even to experienced privacy lawyers. This chapter provides an overview of the most important laws, as well as guidance on everyday uses and disclosures of health information in the hospital and clinic setting. This chapter also addresses searching patients and their belongings.

This chapter is intended to address common situations encountered by clinical staff and management, rather than unusual circumstances or technical areas within the privacy officer's purview. The hospital's privacy officer or legal counsel should be consulted whenever questions arise. For privacy officers, legal counsel, and others tasked with health information privacy compliance, the California Hospital Association publishes the *California Health Information Privacy Manual*, which describes in detail all of the relevant laws about health information privacy, including permissible and impermissible uses and disclosures; technical, administrative and physical security safeguards; risk assessment; breaches; patient access to their information and other patient privacy rights; employee health; administrative processes; government and private enforcement; and penalties. For more information about this more than 450-page manual, visit www.calhospital.org/privacy.

A. Important Laws to Know

The important privacy laws that California health care providers must follow are briefly described below.

1. The Health Insurance Portability and Accountability Act (HIPAA) regulations published by the U.S. Department of Health and Human Services (DHHS) form the overarching federal law about medical privacy. The regulations give patients certain rights *(see II. "Patient Privacy Rights," page 6.4)* and restrict how health care providers and payers can use and disclose patient information. Health care providers must comply with HIPAA and applicable state law. [45 C.F.R. parts 160 and 164]
2. The Confidentiality of Medical Information Act (CMIA) is California's general health information privacy law. This law applies to all general acute care hospital patients except for some (but not all) mental health patients. [Civil Code Section 56 *et seq.*]
3. The Lanterman-Petris-Short Act (LPS) includes several confidentiality provisions that apply to records of some (but not all) mental health patients. The confidentiality provisions of LPS apply to all information and records obtained in the course of providing services to:
    a. Patients who are treated or evaluated under Welfare and Institutions Code Sections 5150-5344. These code sections include involuntary evaluation and treatment in a designated facility for patients who are a danger to self or others or gravely disabled. These patients do not include patients who may be detained involuntarily for up to 24 hours in a non-designated hospital on an emergency basis (usually, but not always, in the emergency department) under Health and Safety Code Section 1799.111 (chapter 12 of CHA's Consent Manual contains a thorough description of all of these patients); and
    b. Patients who are receiving voluntary or involuntary mental health treatment in a:
        - State mental hospital;
        - County psychiatric ward, facility or hospital;
        - University of California psychiatric facility: Langley Porter Psychiatric Institute and the Neuropsychiatric Institute at UCLA. Other University of California mental health services providers should consult University of California counsel regarding their status under LPS;
        - Federal hospital, psychiatric hospital or unit;
        - Private institution, hospital, clinic or sanitarium which is conducted for, or that includes a department or ward conducted for, the care and treatment of persons who are mentally disordered;

- Psychiatric health facility as described in Health and Safety Code Section 1250.2;
- Mental health rehabilitation center as defined in Welfare and Institutions Code Section 5675;
- Skilled nursing facility with a special treatment program service unit for patients with chronic psychiatric impairments (see Title 22, California Code of Regulations, Sections 51335 and 72443-72475 about such special treatment programs);
- Community program funded by the Bronzan-McCorquodale Act. Because it is often difficult to determine which patients received services funded under the Bronzan-McCorquodale Act, each program and its legal counsel should review any funds received under the Bronzan-McCorquodale Act to determine the applicability, if any, of those confidentiality provisions as a result of such funding [Welfare and Institutions Code Sections 5600-5778]; and
- Community program specified in the Welfare and Institutions Code Sections 4000-4390 and Welfare and Institutions Code Sections 6000-6008.

Absent some tie-in to one of the above described programs, LPS does not apply to other mental health patients or their records, even though those records may describe mental health treatment similar to what is protected under LPS. These records are instead subject to the Confidentiality of Medical Information Act (CMIA)

4. California's Health and Safety Code gives special confidentiality protection to HIV test results. This law does not apply to a diagnosis of AIDS; it applies only to the HIV test results, whether the results are positive or negative. [Health and Safety Code Section 120980 *et seq.*] HIV test results may be disclosed to the patient and to other health care providers with a need to know to diagnose or treat the patient. Hospital employees should check with their privacy officers or legal counsel before disclosing HIV test results to others.

5. Federal law gives special confidentiality protection to records of substance use disorder programs. These rules do not apply to all substance use disorder patients; they apply only to patients served by "federally-assisted substance use disorder programs." If a not-for-profit hospital has a service line identified to the public as a substance use disorder program or unit, or has personnel whose primary function is the provision of substance use disorder treatment and who are identified as such providers, the hospital must follow these strict confidentiality rules. These rules are described in detail in CHA's *California Health Information Privacy Manual*, available at www.calhospital.org/privacy.

6. Federal law gives special confidentiality protection to "psychotherapy notes," a concept introduced by HIPAA. **"Psychotherapy notes"** means:

   > [N]otes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint, or family counseling session and *that are separated from the rest of the individual's medical record*. [emphasis added]

   Psychotherapy notes exclude medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; and any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   A psychotherapist is not required to maintain psychotherapy notes. Most hospitals, skilled nursing facilities, and other institutional providers do not have psychotherapy notes, as defined in HIPAA, because the definition requires the notes to be separate from the rest of the medical record. If the notes are included with the rest of the medical record, then they are not psychotherapy notes and are not subject to the special restrictions. A separate authorization for the disclosure of psychotherapy notes, even for treatment purposes (except by the provider who created the notes), is almost always required. [42 C.F.R. Sections 164.501, 164.508(a)(2)]

7. The Patient Access to Health Records Act gives patients the right to review, and obtain copies of, their medical information [Health and Safety Code Section 123000 *et seq.*]. HIPAA has a similar provision [45 C.F.R. Section 164.524].

8. Both state and federal law require health care providers to notify patients and government agencies if a privacy breach occurs. Clinical staff should immediately notify the hospital's privacy officer if they believe a breach has occurred or if a patient complains about an alleged breach. The laws are complicated, and what may seem like a breach may not, in fact, constitute a reportable incident. On the other hand, if a breach has occurred,

the timeline for making the required notifications is short, and the privacy officer will want as much time as possible to investigate, document, and report. [45 C.F.R. Section 164.402; Civil Code Section 1798.82; Health and Safety Code Section 1280.15]

9. The law permits hospitals and other businesses to examine a driver's license or DMV identification card, photocopy it, and retain the photocopy. However, a license or ID card may be scanned or swiped only:

    a. To verify the age or authenticity of the card.

    b. To comply with a legal requirement.

    c. To transmit to a check service company.

    d. To collect or disclose information required for reporting, investigating, or preventing fraud, abuse, or material misrepresentation.

    A hospital or other business may not retain or use any of the information obtained by electronic scanning or swiping for any purpose not listed above. [Civil Code Section 1798.90.1]

10. California law contains limitations on requiring patients or consumers to submit their Social Security number (SSN) over the internet, as well as printing SSNs on identification cards or on materials mailed to the holder of the number. The law does not prevent the collection, use or release of an SSN as required by law, or the use of an SSN for internal verification or administrative purposes. [Civil Code Section 1798.85]

11. California law limits the information that a business can require a customer to provide when accepting a check or a credit card as payment for goods and services [Civil Code Sections 1725 and 1747.08].

California hospitals (and most other health care providers) must comply with either the CMIA or LPS, and with all the other laws listed above. If there is a state law and a federal law on the same topic, under federal preemption rules, health care providers must comply with whichever law is more stringent — that is, the law that is more protective of the patient's privacy or that gives the patient greater access to their information. Complicating matters further, providers must comply with whichever *provision* of the laws is stricter. This means if the state law is more stringent than the federal law, with the exception of one provision, providers must comply with the state law and the one provision in federal law that gives patients greater privacy protection or greater access to their own information.

B. Enforcement and Penalties

FEDERAL

The DHHS Office for Civil Rights (OCR) is responsible for enforcing HIPAA. Any person, organization, or group that believes a hospital or other health care provider has violated HIPAA may file a complaint with OCR; the complainant does not need to be the patient. Therefore, complainants may include a provider's employees, unions, medical staff members, business associates, or patients, as well as accrediting, health oversight or advocacy agencies. OCR is also required by law to conduct random audits and compliance reviews.

Noncompliance with the HIPAA rules has serious potential implications. HIPAA provides for fines of up to $55,010 per violation and criminal penalties of up to 10 years in prison. A California hospital is subject to both state and federal penalties.

A state attorney general may also enforce HIPAA.

STATE

The California Department of Public Health (CDPH) is responsible for investigating violations of California law in hospitals and other health care facilities, and may assess fines of up to $25,000 per patient, per privacy breach (with some limits).

In addition, the CMIA authorizes several levels of administrative fines or civil penalties, depending upon whether a violation was negligent, knowing or willful, or done for financial gain. The upper levels of fines are $250,000 per violation. These penalties may be sought by the California Attorney General, any district attorney or county counsel, or others. A violation of CMIA may also be punished as a misdemeanor.

There are also financial penalties available under the law for violations of LPS and the special laws for confidentiality of HIV test results.

Finally, a patient may recover monetary damages from a health care provider for a violation of state health information privacy laws. Many class action lawsuits have been brought against providers asking for statutory damages of $1,000 per patient whose information was hacked or was contained in stolen computer equipment. Although many of these lawsuits have been successfully defended, it is clear that privacy breaches are an area of high-dollar risk.

II. PATIENT PRIVACY RIGHTS

State and federal laws give patients certain rights regarding their privacy and their medical information. Patients have a right to:

1. Obtain a written notice from their health care provider explaining how it will use and disclose their information. This is called the Notice of Privacy Practices.
2. Access their medical records. This means patients can see their records, request copies, and request a correction/amendment to their record. Limited exceptions to this right exist; if a health care provider believes that a patient seeing his or her own medical record might be detrimental to the patient or another person, the provider should consult legal counsel or the privacy officer. Patients are not entitled to take the original medical record, and may be monitored while they review the record to ensure no changes are made.
3. Request that a provider not use or disclose certain information for purposes of treatment, payment, and health care operations. It is important to know that although patients have the right to make these requests, providers are generally not required to comply. Hospital personnel should be trained that whenever a patient makes a special request about the privacy of their information, the hospital's privacy officer should be contacted. The bedside nurse or emergency department physician should not, for example, assure the patient that their information will not be disclosed to a certain physician or insurance company. Only the privacy officer should make such commitments to patients.
4. Request that information be communicated to them in particular ways to ensure confidentiality. For example, the patient may request to have information sent to work rather than their home. These requests must be accommodated, if reasonable. Hospitals and other health care providers should have a process in place to document these requests, respond to them, and implement them if reasonable.
5. Obtain an accounting of how their information has been disclosed for purposes not related to treatment, payment or health care operations. *(See C. "Treatment, Payment and Health Care Operations," page 6.6.)*
6. Refuse to authorize the release of their information for most purposes that are not related to treatment, payment or health care operations. *(See C. "Treatment, Payment and Health Care Operations," page 6.6.)*
7. Be notified of breaches to the extent required by law.

For more information about these patient rights, consult your hospital's privacy officer or legal counsel, or refer to CHA's *California Health Information Privacy Manual*.

III. HEALTH CARE PROVIDER OBLIGATIONS

Hospitals and other health care providers must:

1. Give each patient a Notice of Privacy Practices.
2. Limit the circumstances under which patient information is used or disclosed.
3. Develop policies, procedures and systems to protect patient privacy and allow patients to access and correct their records.
4. Train staff on privacy policies and procedures.
5. Appoint a privacy officer to make sure privacy procedures are developed, adopted and followed.
6. Appoint a security officer to make sure security procedures are developed, adopted and followed.
7. Implement appropriate administrative, technical and physical safeguards to protect patient records from individuals who shouldn't see them.
8. Account for specified disclosures of patient information.
9. Establish a complaint mechanism for privacy concerns.
10. Establish and enforce a system of sanctions for employees who violate privacy policies and procedures.
11. Establish written agreements with business associates.
12. Notify patients and government agencies of a breach to the extent required by law.

For more information about these requirements, consult your hospital's privacy officer or legal counsel, or refer to CHA's *California Health Information Privacy Manual*.

IV. USE AND DISCLOSURE OF PATIENT INFORMATION

A. What Information is Protected?

State and federal laws protect individually-identifiable health information in every form — electronic, on paper or oral. **"Individually-identifiable health information"** is health information that identifies, or there is a reasonable basis to believe it can be used to identify, a patient. Federal law in particular has very detailed requirements about

de-identified information, because computer-savvy people can take a little bit of health information, combine it with other publicly available data such as voter registration or social media information, and determine to which patient the health information pertains. Hospital staff should consult the hospital's privacy officer or legal counsel to learn if a particular set of data elements is considered individually-identifiable.

"Health information" is broadly defined to include any information relating to the physical or mental health or condition of a patient, the health care provided to a patient, or payment for health care provided to a patient. This includes medical records, billing records, and other types of records.

It is important to understand that the restrictions on the use and disclosure of individually-identifiable health information apply to the hospital's use of patient information internally, among staff and throughout departments — not just to disclosures of information outside the facility.

B. General Rule

In general, providers cannot use or disclose individually-identifiable health information unless:

1. The patient completes an authorization form. An authorization for a disclosure of medical information must be in writing and contain several specified elements. CHA has developed the "Authorization for Use or Disclosure of Health Information" (CHA Form 16-1) to comply with all state and federal requirements. If the patient is a minor, deceased, or lacks the capacity to make health care decisions, the patient's legal representative may sign the authorization form. Hospital staff should consult the privacy officer or legal counsel about who is considered a legal representative.
2. The use or disclosure is made directly to another health care provider for the purposes of treatment or payment.
3. The information is used within the facility for its own health care operations *(see C. "Treatment, Payment and Health Care Operations," page 6.6)*.
4. The requirements for communicating with patients' family or friends are followed *(see E. "Family and Friends: Patients Covered by CMIA," page 6.7 and F. "Family and Friends: Patients Covered by LPS," page 6.7)*.
5. The disclosure is required by law. A health care provider is permitted to disclose patient-identifiable information to the extent necessary to make a legally-mandated report, such as a report of child abuse, communicable disease, gunshot wound or other suspicious injury, etc. The information disclosed must be limited to the minimum information necessary to comply with the reporting requirement.

   It is important to note that this "required by law" permission does not mean that a health care provider can disclose information to law enforcement officers. In fact, there are very strict rules about giving information to law enforcement officers. The hospital's privacy officer or legal counsel should be consulted before giving a law enforcement officer any patient information.
6. A specific provision of law permits the use or disclosure.

There are many complicated exceptions to the general rule. Front line clinical staff should consult the hospital's privacy officer or legal counsel in situations that are not listed above.

If a question arises about whether a particular use or disclosure is permissible, providers should remember that obtaining a written authorization from the patient or the patient's legal representative is almost always a safe course of action.

THE CONCEPT OF MINIMUM NECESSARY

HIPAA introduced the concept of "minimum necessary." Providers must limit their use and disclosure of individually-Identifiable health information to the minimum amount of information necessary to accomplish the intended purpose of the use or disclosure. For example, if the hospital's auditor needs patient medical record information to determine if a bill is accurate, the auditor should be allowed access to only that portion of the medical record that the bill covers. The auditor should not be able to see the rest of the medical record.

The minimum necessary standard does not apply to:

1. Disclosures to, or requests by, a health care provider for treatment purposes. Physicians, nurses and other providers may need the complete medical record to provide the best care possible.
2. Uses or disclosures made to the patient. A patient has the right to access his or her information.
3. Uses or disclosures made according to a patient's written authorization. A patient is allowed to authorize the disclosure of the entire medical record.

Implementation of Minimum Necessary

A health care provider must identify the employees or classes of employees who need access to health information to carry out their duties. For each employee or class of employees, the provider must identify the categories of information to which access is needed and any conditions appropriate to such access. The provider must make reasonable efforts to limit access to the minimum information needed.

For routine and recurring disclosures (or requests), a provider must implement policies and procedures (which may be standard protocols) that limit the information disclosed (or requested from another covered entity) to the amount reasonably necessary to achieve the purpose of the disclosure (or request).

For all other disclosures (or requests) — that is, nonroutine and nonrecurring — a provider must develop criteria designed to limit the information disclosed to what is reasonably necessary to accomplish the purpose for which disclosure is sought, and must review each request for disclosure on an individual basis in accordance with those criteria.

When the minimum necessary standard applies, a provider may not use, disclose or request an entire medical record, except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure or request.

[45 C.F.R. Section 164.514(d)]

INCIDENTAL USES AND DISCLOSURES

HIPAA recognizes that "incidental" uses and disclosures will occur. For example, if two hospitalized patients share a room, it is inevitable that one patient will overhear medical information about the other. HIPAA explicitly permits covered entities to use or disclose health information "incident to a use or disclosure otherwise permitted or required by" HIPAA, if the hospital has complied with the minimum necessary standard; implemented appropriate administrative, technical, and physical safeguards; and made reasonable attempts to limit incidental uses and disclosures. For example, if a nurse needs to talk to a patient about his or her medical condition, it would be reasonable to ask the roommate's visitors to step outside the room temporarily. However, it would not be necessary to transfer the roommate to another room temporarily.
[45 C.F.R. Section 164.502(a)(1)(iii)]

VERIFICATION OF IDENTITY/AUTHORITY

Health care providers must verify the identity of any person requesting individually-identifiable information, and their authority to have it, if the identity or authority is not already known to the provider. Providers must also obtain any documentation, statements or representations (whether oral or written) that are a condition of disclosure. In the case of parents, guardians, or other legal representatives, this includes verifying that the person requesting health information is indeed the parent, guardian, or a legal representative.

Providers should have policies and procedures to verify the identity and authority of requestors, and to document this was done.

C. Treatment, Payment and Health Care Operations

A health care provider may use or disclose patient information, without a written authorization from the patient, for what HIPAA calls "treatment, payment, and health care operations" (TPO).

"Treatment" means providing, coordinating or managing a patient's care, including consultations between providers and referrals.

"Payment" is defined as activities related to paying or being paid for services rendered. These include eligibility and coverage determinations, billing, claims management, utilization review and the like.

"Health care operations" covers a broad range of activities such as quality assessment and improvement, patient education and training, health practitioner training, contracting for health care services, medical review, legal services, auditing functions, compliance, business planning and development, business management and general administrative activities.

Clinical staff should consult the hospital's privacy officer or legal counsel if questions arise about which activities are considered TPO.

D. Hospital Directory

State and federal health information privacy laws significantly restrict the information that may be disclosed without patient authorization to the public, including visitors, florists, clergy, media and others. A patient has the right to prevent even this restricted information from being released. Patients should be advised of this right in the Notice of Privacy Practices they receive upon admission to

the hospital. If a patient objects to the release of information to the public, the patient should be asked to complete the "Request to Withhold Public Release of Information" (CHA Form 16-2) or a similar form.

If the patient has not requested that information be withheld *and* the request for information contains the patient's name, HIPAA and the CMIA allow hospitals to release:

1. The patient's condition, described in general terms that do not communicate specific medical information about the individual (for example, "undetermined," "good," "fair," "critical," etc.).
2. The patient's location within the hospital. Release of location is intended to facilitate visits by family and friends, as well as delivery of gifts or flowers. Caution should be exercised in disclosing this information over the telephone. Precise directions (e.g., floor or room number) are best disclosed only on a face-to-face basis so that there is an opportunity to verify the individual's purpose or intended use of the information.

As a reminder, patients in psychiatric units are covered by the Lanterman-Petris-Short Act, not the CMIA *(see 3. on page 6.1)*. A hospital should neither confirm nor deny that a patient is in an acute psychiatric hospital or a psychiatric unit of a general acute care hospital without the patient's authorization.

[45 C.F.R. Section 164.510(a)(1)(i)(C)]; Civil Code Section 56.16]

(See E. "Family and Friends: Patients Covered by CMIA," page 6.7 below, about disclosures that may be made to family and friends involved in the care of the patient.)

E. Family and Friends: Patients Covered by CMIA

Both the CMIA and HIPAA (but not LPS) permit disclosure of limited information to a family member, other relative, domestic partner, close personal friend, or other person identified by the patient. Information is limited to the information directly relevant to that person's involvement with the patient's health care or payment for the care. This rule applies to minors as well as adults. This rule does not apply to HIV test results or information held by federally-assisted substance use disorder programs.

Disclosure or use of health information is also permitted to notify, or assist in the notification of (including identifying or locating), a family member, personal representative of the patient, domestic partner, or other person responsible for the care of the patient, of the patient's location, general condition, or death.

Disclosure to family and friends is subject to the conditions described below. [Civil Code Section 56.1007; 45 C.F.R. Section 164.510(b)]

CAUTION: LPS information may not be disclosed under this provision of law. If a patient is an involuntarily detained mental health patient, or a patient in an acute psychiatric hospital, psychiatric unit in a general acute care hospital, or a mental health patient in a government-operated hospital or clinic, the patient's authorization must be obtained prior to disclosing information to family or friends *(see 3. on page 6.1)*.

PATIENT IS PRESENT AND HAS DECISION-MAKING CAPACITY

Where the patient is available and has decision-making capacity, disclosure may be made to family/friends if the provider:

1. Obtains the patient's verbal agreement;
2. Provides the patient with the opportunity to object to the disclosure, and the patient does not do so; or
3. Reasonably infers from the circumstances, based upon their professional judgment that the patient does not object to the disclosure. However, this provision does not apply if the provider is a psychotherapist [Civil Code Section 56.1007(c)(2))].

PATIENT IS UNAVAILABLE OR INCAPACITATED

If the patient is not present, or the opportunity to agree or object to the use or disclosure to family/friends cannot practicably be provided because of the patient's incapacity or an emergency circumstance, disclosure may be made if the provider, in the exercise of professional judgment, determines the disclosure is in the best interests of the patient. As a reminder, the provider may disclose only the information directly relevant to the person's involvement with the patient's health care, payment for the care, or needed for notification purposes.

F. Family and Friends: Patients Covered by LPS

As a general rule, a hospital may not disclose patient-identifiable information to family or friends without the patient's authorization, unless a special exception to the law applies. The law is especially strict with respect to mental health patients whose records are subject to the LPS confidentiality provisions *(see below for information about which patients are covered)*. For these patients, a hospital usually should not disclose even whether the person is or has been a patient ("we can neither confirm

nor deny that this person is or has been a patient here") without patient permission. However, LPS requires that limited information be disclosed to family and others in the situations described below. In each case, the hospital should disclose only the minimum information necessary to comply with the law.

WHICH PATIENTS ARE COVERED BY THESE NOTIFICATION REQUIREMENTS?

The LPS notification requirements apply to patients who are receiving voluntary or involuntary treatment in a:

1. Hospital designated by the county for patients who are a danger to self or others or gravely disabled;
2. State mental hospital;
3. County psychiatric ward, facility or hospital;
4. University of California psychiatric facility: Langley Porter Psychiatric Institute and the Neuropsychiatric Institute at UCLA. Other University of California mental health services providers should consult University of California counsel regarding their status under LPS;
5. Federal hospital, psychiatric hospital or unit;
6. Private institution, hospital, clinic or sanitarium which is conducted for, or that includes a department or ward conducted for, the care and treatment of persons who are mentally disordered;
7. Psychiatric health facility as described in Health and Safety Code Section 1250.2;
8. Mental health rehabilitation center as defined in Welfare and Institutions Code Section 5675;
9. Skilled nursing facility with a special treatment program service unit for patients with chronic psychiatric impairments *(see Title 22, California Code of Regulations, Sections 51335 and 72443-72475 regarding such special treatment programs)*;
10. Community program funded by the Bronzan-McCorquodale Act. Because it is often difficult to determine which patients received services funded under the Bronzan-McCorquodale Act, each program and its legal counsel should review any funds received under the Bronzan-McCorquodale Act to determine the applicability, if any, of those confidentiality provisions as a result of such funding [Welfare and Institutions Code Sections 5600-5778]; and
11. Community program specified in the Welfare and Institutions Code Sections 4000-4390 and Welfare and Institutions Code Sections 6000-6008.

Absent some tie-in to one of the above-described programs, LPS does not apply to other mental health patients, even though they may receive mental health treatment similar to what is covered by LPS. These patients and their records are instead subject to the Confidentiality of Medical Information Act (CMIA). For example, mental health services provided to an involuntary patient in a private, non-designated hospital emergency department under Health and Safety Code Section 1799.111 are subject to the CMIA rather than LPS.

DEFINITIONS

The reporting requirements described below use the terms "next of kin" and "reasonable attempt," but do not define these terms. The facility should specify by policy the order in which relatives will be notified, and may, for example, use the priority in which people inherit as a starting point. Therefore, when an adult patient is admitted, the facility could decide that it should attempt to contact one of the following persons, in the priority stated:

1. Spouse or domestic partner
2. Adult son or daughter
3. Either parent
4. Adult brother or sister
5. Grandparents
6. Adult aunt or uncle

If the patient is a minor, the parent(s) or legal guardian should be contacted.

The hospital should also establish in its policy what actions constitute a "reasonable attempt" to notify the family.

NOTIFICATION OBLIGATIONS

Notifying Family and Others of Admission

A hospital must make reasonable attempts to notify an LPS patient's next of kin or other person designated by the patient when he or she is admitted for inpatient services to a 24-hour public or private health facility licensed under Health and Safety Code Section 1250 (for example, a general acute care hospital or an acute psychiatric hospital), unless the patient asks that this information not be provided. The patient must be advised by the facility that he or she has the right to request that this information not be provided.

The following information must be documented in the patient's medical record:

1. That the patient was advised that next of kin would be notified unless the patient asks that this notification not be made;
2. The patient's response to the advisement;
3. The date and circumstances under which the notification (if any) was made or attempted;
4. The names and relationships to the patient, if any, of persons or agencies to whom the notification was made; and
5. The specific information disclosed.

[Welfare and Institutions Code Section 5328.1(b); see also 45 C.F.R. Section 164.512(a)]

Different notification requirements apply to patients who arrive in the emergency department of a general acute care hospital who are unconscious or otherwise unable to communicate. *(See CHA's* Consent Manual*, chapter 1, for further information.)*

Notifying Family and Others of Inpatient's Release, Transfer, Illness or Death

A hospital must make reasonable attempts to notify an LPS inpatient's next of kin or other person designated by the patient of the patient's release, transfer, serious illness, injury or death, upon the request of the family member, unless the patient asks that this information not be provided [Welfare and Institutions Code Section 5328.1(b); *see also 45 C.F.R. Section 164.512(a)*].

The hospital must advise the patient that it is required to and will attempt to contact his or her next of kin or other person the patient designates, to provide this information. The hospital also must inform the patient of the right to request that this information not be disclosed.

The following information must be documented in the patient's medical record:

1. That the patient was advised that next of kin would be notified unless the patient asks that this notification not be made;
2. The patient's response to the advisement;
3. The date and circumstances under which the notification (if any) was made or attempted;
4. The names and relationships to the patient, if any, of persons or agencies to whom the notification was made; and
5. The specific information disclosed.

Notifying Family and Others of the Patient's Condition

Upon request of a family member of a patient (or other person designated by the patient), a facility must tell the family member (or the designee) of an LPS patient's diagnosis, the prognosis, the medications prescribed, the side effects of medications prescribed, if any, and the progress of the patient, if, after notifying the patient that this information is requested, the patient authorizes its disclosure [Welfare and Institutions Code Section 5328.1(a)].

The patient's written authorization should be obtained. The "Authorization for Use or Disclosure of Health Information" form (CHA Form 16-1) or a similar form, should be completed and placed in the patient's medical record.

If the patient is unable to authorize the release of this information, the hospital must document the attempt to obtain the patient's authorization in the medical record. Daily efforts must be made to secure the patient's authorization or refusal.

However, if a request for information is made by the spouse, parent, child or sibling of the patient and the patient is unable to authorize the release of such information, the requestor must be told of the patient's presence in the facility, except to the extent prohibited by federal law (this last qualification was likely inserted originally to accommodate the federal substance use disorder confidentiality regulations, which limit disclosure of a patient's presence in a facility) [Welfare and Institutions Code Section 5328.1(a); *see also 45 C.F.R. Section 164.512(a)*].

The following information must be documented in the patient's medical record:

1. The date and circumstances under which the notification was made or attempted;
2. The names and relationships to the patient, if any, of persons or agencies to whom the notification was made; and
3. The specific information disclosed.

IMMUNITY FROM LIABILITY

Facilities and their employees are not liable for damages caused, or allegedly caused, by the release of information, or failure to release information, under this law.

G. Mental Health Advocates

Mental health advocates may have the legal authority to access patient information and records. This authority is described in V. "Mental Health Advocacy Programs," page 4.7.

H. Notifying Law Enforcement Officers of Patient Presence, Release or Disappearance

As a general rule, a hospital may not disclose patient-identifiable information to law enforcement officers without the written authorization of the patient, unless a special exception to the law applies *(see chapter 6)*. The law is especially strict when an officer requests information about a mental health patient whose records are subject to the LPS confidentiality provisions *(see chapter 6 for information about which patients are covered)*. For these patients, a hospital usually should not disclose even whether the person is or has been a patient ("we can neither confirm nor deny that this person is or has been a patient here"). However, LPS requires that limited information be disclosed to law enforcement officers in the situations described below. In each case, the hospital should disclose only the minimum information necessary to comply with the law.

"HOLDABLE" VOLUNTARY PATIENT

If a voluntary patient who is a danger to self/others or gravely disabled (that is, the patient meets the criteria for involuntary commitment for 72-hour treatment and evaluation) disappears from the hospital, the physician in charge of the patient or the professional person in charge of the facility or his or her designee may designate a governmental law enforcement agency or agencies to be notified. The whereabouts of the patient must be unknown, and the disclosure must be necessary for the protection of the patient or others. The hospital may also notify the patient's relatives. The information disclosed should be the minimum necessary to assist in finding the patient. [Welfare and Institutions Code Section 5328.3(a); see also 45 C.F.R. Sections 164.508(a)(2)(ii) and 164.512(j)]

The following information must be documented in the patient's medical record:

1. The date and circumstances under which the notification was made;
2. The names and relationships to the patient, if any, of persons or agencies to whom the notification was made; and
3. The specific information disclosed.

The law does not define the term "relatives" or specify which relatives may be notified. It would make sense to notify the relative(s) in the best position to find the patient and take steps to keep the patient and others safe.

[Welfare and Institutions Code Section 5328.6]

INVOLUNTARY PATIENT

LPS-designated hospitals, state hospitals, and Veterans' Administration facilities must notify the law enforcement agency of the county or city in which the hospital is located when a patient listed in one of the following categories escapes:

1. A patient judicially committed.
2. A patient involuntarily detained under Welfare and Institutions Code Sections 5000 to 5550. *(See chapter 3 regarding involuntary detainment for mental health evaluation and treatment.)*
3. A patient who has been placed in a facility by his or her conservator pursuant to Welfare and Institutions Code Section 5350.

The notification must be in writing and include:

1. The name and physical description of the patient;
2. The patient's home address;
3. The degree of dangerousness of the patient, including specific information about the patient if he or she is deemed likely to cause harm to himself or herself or others; and
4. Any additional information that is necessary to apprehend and return the patient.

The person in charge of the hospital or facility (or a designee) may notify the law enforcement agency by phone and follow up with written notification. The written notification must include the time and date of the telephonic notification, the person notified, and the person who made the notification. [Welfare and Institutions Code Section 7325; see also 45 C.F.R. Section 164.512(a) and (f)]

INVOLUNTARY PATIENT UNDER CRIMINAL INVESTIGATION

A hospital must notify the county behavioral health director (or designee) and law enforcement agency upon the discharge of a patient after a peace officer initiated a 72-hour hold and requested to be notified when the patient was released. The peace officer must have certified in writing at the time of detention that the facts would support the filing of a criminal complaint against the patient. The information disclosed must be limited to:

1. The patient's name and address;
2. The date of admission for 72-hour evaluation and treatment;
3. The date of certification for intensive treatment (if applicable); and

4. The date of release.

Notification is required whether the hospital decides not to detain the patient at all, detains him or her for the full 72 hours, or detains him or her for less than 72 hours.

(See "Notification of Release to County Behavioral Health Director and Peace Officer," page 3.12, regarding patients brought to the facility for a 72-hour evaluation period. See "Notification of Release to County Behavioral Health Director and Peace Officer," page 3.19, regarding patients receiving 14-day intensive treatment.)

[Welfare and Institutions Code Sections 5152.1, 5250.1 and 5328(a)(16); see also 45 C.F.R. Section 164.512(a) and (f)]

DANGEROUS FELON

A hospital must report to the California Department of Justice movement and identification information about a patient committed to the California Department of State Hospitals, a state hospital, or any other public or private mental health facility approved by the county behavioral health director for observation or for an indeterminate period as a mentally disordered sex offender, a sexually violent predator, a person committed pursuant to Penal Code Sections 1026 (not guilty by reason of insanity) or 1370 (mentally incompetent to stand trial), or Welfare and Institutions Code Section 5300 (imminently dangerous). The information that may be disclosed is limited to:

1. Patient's name and address;
2. Fingerprints;
3. Dates of admission and discharge;
4. Date of escape or return from escape;
5. Date of any home leave, parole, or leave of absence; and
6. The county in which the person will reside upon release, if known.

[Welfare and Institutions Code Section 5328.2; see also 45 C.F.R. Section 164.512(a) and (f)(1)(i)]

CRIMINAL DEFENDANT DETERMINED TO BE MENTALLY INCOMPETENT TO STAND TRIAL

A hospital must report the disappearance or transfer between state hospitals of a patient who is a criminal defendant who was committed following a determination of incompetency to stand trial with respect to a pending felony charge involving death, great bodily harm, or a serious threat to the physical well-being of another person [Welfare and Institutions Code Section 5008(h)(1)(B); Penal Code Section 1370].

Notice of the disappearance or transfer must be made to:

1. The court initially ordering the patient's commitment;
2. The district attorney for the county that ordered the commitment; and
3. Governmental law enforcement agencies designated by the physician in charge of the patient or the person in charge of the facility.

This notice must be made within 24 hours of the patient's disappearance or transfer.

[Welfare and Institutions Code Section 5328.3(b)(1); see also 45 C.F.R. Section 164.512(a) and (f)]

The following information must be documented in the patient's medical record:

1. The date and circumstances under which the report was made;
2. The names and relationships to the patient, if any, of persons or agencies to whom the report was made; and
3. The specific information disclosed.

[Welfare and Institutions Code Section 5328.6]

LAW ENFORCEMENT OFFICER WITH A WARRANT

A facility must advise a law enforcement officer who personally lodges a warrant of arrest or an abstract of such a warrant showing that the person sought is wanted for a serious felony (as defined in Penal Code Section 1192.7) or a violent felony (as defined in Penal Code Section 667.5), whether the person named in the arrest warrant is currently in the facility. The information to be disclosed is limited to whether or not the person named in the warrant is in the facility.

An officer may not enter the facility to arrest the person without obtaining a valid search warrant or the permission of the facility.

For purposes of this law, **"facility"** means:

1. A state hospital as defined in Welfare and Institutions Code Section 4001;
2. A general acute care hospital as defined in Health and Safety Code Section 1250(a), solely with regard to information pertaining to a person with mental illness subject to LPS;
3. An acute psychiatric hospital as defined in Health and Safety Code Section 1250(b);

4. A psychiatric health facility as defined in Health and Safety Code Section 1250.2;
5. A mental health rehabilitation center as defined in Welfare and Institutions Code Section 5675; and
6. A skilled nursing facility with a special treatment program for individuals with mental illness, as described in Title 22, California Code of Regulations, Sections 51335 and 72445-72475.

[Welfare and Institutions Code Section 5328(a)(20); see also 45 C.F.R. Section 164.512(a) and (f)]

PATIENT HAD WEAPON CONFISCATED

A hospital must report the release of a patient who had a weapon confiscated to the confiscating law enforcement agency. *(See "Reporting to Confiscating Law Enforcement Agency," page 7.37.)*

I. Minor's Medical Records

In general, state and federal health information privacy laws apply equally to the records of adults and the records of minors. Minors' health information enjoys the same legal privacy protections as that of adults, and the health information of minors may generally be used and disclosed in the same ways as that of adults. However, the law often gives parents or guardians the ability to exercise the privacy rights of minors on their behalf. This is not always the case, though, as described more fully below. [45 C.F.R. Section 164.502(g); Civil Code Section 56.11(c); Health and Safety Code Sections 123110 and 123115; Welfare and Institutions Code Section 5328(a)(4)]

Note that disclosures may be made to family and close personal friends of minors as described In E. "Family and Friends: Patients Covered by CMIA," page 6.7.

GENERAL RULE: ACCESS TO RECORDS CORRESPONDS TO CONSENT FOR TREATMENT

The laws governing who may access a minor's medical information and disclose a minor's medical information to third parties correspond with the laws governing who may consent to the treatment that the information covers. Chapter 2 describes the laws about minors' consent to treatment.

Access to a minor's medical and dental records may not be denied to a parent solely because that parent is not the minor's custodial parent [Family Code Section 3025]. However, this law does not give noncustodial parents the right to access medical records where the minor has the legal authority to consent to the treatment.

Special laws apply to records of dependent children of the juvenile court and foster children. The hospital's privacy officer or legal counsel should be consulted.

Minor Has Legal Authority to Consent to the Treatment

If the minor has the authority to consent to medical treatment under state law, then the minor is generally the person authorized to have access to the records regarding the treatment, and to decide whether the records may be released to others (including the parent or other legal representative). This is true even where the parent or other legal representative, as a practical matter, solicits and consents to the treatment. However, the minor may request that the parent or other legal representative be treated as the minor's personal representative under HIPAA. This means that the minor can request that the parent be told about the minor's health conditions and have access to the minor's record.

Exceptions. There are several situations in which the minor has the legal authority to consent to medical treatment, but the provider is authorized, or required, to provide specified information to the parents. These situations involve self-sufficient minors, minor victims of sexual assault, minors receiving outpatient mental health treatment or residential shelter services, and minors receiving substance use disorder treatment. Chapter 2 contains more information about these situations.

Minor Does Not Have Legal Authority to Consent to the Treatment

If the parent (or other legal representative) has the authority to consent to medical treatment for a minor, then the parent is generally the person authorized to have access to the minor's records about the treatment, and to decide whether the records may be released to others. Three exceptions are described below.

Exception: Parent Assents to Confidentiality. A parent (or other legal representative) may assent to an agreement of confidentiality between a health care provider and the minor with respect to a health care service for which the minor does not have the legal authority to consent. In this case, the provider may not disclose information to the parent without the minor's authorization.

Exception: Access by Parent Would Be Detrimental to Minor. A health care provider may deny a parent (or other legal representative) access to the minor's records, even though the parent had the authority to consent to the treatment, if the provider determines that access to

the records by the parent would have a detrimental effect on the provider's professional relationship with the minor patient, or the minor's physical safety or psychological well-being. The decision of the health care provider about whether or not to make the minor's records available will not result in any liability to the provider, unless the decision is found to be in bad faith.

Exception: Dependent Child of the Juvenile Court/ Foster Child. A minor may be removed from the physical custody of his or her parent or guardian by the juvenile court because the minor has suffered, or there is a substantial risk that the minor will suffer, abuse or harm. Such a minor is called a "dependent child of the court" for a foster child. A psychotherapist may not disclose mental health information about the minor to the parent, or to third parties based on the parent's authorization. For a detailed discussion of this law, see CHA's *California Health Information Privacy Manual* or *Minors and Health Care Law Manual*.

Cautions

"Mixed" Medical Record. A minor's medical record may contain information about treatment that the minor may consent to, and information about treatment that the parent or other legal representative must consent to. In such cases, the health care provider should take extra care to ensure that records are released appropriately. Records released to the wrong person, or at the wrong person's request, may constitute a privacy breach.

Billing for Services. If a minor has the legal authority to consent to medical treatment, then the minor is responsible for payment. Health care providers should establish a system to ensure that they do not bill parents for services for which the minor may lawfully consent, as this may be considered a breach of the minor's privacy rights (unless the minor's consent to bill is obtained). The provider may bill insurance companies — it is the insurer's responsibility to insure that Explanation of Benefits (EOB) forms are not sent to parents for services the minor can consent to.

Medi-Cal has a special program to pay for some services for which minors may consent regardless of parental income or assets, and without contacting the parents.

(See C. "Financial Responsibility for Treatment of Minors," page 2.25.)

V. SEARCHING PATIENTS AND THEIR BELONGINGS

A. Culture of Safety and Right to Privacy

Hospitals are responsible for keeping their patients and employees safe. *(See, for example, 42 C.F.R Section 482.13(c)(2) and Title 8, California Code of Regulations, Section 3342.)* At times, this may require searching a patient and his or her belongings.

Hospitals should have a form and a process to document the belongings patients bring to the hospital — mundane items as well as valuables — and where they will be kept (such as at the patient's bedside or in the hospital's safe). Chapter 20 of CHA's *Consent Manual* describes the legal limitations on a hospital's liability for patients' personal belongings and includes a suggested process for inventorying and documenting belongings. Chapter 11 of CHA's *Consent Manual* contains sample language for the hospital's "Conditions of Admissions" form informing the patient that the hospital is not liable for the patient's personal articles that are not deposited with the hospital for safekeeping (such as eyeglasses, dentures, hearing aids, cell phones, laptops, etc.). This portion of this manual addresses the purposeful search of patients and their belongings for potentially dangerous items rather than the routine cataloguing of patients' belongings.

There is no state or federal law specifically addressing patient searches. However, state and federal laws acknowledge that patients have a general right to privacy. This right at times must give way to the hospital's obligation to keep its patients and employees safe. Hospitals may wish to develop and implement a patient search policy to guide clinicians in the hospital's requirements for, and process of, searching patients and their belongings. The policy should address situations where a patient does not cooperate with a search.

B. When to Search

Health care facilities or units that care for patients who have been detained as a danger to self or others or gravely disabled will generally search all patients and their belongings. Even if a particular patient is not considered to be potentially dangerous, the hospital cannot take the risk that another patient in the same room or common area will obtain a potentially harmful item.

Health care facilities or units that do not care for patients who may be a danger to self or others or gravely disabled will usually conduct searches only upon specific

justification. These facilities may wish to document the justification in the patient's medical record or include a space to document the justification on a search/inventory form they develop.

If the patient has (or if there is a suspicion that a patient has) firearms or other dangerous weapons, hospital policy may require that staff contact security and/or law enforcement immediately. Clinical staff should not be put in the position of attempting to remove weapons from a patient.

C. Process of Search

The patient should be informed that the hospital is required to keep the patient, other patients, staff and visitors safe, and that any belongings not sent home with family or friends may be searched to remove any objects that may be used in an unsafe or disruptive manner. In addition, hospitals are required to protect the privacy of other patients, so the use of cell phones and cameras may be restricted. Efforts should be made to accomplish the search in a consensual, non-forcible manner.

Hospital policy should describe when a full search is required (as opposed to having the patient empty his or her pockets and submit to a "patdown"). If a full search is necessary, hospitals typically have the patient remove all street clothing and change into a paper or cloth gown, putting their clothing and other belongings into a bag provided by the hospital. The patient should be given as much privacy to undress as is safe. An employee who observes the patient should be of the same gender as the patient. A hospital employee will then inventory the possessions (including the contents of any suitcases, purses and bags). If the patient is able and willing to cooperate, this should be done in the presence of the patient. Hospitals often require that two staff members participate in the search; both should sign the inventory form.

If a patient wishes to wear his or her own clothes while hospitalized, the searched clothing may be returned to the patient if it is safe (no drawstrings, belts, neckties, etc.). If the patient wishes a friend or family member to take home any items, this should be documented. The hospital may wish to have the patient or family member sign for the item(s) taken home. The patient should be told where the belongings will be kept and how and when he or she may access them.

A body cavity search is generally performed only when the attending physician believes that this level of search is warranted. This type of search should only be conducted by a physician, usually in the presence of a second clinician. At least one of the clinicians should be the same gender as the patient.

If a patient refuses to cooperate with a needed search, and holding or restraint is necessary to accomplish it, staff must follow the hospital restraint policy. Chapter 5 describes all state and federal laws governing the use of seclusion and restraint.

The search should be documented so that it is not unnecessarily repeated.

D. Potentially Dangerous Items

Hospitals should develop a policy about storage, disposition or destruction of weapons, legal or illegal drugs, or other potentially harmful objects or substances encountered.

E. Related Laws

Mental health patients covered by the Lanterman-Petris-Short Act have certain rights, including the right to wear their own clothing; the right to have access to storage space for personal belongings; and the right to keep and use their own personal possessions, including toilet articles. These rights may be denied for good cause. There are documentation and reporting requirements when rights are denied. A complete description of mental health patient rights is found in chapter 4.

In addition, certain mental health patients are prohibited by law from possessing firearms and other deadly weapons for a specified period of time after their treatment. The law requires hospitals to report these patients to the California Department of Justice. Chapter 7 contains complete information about weapons prohibitions laws.

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Forms and Appendices can be found at the back of the manual and online for CHA members at www.calhospital.org/free-resources.

"S" denotes that the form is provided in English and Spanish.

7 Reporting Assaults, Potentially Dangerous Patients and Firearms Prohibitions

I. REPORTS REQUIRED BY LAW

A. Scope of Chapter

Hospitals and other health care providers are required by law to make certain reports, many of which arise in the context of mental health services. This chapter addresses the laws that require reporting of assault and abuse, including injuries by deadly weapon, rape, child abuse, elder abuse, dependent adult abuse and injuries/conditions resulting from abuse or neglect found in a patient received from a health facility, such as a skilled nursing or community care facility. These reports must be made whether the patient is assaulted inside or outside the hospital, if the triggers for the reporting requirement are met.

NOTE: This manual does not address required reporting of injured employees to Cal/OSHA, law enforcement agencies, or CDPH. CHA publishes other guidebooks and manuals that address employer obligations, including *Healthcare Workplace Violence Prevention* and *The Cal/OSHA Safe Patient Handling Regulation* guidebook. Visit www.calhospital.org/publications for information about other CHA publications.

B. Confidentiality Considerations

State and federal health information privacy laws permit the disclosure of patient-identifiable information to report suspicious injuries and suspected abuse as described in this chapter [45 C.F.R. Section 164.512(a) and (c); Civil Code Section 56.10(c)(14) and (22)]. The special restrictions that apply to certain mental health patient information and records, federally-assisted substance use disorder program records, and HIV test results must be followed, if applicable *(see chapter 6)*. In all cases, disclosure should be limited to the minimum amount of information necessary to fulfill the reporting requirement. Specifics about the patient's diagnosis, medications, and other details are ordinarily not required to be disclosed to fulfill reporting obligations.

CHILD ABUSE

HIPAA contains a specific provision allowing disclosure of protected health information (PHI) to appropriate government authorities authorized by law to receive reports of child abuse or neglect [45 C.F.R. Section 164.512(b)(1)(ii)].

OTHER ABUSE

HIPAA authorizes disclosure of information about individuals reasonably believed to be victims of abuse, neglect or domestic violence to government authorities legally authorized to receive such reports as follows:

1. To the extent required by law; or
2. If the individual agrees to the disclosure; or
3. To the extent disclosure is expressly authorized by law and either:
    a. Disclosure is necessary to prevent serious harm to the individual or other potential victims; or
    b. The individual is unable to agree to due to incapacity, the government authority represents that the PHI is not intended to be used against the individual, and an immediate enforcement activity depends upon the disclosure and would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

[45 C.F.R. Section 164.512(c)(1)]

Therefore, if state law *requires* a report, it may be made. If state law merely authorizes (but does not require) a report, it may be made only if the criteria in paragraph 3.a. or 3.b. are satisfied.

C. Informing the Patient of Reporting

If the patient was a victim of abuse, neglect or domestic violence (except child abuse or neglect), the health care provider must promptly inform the patient that a report has been or will be made, unless:

1. The provider believes, in the exercise of professional judgment, that informing the patient would place him or her at risk of serious harm; or
2. The provider would be informing a personal representative, and the provider reasonably believes the personal representative is responsible for the abuse, neglect or other injury, and that informing the personal representative would not be in the patient's best interest as determined by the provider in the exercise of professional judgment. [45 C.F.R. Section 164.512(c)(2)]

Verbal notification to the patient is sufficient. A report must be made even if the patient objects. The health care provider may wish to suggest that the victim go to a protected environment due to the risk of the abuser's retaliation after the report is made.

If the patient was not a victim of abuse, neglect or domestic violence (for example, the patient was shot by accident or attempted suicide), the patient need not be notified that a report has been or will be made.

D. Summary of Assault and Abuse Reporting Requirements

CHA has included a table at the end of this manual titled "Assault and Abuse Reporting Requirements" (CHA Table 19-A) summarizing assault and abuse reporting requirements.

II. STATUTORY DUTY TO REPORT CERTAIN INJURIES AND CONDITIONS

A. Nature of the Duty to Report

California law imposes a duty on hospitals and physicians to make oral and written reports to local authorities when a person comes, or is brought to, a hospital, or is under the professional care of a physician, and the person is suffering from:

1. An injury caused by a firearm or assaultive or abusive conduct *(see III. "Reporting Injuries by Firearm or Assaultive or Abusive Conduct ("Suspicious Injuries")," page 7.3)*;
2. Sexual assault/rape *(see IV. "Sexual Assault and Rape," page 7.5)*;
3. Child abuse *(see V. "Child Abuse and Neglect," page 7.8)*;
4. Abuse of elders and dependent adults *(see VI. "Abuse of Elders and Dependent Adults," page 7.19)*;
5. An injury or condition resulting from neglect or abuse in a patient transferred from another health facility *(see VII. "Injury or Condition in a Patient Received From a Licensed Health Facility Resulting From Neglect or Abuse," page 7.31)*.

In addition, hospitals must report violence against hospital personnel in specified circumstances. These reporting requirements are described in CHA's *Healthcare Workplace Violence Prevention* guidebook. Go to www.calhospital.org/wvp-guidebook for more information or to order.

B. Failure to Report

CRIMINAL LIABILITY

A person required to report injuries by firearms or by assaultive or abusive conduct *(see III. "Reporting Injuries by Firearm or Assaultive or Abusive Conduct ("Suspicious Injuries")" below)* but who fails to do so is guilty of a misdemeanor, punishable by imprisonment in the county jail not exceeding six months or by a fine not exceeding $1,000, or both.

A mandated reporter who fails to report an incident of known or reasonably suspected child abuse or neglect *(see V. "Child Abuse and Neglect," page 7.8)* is also guilty of a misdemeanor (same punishment as above). The law contains similar penalties for failure to report elder or dependent adult abuse *(see VI. "Abuse of Elders and Dependent Adults," page 7.19)*.

[Penal Code Sections 11162 and 11166; Welfare and Institutions Code Section 15630(h)]

CIVIL LIABILITY

In *Landeros v. Flood*, 17 Cal.3d 399 (1976), the California Supreme Court ruled that an abused child may recover damages for subsequent injuries suffered at the hands of his or her parents, from a hospital or physician if it can be proven that the hospital or physician knew, or should have known, that the child was a victim of child abuse or neglect, but failed to report the abuse in accordance with the law.

This ruling may be extended to other situations, such as imposition of civil liability for failure to report elder abuse or an injury or condition resulting from neglect or abuse in a patient transferred from another health facility.

III. REPORTING INJURIES BY FIREARM OR ASSAULTIVE OR ABUSIVE CONDUCT ("SUSPICIOUS INJURIES")

Health practitioners employed by specified entities are required to make reports to a local law enforcement agency when they treat persons with specified injuries (sometimes called "suspicious injury reports"). Additionally, every physician treating such persons also has a duty to make a report, even if the physician is not an employee. [Penal Code Sections 11160 and 11161]

A. Who Must Report

Reports must be made by:

1. A health practitioner employed in a health facility, clinic, physician's office, local or state public health department, local government agency, or a clinic or other type of facility operated by a local or state public health department; and
2. A physician who has an injured patient under his or her charge or care.

For purposes of this law, "employed by a local government agency" includes an employee of an entity under contract with a local government agency to provide medical services. This would include paramedics and emergency medical technicians working for ambulance companies or hospitals that have a contract with a local government agency. [Penal Code Section 11160(i)]

The reporting duties under this law apply to each individual. However, when two or more persons who are required to report are present and jointly have knowledge of a reportable event, they may agree among themselves to report as a team and make a single report. The team may mutually select a member of the team to make a report by telephone and a single written report. The written report must be signed by the selected member of the reporting team. A member who has knowledge that the member designated to report has failed to do so must thereafter make the report.

California's legislative counsel has opined that licensed clinical social workers are not required to report suspicious injuries because they do not provide medical services for a physical condition [Opinion dated 4-1-98].

No supervisor or administrator may impede or inhibit the reporting duties required under the law, and no person making a report may be subject to any penalties for making the report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established. The internal procedures must not require any employee required to make a report to disclose his or her identity to the employer.

B. Reports Required to be Made

A report must be made when a health practitioner, in his or her professional capacity or within the scope of his or her employment, provides medical services *for a physical condition* to a patient whom he or she knows or reasonably suspects is a person:

1. Suffering from any wound or other *physical* injury where the injury is by means of a firearm, whether inflicted by the patient him/herself or by another person.
2. Suffering from any wound or other *physical* injury inflicted upon the person where the injury is the result of assaultive or abusive conduct.

[Penal Code Section 11160]

The duty to report arises where the health practitioner provides medical services to a patient for *any* physical condition, not just the condition or injury arising from the assault, battery or firearm incident. A report must be made even if the injury is not serious. So, for example, if a patient in a mental health facility is assaulted by another patient and requires any type of treatment for a physical injury – even if relatively minor — a report must be made.

A report must also be made by every physician who has such a person under his or her charge or care [Penal Code Section 11161(a)].

RELATED REPORTING REQUIREMENTS

If a patient or staff member is assaulted or abused in a health facility and medical services are provided to treat the injury, a report must be made under the law discussed above as well as the laws that are specific to violence against hospital personnel *(see CHA's* Healthcare Workplace Violence Prevention *guidebook for more information)*. If death or significant injury occurs to a patient or staff member resulting from a physical assault on the grounds of a facility, an adverse event must be reported to the California Department of Public Health (CDPH) *(see VII. "CDPH Adverse Events Reporting," page 8.7)*, as well as reporting under the law described above.

C. Definitions

"Assaultive or abusive conduct" includes any of the following offenses, as they are defined in the Penal Code:

1. Murder
2. Manslaughter
3. Mayhem
4. Aggravated mayhem
5. Torture
6. Assault with intent to commit mayhem, rape, sodomy or oral copulation
7. Administering controlled substances or anesthetic to aid in commission of a felony
8. Battery
9. Sexual battery
10. Incest
11. Throwing any vitriol, corrosive acid or caustic chemical with intent to injure or disfigure
12. Assault with a stun gun or taser
13. Assault with a deadly weapon, firearm, assault weapon or machine gun, or by means likely to produce great bodily injury
14. Rape
15. Spousal rape
16. Procuring any female to have sex with another man
17. Child abuse or endangerment
18. Abuse of spouse or cohabitant
19. Sodomy
20. Lewd and lascivious acts with a child
21. Oral copulation
22. Sexual penetration by a foreign object
23. Elder abuse
24. An attempt to commit any crime specified in the offenses listed above.

[Penal Code Section 11160(d)]

"Health practitioner" is defined in the law to include:

1. A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage and family therapist, clinical social worker or any other person who is currently licensed under Business and Professions Code Section 500 *et seq.*;
2. An emergency medical technician I or II, paramedic or other person certified pursuant to Health and Safety Code Section 1797 *et seq.*;
3. A psychological assistant registered pursuant to Business and Professions Code Section 2913;
4. A marriage and family therapist trainee, as defined in Business and Professions Code Section 4980.03(c);
5. An unlicensed associate marriage and family therapist registered under Business and Professions Code Section 4980.44;
6. A state or county public health employee who treats a minor for venereal disease or any other condition;
7. A coroner; or
8. A medical examiner or any person who performs autopsies.

[Penal Code Sections 11162.5(a) and 11165.7]

"Injury" does not include any psychological or physical condition brought about solely through the voluntary administration of a narcotic or restrictive dangerous drug [Penal Code Section 11160(c)].

"Reasonably suspects" means that it is objectively reasonable for a person to entertain such a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate from his or her training and experience, to suspect [Penal Code Section 11162.5(d)].

D. Timing and Form of Report

A report by telephone must be made immediately or as soon as practically possible to a local law enforcement agency.

A written report must be prepared and sent to a local law enforcement agency within two working days. The California Office of Emergency Services (Cal OES) has developed a standard form to be used by health practitioners. The "Suspicious Injury Report" (Cal OES 2-920) may be found at www.ccfmtc.org.

A report must be made even if the person who suffered the injury has died, regardless of whether or not the injury or assaultive or abusive conduct was a factor contributing to the death, and even if the evidence of the conduct of the perpetrator of the injury or assaultive or abusive conduct was discovered during an autopsy.

E. Notification of Patient/Victim That Report Will be Made

The patient usually must be notified that a report has been or will be made. *(See C. "Informing the Patient of Reporting," page 7.1, for information about this requirement.)*

F. Medical Record Documentation

Penal Code Section 11161 recommends (but does not require) that the medical record of a person who is the subject of a report include the following:

1. Any comments by the injured person about past domestic violence or the name of any persons suspected of inflicting the wound, other physical injury, or assaultive or abusive conduct upon the person.
2. A map of the injured person's body showing and identifying injuries and bruises.
3. A copy of the law enforcement reporting form.

Hospitals may wish to consider putting the forensic medical reports in a separate section of the medical record to prevent routine copying and disclosure of these reports for purposes not related to the criminal justice system, and to prevent improper release to unauthorized persons.

G. Immunity From Liability

A health practitioner who makes a report of injury or abuse as required or authorized by law shall not incur civil or criminal liability as a result. Furthermore, the practitioner shall not incur civil or criminal liability as a result of providing access to the victim at the request of an adult protective services agency or a law enforcement agency.

Health practitioners who have made reports and who incur attorneys' fees as a result of legal action taken against them on the basis of making the report may present a claim to the California Board of Control for their reasonable attorney's fees if the health practitioner prevails in the legal action.

Immunity is also provided in connection with the taking of photographs of a person about whom a report is made or for disseminating the photographs to local law enforcement with the reports. However, no immunity is provided for any other use of the photographs.

No employee may be discharged, suspended, disciplined or harassed for making a report pursuant to this law.

[Penal Code Sections 11161.9 and 11163]

H. Confidentiality

The reports required by this law must be kept confidential by the health facility, clinic or physician's office that submitted the report, and by local law enforcement agencies [Penal Code Section 11163.2(b)].

However, counties may establish domestic violence death or elder death review teams, which may include medical personnel with expertise in domestic violence. Each organization represented on the team may share otherwise confidential information, upon written request, with other team members if pertinent to the review. This includes medical information covered by the Confidentiality of Medical Information Act or the Lanterman-Petris-Short Act. [Penal Code Sections 11163.3 and 11174.8]

In no case shall the person suspected of the assaultive or abusive conduct or his or her attorney be allowed access to the injured person's whereabouts.

In a court proceeding or administrative hearing, neither the physician-patient privilege nor the psychotherapist-patient privilege applies to the information required to be reported under this law [Penal Code Section 11163.2(a)].

IV. SEXUAL ASSAULT AND RAPE

A. Reporting Requirements

Cases of sexual assault and rape must be reported under Penal Code Section 11160 (described in III. "Reporting Injuries by Firearm or Assaultive or Abusive Conduct ("Suspicious Injuries")," page 7.3).

B. Examination or Referral of Victims

Penal Code Section 13823.9(c) requires each county to designate at least one general acute care hospital to perform forensic examinations on victims of sexual assault, including child molestation. All other public and private general acute care hospitals must either comply with the legal standards, protocols and guidelines in examining or treating victims of sexual assault and attempted sexual assault (including child molestation) or "adopt a protocol for immediate referral of these victims to a local hospital that so complies and shall notify local law enforcement agencies, the district attorney and local victim assistance agencies of the adoption of the referral protocol." [Health and Safety Code Section 1281].

C. Required Examination Report Forms

Each physician or nurse who conducts an examination for evidence of a sexual assault or attempted sexual assault (including child molestation) must use the standard form(s) adopted by the California Office of Emergency Services (Cal OES). The health care professional must make the observations and perform the tests required to complete the form if the patient consents. Reports must be made on the forms listed below. [Penal Code Section 13823.5]

FORMS

The forms are:

1. Cal OES 2-923: "Forensic Medical Report: Acute (less than 72 hours) Adult/Adolescent Sexual Assault Examination"
2. Cal OES 2-924: "Forensic Medical Report: Abbreviated Adult/Adolescent Sexual Assault Examination"
3. Cal OES 2-925: "Forensic Medical Report: Nonacute (greater than 72 hours) Child/Adolescent Sexual Abuse Examination"
4. Cal OES 2-930: "Forensic Medical Report: Acute (less than 72 hours) Child/Adolescent Sexual Abuse Examination"

Copies of these forms and instructions are available at www.ccfmtc.org. The website also has instructions, protocols for examination of victims, and other information.

For information about the forms or assistance in completing them, contact the California Clinical Forensic Medical Training Center at (916) 930-3080 or see their website at www.ccfmtc.org.

D. Consent to the Forensic Examination

Forms Cal OES 2-923, OES 2-924, 2-925 and 2-930 contain distinct consent requirements in addition to those generally included in consent forms used by emergency departments, including:

1. An acknowledgment of the provider's duty to report to law enforcement authorities the name and whereabouts of any persons who are victims of sexual assault *(see A. "Reporting Requirements," page 7.5)*.
2. A consent to a separate medical examination for evidence of sexual assault at public (county) expense to discover and preserve evidence of the assault.

Consent for a physical examination, treatment and collection of evidence is required [Penal Code Section 13823.11]. Consent to an examination for evidence of sexual assault must be obtained prior to the exam and must include written documentation of each of the following:

1. Examination for the presence of injuries sustained as a result of the assault.
2. Examination for evidence of sexual assault and collection of physical evidence.
3. Photographs of injuries.

The victim (or parent or guardian) must be informed that he or she may refuse to consent to an evidentiary exam, and that such a refusal will not result in a denial of treatment of injuries, possible pregnancy and sexually transmitted diseases if the victim wishes to obtain treatment. *(See "Consent for Abuse-Related Exams," page 7.12, for information about minors ability to consent to sexual assault examination and treatment.)*

E. Protocol for Examination and Treatment of Victim

Cal OES has prepared protocols for examination of victims, available at www.ccfmtc.org. This portion of the manual identifies several preliminary legal requirements.

INFORMATIONAL CARD

Before starting an evidentiary or other physical exam for a sexual assault, the physician or nurse must give the victim an informational card designed by law enforcement for sexual assault victims [Penal Code Section 680.2(a)]. This requirement applies only if the law enforcement agency has given cards to the medical provider in a language understood by the victim. Hospitals should check with their local law enforcement agency to obtain a supply of these cards. [Penal Code Section 264.2(b)(2)]

POSTCOITAL CONTRACEPTION

If the sexual assault could result in pregnancy, the victim must be provided with the option of postcoital contraception. If the victim requests it, postcoital contraception must be dispensed at no cost to the victim. [Penal Code Section 13823.11]

SEXUAL ASSAULT COUNSELOR

The victim has the right to have a sexual assault counselor and at least one other support person of the victim's choosing present at any medical evidentiary or physical examination. The victim must be informed by the medical provider of this right, either orally or in writing, prior to the

examination. A support person may be excluded from the exam if the law enforcement officer or medical provider determines that the presence of that individual would be detrimental to the purpose of the exam. [Penal Code Section 264.2]

NOTIFY RAPE VICTIM COUNSELING CENTER

The law enforcement officer or agency is supposed to notify the local rape victim counseling center whenever a victim is transported to a hospital for a medical evidentiary or physical exam. The hospital may verify with the law enforcement officer or agency that the rape victim counseling center has been notified, if the victim approves. In addition, the hospital may notify the rape victim counseling center, if the victim approves. [Penal Code Section 264.2(b)(1)]

OPPORTUNITY TO SHOWER/BATHE

After conducting a medical evidentiary or physical examination, the medical provider is required to give the victim the opportunity to shower or bathe at no cost, unless a showering or bathing facility is not available. [Penal Code Section 264.2(b)(5)]

NOTIFY LAW ENFORCEMENT AGENCY

A medical provider must, within 24 hours of obtaining sexual assault forensic evidence from the victim, notify the law enforcement agency having jurisdiction over the alleged violation if the medical provider knows the appropriate jurisdiction. If the medical provider does not know the appropriate jurisdiction, the medical provider must notify the local law enforcement agency. [Penal Code Section 264.2(b)(6)]

F. Confidentiality

The suspected sexual assault forms Cal OES 2-923, OES 2-924, 2-925 and 2-930 are subject to the same principles of confidentiality applicable to any other aspect of the medical record [Penal Code Section 13823.5(c)]. No information may be disclosed except that which is required to complete the form, except as permitted or required by another law (for example, in response to a court order or pursuant to child abuse or elder abuse reporting laws). The special confidentiality rules regarding child/elder/dependent adult abuse reports are described in the respective portions of this chapter.

G. Forensic Exam of Suspect

A health practitioner who, in his or her professional capacity or within the scope of his or her employment, performs a forensic medical examination on a person in the custody of law enforcement from whom evidence is sought in connection with the commission or investigation of sexual assault, must prepare a written report. The report must be on the form developed by Cal OES, and must be immediately provided to the law enforcement agency that has custody of the person examined. The required form is Cal OES 2-950, "Forensic Medical Report: Sexual Assault Suspect Examination" and is available at www.ccfmtc.org. Instructions and an examination protocol are also available at this website.

The health practitioners covered by this law are those who are employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department.

The examination and report are subject to the Confidentiality of Medical Information Act, the physician-patient privilege, and the privilege of official information pursuant to Evidence Code Section 1040 *et seq.* However, the report must be released upon oral or written request to any person or agency involved in any related investigation or prosecution of a criminal case. The persons to whom the report must be released upon request include, but are not limited to, a law enforcement officer, district attorney, city attorney, crime laboratory, county licensing agency, and a coroner. The report may be released to defense counsel or another third party only through discovery of documents in the possession of a prosecuting agency or by court order.

A health practitioner who makes a report in accordance with this law is immune from civil or criminal liability.

No person, agency, or their designee required or authorized to report pursuant to this law, who takes photographs of a suspect is civilly or criminally liable for taking the photographs, causing the photographs to be taken, or disseminating the photographs to a law enforcement officer, district attorney, city attorney, crime laboratory, county licensing agency, or coroner with the reports required in accordance with this law. However, the photographs may not be used in any other way.

No health practitioner may be required to perform a forensic medical examination as part of his or her duties as a health practitioner, except for those health practitioners who have entered into a contract to perform forensic medical exams.

[Penal Code Section 11160.1]

V. CHILD ABUSE AND NEGLECT

A. Basic Reporting Requirement

Health practitioners and others who have knowledge of or observe a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse or neglect are required to report to a designated law enforcement agency. The initial report must be made immediately, or as soon as practically possible, by telephone. A follow-up written report must then be made within 36 hours. These requirements, as well as definitions of terms used in the law, are explained in this section of the manual.

California's child abuse and neglect reporting laws cover children under the age of 18. [Penal Code Sections 11164-11174.3]

This reporting requirement applies even if the child has died, regardless of whether or not the possible abuse was a factor contributing to the child's death, and even if suspected child abuse was discovered during an autopsy.

[Penal Code Section 11166(a)]

UNSUITABLE HOME

A mandated reporter who knows or reasonably suspects that the home or institution in which a child resides is unsuitable for the child because of abuse or neglect of the child is required to bring the condition to the attention of the agency to which he or she makes a report of the abuse or neglect, and must do so at the same time as the report is made [Penal Code Section 11166(f)].

EMOTIONAL DAMAGE

A mandated reporter who has knowledge of or who reasonably suspects that a child is suffering serious emotional damage or is at substantial risk of suffering serious emotional damage, evidenced by states of being or behavior, including, but not limited to, severe anxiety, depression, withdrawal or untoward aggressive behavior toward self or others, may (but is not required to) make a report to the appropriate agency. [Penal Code Section 11166.05]

B. Definitions

"Abuse or neglect in out-of-home care" includes:

1. Physical injury or death inflicted upon a child by another person (by other than accidental means);
2. Sexual abuse;
3. Neglect;
4. Unlawful corporal punishment or injury; or
5. The willful harming or injuring of a child or the endangering of the person or health of a child.

This applies where the person responsible for the child's welfare is:

1. A licensee, administrator or employee of a licensed community care or child day care facility or a facility licensed to care for children; or
2. The administrator or employee of a public or private residential home, school or other institution.

This term does not include an injury caused by a peace officer's reasonable and necessary force while acting within the course and scope of the officer's employment as a peace officer. [Penal Code Section 11165.5]

"Child abuse or neglect" includes the following:

1. A physical injury or death that is inflicted by other than accidental means on a child by another person;
2. Sexual abuse;
3. Neglect;
4. Unlawful corporal punishment or injury;
5. Willful harming or injuring of a child or endangering of the person or health of a child; and
6. Abuse or neglect in out-of-home care.

[Penal Code Section 11165.6]

NOTE: Child abuse does not include a mutual affray between minors or an injury caused by a peace officer's reasonable and necessary force used while acting within the course and scope of the officer's employment as a peace officer. **"Affray"** is not defined in the law, but the dictionary defines it as a fight, quarrel or brawl.

"Neglect" means the negligent treatment or maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person. [Penal Code Section 11165.2]

"Neglect" includes **"general neglect"** which means:

> the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care or supervision where no physical injury to the child has occurred.

"Neglect" also includes **"severe neglect"** which means:

> the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where a person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as proscribed by section 11165.3, including the intentional failure to provide adequate food, clothing, shelter or medical care.

A child receiving treatment by spiritual means as provided in Welfare and Institutions Code Section 16509.1 or not receiving specified medical treatment for religious reasons, shall not be, for that reason alone, considered a neglected child.

The law also provides that "an informed and appropriate medical decision made by (the) parent or guardian after consultation with a physician or physicians who have examined the child does not constitute neglect" [Penal Code Section 11165.2]. This provision leaves open the question as to what constitutes an "informed and appropriate medical decision," but it appears to require reporting in situations in which the physician or another member of the health care team believes that a decision made by a child's parent or guardian after receiving the relevant information is not appropriate, in the sense that it is not consistent with the child's best interests.

"Reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. "Reasonable suspicion" does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect. Any reasonable suspicion is sufficient. However, the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse *(see "When a Child Seeks Treatment for a Sexually Transmitted Disease, Pregnancy or Abortion," page 7.13)*. [Penal Code Section 11166(a)] In addition, the laws regarding "safe surrender" of a newborn and maternal substance abuse contain provisions stating that these activities in and of themselves do not trigger child abuse reporting. *(See "Maternal Substance Abuse," page 7.14, and "Safe Surrender of a Newborn," page 7.15.)*

"Sexual abuse" means sexual assault or sexual exploitation [Penal Code Section 11165.1].

"Sexual assault" means conduct in violation of various Penal Code sections including rape, rape in concert, statutory rape, incest, sodomy, lewd or lascivious acts upon a child, oral copulation, sexual penetration and child molestation.

Conduct described as "sexual assault" includes, but is not limited to, all of the following:

1. Penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is emission of semen.
2. Sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person.
3. Intrusion by one person into the genitals or anal opening of another person, including the use of an object for this purpose, except that it does not include acts performed for a valid medical purpose.
4. The intentional touching of the genitals or intimate parts, including the breasts, genital area, groin, inner thighs and buttocks, or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, except that it does not include acts which may reasonably be construed to be normal caretaker responsibilities; interactions with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose.
5. The intentional masturbation of one's genitals in the presence of a child.

"Sexual exploitation" refers to any of the following:

1. Conduct involving matter depicting a minor engaged in obscene acts, which violates the law prohibiting the preparation, sale or distribution of obscene matter or employment of minors to perform obscene acts.
2. A person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or a person responsible for a child's welfare who knowingly permits or encourages a child to engage in, or assist others to engage in, prostitution or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting or other pictorial depiction involving obscene sexual conduct. (**"Person responsible for a child's welfare"** means a parent; guardian; foster parent; or a licensed administrator or employee of a public or private residential home, residential school or other residential institution.)
3. A person who depicts a child in, or who knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or

exchanges, a film, photograph, videotape, video recording, negative or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in Penal Code Section 311.3.

"Commercial sexual exploitation" refers to either of the following:

1. The sexual trafficking of a child, as described in Penal Code Section 236.1(c).
2. The provision of food, shelter, or payment to a child in exchange for the performance of any sexual act described in this law or Penal Code Section 236.1(c).

"Unlawful corporal punishment or injury" means a situation where a person willfully inflicts upon a child cruel or inhuman corporal punishment or injury resulting in a traumatic condition. It does not include an amount of force that is reasonable and necessary for a person employed by or engaged in a public school to quell a disturbance threatening physical injury to a person or damage to property, for purposes of self-defense, or to obtain possession of weapons or other dangerous objects within the control of the pupil, as authorized by Education Code Section 49001. It also does not include the exercise of the degree of physical control authorized by Education Code Section 44807. In addition, unlawful corporal punishment or injury does not include an injury caused by a peace officer's reasonable and necessary force while acting within the course and scope of the officer's employment as a peace officer. [Penal Code Section 11165.4]

"Willful harming or endangering of a child" means a situation in which any person willfully causes or permits a child to suffer, or inflicts upon a child, unjustifiable physical pain or mental suffering, or having the care and custody of the child, willfully causes or permits the person or health of the child to be placed in a situation in which the child's person or health is endangered. [Penal Code Section 11165.3]

C. Persons Required or Permitted to Report

MANDATED REPORTERS

Penal Code Section 11165.7 requires specified health care providers and clergy members (among others) to report suspected child abuse and neglect. Persons required by law to report are called "mandated reporters."

The law describes more than 44 categories of professionals or individuals who are considered mandatory reporters under the law [Penal Code Section 11165.7]. These categories of mandated reporters include social workers; teachers; teacher's aides and assistants; certain court employees; licensed day care workers; employees of child care institutions; peace officers; firefighters; probation officers; parole officers; custodial officers; specified district attorney investigators; local child support agency caseworkers; persons providing in-home supportive services to minors; film developers; commercial computer technicians (who work for a company in the business of repairing or installing computers for a fee); and various community professionals and workers in schools, day care programs, youth centers and camps.

Health care providers that are mandated reporters are physicians, surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, marriage and family therapists, clinical social workers, professional clinical counselors, or any other person who is currently licensed under Business and Professions Code Section 500 *et seq.*; an emergency medical technician I or II, paramedic, or other person certified pursuant to Health and Safety Code Section 1797 *et seq.*; a psychological assistant registered pursuant to Business and Professions Code Section 2913; a marriage and family therapist trainee, as defined in Business and Professions Code Section 4980.03(c); an unlicensed associate marriage and family therapist registered under Business and Professions Code Section 4980.44; an alcohol and drug counselor; a professional clinical counselor trainee; an associate professional clinical counselor; a state or county public health employee who treats a minor for venereal disease or any other condition; a coroner; or a medical examiner or any person who performs autopsies. [Penal Code Sections 11162.5 and 11165.7]

Clergy

"Clergy member" means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization [Penal Code Section 11165.7(a)(32)]. Any clergy member who has knowledge of, or observes a child in his or her professional capacity or within the scope of his or her duties, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect, must comply with the requirements of this law. However, a clergy member who acquires knowledge or reasonable suspicion of child abuse or neglect during a "penitential communication" is not required to report. A **"penitential communication"** means a communication, intended to be in confidence, including, but not limited to, a sacramental confession, made to

a clergy member, who in the course of the discipline or practice of his or her church, denomination or organization, is authorized or accustomed to hear those communications, and under the discipline, tenets, customs or practices of his or her church, denomination or organization, has a duty to keep those communications secret. This exception must not be construed to modify or limit a clergy member's duty to report known or suspected child abuse or neglect when he or she is acting in some other capacity that would otherwise make the clergy member a mandated reporter [Penal Code Section 11166(d)]. A custodian of records of a clergy member is also a mandated reporter.

Alcohol and Drug Counselor

Alcohol and drug counselors are mandatory reporters. An **"alcohol and drug counselor"** is a person providing counseling, therapy, or other clinical services for a state-licensed or certified drug, alcohol, or drug and alcohol treatment program.

VOLUNTARY REPORTERS

Penal Code Section 11166(g) permits, but does not require, reporting from any other person (who is not a mandated reporter) who has knowledge of or reasonably suspects a child has been the victim of child abuse or neglect [Penal Code 11166(g)]. This includes a mandated reporter who acts in his or her private capacity and not in his or her professional capacity or within the scope of his or her employment.

Volunteers

Although hospital volunteers (and other volunteers, except volunteers of a Court Appointed Special Advocate Program) are not mandated reporters, the law encourages volunteers who have contact with children to obtain training in the identification and reporting of child abuse and to report known or suspected instances of child abuse to agencies specified under the law to receive such reports [Penal Code Section 11165.7(b)]. Employers are encouraged to provide training to volunteers [Penal Code Section 11165.7(g)].

SELECTION OF A PERSON TO REPORT

Reporting information about possible child abuse to a supervisor, employer, coworker or other person is not a substitute for reporting to a law enforcement agency. However, in a hospital or clinic, two or more mandated reporters may become jointly aware of the same instance of reportable child abuse or neglect. The law allows the team to select, by mutual agreement, a single member who will be responsible for making the telephone report and making and signing the written report. However, if any member of the team knows the designated member failed to report, he or she must thereafter make the report.

The law allows the hospital or clinic to create internal procedures to facilitate reporting and apprise supervisors and administrators of reports. However, a hospital's internal policy may not direct employees to allow their supervisor to file or process a mandated report under any circumstances. No supervisor or administrator may impede or inhibit child abuse reporting, and employees must not be subject to sanctions for making a report. [Penal Code 11166]

The internal procedures must not require an employee required to make reports by the statute to disclose his or her identity to the employer [Penal Code Section 11166(i)(2)].

D. Reporting to Law Enforcement

A telephone report, followed by a written report, must be made to any police department (not including a school district police or security department), sheriff's department, county probation department (if designated by the county to receive child abuse reports) or the county welfare department. Agencies that are required to receive child abuse reports may not refuse to accept them. They must maintain a record of all reports received. [Penal Code Section 11165.9]

CONTENT OF REPORT

Reports of suspected child abuse or neglect must include the following information [Penal Code Section 11167]:

1. The name, business address and telephone number of the mandated reporter, and the capacity that makes the person a mandated reporter.

   If the person is not a mandated reporter, he or she is not required to include his or her name [Penal Code Section 11167(f)]. If the name is given, the person's identity is confidential and may be disclosed only in limited circumstances.

2. The information that gave rise to the reasonable suspicion of child abuse or neglect and the source or sources of that information.

If a report is made, the following information, if known, must also be included in the report:

1. The child's name, address and present location, and, if applicable, the child's school, grade and class.

2. The names, addresses and telephone numbers of the child's parents or guardians.
3. The name, address, telephone number and other relevant personal information about the person or persons who might have abused or neglected the child.

A mandated reporter may include with the report any nonprivileged documentary evidence related to the incident [Penal Code Section 11166(a)]. *(See F. "Privileges Inapplicable," page 7.15.)*

The mandated reporter shall make a report even if some of this information is not known or is uncertain to him or her.

HOW REPORTS ARE MADE

An initial telephone report must be made immediately or as soon as is practically possible after receiving the information concerning the incident [Penal Code Section 11166(a)].

A written follow-up report must be sent by mail, facsimile, or email to the law enforcement agency within 36 hours of receiving the information concerning the incident.

Required Form

The California Department of Justice has adopted "Suspected Child Abuse Report," form SS 8572, which must be used for the written report. The form may be obtained from the local social services department or child protective services agency. (The form may be downloaded at www.ag.ca.gov/childabuse/pdf/ss_8572.pdf or www.ccfmtc.org.)

Procedure

The person or the team member designated to report should fill in and sign the written report. The same person should make both the telephone and the written report.

FORENSIC MEDICAL REPORTS

A medical professional who examines a child for physical injury or sexual assault that is suspected child abuse must complete a medical report within 36 hours of receiving the information concerning the incident. This medical report should be submitted along with "Suspected Child Abuse Report," form SS 8572. This medical report should be the "Medical Report: Suspected Child Physical Abuse and Neglect Examination" (Cal OES 2-900) or one of the forms described in "Forms," page 7.6. The forms, instructions, and examination protocols may be found at www.ccfmtc.org.

A medical exam relating to sexual assault must be documented on standard forms adopted by Cal OES [Penal Code Section 13823.5]. That office developed the forms described in "Forms," page 7.6. Therefore, when there is evidence of child sexual abuse, one of these forms must be used. When no sexual abuse is indicated, form Cal OES 2-900 is the more appropriate form since it is better suited to gathering evidence of physical abuse or neglect.

For information about the forms or assistance in completing them, contact the California Clinical Forensic Medical Training Center at (916) 930-3080.

Documentation in the Medical Record

The forensic medical reports must become part of the patient's medical record pursuant to guidelines established by the advisory committee of Cal OES. Hospitals may wish to consider putting the forensic medical reports in a separate section of the medical record to prevent routine copying and disclosure of these reports for purposes not related to the criminal justice system, and to prevent improper release to unauthorized persons. The completed forms are subject to the special confidentiality laws pertaining to the release of forensic medical examination records *(see G. "Disclosure and Follow-Up Procedures," page 7.16, and I. "Confidentiality of Reports," page 7.18)*. [Penal Code Section 11171(d)]

The hospital's initial report to law enforcement is not required to be placed in the medical record. Hospitals should develop a policy regarding maintenance of reports to maintain confidentiality of the reporter's identity *(see I. "Confidentiality of Reports," page 7.18)*.

CONSENT FOR ABUSE-RELATED EXAMS

Special Law for X-Rays

A physician or dentist (or their agents at their direction) may take skeletal X-rays of a child without the consent of the child's parent or guardian, but only for the purpose of diagnosing the case as one of possible child abuse or neglect and determining the extent of such child abuse or neglect [Penal Code Section 11171.2].

Additionally, if a peace officer in the course of investigation of child abuse or neglect has reasonable cause to believe that the child has been physically abused, the officer may apply to a magistrate for an order directing that the child be X-rayed without parental consent [Penal Code Section 11171.5]. X-rays performed pursuant to such an order must be performed by a physician or dentist or their agents.

Reimbursement by the county for administrative costs of such X-rays will not exceed 5 percent of the cost of the X-rays.

Other Treatment

If further treatment beyond X-rays is necessary and the parents object, the hospital should consult legal counsel. It may be appropriate to seek a petition to declare the minor a dependent child of the juvenile court pursuant to Welfare and Institutions Code Section 300 for the purposes of assuring that he or she receives the proper medical care.

If the minor has been raped or sexually assaulted, the minor may give consent to medical treatment *(see below)*.

Rape

A minor 12 years of age or older who has allegedly been raped may consent to the furnishing of hospital, medical, and surgical care related to the diagnosis or treatment of such condition. This includes information concerning, and access to, the "morning after" pill [*Brownfield v. Daniel Freeman Marina Hospital*, 208 Cal.App.3d 405(1989)]. The minor may also consent to the collection of evidence with regard to the alleged rape. The consent of the minor's parent(s) or guardian is not necessary. [Family Code Section 6927; Title 11, California Code of Regulations, Section 925]

A minor who has been raped has also been sexually assaulted, according to the legal definitions. It is unclear why California law contains two different statutes pertaining to these victims (Family Code Sections 6927 and 6928, which is discussed below). The only difference in the two statutes is that Family Code Section 6928 (regarding sexual assault) requires the professional person providing medical treatment to a minor victim of sexual assault must attempt to contact the minor's parent/guardian unless the treating professional person reasonably believes the parent/guardian was the perpetrator. CHA recommends that the treating professional talk to the minor sexual assault victim about contacting the parent, and then contact the parent unless the minor voices significant concern. This discussion and the outcome should be documented.

Sexual Assault

A minor who is alleged to have been sexually assaulted may consent to the furnishing of hospital, medical and surgical care related to the diagnosis and treatment of such condition. Sexual assault includes, but is not limited to, rape, sodomy, or oral copulation. The minor may also consent to collection of medical evidence with regard to the alleged sexual assault. The consent of the minor's parent(s) or guardian is not necessary [Family Code Section 6928; Title 11, California Code of Regulations, Section 925].

The professional person providing the medical treatment must attempt to contact the minor's parent(s) or guardian and note the date and time of such contact or, if unsuccessful, when contact was attempted. However, the professional person need not make this contact if he or she reasonably believes that the parent(s) or guardian committed the sexual assault on the minor. [Family Code Section 6928]

E. Special Situations Regarding Reporting

WHEN A CHILD SEEKS TREATMENT FOR A SEXUALLY TRANSMITTED DISEASE, PREGNANCY OR ABORTION

The pregnancy of a minor, in and of itself, does not constitute the basis for reasonable suspicion of child abuse [Penal Code Section 11166(a)]. Neither does, by itself, a request for birth control assistance [67 Ops.Cal.Atty.Gen. 235 (1984)], which a minor is legally authorized to obtain under Family Code Section 6925 *(see chapter 2)*.

Notwithstanding the foregoing, child abuse reporting may be required when particular types of medical attention are rendered to a child *if there are additional facts indicating that the child was sexually assaulted* [67 Ops. Cal. Atty. Gen. 235 (1984)]. Thus, reporting may be required when a minor seeks treatment for a sexually transmitted disease or pregnancy or requests an abortion or birth control assistance and there is reasonable suspicion to believe that there has been a violation of the law amounting to sexual assault (as defined above). *(See "Minors Under 14 Years of Age: Lewd and Lascivious Conduct Versus Statutory Rape" below, for discussion of reports concerning children under age 14.)*

Reasonable Suspicion

In *People v. Stockton Pregnancy Control Medical Clinic*, 203 Cal.App.3d 225, 239-240 (1988), which is discussed below, the court stated:

> The [Child Abuse and Neglect Reporting] Act makes clear that professionals subject to the Act must evaluate facts known to them in light of their training and experience to determine whether they have an objectively reasonable suspicion of child abuse ... However, nothing in the Act requires professionals such as health practitioners to obtain information they would not ordinarily obtain in the course of providing care or treatment. Thus, the duty to report must be premised on information obtained by the

> health practitioner in the ordinary course of providing care and treatment according to standards prevailing in the medical profession.

According to the California Attorney General [67 Ops. Cal.Atty.Gen. 235 (1984)], the facts to be used to evaluate whether there is reasonable suspicion to believe that a child who seeks care for a sexually transmitted disease, pregnancy or abortion was the victim of child abuse include:

1. The child's medical history;
2. Other information available to the professional through consultation or examination; and
3. Whether the child is immature or mentally deficient. Pregnancy in a mentally or physically impaired child or an intellectually disabled child does, according to the California Attorney General, raise a reasonable suspicion of child abuse.

Minors Under 14 Years of Age: Lewd and Lascivious Conduct Versus Statutory Rape

As noted above, the commission of a lewd or lascivious act upon a child under 14 years of age, which is a violation of Penal Code Section 288, constitutes sexual assault. In *Planned Parenthood Affiliates v. Van de Kamp*, 181 Cal. App.3d 245 (1986), the Court of Appeal held that no child abuse report need be made where the conduct involved is voluntary sexual activity between minors who are both under age 14 and are of a similar age. This ruling was affirmed in *People v. Stockton Pregnancy Control Medical Clinic*, supra, 203 Cal.App.3d at 234, where the court stated:

> In practical effect, the [Child Abuse and Neglect Reporting] Act, as construed in *Planned Parenthood*, exempts from reporting as "child abuse" the voluntary sexual conduct of sexually mature boyfriends and girlfriends (i.e., minors age 14 and older) and the conduct of younger children of similar ages who voluntarily play doctor or otherwise engage in sexual experimentation.

However, the appellate court in the *Stockton* case also held that a report of child abuse is still required where the sexual activity, even though voluntary, is between a minor under age 14 and a person of disparate age. This includes instances in which the other person is an adult or a minor age 14 or older. Penal Code Section 288(c)(1) clarifies that it is deemed an offense where lewd or lascivious acts are committed with a minor of 14 or 15 years and the defendant is at least 10 years older than the victim. Moreover, Penal Code Section 261.5 sets forth degrees of liability for sexual intercourse with a minor more than two years younger than the age of the perpetrator.

WHEN TREATING SUBSTANCE USE DISORDER PATIENTS

Alcohol and/or drug abuse is not, in and of itself, a sufficient basis for reporting child abuse or neglect [Penal Code Section 11165.7(a)(38)].

The federal laws regulating the disclosure of patient records maintained in connection with the treatment of substance use disorders by federally assisted programs expressly permit the reporting under state law of incidents of suspected child abuse and neglect to appropriate state or local authorities [42 U.S.C. Section 290dd-2(e)] *(see chapter 6 regarding federal laws governing the confidentiality of substance use disorder information)*.

MATERNAL SUBSTANCE ABUSE

When a Report Must Be Made

A positive toxicology screen at the time of an infant's delivery is not in and of itself a sufficient basis for reporting child abuse or neglect. However, any indication of maternal substance abuse requires an assessment of the needs of the mother and child under Health and Safety Code Section 123605. If other factors are present that indicate risk to a child, then a child abuse report must be made. However, a report based on risk to a child which relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse must be made only to a county welfare or probation department and not to a law enforcement agency. [Penal Code Section 11165.13]

Needs Assessment

Each county must establish protocols between county health departments, county welfare departments, and all public and private hospitals in the county regarding the application and use of an assessment of the needs of, and a referral for, a substance abuse-exposed infant to a county welfare department.

The needs assessment must be performed by a health practitioner or a medical social worker before the infant is released from the hospital.

The purpose of the needs assessment is to:

1. Identify needed services for the mother, child or family, including, where applicable, services to assist the mother in caring for her child and services to assist maintaining children in their homes.
2. Determine the level of risk to the newborn upon release to the home and the corresponding level of services and intervention, if any, necessary to protect the

newborn's health and safety, including a referral to the county welfare department for child welfare services.

3. Gather data for information and planning purposes.

[Health and Safety Code Section 123605; Penal Code Section 11165.13]

Government Facilities

In *Ferguson et al. v. City of Charleston et al.*, 532 U.S. 67 (2001), the U.S. Supreme Court ruled that a state hospital's performance of a drug test to obtain evidence of a patient's criminal conduct for law enforcement purposes is an unreasonable search if the patient has not consented to the procedure. In that case, a state hospital worked with local law enforcement personnel to develop policies to identify and report pregnant drug users. Criteria for testing pregnant women were developed which, according to the court, were not sufficiently related to illegal drug use to constitute probable cause or even a basis for a reasonable suspicion. No search warrants were sought. Chain of custody procedures and documentation were developed to make sure test results could be used in subsequent criminal proceedings. The hospital policy set forth the range of possible criminal charges and the logistics of police notification and arrests. The policy did not discuss different courses of medical treatment for either the mother or infant. For purposes of this case, it was assumed that the women did not consent to taking the urine sample (although there were no allegations that the urine was forcibly removed), testing the urine for drugs, or reporting the positive result to law enforcement.

The court found that the focus of the policy was on the arrest and prosecution of drug-abusing mothers, not medical care. The court held that because the hospital is a state hospital, the members of its staff are government actors and subject to the Fourth Amendment prohibitions against unreasonable search and seizure. The court stated that when a hospital undertakes to obtain evidence from its patients for the specific purpose of incriminating those patients, the hospital has a special obligation to make sure that the patients are fully informed about their constitutional rights. The court sent the case back to a lower court to determine whether informed consent was given by the patients.

The court distinguished this case from circumstances in which physicians, in the course of ordinary medical procedures aimed at helping the patient, come across information that under rules of law or ethics is subject to reporting requirements. However, the court also stated that the "reasonable expectation of privacy enjoyed by the typical patient undergoing diagnostic tests in a hospital is that the results of those tests will not be shared with nonmedical personnel without her consent."

Government hospitals should work with their legal counsel to develop a drug testing policy that satisfies the concerns outlined by the court in the *Ferguson* case.

SAFE SURRENDER OF A NEWBORN

The voluntary surrendering of a newborn in accordance with California's "safe surrender" law is not, in and of itself, a sufficient basis for reporting child abuse or neglect.

HOMELESS CHILDREN

The fact that a child is homeless or is classified as an unaccompanied minor is not, in and of itself, a sufficient basis for reporting child abuse or neglect. However, this law is not intended to limit reports when a mandated reporter has knowledge of or observes an unaccompanied minor whom the mandated reporter knows or reasonably suspects to be the victim of abuse or neglect. [Penal Code Section 11165.15]

For purposes of this law, **"homeless children and youths"** means individuals who lack a fixed, regular, and adequate nighttime residence, and includes:

1. Children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;
2. Children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; and
3. Children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.

"Unaccompanied youth" includes a homeless child or youth not in the physical custody of a parent or guardian.

[42 U.S.C. Section 11301 *et seq.*; 42 U.S.C. Section 11434a]

F. Privileges Inapplicable

Neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information that must be reported pursuant to child abuse reporting laws in

a court proceeding or administrative hearing [Penal Code Section 11171.2].

In *People v. Stritzinger*, 34 Cal.3d 505 (1983), the California Supreme Court held that the child abuse or neglect reporting requirements supersede the psychotherapist-patient privilege, and that confidential information must be disclosed by a psychotherapist in order to fulfill the reporting requirements. However, the court also held that only the information which must be reported may be disclosed, and that a psychotherapist cannot disclose information received after the report was made if it pertains to the identical situation that was reported.

The California Attorney General has opined that the child abuse reporting requirements supersede the confidentiality provisions of the Lanterman-Petris-Short Act *(see chapter 17 regarding the Lanterman-Petris-Short Act requirements)* [65 Ops.Cal.Atty.Gen. 345 (1982)]. Facilities should consult their legal counsel regarding the scope of disclosure that is required by the child abuse reporting statute.

G. Disclosure and Follow-Up Procedures

DISCLOSURE TO INVESTIGATOR

Information relevant to the incident of child abuse or neglect and information relevant to a report made pursuant to Penal Code Section 11166.05 *(see "Emotional Damage," page 7.8)* may be given to an investigator from an agency that is investigating a known or suspected case of child abuse or neglect [Penal Code Section 11167(b)]. However, the only information that may be disclosed is that which is relevant to the incident of child abuse or neglect. Thus, medical information regarding the involved persons (e.g., a suspected victim or perpetrator) should be disclosed only if it appears to satisfy this relevancy test.

Scope of Information to be Released

In *Ferraro v. Chadwick*, 221 Cal.App.3d 86 (1990), parents who were reported for child abuse sued the reporting hospital and physician alleging that statements made and information provided after the initial report of child abuse were outside the immunity provided under Penal Code Section 11172 *(see the discussion of immunity in G. "Immunity From Liability," page 7.5)*. In rejecting this argument, the court made several points relevant to the scope of permissible disclosure of information to investigators:

1. The type of report or communication contemplated by Section 11167(b) most often is going to occur after an initial report of suspected abuse.
2. Section 11167 anticipates that, in the course of an investigation into suspected abuse, the reporter ("particularly if the reporter is a doctor") is going to be contacted and interviewed by the agency conducting the investigation, and the law approves communications between the reporter and the investigating agency.
3. The child abuse reporting laws both authorize and protect these subsequent communications, regardless of whether they were in response to law enforcement inquiries or were initiated by the doctor and/or hospital.

These comments show that the court in *Ferraro* obviously considered release of information under Penal Code Section 11167(b) to be authorized reports under the immunity statute. However, the only information that may be disclosed is information that is *relevant to the incident of suspected abuse*. Thus, medical information regarding the involved persons, whether a suspected victim or perpetrator, should be disclosed under this provision only if it appears to satisfy this relevancy test.

If the information being requested does not appear to meet this test, then the law enforcement officers should be asked to obtain a court order or search warrant. As the California Attorney General points out in its *Child Abuse Prevention Handbook* (revised January 2000) (p. 56):

> As in all areas of criminal law, all searches, seizures, and arrests made in the course of child abuse investigations must comply with the requirements of the Fourth Amendment.

Mental Health and Substance Abuse Information

There are also some restrictions that have particular application to mental health information *(see chapter 6 regarding laws governing the confidentiality of mental health information)*.

While the psychotherapist-patient privilege does not apply to information required to be reported pursuant to the child abuse reporting laws, at least one court has ruled that the privilege continues to apply to information not required to make the report. In *People v. Stritzinger*, 34 Cal.3d 505 (1983), the court ruled that while a psychotherapist was required to disclose privileged information in order to make a child abuse report, the psychotherapist should *not* have disclosed information received after the report was made that did not disclose new incidents of abuse.

In addition, the California Attorney General has stated its view that while the child abuse reporting laws override the Lanterman-Petris-Short confidentiality law for mental health information, it does so only to permit persons to report "what they know or have observed" [65 Ops.Cal.Atty. Gen 345, 355 (1982)]. According to the Attorney General's opinion, the reporting law does not give child protection agencies direct access to mental health records and information protected by the Lanterman-Petris-Short Act.

Similarly, the federal law regarding the confidentiality of substance use disorder program records contains an exception to confidentiality to report suspected child abuse [42 U.S.C. Section 290dd-2(e)]. However, this exception does not permit disclosure of patient records in any legal proceeding that may later arise from the initial child abuse report. Records requested for court proceedings may be released only if the requestor has complied with the procedures set forth in the federal regulations that apply to federally-funded substance use disorder programs. [42 C.F.R. Sections 2.12(c)(12) and 2.61-2.67] *(See chapter 6 regarding laws governing the confidentiality of substance use disorder information.)*

DISCLOSURE TO LICENSING AGENCY

Information relevant to an incident of child abuse or neglect (including the investigation report and other pertinent materials) as well as information relevant to a report made pursuant to Penal Code Section 11166.05 *(see "Emotional Damage," page 7.8)*, may be given to the California Department of Social Services, or the county licensing agency that has contracted with the state for the performance of its services, when it is investigating a known or suspected case of child abuse or neglect [Penal Code Sections 11167(c), 11167.5(b)(6), 11170(b)(4)]. However, the only information that may be disclosed is that which is relevant to the incident of child abuse or neglect. Thus, medical information regarding the involved persons (e.g., a suspected victim or perpetrator) should be disclosed only if it appears to satisfy this relevancy test.

Interestingly, as used in the child abuse law, "licensing agency" does not appear to include the California Department of Public Health (CDPH) *(see Penal Code Section 11165.11 for the definition of "licensing agency")*. However, CDPH has other legal authority to review hospital records; an attorney should be consulted if doubt exists as to whether particular records should be disclosed to CDPH.

H. Immunity From Liability

MANDATED REPORTERS

No mandated reporter shall incur any civil or criminal liability as a result of making a report required or authorized by the child abuse reporting law. This immunity applies even if the mandated reporter acquired the knowledge or reasonable suspicion of child abuse or neglect outside of his or her professional capacity or outside the scope of his or her employment. [Penal Code Section 11172]

Two court decisions have emphasized that this immunity for mandated reporters is absolute — that is, the immunity applies regardless of whether or not the person making the report knew or should have known that the report was not true [*Krikorian v. Barry*, 196 Cal.App.3d 1211 (1987); *Storch v. Silverman*, 186 Cal.App.3d 671 (1986)]. Additionally, the immunity applies not only to the person who makes the report (i.e., telephones the agency and submits the written report) but to any other mandated reporter involved in the identification of an instance of child abuse even though they did not personally report it to the authorities [*Storch v. Silverman*, supra, 186 Cal. App.3d at 681]. This recognizes that in many instances, especially in hospitals, the discovery of child abuse will be a collaborative event, involving more than one person.

In *Krikorian v. Barry*, supra, 196 Cal.App.3d at 1223, the court held that Penal Code Section 11172 immunity encompasses not only the actual act of reporting but also:

> conduct giving rise to the obligation to report, such as the collection of data, or the observation, examination or treatment of the suspected victim or perpetrator of child abuse, performed in a professional capacity or within the scope of employment.... [Accord, *McMartin v. Children's Institute International*, 212 Cal.App.3d 1393 (1989), cert. den., 494 U.S. 1057 (1990)]

Mandated reporters are immunized not only for activity related to the initial mandated report but also with respect to activity after the initial report that is authorized under the child abuse reporting law. [*Ferraro v. Chadwick*, 221 Cal.App.3d 86 (1990) and *Thomas v. Chadwick*, 224 Cal. App.3d 813 (1990) modified, 224 Cal.App.3d 1637]

Attorneys' Fees

In addition, the California Legislature recognized that while the immunity from liability prevents imposition of liability, it cannot prevent the filing of a lawsuit against a person who reports. Thus, to limit the financial hardship that persons may incur as a result of fulfilling their legal reporting responsibilities, the law allows a person who is sued as a result of fulfilling his or her mandatory reporting

obligation to recover from the state the attorneys' fees spent defending the action, if the person prevails. The state is required to reimburse the person for reasonable attorneys' fees at hourly rates based upon the rates charged by the California Attorney General, up to $50,000 [Penal Code Section 11172(d)]. A claim may be filed with the Department of General Services.

VOLUNTARY REPORTERS

Penal Code Section 11172 also provides that any other person reporting a suspected instance of child abuse or neglect (i.e., those making voluntary reports) shall not incur civil or criminal liability as a result of making the report unless it can be proved that the report was false and that the person knew it was false or that the report was made with reckless disregard of its truth or falsity. In such a case, the person making the report is liable for any damages caused [Penal Code Section 11172(a)].

IMMUNITY FOR PROVIDING ACCESS TO THE VICTIM

Health practitioners and other persons are granted immunity from civil or criminal liability for providing access to a suspected or known victim of child abuse or neglect to a government agency investigating a report of suspected child abuse or neglect [Penal Code Section 11172(b)].

IMMUNITY FOR PHOTOGRAPHING OF SUSPECTED ABUSE

Mandated reporters (and others taking photographs at the mandated reporter's direction) are not subject to civil or criminal liability for photographing a suspected victim of child abuse or neglect, or causing photographs to be taken, without parental consent, or for disseminating the photographs or images with the required reports. However, this law does not give immunity from liability for other uses of the photographs [Penal Code Section 11172(a)].

The health care provider may wish to obtain photographs to assist the investigating agency and to provide documentation should a question arise about the justification for a report made by the hospital.

I. Confidentiality of Reports

Reports of child abuse and the information contained in them, as well as certain child abuse or neglect investigative reports, are confidential and may be disclosed only as provided by statute [Penal Code Section 11167.5(a)]. Those to whom the statute permits disclosure include various law enforcement and governmental agencies, coroners and medical examiners, multidisciplinary teams, hospital scan teams, agencies responsible for licensing facilities that care for children, adoption agencies, and others as specified. *(See Penal Code Sections 11167-11170.5 and G. "Disclosure and Follow-Up Procedures," page 7.16.)* Such disclosures should typically be made by the agency to which the original report is made, rather than by initial reporters.

The identity of all persons who make child abuse reports is confidential and may be disclosed only among the following agencies receiving or investigating mandated reports:

1. To the prosecutor in a criminal prosecution or in an action initiated under Welfare and Institutions Code Section 602 arising from alleged child abuse;
2. To counsel appointed to represent the child pursuant to Welfare and Institutions Code Section 317(c);
3. To the county counsel or prosecutor in a proceeding under Family Code Section 7800 *et seq.* or Welfare and Institutions Code Section 300 *et seq.*; or
4. To a licensing agency when abuse or neglect in out-of-home care is reasonably suspected.

In addition, the identity may be disclosed when the reporter waives confidentiality or by court order.

No agency or person may disclose the identity of a person who makes a child abuse report to that person's employer, except with the employee's consent or by court order.

[Penal Code Section 11167(d)]

Notwithstanding these confidentiality requirements, a representative of a child protective services agency performing an investigation that results from a report of suspected child abuse or neglect made pursuant to the child abuse reporting law, at the time of the initial contact with the individual who is subject to the investigation, shall advise the individual of the complaints or allegations against him or her, in a manner that is consistent with the requirement to protect the identity of the reporter. [Penal Code Section 11167(e)]

Violation of this confidentiality requirement is a misdemeanor punishable by imprisonment in a county jail not to exceed six months, by a fine of $500, or by both that imprisonment and fine. [Penal Code Section 11167.5(a)]

J. Sanctions for a Failure to Report

A person who is required to, but fails to, report an instance of known or reasonably suspected child abuse or neglect may be found guilty of a misdemeanor. The punishment may include up to six months imprisonment in the county

jail, a fine of up to $1,000, or both [Penal Code Section 11166(c)]. A supervisor or administrator who impedes or inhibits an employee's reporting of child abuse may be subject to up to six months imprisonment in the county jail or a fine not to exceed $1,000, or both. A mandated reporter who willfully fails to report abuse or neglect, or a person who impedes or inhibits a report of abuse or neglect, where that abuse or neglect results in death or great bodily injury, will be punished by not more than one year in a county jail, a fine of up to $5,000, or both [Penal Code Section 11166.01] The statutory provisions do not affect the principle established in *Landeros v. Flood*, 17 Cal.3d 399 (1976), which imposes civil liability for a failure to report child abuse *(see "Civil Liability," page 7.2)*.

If a mandated reporter intentionally conceals his or her failure to report an incident known by the mandated reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until an agency specified in Section 11165.9 discovers the offense [Penal Code Section 11166(c)].

K. Employer Obligations

OBTAIN EMPLOYEES' ACKNOWLEDGMENT OF REPORTING OBLIGATIONS

Hospitals and other employers of mandated reporters are required to provide forms on which the mandated reporters acknowledge that they are aware of the child abuse and neglect reporting requirements and will comply with them. The form must inform the employee that he or she is a mandated reporter and inform the employee of his or her reporting obligations under Penal Code Section 11166 and of his or her confidentiality rights under Penal Code Section 11167(d). The employer must provide a copy of Penal Code Sections 11165.7, 11166 and 11167 to the employee. These statements must be retained by the employer. The employer must bear the costs of printing, distributing and filing the acknowledgment forms [Penal Code Section 11166.5].

The statements must be signed by any person hired after Jan. 1, 1985, who is required to report.

Because this requirement applies only to employees hired by a hospital, it does not apply specifically to medical staff members who have no employment relationship with the hospital. However, hospitals may choose to have medical staff members acknowledge their awareness of their obligations to report suspected instances of child abuse or neglect, particularly if the medical staff members may be treating possible victims of child abuse who present to the emergency room.

The hospital may supplement its form by discussing any special policy it has regarding notifying supervisors and administration about reports that will be or are made, and how the reporting is coordinated when several employees become aware of the same instance of suspected child abuse or neglect. Hospitals may use the "Employee Acknowledgment of Child Abuse and Neglect Reporting Obligations" form (CHA Form 19-2) for this purpose.

TRAIN EMPLOYEES

The law also strongly encourages employers to provide their employees who are mandated reporters with training in child abuse and neglect identification and reporting. Whether or not employers provide this training, the employers must provide their employees who are mandated reporters with the required notice of their status as a mandated reporter.

VI. ABUSE OF ELDERS AND DEPENDENT ADULTS

A. Introduction

The Elder Abuse and Dependent Adult Civil Protection Act [Welfare and Institutions Code Sections 15600-15659] imposes mandatory reporting requirements for abuse of elders and dependent adults. The reporting requirements for elders and dependent adults are identical. Abuse of an elder or dependent adult is a criminal act [Penal Code Section 368].

Under the law, any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting abuse, must report the known or suspected instance of abuse by telephone or through a confidential Internet reporting tool (when available) immediately or as soon as practicably possible. If initially reported by telephone, a written report or an Internet report must be sent within two working days. Quicker reporting is required if the abuse occurred in a long-term care facility. *(See "To Whom Reports are Made; Time Frames," page 7.25, for time frames.)*

Abuse of an elder or a dependent adult includes physical abuse, neglect, financial abuse, abandonment, isolation, abduction or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods or services that are necessary to avoid

physical harm or mental suffering [Welfare and Institutions Code Section 15610.07]. Abuse does not include the use of reasonable and necessary force by a peace officer acting within the course of his or her employment [Penal Code Section 11174.4].

WHO IS AN ELDER OR DEPENDENT ADULT?

Elders are persons 65 years of age or older. Dependent adults are persons between ages 18 and 64 with physical or mental limitations that restrict their ability to carry out normal activities or protect their rights, including persons with physical or developmental disabilities or age-diminished physical or mental abilities. A person may be considered a dependent adult even if he or she lives independently. The law also expressly states that *any person between the ages of 18 and 64 who is admitted as an inpatient* in an acute care hospital or other 24-hour health facility is a dependent adult. *(See Welfare and Institutions Code Sections 15610.23 and 15610.27 for definitions of relevant facilities.)* [Welfare and Institutions Code Sections 15610.23 and 15610.27]

B. Definitions

"Abandonment" means the desertion or willful forsaking of an elder or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody [Welfare and Institutions Code Section 15610.05].

"Abuse of an elder or a dependent adult" means physical abuse, neglect, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. Abuse of an elder or a dependent adult also includes financial abuse as defined below. [Welfare and Institutions Code Section 15610.07]

"Adult protective services agency" means a county welfare department, except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff [Welfare and Institutions Code Section 15610.13].

"Care custodian" means an administrator or an employee of any of specified public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff [Welfare and Institutions Code Section 15610.17]. These facilities and agencies include the following: 24-hour health facilities as defined in Health and Safety Code Sections 1250, 1250.2 and 1250.3; clinics; home health agencies; agencies providing publicly funded in-home supportive services, nutrition services, or other home- and community-based support services; adult day health care centers and adult day care; Alzheimer's Disease day care resource centers; community care facilities as defined in Health and Safety Code Section 1502; residential care facilities for the elderly as defined in Health and Safety Code Section 1569.2; respite care facilities; and other protective, public, sectarian, mental health, or private assistance or advocacy agencies and persons providing health services or social services to elders or dependent adults. *(See Welfare and Institutions Code Section 15610.17 for a complete list of "care custodians.")*

"Clergy member" means a priest, minister, rabbi, religious practitioner or similar functionary of a church, synagogue, temple, mosque or recognized religious denomination or organization. Clergy member does not include unpaid volunteers whose principal occupation or vocation does not involve active or ordained ministry in a church, synagogue, temple, mosque or recognized religious denomination or organization, and who periodically visit elder or dependent adults on behalf of that church, synagogue, temple, mosque or recognized religious denomination or organization. [Welfare and Institutions Code Section 15610.19]

"Endangered adult" means a dependent or elder adult who is at immediate risk of serious injury or death, due to suspected abuse or neglect and who demonstrates the inability to take action to protect himself or herself from the consequences of remaining in that situation or condition [Welfare and Institutions Code Section 15701.25].

"Financial abuse" occurs when a person or entity takes, secretes, appropriates, obtains, or retains (or assists another to do so) real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud or both, or by undue influence. A person or entity shall be deemed to have taken, secreted, appropriated, obtained, or retained for a wrongful use if, among other things, the person did so knowing (or if the person should have known) that this would likely be harmful to the elder or dependent adult. Property includes any property right, including by means of an agreement, donative transfer, or testamentary bequest, regardless of whether the property is held directly or by a representative. A representative is a conservator, trustee or other representative of the estate of an elder or dependent adult, or an attorney-in-fact acting within the authority of the power of attorney. [Welfare and Institutions Code Section 15610.30]

"Goods and services necessary to avoid physical harm or mental suffering" include, but are not limited to, all of the following [Welfare and Institutions Code Section 15610.35]:

1. The provision of medical care for physical and mental health needs.
2. Assistance in personal hygiene.
3. Adequate clothing.
4. Adequately heated and ventilated shelter.
5. Protection from health and safety hazards.
6. Protection from malnutrition, under those circumstances where the results include, but are not limited to, malnutrition and deprivation of necessities or physical punishment.
7. Transportation and assistance necessary to secure any of the needs set forth above.

"Health practitioner" includes a physician; psychiatrist; psychologist; dentist; resident; intern; podiatrist; chiropractor; registered nurse; dental hygienist; licensed clinical social worker or associate clinical social worker; associate clinical marriage and family therapist; licensed professional clinical counselor; any other person who is currently licensed under Business and Professions Code Section 500 *et seq.*; emergency medical technician I or II; paramedic; person certified pursuant to Health and Safety Code Section 1797 *et seq.*; psychological assistant registered pursuant to Business and Professions Code Section 2913; marriage and family therapist trainee, as defined in Business and Professions Code Section 4980.03; unlicensed associate marriage and family therapist registered under Business and Professions Code Section 4980.44; a professional clinical counselor trainee; an associate professional clinical counselor; state or county public health or social service employee who treats an elder or a dependent adult for any condition; substance use disorder counselor; or a coroner [Welfare and Institutions Code Section 15610.37].

"Imminent danger" means a substantial probability that an elder or dependent adult is in imminent or immediate risk of death or serious physical harm, through either his or her own action or inaction, or as a result of the action or inaction of another person [Welfare and Institutions Code Section 15610.39].

"Isolation" means any of the following [Welfare and Institutions Code Section 15610.43]:

1. Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls.
2. Telling a caller or prospective visitor that an elder or dependent adult is not present, does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is:
   a. False;
   b. Contrary to the express wishes of the elder or dependent adult, whether he or she is competent or not; and
   c. Made for the purpose of preventing the elder or dependent adult from having contact with family, friends or concerned persons.
3. False imprisonment, as defined in Penal Code Section 236.
4. Physical restraint of an elder or dependent adult for the purpose of preventing him or her from meeting with visitors.

These acts are subject to a rebuttable presumption that they do not constitute isolation if they are performed pursuant to the instructions of a physician licensed to practice medicine in California, who is caring for the elder or dependent adult at the time the instructions are given, and who gives the instructions as part of his or her medical care.

Also, these acts shall not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety.

"Local law enforcement agency" means a city police or county sheriff's department, or a county probation department, except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff [Welfare and Institutions Code Section 15610.45].

"Long-term care facility" means any of the following [Welfare and Institutions Code Section 15610.47]:

1. A long-term health care facility, as defined in Health and Safety Code Section 1418(a).
2. A community care facility, as defined in Health and Safety Code Section 1502(a), whether licensed or unlicensed.
3. A swing bed in an acute care facility, or an extended care facility.
4. An adult day health care center as defined in Health and Safety Code Section 1570.7(b).

5. A residential care facility for the elderly as defined in Health and Safety Code Section 1569.2.

"Long-term care ombudsman" means the California Long-Term Care Ombudsman, local ombudsman coordinators, and other persons currently certified as ombudsmen by the California Department of Aging as described in Welfare and Institutions Code Section 9700 *et seq.* [Welfare and Institutions Code Section 15610.50].

"Mental suffering" means:

1. Fear, agitation, confusion, severe depression or other forms of serious emotional distress that is brought about by forms of intimidating behavior, threats, harassment or by deceptive acts performed; or
2. False or misleading statements made with malicious intent to agitate, confuse, frighten or cause severe depression or serious emotional distress of the elder or dependent adult.

[Welfare and Institutions Code Section 15610.53]

"Neglect" means:

1. The negligent failure of a person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or
2. The negligent failure of an elder or dependent adult to exercise that degree of self-care that a reasonable person in a like position would exercise.

Neglect includes, but is not limited to, all of the following:

1. Failure to assist in personal hygiene, or in the provision of food, clothing or shelter.
2. Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.
3. Failure to protect from health and safety hazards.
4. Failure to prevent malnutrition or dehydration.

If a person cannot provide the above for himself or herself due to poor cognitive functions, mental limitation, substance abuse or chronic poor health, this also constitutes neglect.

[Welfare and Institutions Code Section 15610.57]

"Physical abuse" means all of the following, as these terms are defined in the Penal Code [Welfare and Institutions Code Section 15610.63]:

1. Assault
2. Battery
3. Assault with a deadly weapon or force likely to produce great bodily injury
4. Unreasonable physical constraint, or prolonged or continual deprivation of food or water
5. Sexual assault, which means any of the following:
    a. Sexual battery
    b. Rape
    c. Rape in concert
    d. Spousal rape
    e. Incest
    f. Sodomy
    g. Oral copulation
    h. Sexual penetration
    i. Lewd or lascivious act
6. Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
    a. For punishment
    b. For a period significantly beyond that for which the restraint or medication is authorized by a physician licensed in California who is providing medical care to the elder or dependent adult at the time the instructions are given
    c. For any purpose not authorized by the physician

"Reasonable suspicion" means an objectively reasonable suspicion that a person would entertain, based upon facts that could cause a reasonable person in a like position, drawing when appropriate upon his or her training and experience, to suspect abuse [Welfare and Institutions Code Section 15610.65].

"Serious bodily injury" means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation [Welfare and Institutions Code Section 15610.67].

"Substance use disorder counselor" is a person providing counseling services in an alcoholism or drug abuse recovery and treatment program licensed, certified, or funded under Part 2 (commencing with Section 11760) of Division 10.5 of the Health and Safety Code.

"Undue influence" means excessive persuasion that causes another person to act or refrain from acting by overcoming that person's free will and results in inequity. In determining whether a result was produced by undue influence, all of the following must be considered:

1. The vulnerability of the victim. Evidence of vulnerability may include, but is not limited to, incapacity, illness, disability, injury, age, education, impaired cognitive function, emotional distress, isolation, or dependency, and whether the influencer knew or should have known of the alleged victim's vulnerability.
2. The influencer's apparent authority. Evidence of apparent authority may include, but is not limited to, status as a fiduciary, family member, care provider, health care professional, legal professional, spiritual adviser, expert, or other qualification.
3. The actions or tactics used by the influencer. Evidence of actions or tactics used may include, but is not limited to, all of the following:
    a. Controlling necessaries of life, medication, the victim's interactions with others, access to information, or sleep.
    b. Use of affection, intimidation, or coercion.
    c. Initiation of changes in personal or property rights, use of haste or secrecy in effecting those changes, effecting changes at inappropriate times and places, and claims of expertise in effecting changes.
4. The equity of the result. Evidence of the equity of the result may include, but is not limited to, the economic consequences to the victim, any divergence from the victim's prior intent or course of conduct or dealing, the relationship of the value conveyed to the value of any services or consideration received, or the appropriateness of the change in light of the length and nature of the relationship.

Evidence of an inequitable result, without more, is not sufficient to prove undue influence.

[Welfare and Institutions Code Section 15610.70]

C. Mandatory Reporting of Abuse

Certain categories of persons, referred to as mandated reporters, are *required* to report any suspected abuse, as defined, of elders or dependent adults.

MANDATED REPORTERS

Persons required to report elder or dependent adult abuse are:

1. Elder or dependent adult "care custodians" *(see definition on page 7.20; every employee of a hospital is a "care custodian")*.
2. Health practitioners *(see page 7.21.)*
3. Clergy members.
4. Employees of a county adult protective services agency or local law enforcement agency.
5. Any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults [Welfare and Institutions Code Section 15630(a)].

Exception

A mandated reporter who is a clergy member who acquires knowledge or reasonable suspicion of elder or dependent adult abuse during a penitential communication is not required to report. **"Penitential communication"** means a communication that is intended to be in confidence, including, but not limited to, a sacramental confession made to a clergy member who, in the course of the discipline or practice of his or her church, denomination or organization is authorized or accustomed to hear those communications and under the discipline, tenets, customs or practices of his or her church, denomination or organization, has a duty to keep those communications secret.

However, this exception does not modify or limit a clergy member's duty to report known or suspected elder and dependent adult abuse if he or she is acting in the capacity of a care custodian, health practitioner or employee of an adult protective agency.

A clergy member who is not regularly employed on either a full-time or part-time basis in a long-term care facility or does not have care or custody of an elder or dependent adult is not required to report abuse or neglect that is not reasonably observable or discernible to a reasonably prudent person having no specialized training or experience in elder or dependent care.

WHAT TRIGGERS REPORTING OBLIGATION

General Rule

A report must be made by a mandated reporter who, in his or her professional capacity or within the scope of his or her employment [Welfare and Institutions Code Section 15630(b)]:

1. Has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect; or
2. Is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect; or
3. Reasonably suspects abuse.

No Duty to Investigate

A mandated reporter does not have a duty to investigate a known or suspected incident of abuse. In fact, criminal liability may arise where a mandated reporter undertakes an investigation and determines that no report is needed [*People v. Davis*, 126 Cal. App. 4th 1416 (2005)]. It is up to the mandated reporter to report the facts giving rise to the suspicion of abuse, and it is up to law enforcement to investigate and determine whether abuse occurred.

Incidents That Do Not Need to Be Reported

A physician, registered nurse or psychotherapist as defined in Evidence Code Section 1010 need not report an incident if all of the following conditions exist:

1. The mandated reporter has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect.
2. The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
3. The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
4. The physician, registered nurse or psychotherapist as defined in Evidence Code Section 1010 reasonably believes, in the exercise of clinical judgment, that the abuse did not occur.

(See "Definition of Psychotherapist," page 7.34, for a list of which professionals are considered "psychotherapists" pursuant to Evidence Code Section 1010.)

In addition, in a long-term care facility, a mandated reporter need not report an incident where all of the following conditions exist:

1. The mandated reporter is aware that there is a proper plan of care.
2. The mandated reporter is aware that the plan of care was properly provided or executed.
3. A physical, mental or medical injury occurred as a result of care provided pursuant to the above.
4. The mandated reporter reasonably believes that the injury was not the result of abuse.

This exception applies only to those categories of mandated reporters that the California Department of Public Health (CDPH) determines have access to plans of care and have the training and experience necessary to determine whether the conditions specified have been met. A mandated reporter in a long-term care facility is not required to seek, nor is precluded from seeking, information regarding a known or suspected incident of abuse prior to reporting.

D. Nonmandated Reporting

In addition to the reports of abuse that must be made by mandated reporters, reports of other types of elder or dependent adult abuse may be made by any person, whether mandated reporters or other persons. Other forms of elder or dependent adult abuse may include intimidation, cruel punishment or other treatment that endangers an elder or dependent adult's emotional well-being. If a report is not required to be made under California law, then it may not be made by the patient's health care provider unless it also complies with federal privacy regulations, which require that:

1. The victim agrees to the disclosure; or
2. The health care provider, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the victim or other potential victims; or
3. If the victim is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information to be disclosed is not intended to be used against the victim and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the victim is able to agree to the disclosure. [45 C.F.R. Section 164.512(c); Civil Code Section 56.10(c)(14)]

BY MANDATED REPORTERS

If making the report satisfies the standards described above, then a mandated reporter may file a report where that person knows, or reasonably suspects, that types of elder or dependent adult abuse for which reports are not mandated have been inflicted on an elder or dependent adult or that the emotional well-being of an elder or dependent adult is endangered in any other way [Welfare and Institutions Code Section 15630(c)].

If the suspected abuse occurred in a long-term care facility other than a state mental health hospital or a state developmental center, the report may be made to the long-term care ombudsman program.

If the suspected abuse occurred in a state mental health hospital or a state developmental center, the report may be made to the designated investigator of the California Department of State Hospitals or the California Department of Developmental Services, or to a local law enforcement agency or to the local ombudsman.

If the suspected abuse occurred in any other place, the report may be made to the county adult protective services agency.

If the conduct involves criminal activity not constituting abuse, it may also be immediately reported to the appropriate law enforcement agency, if such reporting complies with federal privacy regulations *(see chapter 6)*. *(See also M. "Federal Requirements," page 7.30.)*

BY OTHER PERSONS

A person who is not a mandated reporter who knows or reasonably suspects that an elder or dependent adult has been the victim of abuse may report that abuse as follows [Welfare and Institutions Code Section 15631]:

1. If the abuse is alleged to have occurred in a long-term care facility, the report may be made to a long-term care ombudsman program or local law enforcement agency, or both.
2. If the abuse is alleged to have occurred in any place other than a long-term care facility, the report may be made to the county adult protective services agency or local law enforcement agency.

However, the federal privacy requirements described in D. "Nonmandated Reporting," page 7.24, must be met before a report may be made by the victim's health care provider.

E. Making Reports

TO WHOM REPORTS ARE MADE; TIME FRAMES

Abuse Occurring in a Long-Term Care Facility

If suspected or alleged abuse occurred in a long-term care facility (except a state mental health hospital or a state developmental center), the following reporting requirements apply.

Physical Abuse. If suspected or alleged physical abuse occurred in a long-term care facility and results in serious bodily injury:

1. A telephone report must be made to the local law enforcement agency immediately, but also no later than within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse; and
2. A written report must be made to the local ombudsman, the facility's licensing agency (CDPH for hospitals and nursing facilities, Department of Social Services for board and care facilities), and the local law enforcement agency within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse.

If suspected or alleged physical abuse occurred in a long-term care facility and does not result in serious bodily injury:

1. A telephone report must be made to the local law enforcement agency within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse; and
2. A written report must be made to the local ombudsman, the facility's licensing agency (CDPH for hospitals and nursing facilities), and the local law enforcement agency within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse.

However, if the suspected abuse is allegedly caused by a resident with a physician's diagnosis of dementia, and there is no serious bodily injury (as reasonably determined by the mandated reporter, drawing upon his or her training or experience), the reporter must:

1. Report to the local ombudsman or law enforcement agency by telephone, immediately or as soon as practicably possible; and
2. Make a written report within 24 hours.

Abuse Other Than Physical Abuse. If suspected or alleged abuse other than physical abuse occurred in a long-term care facility (except a state mental health hospital or a state developmental center), a telephone report and a written report must be made to the local ombudsman or the local law enforcement agency within the time frames noted above for physical abuse that does not result in serious bodily injury *(see above)*.

A report must also be made to CDPH immediately or within 24 hours [Health and Safety Code Section 1418.91; Title 22, California Code of Regulations, Section 72541].

Abuse Occurring in a State Facility

If the suspected or alleged abuse occurred in a state mental health hospital or a state developmental center, the report must be made to designated investigators of the California Department of State Hospitals or the California Department of Developmental Services, *or* to the local law enforcement agency. The report must be made by telephone or through a confidential Internet reporting tool immediately or as soon as practicably possible after receiving the information concerning the incident. If the initial report is made by telephone, a written report or an Internet report must be sent to the appropriate agency within two working days of receiving the information concerning the incident.

If the suspected or alleged abuse or neglect resulted in any of the following incidents, a report must be made to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services, *and* also to the local law enforcement agency:

1. A death.
2. A sexual assault, as defined in Welfare and Institutions Code Section 15610.63.
3. An assault with a deadly weapon, as described Penal Code Section 245, by a nonresident of the state mental hospital or state developmental center.
4. An assault with force likely to produce great bodily injury, as described in Penal Code Section 245.
5. An injury to the genitals when the cause of the injury is undetermined.
6. A broken bone when the cause of the break is undetermined.

Abuse Occurring Elsewhere

If the suspected or alleged abuse occurred in any other place, the report must be made to the adult protective services agency or the local law enforcement agency.

The report must be made by telephone or through a confidential Internet reporting tool immediately or as soon as practicably possible after receiving the information concerning the incident. If the initial report is made by telephone, a written report or an Internet report must be sent to the appropriate agency within two working days of receiving the information concerning the incident.

TELEPHONE OR INTERNET REPORT

A report by telephone or through a confidential Internet reporting tool must include, if known:

1. The name of the person making the report.
    a. If the person is one who is not a mandated reporter, the person is not required to include his or her name [Welfare and Institutions Code Section 15633.5(d)].
    b. If the name is given, the person's identity is confidential and disclosed only under limited circumstances.
2. The name and age of the elder or dependent adult.
3. The present location of the elder or dependent adult.
4. The names and addresses of family members or any other adult responsible for the elder's or dependent adult's care.
5. The nature and extent of the elder's or dependent adult's condition.
6. The date of the incident.
7. Any other information requested by the agency receiving the report, including information that led the person to suspect elder or dependent adult abuse.

[Welfare and Institutions Code Section 15630(e)]

WRITTEN REPORT

If the initial report is made by telephone, a written report or an Internet report must be sent to the appropriate agency [Welfare and Institutions Code Section 15630(b)]. Reports should be submitted on forms adopted by the California Department of Social Services [Welfare and Institutions Code Section 15658(a)]. The current form is "Report of Suspected Dependent Adult/Elder Abuse" (SOC 341). This form can be obtained from county adult protective services agencies, long-term care ombudsman coordinators or at www.ccfmtc.org.

SELECTION OF A PERSON TO REPORT

In the hospital, two or more people may become jointly aware of the same instance of reportable elder or dependent adult abuse. The law allows them to select, by mutual agreement, a single person who will be responsible for making the report. However, if one of these persons knows that the designated person failed to report, that person must thereafter make the report [Welfare and Institutions Code Section 15630(d)].

The law allows the hospital to create internal procedures to facilitate reporting, ensure confidentiality and apprise supervisors and administrators of reports. These procedures must make clear that reporting duties are individual, that no supervisor or administrator may impede or inhibit such reporting, and that a person is not subject to sanctions for making a report [Welfare and Institutions Code Section 15630(f)].

F. Notification of Patient/Victim That Report Will be Made

The victim must be notified that a report has been or will be made. *(See C. "Informing the Patient of Reporting," page 7.1, for information about this requirement.)*

G. Forensic Medical Reports

Cal OES has developed forensic medical report forms, instructions, and examination protocols, available at www.ccfmtc.org. The form that providers must use for elder and dependent adult abuse and neglect is "Forensic Medical Report: Elder and Dependent Adult Abuse and Neglect Examination" (Cal OES 2-602).

DOCUMENTATION IN THE MEDICAL RECORD

The forensic medical forms must become part of the patient's medical record pursuant to guidelines established by the agency or agencies designated by the California Offices of Emergency Services advisory committee. Hospitals may wish to consider putting the forensic medical reports in a separate section of the medical record to prevent routine copying and disclosure of these reports for purposes not related to the criminal justice system, and to prevent improper release to unauthorized persons. The completed forms are subject to the special confidentiality laws pertaining to release of forensic medical examination records *(see I. "Confidentiality of Reports," page 7.18)*. [Penal Code Section 11161.2(b)(3)]

The hospital's initial report to law enforcement is not required to be placed in the medical record. Hospitals should develop a policy regarding maintenance of reports to maintain confidentiality of the reporter's identity *(see J. "Confidentiality of Reports; Disclosures," page 7.28)*.

H. Sanctions for a Failure to Report

A person who is required, but fails, to report an instance of elder or dependent adult abuse may be found guilty of a misdemeanor. A person who impedes or inhibits a report may also be found guilty of a misdemeanor. The punishment may include up to six months imprisonment in the county jail, a fine of up to $1,000, or both. Any mandated reporter who willfully fails to report an instance of elder or dependent adult abuse, or impedes or inhibits a report, where that abuse results in death or great bodily injury, is punishable by not more than one year in a county jail or by a fine of up to $5,000 or both. If a mandated reporter intentionally conceals his or her failure to report an incident known by the mandated reporter to be abuse or severe neglect, the failure to report is a continuing offense until the responsible law enforcement agency discovers the offense. [Welfare and Institutions Code Section 15630(h)]

It is illegal for a person to do any of the following under circumstances likely to produce great bodily harm or death:

1. Willfully cause or permit any elder or dependent adult to suffer, or
2. Inflict unjustifiable physical pain or mental suffering upon any elder or dependent adult, or
3. Having the care or custody of any elder or dependent adult, willfully cause or permit the person or health of the elder or dependent adult to be injured, or willfully cause or permit the elder or dependent adult to be placed in a situation in which his or her person or health is endangered.

This illegal behavior is punishable by imprisonment in a county jail not exceeding one year, by a fine not to exceed $6,000 upon a first conviction or $10,000 for a subsequent conviction, by both that fine and imprisonment, or by imprisonment in the state prison for two, three, or four years. If in the commission of this offense the victim suffers great bodily injury, as defined, or death, the defendant shall receive an additional term in the state prison. [Penal Code Section 368]

I. Immunity From Liability

No care custodian, clergy member, health practitioner, mandated reporter of suspected financial abuse of an elder or dependent adult, or employee of an adult protective services agency or local law enforcement agency shall incur any civil or criminal liability as a result of making a report required or authorized by the statute. No other person reporting a suspected instance of dependent adult abuse shall incur civil or criminal liability as a result of making any report authorized by the law unless it can be proved that a false report was made and the person knew it was false [Welfare and Institutions Code Section 15634(a)].

PROVIDING ACCESS TO THE VICTIM

No care custodian, clergy member, health practitioner, mandated reporter of suspected financial abuse of an elder or dependent adult, or employee of an adult protective services agency or local law enforcement agency investigating a report of known or suspected elder or dependent adult abuse shall incur any civil or criminal liability for providing an adult protective services agency or local law enforcement agency with access to a victim of suspected or known dependent adult abuse, when done at the request of the agency [Welfare and Institutions Code Section 15634(b)].

PHOTOGRAPHING OF SUSPECTED ABUSE

No person required to make a report, nor any person taking photographs at his or her direction, shall incur any civil or criminal liability for taking photographs of a suspected victim of elder or dependent adult abuse, or causing photographs to be taken of such a victim, or for disseminating such photographs with the reports required by statute. However, the law does not confer immunity from liability with respect to any other use of such photographs [Welfare and Institutions Code Section 15634(a)].

If the hospital can do so, it may wish to obtain such photographs to provide documentation should a question arise in the future concerning the justification for any report made by hospital personnel.

ATTORNEYS' FEES

A care custodian, clergy member, health practitioner or employee of an adult protective services agency or local law enforcement agency who is sued as a result of making a report that is required or authorized under the statute may recover from the state the attorneys' fees spent defending against the action, if the person prevails. The state is required to reimburse the person for the reasonable attorneys' fees at hourly rates based upon the rates charged by the California Attorney General, up to $50,000. A claim may be filed with the Department of General Services. [Welfare and Institutions Code Section 15634(c)]

EMPLOYERS

The failure of any employee or other person associated with the employer to report physical abuse of elders or dependent adults or otherwise meet the requirements of the abuse reporting law is the sole responsibility of such person. The person's employer or facility shall incur no civil or other liability for the failure of these persons to comply with the abuse reporting law [Welfare and Institutions Code Section 15659(f)].

J. Confidentiality of Reports; Disclosures

Reports of elder and dependent adult abuse are confidential and may be disclosed only as provided by statute [Welfare and Institutions Code Section 15633]. According to the statute, reports (and the information contained therein) may be disclosed only as follows:

1. To persons or agencies to whom disclosure of information or the identity of the reporter is permitted *(see below)*.
2. Persons who are trained and qualified to serve on multidisciplinary personnel teams may disclose to one another information and records that are relevant to the prevention, identification or treatment of abuse of elderly or dependent adults.

Disclosure is *not* authorized by this statute if such disclosure is prohibited by any other applicable provision of state or federal law. *(See chapter 6 for further information about privacy implications.)*

However, these disclosures may be made only:

1. If the victim agrees to the disclosure; or
2. If the health care provider, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the victim or other potential victims; or
3. If the victim is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information to be disclosed is not intended to be used against the victim and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the victim is able to agree to the disclosure. [45 C.F.R. Section 164.512(c)]

DISCLOSURE OF INFORMATION REGARDING ABUSE

Information relevant to the incident of elder or dependent adult abuse may be given to an investigator from an adult protective services agency, a local law enforcement agency, the office of the district attorney, the office of the public guardian, the probate court, the bureau, or an investigator of the Department of Consumer Affairs, Division of Investigation who is investigating a known or suspected case of elder or dependent adult abuse. [Welfare and Institutions Code Section 15633]

In addition, a health care provider may, upon written request, disclose otherwise confidential medical information to an elder death review team in certain circumstances *(see CHA's* California Health Information Privacy Manual*; order online at www.calhospital.org/privacy)*.

[Penal Code Section 11174.8]

DISCLOSURE OF REPORTER'S IDENTITY

The identity of persons making reports is confidential and may be disclosed only among the following agencies or persons representing an agency:

1. An adult protective services agency.
2. A long-term care ombudsperson program.
3. A licensing agency.
4. A local law enforcement agency.
5. The office of the district attorney.
6. The office of the public guardian.
7. The probate court.
8. The Bureau of Medi-Cal Fraud within the Office of the California Attorney General.
9. The California Department of Consumer Affairs, Division of Investigation.
10. Counsel representing an adult protective services agency.

The identity of a person who reports under this law may also be disclosed under the following circumstances:

1. To the district attorney in a criminal prosecution.
2. When a person reporting waives confidentiality.
3. By court order.

[Welfare and Institutions Code Section 15633.5]

K. Employees' Acknowledgment of Reporting Obligations

Hospitals, and other employers of health practitioners, clergy members and care custodians, are required to provide forms on which persons hired for such positions acknowledge that they are aware of the elder and dependent adult abuse reporting requirements (specifically, Welfare and Institutions Code Section 15630) and will comply with them. A copy of Welfare and Institutions Code Section 15630 must be provided to each employee. These statements must be signed by the employee prior to commencing employment (for employees hired after Jan. 1, 1995). The signed statements must be retained by the employer. The law does not specify how long the statements must be retained; it is recommended that they be retained at least as long as the employee remains employed. [Welfare and Institutions Code Section 15659] A form developed by the California Department of Social Services may be used (SOC 341A) and can be downloaded at www.cdss.ca.gov/inforesources/Forms-Brochures/Forms-Alphabetic-List/Q-T#soc. CHA has also developed a form, "Employee Acknowledgment of Elder and Dependent Adult Abuse Reporting Obligations" (CHA Form 19-4), that hospitals may use.

The hospital may supplement the acknowledgment and notice by discussing any special policy it has regarding notifying supervisors and administration about reports that will be or are made, and how the reporting is coordinated when several employees become aware of the same instance of suspected elder or dependent adult abuse.

L. Employer Obligation to Train Employees

Every long-term care facility (as defined in Health and Safety Code Section 1418), every community care facility (as defined in Health and Safety Code Section 1502), and every residential care facility for the elderly (as defined in Health and Safety Code Section 1569.2) that provides care to adults, must train its employees in recognizing and reporting elder and dependent adult abuse, as prescribed by the California Department of Justice. It is recommended that general acute care hospitals also provide this training.

These facilities must also provide all staff being trained a written copy of the reporting requirements and written notification of the staff's confidentiality rights under Welfare and Institutions Code Section 15633.5 *(see I. "Confidentiality of Reports," page 7.18)*. The "Employee Acknowledgment of Elder and Dependent Adult Abuse Reporting Obligations" (CHA Form 19-4) fulfills these requirements. Facilities may provide employees being

trained a copy of the portion of CHA's *Consent Manual* that describes the California elder and dependent adult abuse reporting laws to comply with this requirement.

New employees must be trained within 60 days of the first day of employment. [Welfare and Institutions Code Section 15655]

The California Department of Justice, in cooperation with the California Department of Public Health and the California Department of Social Services has developed a minimal core training program that facilities may use.

M. Federal Requirements

REPORTING

The Elder Justice Act requires specified long-term care facilities to report a reasonable suspicion of a crime against a resident or other person receiving care from the facility. The age of the resident and the location where the crime occurred are irrelevant under this law. If the incident results in serious bodily injury, it must be reported within two hours of becoming aware of it. Otherwise, reporting must take place within 24 hours. *(See "Abuse Occurring in a Long-Term Care Facility," page 7.25, for information regarding to whom reports must be made.)*

Failure to report as required by federal law may result in a civil money penalty of up to $300,000 and exclusion from participation in federal health care programs.

NOTIFYING EMPLOYEES AND OTHERS OF REPORTING OBLIGATIONS

The Elder Justice Act requires the owner or operator of a long-term care facility to annually notify each covered individual of his/her obligation to comply with the federal reporting requirements. A **"covered individual"** includes each individual who is an owner, operator, employee, manager, agent or contractor of the facility.

NONRETALIATION AND SIGNAGE

Facilities must adopt a non-retaliation policy and post signs that specify the rights of employees under this law and tell how an employee may file a complaint with the Secretary of the U.S. Department of Health and Human Services against a facility that violates this law. The Centers for Medicare & Medicaid Services (CMS) is required to develop a model sign. However, at the time of publication of this manual, CMS had not done so. However, CMS issued a guidance about the poster, S&C: 11-30-NH (revised 1-20-12) available at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter11_30.pdf.

[42 U.S.C. Section 1320b-25]

N. Detention of Endangered Adults

The law allows (but does not require) a physician treating an adult, if he/she determines that the adult is an endangered adult (defined in B. "Definitions," page 7.20), to delay the release of the endangered adult until:

1. A local law enforcement agency takes custody of the endangered adult;
2. The responding agency determines that the adult is not endangered; or
3. The responding agency takes other appropriate action to ensure the safety of the endangered adult.

This law applies whether or not medical treatment is required by the adult. [Welfare and Institutions Code Section 15703.05]

Law enforcement officers and other designated persons may take an endangered adult to temporary emergency protective custody in certain circumstances for up to 72 hours. In such cases, the endangered adult must be taken to a hospital if medical evaluation and treatment is required. [Welfare and Institutions Code Section 15703]

During the 72-hour custody, the endangered adult will be transferred to an appropriate temporary residence while an investigation is conducted and a judicial hearing takes place. The temporary residence may include a hospital [Welfare and Institutions Code Section 15701.05].

Following the judicial hearing, the court may order the provision of protective services on an emergency basis for up to 14 business days. The court must specifically designate the approved services in the emergency order. An emergency order for protective services does not include hospitalization unless the court order specifically states otherwise. The emergency order will designate an appropriate temporary conservator of the endangered adult who is responsible for the care of the endangered adult and who may consent for the provision of protective services, including health related services, for the endangered adult.

This law specifically states that it must not be used to circumvent the involuntary commitment process provided for in Welfare and Institutions Code Section 5150 *et seq.* [Welfare and Institutions Code Sections 15703-15705.40]. *(See chapter 3 regarding involuntary commitment laws.)*

VII. INJURY OR CONDITION IN A PATIENT RECEIVED FROM A LICENSED HEALTH FACILITY RESULTING FROM NEGLECT OR ABUSE

A. Statutory Duty of Hospital and Physician to Report

Hospitals and physicians must report by telephone and in writing within 36 hours to the local police and the county health department if a patient is *received from a health facility or community care facility* (as defined in Health and Safety Code Sections 1250 *et seq.* and 1502 *et seq.*) who exhibits a physical injury or condition which, in the opinion of the examining physician, reasonably appears to be the result of neglect or abuse. [Penal Code Section 11161.8]

Although the initial justification for and apparent legislative intent was to require reporting in cases of suspected neglect or abuse in patients received from nursing homes only, the present statutory language is much broader and requires reporting with respect to neglected or abused patients of any age received from essentially any licensed health care facility or community care facility.

This law was written long before the law regarding elder and dependent adult abuse and neglect was amended to require reporting of abuse that occurs in a long-term care facility within two or 24 hours. Facilities should follow the requirements of both laws if the patient is an elder or dependent adult. *(See VI. "Abuse of Elders and Dependent Adults," page 7.19.)*

CONTENTS OF REPORT

Telephone and written reports must state the character and extent of the physical injury or condition.

Telephone Report

Although both the physician and hospital have an independent duty to report, a single telephone report will satisfy the requirement for an oral report. It is recommended that the examining physician make the telephone report.

Written Report

The "Report of Injury or Condition Resulting from Neglect or Abuse *(To a Patient Received from a Licensed Health Facility)*" (CHA Form 19-3) has been developed to meet this reporting requirement. It is recommended that the form be completed and signed by the examining physician and then forwarded to the hospital administrator, or his or her designee, for signature and transmission to both the local police authority having jurisdiction and the county health department.

NOTIFICATION OF PATIENT/VICTIM THAT REPORT WILL BE MADE

The patient must be informed that a report has been or will be made. *(See C. "Informing the Patient of Reporting," page 7.1.)*

B. Optional Reporting by Nurses and Social Workers

A registered nurse, licensed vocational nurse or licensed clinical social worker employed at the admitting hospital may report to the local police authority and the county health department the fact that a patient received from a health facility or community care facility, (as defined in Health and Safety Code Sections 1250 and 1502), exhibits a physical injury or condition which, in the opinion of the nurse or social worker, reasonably appears to be the result of neglect or abuse. [Penal Code Section 11161.8]

Reporting by nurses and social workers is not required by statute, and hence, penalties for failure to report do not apply. Except for victims of child abuse, federal privacy regulations restrict the making of an optional report to situations in which:

1. The victim agrees to the disclosure; or
2. The health care provider, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the victim or other potential victims; or
3. If the victim is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information to be disclosed is not intended to be used against the victim and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the victim is able to agree to the disclosure. [45 C.F.R. Section 164.512(c)]

No employee may be discharged, suspended, disciplined or harassed for making such a report.

C. Immunity From Liability

Penal Code Section 11161.8 provides that no person shall incur any civil or criminal liability as a result of making a report authorized by the law.

VIII. SCREENING FOR DOMESTIC VIOLENCE

A. Screening Policies

General acute care hospitals, acute psychiatric hospitals, special hospitals, psychiatric health facilities and chemical dependency recovery hospitals must establish written policies and procedures for routine screening of patients for purposes of detecting spousal or partner abuse [Health and Safety Code Section 1259.5]. The policies must include guidelines on all of the following:

1. Identifying, through routine screening, spousal or partner abuse among patients.
2. Documenting patient injuries or illnesses attributable to spousal or partner abuse.
3. Educating appropriate hospital staff about the criteria for identifying, and the procedures for handling, patients whose injuries or illnesses are attributable to spousal or partner abuse.
4. Advising patients exhibiting signs of spousal or partner abuse of crisis intervention services that are available either through the hospital or through community-based intervention and counseling services.
5. Providing patients who exhibit signs of spousal or partner abuse with information on domestic violence and a referral list, to be updated periodically, of private and public community agencies that serve persons experiencing spousal or partner abuse, including hotlines, shelters, legal services and information about temporary restraining orders.

This law does not define "spousal abuse" or "partner abuse." However, Penal Code Section 273.5 states that any person who willfully inflicts upon a person who is his or her current or former spouse, cohabitant, fiancé or fiancée, or dating partner, or the mother or father of his or her child, corporal injury resulting in a traumatic condition is guilty of a felony, and upon conviction thereof shall be punished by imprisonment or by a fine or by both. As used in this law, **"traumatic condition"** means a condition of the body, such as a wound, or external or internal injury, including, but not limited to, injury as a result of strangulation or suffocation, whether of a minor or serious nature, caused by a physical force. For purposes of this section, **"strangulation"** and **"suffocation"** include impeding the normal breathing or circulation of the blood of a person by applying pressure on the throat or neck.

The Penal Code section discussed above does not discuss abuse of persons who are dating but not cohabiting or coparenting, or abuse of same-sex partners. However, such abuse should also be reported as assaultive or abusive conduct *(see III. "Reporting Injuries by Firearm or Assaultive or Abusive Conduct ("Suspicious Injuries")," page 7.3)*.

Emotional or verbal abuse does not appear to be reportable.

Similar requirements apply to licensed clinics [Health and Safety Code Section 1233.5; Penal Code Section 13700].

B. Domestic Violence Indicators

Some indicators that may raise a suspicion of domestic violence include:

1. Patient's explanation of injury is inconsistent with appearance of injury
2. Unexplained delay in seeking treatment
3. Patient is under or overly concerned with an injury
4. History of non-specific physical or somatic complaints
5. Overly attentive or aggressive partner
6. Multiple injuries with varying stages of healing

The health care provider may wish to question the patient when he or she is alone and ask something along the lines of, "Because violence is so prevalent in our society, I ask all my patients about abuse. Have you ever been hurt or threatened by a partner or ex-partner?"

If the patient answers in the affirmative, providers may take a history, assess patient safety, provide emotional support, provide medical/legal/social services referral information, and document. Providers may wish to discuss with the patient the legal obligation to report (if applicable) and provide the patient with referrals so they can go to a protected environment due to the risk of the abuser's retaliation after a report is made.

C. Reporting Requirements

Domestic violence must be reported if it meets the requirements of any of the following reporting laws:

1. Injury by firearm or assaultive or abusive conduct (also known as "suspicious injury reporting") *(see III. "Reporting Injuries by Firearm or Assaultive or Abusive Conduct ("Suspicious Injuries")," page 7.3)*.
2. Sexual assault or rape *(see IV. "Sexual Assault and Rape," page 7.5)*.
3. Elder or dependent adult abuse *(see VI. "Abuse of Elders and Dependent Adults," page 7.19)*.

D. Forms

Cal OES has developed a form (Cal OES 2-502), instructions, and examination protocol for use in cases of domestic abuse. They may be found at www.ccfmtc.org.

IX. POTENTIALLY DANGEROUS PATIENTS: DUTY TO WARN POTENTIAL VICTIMS AND NOTIFY LAW ENFORCEMENT

A. Duty to Warn Potential Victims

The California Supreme Court held in *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976), that a psychotherapist has a duty to warn, or take other appropriate action to protect, the foreseeable victim or victims of a patient's violent tendencies, if:

1. A psychotherapist-patient relationship exists,
2. The psychotherapist knows or should know that the patient is dangerous, and
3. There is a foreseeable victim or victims of the patient's violent tendencies.

According to the court, when a therapist determines (or pursuant to the standards of the profession should determine) that a patient presents a serious danger of violence to another, the therapist has a duty to use reasonable care to protect the intended victim against the danger. Depending on the nature of the case, the discharge of this duty may require the therapist to take one or more steps, including warning the intended victim or others likely to apprise the victim of the danger, notifying the police, or taking other steps that may be reasonably necessary under the circumstances. After the court's decision, the California legislature enacted an immunity statute under which, if a warning is required, the psychotherapist must at least notify both the potential victim(s) and law enforcement.

In carrying out this duty, the psychotherapist may need to release confidential patient information. The court held that in these situations, the justification for protecting the patient's confidentiality (e.g., to encourage patients to seek treatment and fully disclose information to their psychotherapist) is outweighed by the need to warn potential victims so that they can protect themselves. In addition, the Confidentiality of Medical Information Act and Welfare and Institutions Code Section 5328(a)(18) allow the release of confidential information when a psychotherapist believes that a patient presents a serious danger of violence to a reasonably foreseeable victim or victims. Also, the psychotherapist-patient privilege does not apply 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 *(see Evidence Code Section 1024)*. The HIPAA privacy regulations also permit these disclosures [45 C.F.R. Section 164.512(j)(l)(i)].

B. Duty to Notify Law Enforcement Agency

A licensed psychotherapist is required to report, within 24 hours, to a local law enforcement agency the identity of a person who has communicated to the licensed psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims. A **"licensed psychotherapist,"** for purposes of this requirement, is defined in Evidence Code Section 1010, subdivisions (a) to (e), as a person who is, or is reasonably believed by the patient to be:

1. 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.
2. A licensed psychologist.
3. A licensed clinical social worker, when he or she is engaged in applied psychotherapy of a nonmedical nature.
4. A credentialed school psychologist.
5. A licensed marriage and family therapist.

[Welfare and Institutions Code Sections 8100(b)(1) and 8105(c)]

Note that the definition of "psychotherapist" for the purposes of this requirement is narrower than the definition of "psychotherapist" under the immunity statute discussed below.

The report to law enforcement should be made by telephone and be followed by a written letter documenting the telephone report. A copy of the letter should be retained by the hospital. The psychotherapist may also need to warn potential victims, as described above. *(See also 45 C.F.R. Section 164.512(j)(l)(i).)*

C. Immunity From Liability

IMMUNITY FOR PSYCHOTHERAPISTS

Civil Code Section 43.92 provides immunity to psychotherapists for failure to protect from a patient's violent behavior except if the patient has communicated to the psychotherapist a serious threat of physical violence against persons. That statute describes a duty to warn and protect as well as how that duty might be met.

NOTE: Effective Jan. 1, 2014, the California legislature changed the name of the "duty to warn and protect" to the "duty to protect" in this law. However, the law explicitly stated that changing the name shall not be "construed to be a substantive change, and any duty of a psychotherapist shall not be modified as a result of changing the wording in this section." The law also stated that "it is the intent of the Legislature that a court interpret this section ... in a manner consistent with the interpretation of this section as it read prior to Jan. 1, 2013." [Civil Code Section 43.92(c) and(d)]

Duty to Warn and Protect

Unless the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims, a psychotherapist (as defined in Evidence Code Section 1010 below) is not liable for:

1. Failing to protect from a patient's threatened violent behavior, or
2. Failing to protect from a patient's violent behavior.

NOTE: A 2004 decision by the California Court of Appeal expands the duty to warn under the law described in this part of the manual. In *Ewing v. Goldstein*, 120 Cal. App.4th 807 (2d Dist. 2004), the Court of Appeal ruled that under Civil Code Section 43.92, a psychotherapist has a duty to warn of a patient's threat even if the patient never communicated the threat directly to the psychotherapist, as long as the patient's threat was communicated to the psychotherapist by a member of the patient's family. This ruling that a duty to warn may arise based on communications to the psychotherapist by someone other than the patient creates a duty to warn that exceeds the literal language of Section 43.92. Psychotherapists should consider what action they need to take in light of this decision and consider whether to consult with their legal counsel. Providers should review any documents (including policies or forms) they use to inform patients about the limits of confidentiality.

Satisfying the Duty

If there is a duty to warn and protect under the limited circumstances specified above, the law states that the duty is discharged by the psychotherapist making reasonable efforts to communicate the threat to both the victim or victims and a law enforcement agency. A psychotherapist may also discharge the duty by taking other reasonable measures, depending on the circumstances of the situation. Placing the patient on an involuntary hold under Welfare and Institutions Code Section 5150 might be a reasonable measure also.

Definition of Psychotherapist

"Psychotherapist" is defined for purposes of this law in Evidence Code Section 1010, subdivisions (a) to (p), to mean a person who is, or is reasonably believed by the patient to be:

1. 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.
2. A licensed psychologist.
3. A licensed clinical social worker, when he or she is engaged in applied psychotherapy of a nonmedical nature.
4. A credentialed school psychologist.
5. A licensed marriage and family therapist.
6. A person registered as a psychological assistant who is under the supervision of a licensed psychologist or board certified psychiatrist as required by Business and Professions Code Section 2913, or a person registered as an associate marriage and family therapist who is under the supervision of a licensed marriage and family therapist, licensed clinical social worker, licensed psychologist, licensed professional clinical counselor, or licensed physician certified in psychiatry, as specified in Business and Professions Code Section 4980.44.
7. A person registered as an associate clinical social worker who is under supervision as specified in Business and Professions Code Section 4996.23.
8. A person registered with the Board of Psychology as a registered psychologist and who is under the supervision of a licensed psychologist or board certified psychiatrist.
9. A psychological intern as defined in Business and Professions Code Section 2911 who is under the

supervision of a licensed psychologist or board certified psychiatrist.

10. A trainee, as defined in Business and Professions Code Section 4980.03(c), who is fulfilling his or her supervised practicum required by Business and Professions Code Section 4980.36(d) or 4980.37(c) and is supervised by a licensed psychologist, a board certified psychiatrist, licensed clinical social worker, a licensed marriage and family therapist, or a licensed professional clinical counselor.
11. A California licensed registered nurse 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.
12. An advanced practice registered nurse who is certified as a clinical nurse specialist pursuant to Business and Professions Code Section 2838 *et seq.* and who participates in expert clinical practice in psychiatric-mental health nursing.
13. A person providing outpatient mental health treatment or counseling services to minors as authorized by Family Code Section 6924. This includes psychiatrists, psychologists, social workers, and marriage and family therapists, as well as services provided by a governmental agency, an entity having a contract with a governmental agency to provide the services, a runaway house, or a crisis resolution center.
14. A person licensed as a professional clinical counselor under Business and Professions Code Section 4999.10 *et seq.*
15. 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 Business and Professions Code Sections 4999.42 to 4999.48.
16. A clinical counselor trainee, as defined in Business and Professions Code Section 4999.12(g), who is fulfilling his or her supervised practicum required by Business and Professions Code Section 4999.32(c)(3) or 4999.33(c)(3), 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.

IMMUNITY FOR PSYCHOTHERAPISTS AND OTHERS

As indicated in chapter 3, Welfare and Institutions Code Sections 5154, 5173, 5259.3, 5267 and 5270.50 provide immunity to various persons involved in the treatment, evaluation and certification of involuntary mental health patients, including the professional in charge of a facility, the medical director and the psychiatrist directly responsible for the patient's treatment, provided that certain conditions are met. This immunity may apply even where a psychiatrist fails to carry out his or her obligation under *Tarasoff* to warn or otherwise protect the foreseeable victim of an involuntary patient's violent tendencies [*Lowe v. County of San Diego*, 183 Cal.App.3d 515 (1986), cert. den.; *Karash v. San Diego*, 480 U.S. 946 (1987)].

D. Documenting Decisions

In order to carry out the duty to warn and to notify law enforcement, the psychotherapist must strike a careful balance between protecting the patient's confidentiality and protecting the potential victim. Initially, the psychotherapist should gather relevant information about the patient, including the patient's past treatment. The therapist's decision about whether it is likely that the patient will carry out his or her threats, or that the patient presents a danger to another person, should be documented along with the information that led to the decision. This will provide important protection against claims that the therapist should not have released information to law enforcement and/or the potential victim (if a warning/notification is given) or that the therapist did not carry out his or her duty to warn the potential victim or notify law enforcement (if a warning/notification is not given). If a warning is given, the therapist should disclose only the information that is necessary to enable the potential victim to recognize the seriousness of the threat and take proper precautions to protect himself or herself. A general indication to a person that perhaps the person should avoid the patient may not be a sufficient warning. Also, depending upon the patient's therapeutic condition and possible reaction, it may be advisable to inform the patient that the warning will be given. However, the law does not require that the patient be so informed.

Situations in which a psychotherapist may have a duty to warn a potential victim or notify law enforcement often involve difficult decisions, and hospitals and psychotherapists should seek legal advice in specific situations.

X. NOTIFYING LAW ENFORCEMENT OFFICERS OF PATIENT PRESENCE, RELEASE OR DISAPPEARANCE

As a general rule, a hospital may not disclose patient-identifiable information to law enforcement officers without the written authorization of the patient, unless a special exception to the law applies. These exceptions and required reporting of patient presence, release or disappearance are described in H. "Notifying Law Enforcement Officers of Patient Presence, Release or Disappearance," page 6.x.

XI. PATIENTS PROHIBITED FROM POSSESSING FIREARMS OR OTHER DEADLY WEAPONS

State law prohibits certain psychiatric patients and former psychiatric patients from possessing or purchasing firearms and other deadly weapons. Allowing these persons to possess or purchase firearms or other deadly weapons is also illegal. In order to implement these laws, facilities that provide psychiatric treatment are required to make the reports discussed in C. "Reporting Requirements," page 7.37. [Welfare and Institutions Code Sections 8100-8108]

A. Prohibition Against Possessing or Purchasing a Firearm or Other Deadly Weapon

The persons described in B. "Persons Subject to the Prohibition," page 7.36, are not permitted to possess, control, purchase, receive, or attempt to purchase or receive, any firearm or other deadly weapon.

Besides firearms, "**deadly weapon"** includes certain types of ammunition, knives, explosives, clubs, and martial arts weapons *(see Penal Code Section 16590)*. Facilities should consult their legal counsel if in doubt about whether a particular article comes within the definition of a deadly weapon. *(See also Penal Code Sections 16430 and 16520.)*

A person who knowingly supplies, sells, gives or allows possession of a firearm by a person described below will be incarcerated in the state prison for two to four years. A person who knowingly supplies, sells, gives or allows possession of another deadly weapon by a person described below is subject to incarceration for one year or less and/or fine.

If a person described below is found to have in his or her possession a firearm or other deadly weapon, the weapon must be confiscated by a law enforcement agency or peace officer [Welfare and Institutions Code Section 8102(a)].

B. Persons Subject to the Prohibition

The following persons are subject to the prohibition against possessing or purchasing a firearm or other deadly weapon for the time period specified:

1. A person taken into custody, assessed and admitted to a designated facility under Welfare and Institutions Code Sections 5150-5152 because that person is a danger to self or others (not gravely disabled). The prohibition is effective for five years from the date of discharge [Welfare and Institutions Code Section 8103(f)].
2. A person certified for intensive treatment under Welfare and Institutions Code Sections 5250, 5260 or 5270.15. The prohibition is effective for five years from the date of discharge [Welfare and Institutions Code Section 8103(g)].
3. A person undergoing inpatient treatment, *whether on a voluntary or involuntary basis*, who is a danger to self or others. The prohibition ends once the patient is discharged from the facility. [Welfare and Institutions Code Section 8100(a) and (d)] The attending health professional primarily responsible for the patient's treatment should document the determination that the patient has a mental health disorder and probable cause exists to believe he or she is a danger to self or others. With respect to voluntary patients, **"danger to self"** means a voluntary patient who has made a serious threat of, or attempted, suicide with the use of a firearm or other deadly weapon [Welfare and Institutions Code Section 8100(f)].
4. A person who communicates to a licensed psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims, and the psychotherapist reports this threat to the local law enforcement agency. For purposes of this law, **"psychotherapist"** is defined in Evidence Code Section 1010, subdivisions (a) through (e), inclusive, as a person who is, or is reasonably believed by the patient to be:
    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 licensed psychologist.
    c. A licensed clinical social worker, when he or she is engaged in applied psychotherapy of a nonmedical nature.

d. A credentialed school psychologist.

e. A licensed marriage and family therapist.

The prohibition ends five years after the date of the report. [Welfare and Institutions Code Section 8100(b)]

5. A person who has been adjudicated by a court of any state to be a mentally disordered sex offender or a danger to others as a result of a mental disorder or mental illness. The prohibition is of indefinite duration. [Welfare and Institutions Code Section 8103(a)]

6. A person who has been found not guilty of certain crimes by reason of insanity, or mentally incompetent to stand trial. (Facilities should consult their legal counsel if in doubt about whether a particular crime falls within this law.) The prohibition is of indefinite duration. [Welfare and Institutions Code Section 8103(b), (c) and (d)]

7. A person who has been placed under conservatorship by a court pursuant to Welfare and Institutions Code Section 5350 or the law of any other state because the person is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism, if the court determined that possession of a firearm or other deadly weapon would present a danger to the patient or to others. The prohibition ends when the conservatorship ends. [Welfare and Institutions Code Section 8103(e)]

Some of the persons listed above may gain the right to possess or purchase a firearm by obtaining a court order to this effect. Facilities should consult their legal counsel if in doubt about whether a particular patient has the right to possess a firearm.

C. Reporting Requirements

Facilities must make reports to the California Department of Justice (DOJ), as described below. The law does not require facilities to notify patients that the reports described below have been made.

REPORTING TO CALIFORNIA DEPARTMENT OF JUSTICE

Initial Reporting

California law requires hospitals to report electronically to DOJ information DOJ deems necessary to identify those persons described in paragraphs 1., 2., 3. above. (Persons described in paragraphs 4.-7. are reported to DOJ by local law enforcement or by the courts.) The facility must report within 24 hours of admission. Information about online reporting may be obtained by calling the California DOJ at (916) 227-7550.

A copy of the completed online form should be printed and retained by the hospital. Facilities will be reimbursed by the California DOJ for submitting reports at a rate of 50 cents per report. Facilities must submit a quarterly invoice to DOJ.

Reporting at Time of Discharge

Facilities must report to DOJ the discharge of persons described in paragraph 1. or 2. of B. "Persons Subject to the Prohibition," page 7.36. However, discharge reports are not to be made for persons who are discharged within 31 days after admission [Welfare and Institutions Code Section 8103(h)].

REPORTING TO CONFISCATING LAW ENFORCEMENT AGENCY

If a patient was detained or apprehended for examination of his or her mental condition, or is a person described in B. "Persons Subject to the Prohibition," page 7.36, and has had a weapon or weapons confiscated pursuant to Welfare and Institutions Code Section 8102, health facility personnel must notify the confiscating law enforcement agency upon release of the patient. "Notice to Law Enforcement Agency: Release of Person From Whom A Firearm or Other Deadly Weapon Was Confiscated" (CHA Form 13-4) can be used for this purpose. A copy of this form should be retained by the hospital. [Welfare and Institutions Code Section 8102(b)]

D. Patient Notification Obligations

NOTICE TO PATIENT

Prior to, or concurrent with, the discharge of a person described in paragraph 1. or 2. of B. "Persons Subject to the Prohibition," page 7.36, the facility must inform that person that he or she is prohibited from owning, possessing, controlling, receiving, or purchasing any firearm or other dangerous weapon for five years after discharge. The facility must also tell the patient that he or she may request a court hearing for an order permitting the patient to own, possess, control, receive, or purchase a firearm. The facility should have each such patient sign a form stating that he or she received this information. The California DOJ has developed a form for this purpose, "Patient Notification of Firearms Prohibition and Right to Hearing Form" (BOF 4009B). (This form may be ordered from the California DOJ at the phone number given above.)

A copy of the signed form should be given to the patient; the original should be retained by the hospital. If the person requests a hearing at the time of discharge, the facility must forward the form to the superior court, unless the person states that he or she will submit the form. [Welfare and Institutions Code Section 8103]

PROCEDURE FOR RETURN OF WEAPON

If a patient was detained or apprehended for examination of his or her mental condition or was a person described in B. "Persons Subject to the Prohibition," page 7.36, and had a weapon confiscated by a law enforcement agency, the hospital must notify the patient of the procedure for the return of the weapon. When the patient is released, the facility should have the patient sign a form stating that he or she received this information. A form for this purpose, "Notice to Patient: Procedure for Return of Confiscated Weapon(s)" (CHA Form 13-5), is included at the end of this manual. A copy of the signed form should be given to the patient; the original should be retained by the hospital [Welfare and Institutions Code Section 8102(b)].

E. Confidentiality Considerations

State and federal health information privacy laws permit health facilities and practitioners to make reports that are required by law [45 C.F.R. Section 164.512(a); Civil Code Section 56.10(c)(14); *see also 65 Ops. Cal. Atty. Gen. 345 (1982)*].

Reports submitted to the DOJ regarding patients described in paragraphs 1. and 2. under B. "Persons Subject to the Prohibition," page 7.36, are confidential and may be used only for court proceedings and by DOJ to determine a patient's eligibility to own, possess, control, receive, or purchase a firearm [Welfare and Institutions Code Section 8103(f)(2)(A) and g(2)(A)]. Hospitals should retain copies of reports made, but should consider keeping them separate from the medical record or in a separate portion of the medical record to prevent routine copying and disclosure for purposes not related to the criminal justice system, and to prevent improper release to unauthorized persons.

F. Immunity From Liability

Mental health facilities and treating health professionals are immune from civil liability for making a report required or authorized in the law [Welfare and Institutions Code Section 8108].

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21-1 Incident Report
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Forms and Appendices can be found at the back of the manual and online for CHA members at www.calhospital.org/free-resources.

"S" denotes that the form is provided in English and Spanish.

8 Adverse Events and Incident Reports

I. INTRODUCTION

This chapter describes the legal issues involved in establishing incident report and quality improvement systems that protect the sensitive information generated from subpoena or other discovery attempts in a lawsuit against the hospital. This chapter also describes the legal and accreditation requirements for notifying patients of adverse events, implementing patient safety plans, and reporting adverse events to government agencies.

II. LEGAL ASPECTS OF INTERNAL INCIDENT AND QUALITY REPORTING

Appropriate reporting of incidents within a facility is important for many reasons. First, the proper personnel within the hospital must be alerted to the fact that an incident has occurred so that they may immediately act to mitigate any potential negative effects of the incident. In addition, appropriate personnel must investigate the incident when memories and evidence are fresh, and then take the necessary steps to revise systems, policies and procedures as appropriate to improve quality.

The California Legislature has recognized that incident reporting and related quality improvement activities require a level of confidence on the part of hospital staff that the documents and information they create will not be used against them in litigation. Accordingly, the California Legislature has adopted two legal protections from discovery by plaintiffs' lawyers for certain documents and other information. These legal protections, the attorney-client privilege and the peer review protection from discovery, are discussed below. In addition, the United States Congress has adopted protections described in D. "Patient Safety Organizations," page 8.2.

It is always the obligation of the entity claiming the benefit of a nondisclosure privilege to show that the privileges and protections apply in that particular instance. The legal issues governing the confidentiality of the reports discussed in this chapter are complex, and intended confidentiality is easily thwarted by inadvertent uses or disclosures of the reports. Few areas of health care are as rife with misconceptions as to the circumstances under which the law provides protection. Because of this, it is extremely important for providers to seek legal assistance in the design of their reporting systems and legal review of any modifications made to them.

A. Incident Reports

Many hospitals have used the traditional incident report system whereby an "Incident Report" (CHA Form 21-1) or similar form of report is prepared by nursing staff or other hospital personnel with the intent that the report will remain confidential and be transmitted to the hospital's attorney (perhaps through its insurance carrier) for use in litigation that might arise out of an incident. One purpose of the incident report is to alert the hospital attorney to potential claims. Another is to document the facts and circumstances of the incident in a record that is created at the time the incident occurs. If properly prepared and maintained, incident reports may be protected from discovery by the attorney-client privilege. This means that persons suing the hospital would not be able to obtain the documents, even by use of a subpoena. The procedure for preparing the reports and preserving their confidentiality is discussed in III. "Preparing Confidential Incident Reports," page 8.3. As noted above, legal counsel should be consulted regarding the design and implementation of an incident reporting system.

B. Medical Staff Quality Assurance Reports

An alternative or supplement to the incident report system is a quality assurance reporting system operated through the medical staff quality assurance process. Under this approach, reports describing incidents potentially affecting the quality of patient care are transmitted to the medical staff committee that has responsibility for the hospital's quality assurance program, usually through the hospital's quality assurance coordinator. This report, unlike the incident report, is not prepared for the hospital's attorney for use in litigation, and therefore does not claim protection under the attorney-client privilege. It is, however, prepared for the medical staff committee responsible for quality assurance. As such, the report is intended

to constitute a medical staff committee document and to qualify for protection from discovery under the "peer review" confidentiality of Evidence Code Section 1157 (if properly prepared and maintained). The goal here is the same as with the incident report — i.e., to protect the document from compelled disclosure. Although there are some exceptions to the confidentiality of Evidence Code Section 1157, it protects against compelled disclosure in malpractice and most other private civil actions. *(See, however,* Arnett v. Dal Cielo*, 14 Cal.4th 4 (1996) regarding the exception to Evidence Code Section 1157 protection for administrative investigative subpoenas used in connection with government investigations.)*

As with the incident report, the details of the system through which the report is completed and distributed are important. It is particularly important to show an acceptable connection between the reporting process and the medical staff committee structure.

C. Coordinating Incident and Quality Assurance Reporting

It is possible for the quality assurance reporting system to tie into the incident reporting system. To do this, the coordinator who is responsible for receiving the quality assurance report completes, when appropriate, a "Report to Attorney" form (CHA Form 21-2) or similar report form. Like the incident report, the "Report to Attorney" form is transmitted to the hospital's attorney (perhaps through its insurance carrier) for use in litigation that might arise out of an incident. The "Report to Attorney" form is intended to be protected by the attorney-client privilege in the same manner as the incident report. It bears repeating that since the privileges and protections involved are somewhat technical in nature, hospital legal counsel should be consulted regarding the structure and implementation of such a system.

D. Patient Safety Organizations

A hospital may participate in a Patient Safety Organization (PSO) and develop a Patient Safety Evaluation System (PSES). Data, reports, records, memoranda, analyses, and other information developed as part of a PSES may be considered patient safety work product (PSWP) under the Patient Safety and Quality Improvement Act of 2005. PSWP is protected from discovery or access by subpoena, court order, administrative order, inspection processes and other demands for access.

A complete discussion of PSOs, including the confidentiality of PSWP, is included in CHA's *California Hospital Compliance Manual*.

E. Considerations in Developing the Internal Reporting Process

A medical staff quality assurance reporting system that is protected by Evidence Code Section 1157 should be designed to achieve the goals of improving the quality of care, correcting problems and protecting patients, whereas the incident reporting process that is protected by the attorney-client privilege should be designed to gather the information that will be needed to defend against liability claims.

The medical staff quality assurance system should be designed so that the practitioners involved in any incident that is reported will be given appropriate feedback about the findings from the review and the aspects of any plan of correction that is developed that will affect them in future cases. This feedback should be given routinely when the concerns are identified rather than accumulated in a confidential file that is disclosed only in the context of a hearing on disciplinary action. Care must be taken to balance the confidentiality of the person submitting the report with the need to know sufficient details regarding the report to allow for a meaningful response.

It is also appropriate to plan for feedback to staff who submit reports, so the health care professionals may work cooperatively to improve care. Although it would be inappropriate to disclose information about disciplinary warnings or actions issued to any individual (medical staff member, nurse or other member of the health care team), it is appropriate to convey information about deficiencies that were identified and the plan of correction to avoid future deficiencies, and to encourage the staff to work together to implement the plan of correction.

The peer review protections will allow the disclosure of information in the course of a quality assurance and peer review process that requires identification of issues and development of plans of correction. They also will allow disclosures of the information for the purpose of improving care provided by nonmedical staff members. For example, the information may be used to redesign a pharmacy medication order protocol for a certain drug or for planning a nurse education course in a particular subject such as administration and monitoring of Pitocin during labor. These alternate uses are fully protected as long as the system is subject to the medical staff committee oversight. As is noted above, care must be taken in designing the programs to take advantage of the protections from discovery that are available. A hospital-wide quality assurance plan that has no medical staff committee oversight or participation will not meet the requirements for the protection from discovery that is available for the

records and proceedings of medical staff committees having the responsibility for evaluating and improving the quality of care. However, a multidisciplinary process that includes nonphysicians as well as medical staff members can be fully protected when that process provides for the proper medical staff committee oversight.

III. PREPARING CONFIDENTIAL INCIDENT REPORTS

A. General Principle

California courts have held that incident reports may be regarded as confidential attorney-client communications if the hospital can show that the purpose and intent of the reports is to provide a confidential communication between the hospital and its attorney, even if they are communicated through the hospital's insurance carrier [*Sierra Vista Hospital v. Superior Court*, 248 Cal.App.2d 359 (1967)]. In the Sierra Vista case, the hospital was able to show that:

1. The employee who prepared the report knew it was intended to be made as a confidential communication to the hospital's attorney;
2. The report form itself stated that it was confidential and not to be made part of the patient's medical record; and
3. The hospital retained no copies of the form at the hospital, and did not give a copy to the medical staff or anyone else.

The holding of the Sierra Vista case was reaffirmed in the decision in *Scripps Health v. Superior Court*, 109 Cal. App.4th 529 (4th Dist. 2003). The Scripps Health case is notable for hospitals and systems that collect such reports for use by in-house counsel since the incident reports in this case were prepared for the health system's in-house attorney who used them for the system's self-insurance, risk management and quality assurance programs, as directed by the legal department.

B. Maintaining the Privilege

Privileges may be lost by disclosure of the privileged material. In order to prevent any inadvertent disclosure of incident reports, appropriate physical and/or electronic security measures must be maintained. No copy of the report should be included in the patient's medical record nor should a copy be reviewed or signed by the attending physician or any other member of the medical staff.

If a report must be made to CDPH or The Joint Commission, a separate document containing only that information which must be reported should be submitted. *(See VII. "CDPH Adverse Events Reporting," page 8.7, for adverse event reports that must be made to CDPH. See V. "The Joint Commission Requirements," page 8.5 for more information about reporting to The Joint Commission.)*

DISCLOSURE TO CDPH

Peer Review Documents

CDPH and CMS take the position that they are legally entitled to access peer review information, even if it is protected from discovery during court proceedings by the California Evidence Code. There is some legal support for this position, as CDPH and CMS must assess whether the hospital is complying with regulations governing the medical staff, the hospital governing body, and quality assurance. CMS, in particular, reminds hospitals that as a federal government agency it need not recognize this state law. Information that is protected from discovery under Evidence Code 1157 may remain protected even if it is disclosed to CDPH in the course of an investigation by CDPH [*Fox v. Kramer*, 22 Cal.4th 531 (2000)]. If CMS or CDPH requests peer review information protected by Evidence Code Section 1157 during a survey, the hospital should clearly indicate every report, document and interview that is entitled to 1157 protection, ask the surveyors to note this in their records and reports, and inform them that the hospital intends to assert the applicability of peer review protection. Generally, the surveyors will not copy these documents.

Attorney-Client Privileged Documents

CDPH and CMS do not assert that they are entitled to access documents protected by the attorney-client privilege. California courts have held that incident reports may be regarded as confidential attorney-client communications if the hospital can show that the purpose and intent of the reports is to provide a confidential communication between the hospital and its attorney.

Patient Safety Work Product Documents

The Patient Safety and Quality Improvement Act (PSQIA) of 2005 was enacted to facilitate and accelerate improvements in health care quality and patient safety. The law encourages the voluntary and confidential reporting of events that may adversely affect patients to Patient Safety Organizations (PSOs). PSOs then aggregate and analyze

the data to identify and better understand underlying causes of risks or ham, and share those findings back to participating providers.

The PSQIA alleviates health care providers' fears that trial lawyers, government agencies, or others might obtain and misuse information about these events by providing federal legal confidentiality protections to the information that is assembled and reported by providers to a PSO. The confidentiality protections preempt any state or local law that allows or requires disclosure of information defined as "patient safety work product." Thus, surveyors should not ask hospitals for access to patient safety work product documents, and hospitals should not provide access to these documents. This applies whether the surveyors are conducting a state survey or a federal survey.

"Patient safety work product" means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material):

1. Which could improve patient safety, health care quality, or health care outcomes; and
    a. Which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO, and such documentation includes the date the information entered the patient safety evaluation system; or
    b. Are developed by a PSO for the conduct of patient safety activities; or
2. Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.

However, patient safety work product does not include a patient's medical record, billing and discharge information, or any other original patient or provider information; nor does it include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a PSO shall not by reason of its reporting be considered patient safety work product.

A complete discussion of PSOs, including the confidentiality of PSWP, is included in CHA's *California Hospital Compliance Manual*. Hospitals with questions about which documents may or may not be released to surveyors pursuant to the PSQIA should consult legal counsel.

C. Documenting Incident in the Medical Record

While a copy of the incident report or PSWP itself should not be included in the patient's medical record or reviewed by the attending physician, this prohibition should not be construed as a recommendation that the patient's medical record contain no information relating to an incident that affects the patient or the patient's care. The occurrence of any such incident and its effect on the patient can and must be included in the medical record for the use of the attending physician in properly treating the patient as a result of the occurrence. Such information should, however, be recorded separately in the medical record and not be recorded simply by inserting a copy of the incident report in the record.

The incident report and/or PSWP contain additional, more detailed information which is not necessary to the continued treatment of the patient and which should not be included in the patient's medical record; it is this more detailed information that is intended to be protected from discovery.

Likewise, no documentation should be put in the medical record regarding notification of risk management or consultation with legal counsel.

IV. REQUIRED PATIENT SAFETY PLAN

California law requires general acute care hospitals, acute psychiatric hospitals, and special hospitals to develop, implement, and comply with a patient safety plan for the purpose of improving the health and safety of patients and reducing preventable patient safety events [Health and Safety Code Sections 1279.6 and 1279.7].

A. Written Plan

The patient safety plan must be developed by the hospital, in consultation with the hospital's various health care professionals. The plan must provide for at least the following:

1. A patient safety committee or equivalent committee in composition and function. The responsibilities of the committee are described below.
2. A reporting system for patient safety events that allows anyone involved, including, but not limited to, health care practitioners, hospital employees, patients, and visitors, to make a report of a patient safety event to the hospital. Hospitals should work with their legal counsel to integrate this reporting system with the hospital's incident reporting system and the medical

staff quality assurance report system, as appropriate. Reports by non-hospital employees (patients and visitors) are likely not covered by the attorney-client privilege or Evidence Code Section 1157, although discussions and reports generated by the patient safety committee in response to reports by patients and visitors may enjoy these protections if the committee is organized and operated properly. In addition, hospitals should also work with their legal counsel to integrate reports by patients and visitors into their grievance process as appropriate.

3. A process for a team of hospital staff to conduct analyses, including, but not limited to, root cause analyses of patient safety events. The team must be composed of the hospital's various categories of health care professionals, with the appropriate competencies to conduct the required analyses. Again, hospitals should work with their legal counsel to organize the team/committee and its operations so that its reports and deliberations may enjoy the protections of the attorney-client privilege and Evidence Code Section 1157 as described in this chapter.
4. A reporting process that supports and encourages a culture of safety and reporting patient safety events.
5. A process for providing ongoing patient safety training for hospital personnel and health care practitioners.
6. Measures to prevent adverse events associated with misconnecting enteral feeding and epidural lines. The requirement to include these measures in the patient safety plan ended on July 1, 2016 for enteral feeding connectors, and Jan. 1, 2017 for epidural connectors. As of those dates, health facilities are prohibited from using a connection that would fit into a connection port other than the type it was intended for, unless an emergency or urgent situation exists and the prohibition would impair the ability to provide health care. If a hospital is not able to purchase a sufficient supply of compliant tubing connectors, the hospital should address this issue in its patient safety plan and describe the measures it is taking to manage the noncompliant tubing connectors, including training.
7. A facility-wide hand hygiene program.

B. Patient Safety Committee

The committee must be composed of the hospital's various health care professionals, including, but not limited to, physicians, nurses, pharmacists, and administrators. The committee must do all of the following:

1. Review and approve the patient safety plan.
2. Receive and review reports of patient safety events.
3. Monitor implementation of corrective actions for patient safety events.
4. Make recommendations to eliminate future patient safety events.
5. Review and revise the patient safety plan at least once a year, but more often if necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices.

Hospitals should work with their legal counsel to maximize the likelihood that the reports and deliberations of this committee qualify for the attorney-client privilege and the peer review confidentiality protections of Evidence Code Section 1157 as described in this chapter.

C. Patient Safety Event Definition

Patient safety events must be defined by the patient safety plan and must include, but not be limited to:

1. All adverse events or potential adverse events, as described in Health and Safety Code Section 1279.1 *(see VII. "CDPH Adverse Events Reporting," page 8.7)*, that are determined to be preventable; and
2. Health care-associated infections, as defined in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, that are determined to be preventable. CDPH may instead accept the recommendation of the Healthcare Associated Infection Advisory Committee, or its successor.

Hospitals may wish to include "sentinel events" in the definition of patient safety events *(see A. "Sentinel Events," page 8.5)*.

V. THE JOINT COMMISSION REQUIREMENTS

A. Sentinel Events

Under its policy on "sentinel events," The Joint Commission (TJC) asks hospitals to review all incidents that constitute a sentinel event and, with some exceptions, to share with TJC the results of this review (called a "root cause analysis"). Hospitals are also expected to prepare action plans to address any issues identified in the root cause analysis.

A **"sentinel event"** is defined as "an unexpected occurrence involving death or serious physical or

psychological injury or the risk thereof. The phrase 'or risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." *(See* The Joint Commission Comprehensive Accreditation Manual for Hospitals*, glossary.)*

Since a sentinel event, by definition, involves an event that could lead to litigation, hospitals have reason to be concerned regarding the confidentiality of the information generated by the root cause analysis process. Many hospitals have sought to conduct their root cause analysis through a medical staff committee process that may be protected under Evidence Code Section 1157. Others have used attorney-directed investigations in order to bring the information under the attorney-client privilege or attorney-work product privilege. Once such confidentiality protection is established, the concern becomes whether disclosing this information to TJC may waive whatever privilege or legal protection would otherwise apply to the information.

TJC asks (but does not require) that hospitals report their sentinel events to TJC and share their root cause analyses and action plans with them as well. TJC is aware of the concerns about loss of confidentiality with respect to the root cause analyses if they are shared with TJC. As a result, TJC has offered hospitals several alternatives for handling sentinel events and the root cause analysis process. These alternatives cover a range of options for sharing information with TJC, including the option ("alternative 4") not to share any information at all. Information on these alternatives can be found at www.jointcommission.org/se_Alternatives. Decisions on how best to protect sentinel event reviews should be made in consultation with legal counsel.

CDPH has stated that sentinel events should be reported to CDPH as adverse events or unusual occurrences, whichever is appropriate.

B. Periodic Performance Review

In addition to the sentinel event process, TJC requires that accredited organizations conduct a self-assessment through a process called Periodic Performance Review (PPR). PPR requires accredited organizations to assess themselves against applicable TJC standards, to develop plans of action to address areas of noncompliance and to identify measures of success to demonstrate that the identified deficiencies have been addressed and resolved. Under the full PPR process, all information developed by accredited organizations to comply with PPR is to be shared with TJC, which will use the information in connection with the survey and accreditation process.

As with the sentinel event process, hospitals have decisions to make as to how to conduct these self-assessments and the extent to which they wish to protect the results of such assessments from compelled disclosure (such as a subpoena in a medical malpractice case) and from waiver of confidentiality protection. To address industry concerns regarding the possible loss of confidentiality protection for data shared with it, TJC has followed the approach it has used with regard to sentinel events and developed several options for hospital compliance with PPR requirements that involve disclosure of varying amounts of information. *(See discussion under A. "Sentinel Events," page 8.5.)*

NOTE: In order to use any of the alternatives to full participation in the full PPR, the accredited organization must affirm that it has made its decision not to do the full PPR only after careful consideration with legal counsel.

VI. NOTIFYING THE PATIENT OR FAMILY

State law requires that patients be informed of specified reportable adverse events. In addition, The Joint Commission requires that patients be informed of the outcomes of care, including unanticipated outcomes. In addition to these requirements, there is a growing consensus that disclosure of medical mistakes is ethically appropriate. However, these conversations can be very difficult.

The state law adverse event requirement is discussed under VII. "CDPH Adverse Events Reporting," page 8.7. The Joint Commission requirement is described below. This section of the manual also describes California law that permits health care providers to express sympathy to patients, or to apologize, without admitting liability.

Many organizations have done considerable work outlining how best to approach patients and their families about negative outcomes, whether they are the result of a medical error or not. For example, the Agency for Healthcare Research and Quality has published a toolkit to help hospital leaders and clinicians communicate accurately and openly with patients and families when something goes wrong with their care. The toolkit, called "Communication and Optimal Resolution (CANDOR)," may be found at https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html.

A. Outcomes of Care

TJC requires that patients be informed of the outcomes of care, including unanticipated outcomes *(see* The Joint Commission Comprehensive Accreditation Manual for Hospitals*, RI.01.02.01, EP 20, 21, 22)*. According to this standard, the hospital must provide the patient or surrogate decision maker with the information about the outcomes of care that the patient needs to participate in current and future health care decisions.

The hospital must also inform the patient or surrogate decision maker about unanticipated outcomes of care that relate to sentinel events considered reviewable by TJC.

In addition, the licensed independent practitioner (usually the physician) responsible for managing the patient's care, or his or her designee, must inform the patient about unanticipated outcomes of care related to sentinel events when the patient is not already aware of the occurrence or when further discussion is needed.

B. Statements of Sympathy/Apologies

When discussing an unanticipated outcome or adverse event, it is human nature to want to express sympathy or sorrow. Sometimes people hesitate to express these sentiments for fear they will be used against them in a lawsuit. This fear is unwarranted. California law states that the following is inadmissible as evidence of an admission of liability in a civil or administrative action (such as a malpractice lawsuit):

> The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident and made to the person or to the family of that person.

A statement of fault, however, is admissible.

"Accidents" include any occurrence not the result of willful action. This includes medical errors and alleged malpractice.

"Benevolent gestures" means actions that convey a sense of compassion or commiseration emanating from humane impulses.

"Family" means the spouse, parent, grandparent, stepparent, child, grandchild, sibling, half-sibling or spouse's parent.

[Evidence Code Section 1160, Government Code Section 11440.45]

Hospitals may wish to keep this law in mind when discussing unanticipated outcomes with patients.

VII. CDPH ADVERSE EVENTS REPORTING

In response to media attention on medical errors, the California Legislature passed, and the Governor signed, legislation requiring general acute care hospitals, acute psychiatric hospitals, and special hospitals to report specified adverse events to CDPH [Health and Safety Code Sections 1279.1, 1279.2, 1279.3 and 1280.4]. Outpatient settings must also report adverse events. **"Outpatient settings"** are defined as:

1. Any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Health and Safety Code Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes. A clinic or ambulatory surgery center that does not meet this definition — i.e., does not use general anesthesia — is not subject to this reporting requirement.
2. Facilities that offer in vitro fertilization, as defined in Health and Safety Code Section 1374.55(b).

Outpatient settings do not include, among other settings, any setting where anxiolytics and analgesics are administered, when done so in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

[Health and Safety Code Sections 1248 and 1248.15]

CDPH has confirmed that distinct-part nursing facilities (DP-NFs) need not report adverse events under this law. However, other reporting requirements may apply (for example, the "unusual occurrences" reporting requirement may apply; *see E. "Relationship With Other Reporting Requirements," page 8.9*).

A. Types of Events That Must be Reported

For purposes of this reporting requirement, **"adverse event"** includes the surgical events, product or device events, patient protection events, care management events, environmental events, criminal events, and one other item described below. The term **"serious disability,"** which is used in many places in the list of adverse events, means:

> a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health facility, or the loss of a body part.

The complete list of reportable adverse events is included below. Many do not apply in the mental health setting, such as the list of surgical events. However, many of them can occur in a psychiatric hospital or in the psychiatric unit of a general acute care hospital, so employees should be familiar with the list. The list of adverse events includes the following.

SURGICAL EVENTS

1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. This does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. This does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

PRODUCT OR DEVICE EVENTS

1. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
2. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this requirement, "device" includes, but it not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
3. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

PATIENT PROTECTION EVENTS

1. An infant discharged to the wrong person.
2. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.
3. A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for the admission to the health facility.

CARE MANAGEMENT EVENTS

1. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
2. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
3. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
4. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
5. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this requirement, **"hyperbilirubinemia"** means bilirubin levels greater than 30 milligrams per deciliter.
6. A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to

Stage 3 if Stage 2 was recognized upon admission. *(See AFL 15-03.1 regarding unstageable pressure ulcers, which may be found at https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL15.aspx.)*

7. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.

ENVIRONMENTAL EVENTS

1. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.
2. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
3. A patient death or serious disability associated with a burn incurred from any source while the patient is being cared for in a health facility.
4. A patient death associated with a fall while the patient is being cared for in a health facility.
5. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

CRIMINAL EVENTS

1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
2. The abduction of a patient of any age.
3. The sexual assault of a patient within or on the grounds of a health facility.
4. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

FINAL ITEM

The list of adverse events specified in the law contains a final item that contains a circular definition. The final "catchall" category to be reported is "an adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor." However, an **"adverse event"** is defined as those events listed in the above sections (surgical events, product or device events, patient protection events, care management events, environmental events, and criminal events). Therefore, the final category arguably does not capture any events that are not already described in the law. Hospitals that are considering reporting an event under the "catchall" category should consult legal counsel to determine whether a report under this law is required. Even if a report under this law is determined not to be required, however, hospitals may need to report the incident pursuant to another reporting requirement. *(See E. "Relationship With Other Reporting Requirements," page 8.9.)*

B. Required Time Frame for Reporting

The report must be made no later than five days after the adverse event has been detected. However, if the adverse event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, the report must be made not later than 24 hours after the adverse event has been detected.

C. How to Report

CDPH has developed a web-based reporting tool that health care facilities may use to report adverse events, as well as privacy breaches, called the "California Healthcare Event and Reporting Tool" (CalHEART). Information about the online reporting tool may be found in CDPH All Facility Letter 13-12 at https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL2013.aspx. Hospitals are not required to use this tool; a paper form may be submitted instead. CHA has developed a form, "Adverse Event Report Form" (CHA Form 20-1), that hospitals may use to report an adverse event to CDPH. CDPH has stated it will accept the CHA form.

D. Communication With Affected Patient(s)

The hospital must inform the patient or the party responsible for the patient of the adverse event by the time the report is made. In addition, The Joint Commission requirement to inform the patient of unanticipated outcomes of care may apply. *(See VI. "Notifying the Patient or Family," page 8.6.)*

E. Relationship With Other Reporting Requirements

This law does not change or otherwise affect other hospital reporting requirements regarding reportable diseases or unusual occurrences. Hospitals may also need to report adverse events according to the following requirements:

1. Unusual occurrences — *see XI. "Reportable "Unusual Occurrences"," page 8.14*.
2. Safe Medical Devices Act — *see IX. "Reports Under the Safe Medical Devices Act of 1990," page 8.11.*
3. Restraint/seclusion death reporting — *see X. "Reporting Requirements Related to Restraint or Seclusion," page 8.14.*
4. Medication errors — *see VIII. "Medication Errors," page 8.11.*
5. Injuries by firearm or assaultive or abusive conduct — *see III. "Reporting Injuries by Firearm or Assaultive or Abusive Conduct ("Suspicious Injuries")," page 7.3.*
6. Violence against hospital personnel — *see CHA's* Healthcare Workplace Violence Prevention *guidebook, available to order online at www.calhospital.org/wvp-guidebook.*
7. Radiation overdoses — *see CHA's* Consent Manual *for information about reporting radiation overdoses.*

In addition, a root cause analysis pursuant to The Joint Commission's sentinel event requirements may be required. *(See A. "Sentinel Events," page 8.5)*

F. CDPH Investigations and Reports

ONGOING THREAT OF IMMINENT DANGER

CDPH must make an on-site inspection or investigation whenever it receives an adverse event report or a complaint indicating an ongoing threat of imminent danger of death or serious bodily harm. The on-site inspection or investigation must take place within 48 hours or two business days (whichever is greater) after receipt of the report or complaint. The investigation must be completed within 45 days. If CDPH does not meet this time frame, it must provide written notice to the facility and the complainant (if any) of the basis for the extenuating circumstances preventing it from meeting the time frame, and the anticipated completion date. Until CDPH determines by on-site inspection that the adverse event has been resolved, CDPH must conduct an unannounced inspection at least once per year of any hospital that has reported an adverse event.

NO THREAT OF IMMINENT DANGER

If CDPH receives a complaint or report, but determines from the information available to it that there is no threat of imminent danger of death or serious bodily harm to that patient or other patients, no on-site inspection is required, but an investigation must be undertaken and completed within 45 days. If CDPH does not meet this time frame, it must provide written notice to the facility and the complainant (if any) of the basis for the extenuating circumstances preventing it from meeting the time frame, and the anticipated completion date.

DEFINITION

For purposes of this law, a **"complaint"** means any oral or written notice to CDPH (other than an adverse event report from the hospital) of an alleged violation of any applicable state or federal law, or an allegation of facts that might constitute such a violation.

FOLLOW-UP

CDPH must notify the hospital and the complainant in writing of its determination as a result of its investigation.

CDPH PUBLIC REPORTING OF ADVERSE EVENTS

CDPH provides information about substantiated adverse events and the outcomes of inspections and investigations on its website by posting the hospital's statement of Deficiencies (CDPH Form 2567) and the hospital's plan of correction.

The information provided by CDPH names individual hospitals, and may include compliance information history. The names of patients, health care professionals and health care workers will not be divulged by CDPH.

G. Penalties for Failure to Report

The adverse event reporting law contains specific penalties for failure to report. A hospital that fails to report an adverse event may be assessed a civil penalty in an amount not to exceed $100 per day for each day that the adverse event is not reported following the initial five-day period or 24-hour period, as applicable. If the hospital disputes a determination by CDPH regarding an alleged failure to report an adverse event, the hospital may, within 10 days, request a hearing pursuant to Health and Safety Code Section 100171. Penalties do not have to be paid until all appeals have been exhausted.

CDPH has additional authority to fine hospitals for failing to comply with hospital licensing requirements. It is unclear whether both fines may apply, or if CDPH is limited to assessing penalties under this provision.

VIII. MEDICATION ERRORS

Several reporting requirements may be triggered if a medication error occurs in a hospital.

A pharmacist is required to notify the prescriber and the patient of a medication error, if the drug was administered to or by the patient, or if the error resulted in a clinically significant delay in therapy. The notification must include the steps required to avoid injury or mitigate the error. [Title 16, California Code of Regulations, Section 1711] (In addition, Business and Professions Code Section 4125 requires that medication errors be documented, and protects such documents from discovery in most cases.)

In addition, a medication error may be reportable under the Safe Medical Devices Act if a device, such as an infusion pump, was involved *(see IX. "Reports Under the Safe Medical Devices Act of 1990," page 8.11)*. Also, a medication error may constitute an adverse event that must be reported to CDPH *(see VII. "CDPH Adverse Events Reporting," page 8.7)*. Finally, a medication error may constitute an "unusual occurrence" and thus be reportable to CDPH under that reporting requirement *(see XI. "Reportable "Unusual Occurrences"," page 8.14)*, depending on the facts and circumstances of the incident. Hospitals must comply with all requirements of all applicable reporting laws.

IX. REPORTS UNDER THE SAFE MEDICAL DEVICES ACT OF 1990

The Safe Medical Devices Act requires hospitals and other providers to report incidents involving medical devices (including restraints) that have *or may have* caused or contributed to the serious injury or death of a patient [21 U.S.C. Section 360i(b)]. In addition to the individual reports required, hospitals must provide the FDA with annual summaries of the individual reports made during the preceding year (see below). Regulations implementing the reporting requirements are found at 21 C.F.R. part 803. Detailed information about this reporting requirement may be found at www.fda.gov/MedicalDevices/Safety/ReportaProblem/default.htm.

It is important to note that the requirement to report incidents involving medical devices is not limited to circumstances in which the device malfunctions. When an incident is, or may be, the result of user error, it should be reported. In addition, if an infection results, or may have resulted, from the use of a medical device, that should be reported also. The FDA monitors these types of events to determine if different labeling, instructions, design, or cleaning procedures are needed.

A. When and To Whom Reports of Adverse Events Must be Made

INDIVIDUAL REPORTS

Hospitals and other health care providers ("device user facilities") must make individual (per-incident) reports when they receive or otherwise become aware of information reasonably suggesting that a medical device has or may have caused or contributed to the death or serious injury of a patient. Reports of individual adverse events are to be made on FDA Form 3500A, also known as the "MEDWATCH" form," or an electronic equivalent approved by the FDA [21 C.F.R. Section 803.11]. *(See "Forms to be Used," page 8.12.)* The information required is specified in the MEDWATCH form and described in 21 C.F.R. Section 803.32.

Reports of *deaths* are made to the FDA and to the device manufacturer if the identity of the manufacturer is known [21 C.F.R. Section 803.30(a)(1)].

Reports of *serious injury* are made to the device manufacturer if the identity of the manufacturer is known; if the identity of the manufacturer is not known, the report must be made to the FDA [21 C.F.R. Section 803.30(a)(2)].

Reports must be made as soon as practicable but no later than 10 work days after becoming aware of the information. (**"Work day"** means Monday through Friday, excluding federal holidays.)

Adverse events need not be reported if there is information that would cause a person who is qualified to make a medical judgment (e.g., a physician, nurse, risk manager or biomedical engineer) to reach a reasonable conclusion that a device did not cause or contribute to a death or serious injury, or that a malfunction would not be likely to cause or contribute to a death or serious injury if it were to recur. Information which leads the qualified person to this determination must be contained in the medical device reporting (MDR) event file [21 C.F.R. Section 803.20(c)(2)].

ANNUAL REPORTS

Annual summaries of individual reports must be made to the FDA by January 1 of each year using FDA Form 3419, "Medical Device Reporting Semiannual User Facility Report," or an electronic equivalent as approved by the FDA. If no reports were submitted to the FDA or device manufacturers during the previous year, the hospital need not submit an annual report. [21 C.F.R. Section 803.33]

WHERE TO SUBMIT REPORTS

All reports made to the FDA (individual reports and annual reports) should be sent to:

Food and Drug Administration
Center for Devices and Radiological Health
Medical Device Reporting
P. O. Box 3002
Rockville, MD 20847-3002

Each report and its envelope must be specifically identified — e.g., as "User Facility Report" or "Annual Report." [21 C.F.R. Section 803.12]

DEFINITIONS

"Become aware" means than an employee of an entity required to report has acquired information reasonably suggesting a reportable adverse event has occurred. Device user facilities are considered to have "become aware" when medical personnel who are employed by, or otherwise formally affiliated with (e.g., medical staff), the facility, obtain information about a reportable event [21 C.F.R. Section 803.3]. This requirement means that hospitals and other covered providers must provide appropriate training and notice to those employees and other personnel whose knowledge of reportable events will trigger the facility's obligation to report, as well as the time clock (10 work days) for making such reports.

In making reports, facilities must provide all information specified in the law that is **"reasonably known"** to them. This includes information found in documents in the possession of the device user facility and any information that becomes available as a result of reasonable follow-up within the facility. However, a device user facility is not required to evaluate or investigate the event by obtaining or evaluating information that is not reasonably known to it [21 C.F.R. Section 803.30(b)]. (There may, of course, be other reasons to conduct such investigations, and in such instances the information discovered would be considered to be reasonably known to the facility. The medical device reporting law, however, does not require such investigations.)

"Caused or contributed" means that a death or serious injury was or may have been attributed to a medical device, or that a medical device was or may have been a factor in a death or serious injury, including events occurring as a result of failure, malfunction, improper or inadequate design, manufacture, labeling or user error [21 C.F.R. Section 803.3].

The reporting obligations apply to **"device user facilities,"** which includes hospitals, ambulatory surgical facilities, nursing homes, and outpatient diagnostic and treatment facilities (but not physicians' offices) [21 C.F.R. Section 803.3].

"Serious injury" means an illness or injury that:

1. Is life threatening;
2. Results in permanent impairment of a body function or permanent damage to the body structure; or
3. Necessitates medical or surgical intervention to preclude impairment of a body function or permanent damage to a body structure [21 C.F.R. Section 803.3].

FORMS TO BE USED

Forms may be obtained from:

Food and Drug Administration
Division of International and Consumer Education
Center for Devices and Radiological Health
10903 New Hampshire Ave., Bldg. 66, Rm. 4621
Silver Spring, MD 20993-0002
(800) 638-2041
www.fda.gov/medwatch/getforms.htm
email: DICE@fda.hhs.gov

The MEDWATCH Medical Device Reporting Code Instruction Manual contains adverse event codes for use with FDA Form 3500A [21 C.F.R. Section 803.21]. The manual is available at www.fda.gov/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm106737.htm.

QUESTIONS

The FDA asks that questions about reporting be mailed or faxed to the FDA at the following address:

Food and Drug Administration
Reporting Systems Monitoring Branch (HFZ-533)
Center for Devices and Radiological Health
Medical Devices Reporting Inquiries
1350 Piccard Drive
Rockville, MD 20850
Phone: (240) 276-3464
Fax: (240) 276-3454

The FDA prefers that questions be faxed; however, questions about medical device reporting may also be asked by phone, (240) 276-3464. To report a public health emergency, call the FDA office of Emergency Operations at (866) 300-4374 and follow with an email to emergency.operations@fda.hhs.gov or a fax to (301) 847-8544.

DISCLAIMERS

A report or other information submitted by a reporting entity under this law, and any release by the FDA of that report or information, does not necessarily reflect an admission that the device, or the reporting entity or its employees, caused or contributed to the reportable event. The reporting entity need not admit and may deny that the report or information submitted under this law constitutes an admission that the device, the party submitting the report, or employees thereof, caused or contributed to a reportable event. [21 C.F.R. Section 803.16]

B. Restraints

FDA regulates restraint devices as it regulates other medical devices. Thus, hospitals and other device user facilities must report incidents involving restraints that have or may have caused or contributed to the serious injury or death of a patient.

For purposes of this reporting law, it should be noted that the FDA uses a different definition of restraint than does the Centers for Medicare & Medicaid Services Conditions of Participation or California law. The FDA defines a **"protective restraint"** as:

> a device, including but not limited to a wristlet, anklet, vest, mitt, straight jacket, body/limb holder, or other type of strap, that is intended for medical purposes and that limits the patient's movements to the extent necessary for treatment, examination, or protection of the patient or others [21 C.F.R. Section 880.6760].

Whereas the CMS definition of restraint could include a geri-chair, a tray table, a side rail, a sheet, or even a staff member holding a patient, the FDA definition does not. Therefore, this reporting requirement is somewhat more narrow than the CMS reporting requirement for deaths associated with seclusion or restraints discussed under X. "Reporting Requirements Related to Restraint or Seclusion," page 8.14.

C. Required Policies and Procedures

Hospitals must develop and implement written policies and procedures that provide for the following:

1. Timely and effective identification, communication and evaluation of events that may be subject to medical device reporting requirements;
2. A standardized review process/procedure for determining when an event meets the criteria for reporting to the FDA; and
3. Timely transmission of complete medical device reports to the FDA and/or the device manufacturer.

The policies and procedures must also include documentation and record keeping requirements as described under "Required Documentation" below, including information that was evaluated to determine if an event was reportable [21 C.F.R. Section 803.17].

REQUIRED DOCUMENTATION

Facilities must establish and maintain medical device reporting (MDR) event files. MDR event files must be prominently identified as such and filed to facilitate timely access. The files may be written or electronic, and may incorporate references to other information, such as medical records or engineering reports, in lieu of copying and maintaining duplicates in this file. MDR event files must include the following:

1. Information related to adverse events, including all documentation of the hospital's deliberations and decision-making processes used to determine if a device-related death, serious injury or malfunction was or was not reportable under this part; and
2. Copies of all Safe Medical Devices Act forms and other information related to the event that was submitted to the FDA or manufacturer.

MDR event files must be retained for two years following an adverse event. Hospitals must permit FDA employees to access, copy and verify the records noted above [21 C.F.R. Sections 803.13, 803.17 and 803.18].

D. Request From FDA for Additional Information

The FDA may determine that protection of the public health requires additional or clarifying information for the medical device reports submitted to the FDA under this law. In these instances, and in cases when the additional information is beyond the scope of FDA reporting forms or is not readily accessible, the agency will notify the reporting entity in writing of the additional information that is required.

Any request from the FDA must state the reason or purpose for which the information is being requested, specify the due date for submitting the information and clearly identify the reported event. All verbal requests will be confirmed in writing by the FDA. [21 C.F.R. Section 803.15]

E. Device Tracking

Device manufacturers and distributors are required to develop formal schemes for tracking specified ("tracked")

medical devices [21 U.S.C. Section 360i(e)]. Hospitals, licensed practitioners, retail pharmacists and other types of device user facilities are considered "final distributors" [21 C.F.R. Section 821.3].

Under the regulations, a final distributor must provide the manufacturer with specified information at the time that it purchases a tracked device [21 C.F.R. Section 821.30(a)] and at the time that a tracked device is implanted in or provided to a patient [21 C.F.R. Section 821.30(b)].

At the time that the device is implanted in or provided to the patient, the hospital must provide to the device manufacturer the following information:

1. The name and address of the final distributor (i.e., the hospital itself).
2. The unique device identifier (UDI), lot number, batch number, model number or serial number of the device, or other identifier used by the manufacturer to track the device.
3. The name, address, telephone number and Social Security number (if available) of the patient receiving the device unless not released by the patient *(see "Patient Confidentiality Rights," page 8.14)*.
4. The date the device was provided to the patient or for use in the patient.
5. The name, mailing address and telephone number of the prescribing physician.
6. The name, mailing address and telephone number of the physician regularly following the patient if different from the prescribing physician.
7. When applicable, the date the device was explanted, and the name, mailing address and telephone number of the explanting physician, the date of the patient's death, or the date the device was returned to the manufacturer, permanently retired from use or otherwise permanently disposed of.

[21 C.F.R. Section 821.30(b)]

PATIENT CONFIDENTIALITY RIGHTS

A patient receiving a device subject to tracking may refuse to release, or refuse permission to release, his or her name, address, telephone number and Social Security number, or other identifying information for the purpose of tracking [21 CFR Section 821.55]. FDA guidance states that hospitals must document the refusal and the forwarding of such documentation back to the device manufacturer.

DEVICE TRACKING RECORDS

Hospitals must permit FDA employees to access, copy and verify device tracking records, as well as all other records and information related to the events and persons identified in such records [21 C.F.R. Section 821.50]. In addition, hospitals must make any records required to be kept by the device tracking law available to the manufacturer of the tracked device for audit upon written request by an authorized representative of the manufacturer [21 C.F.R. Section 821.30(d)].

Device tracking records must be maintained for the useful life of the tracked device. The useful life of a device is the time a device is in use or in distribution for use. A record may be retired if the person maintaining the record becomes aware that the device is no longer in use, has been explanted, returned to the manufacturer or the patient has died. [21 C.F.R. Section 821.60]

Records required to be kept by the device tracking law must be kept in a centralized point [21 C.F.R. Section 821.50].

X. REPORTING REQUIREMENTS RELATED TO RESTRAINT OR SECLUSION

There are several state and federal reporting requirements potentially implicated when an adverse event occurs to a patient who is, or has been, in restraints or seclusion. These reporting requirements are described in chapter 5.

XI. REPORTABLE "UNUSUAL OCCURRENCES"

Hospitals are required to notify CDPH immediately, via telephone, of the following:

1. Any discontinuance or disruption of services;
2. Upon the threat of a walkout of a substantial number of employees; or
3. An earthquake, fire, power outage or other calamity that causes damage to the facility or threatens the safety or welfare of patients or clients.

[Title 22, California Code of Regulations, Sections 70746 (general acute care hospitals) and 71544 (acute psychiatric hospitals)]

Title 22 also requires general acute care hospitals and acute psychiatric hospitals to report any occurrence such as an epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety, or health of patients, personnel, or visitors, as soon as reasonably practicable,

by telephone or telegraph, to the local health officer and to CDPH. The hospital must furnish other pertinent information related to the occurrence as may be requested by the local health officer or CDPH [Title 22, California Code of Regulations, Sections 70737 (general acute care hospital), 71535 (acute psychiatric hospital) and 72541 (skilled nursing facility)].

Exactly which types of incidents constitute an "unusual occurrence" has not been further clarified by CDPH. CDPH is aware that its employees as well as hospital employees have inconsistent interpretations of this requirement. CDPH has indicated that sentinel events should be considered unusual occurrences, and reported to CDPH even if the hospital does not report to The Joint Commission. *(See A. "Sentinel Events," page 8.5, regarding sentinel events.)* CDPH has also indicated that a patient death that occurs while a patient is restrained or in seclusion for behavior management is a reportable unusual occurrence. In addition, CDPH has indicated that incidents that are covered by the news media constitute unusual occurrences that should be reported to CDPH. However, CDPH has not promulgated regulations regarding these informal interpretations. There are no financial penalties for a late report or failure to report under this law.

9 Payment for Medi-Cal Emergency and Post-Stabilization Mental Health Services

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Forms and Appendices can be found at the back of the manual and online for CHA members at www.calhospital.org/free-resources.

9 Payment for Medi-Cal Emergency and Post-Stabilization Mental Health Services

I. INTRODUCTION

Consider this scenario: A Medi-Cal patient presents to a hospital's emergency department (ED) complaining of chest pain. The hospital does not have an inpatient psychiatric unit. The hospital provides a medical screening exam and further evaluation and treatment; cardiac conditions are ruled out. The patient is diagnosed with a severe anxiety disorder. The patient's anxiety disorder is treated and the patient is discharged home.

Question: Who is responsible for paying for the services rendered to rule out cardiac conditions? Who is responsible for paying for the services rendered to diagnose and treat the mental health conditions?

California hospitals struggle with situations like this every day, trying to determine who is responsible for paying for the various services rendered — those related to "physical health" conditions, and those related to mental health conditions. Does the hospital bill the Medi-Cal managed care plan (MCP) only? Or the county mental health plan (MHP) only? Both the MCP and the MHP for different services rendered? Or do other factors affect the analysis? What can the hospital do when both the MCP and MHP deny financial responsibility?

This chapter analyzes the various and sometimes conflicting laws governing who is responsible to pay for services rendered in an ED to Medi-Cal patients with mental health conditions.

A. Background

The State of California administers the Medi-Cal program through the Department of Health Care Services (DHCS). DHCS contracts with both MCPs and MHPs to serve Medi-Cal patients. MCPs provide care for the patients' physical conditions, as well as for specified, lower-acuity mental health conditions.[1] Because counties have historically played an important role in providing access to mental health services for Medi-Cal beneficiaries, DHCS delegates payment for other mental health services to MHPs.

Due to the various co-morbidities associated with mental health patients, the line delineating payment responsibility between MCPs and MHPs is often blurred. For example, when a patient presents with multiple diagnoses, especially both mental and physical in nature, both a MCP and MHP may be responsible for payment.

While reading this chapter, it's important to keep in mind that the federal Emergency Medical Treatment and Labor Act (EMTALA) and state hospital licensing requirements to provide emergency services to psychiatric patients, are different from the Medi-Cal requirements to pay for those services. As a result, hospitals are often not reimbursed for all the services they're required to provide.

Hospitals should know that MHPs are not licensed under the Knox-Keene Health Care Service Plan Act, and are not regulated by the California Department of Managed Health Care (DMHC). Most MCPs are licensed under the Knox-Keene Act and are regulated by DMHC, except for county operated health systems with respect to their Medi-Cal lines of service.

B. Scope of This Chapter

This chapter reviews the laws and DHCS interpretations about payment for ED services, including emergency medical services, emergency psychiatric services, and non-emergency services. This chapter also provides

1 This chapter focuses on the typical allocation of payment responsibilities between MCPs and MHPs in California. Certain counties, such as Solano County, and plans, such as Kaiser Geographic Managed Care, are different and not the focus of this chapter. This chapter also does not focus on the responsibility of other types of managed care, such as PACE programs, SCAN programs or the San Francisco Family Mosaic Project.

some arguments that may help hospitals obtain improved reimbursement for mental health services rendered to Medi-Cal patients presenting to the ED with a mental health condition.

Due to the complexities of reimbursement for mental health conditions, this chapter is not fully comprehensive. For example, this chapter does not address the memoranda of understanding (MOU) that DHCS requires between MCPs and MHPs to coordinate mental health services for Medi-Cal patients.[2] Also, this chapter does not address coordination of benefits between Medi-Cal and other health coverage, e.g., where a Medi-Cal patient has private insurance, or is enrolled in Medi-Cal managed care and Medicare fee-for-service or Medicare Advantage, or for a patient enrolled in a Cal MediConnect plan. Nor does this chapter address payment responsibility for a patient who is enrolled in Medi-Cal fee-for-service instead of Medi-Cal managed care. Hospitals may wish to seek separate guidance for these fact-specific issues.

This chapter is organized as follows:

- **Section II — Medi-Cal Payment for Mental Health Services.** Section II describes the mental health services covered by MHPs and MCPs; the respective obligations of MHPs and MCPs to pay for emergency and post-stabilization services rendered by non-contracted providers; and coordination of payment and care management between MHPs and MCPs.
- **Section III — How Hospitals Can Get Reimbursed: A Case-by-Case Analysis.** Section III applies the general payment principles described in Section II to eight scenarios where a patient presents to an ED with a complaint that includes a psychiatric condition.
- **Appendix MH 9-A, "Medical Necessity for MHP Coverage."** This appendix contains the state regulations describing medical necessity for MHP coverage of psychiatric inpatient, emergency and outpatient specialty mental health services.
- **Appendix MH 9-B, "Types of MCPs and MHPs."** This appendix briefly describes the types of MCPs and MHPs throughout the state and their governing authorities.
- **Appendix MH 9-C, "Pertinent DHCS Plan Letters."** This appendix contains excerpts of DHCS plan letters related to emergency services for mental health conditions.
- **Appendix MH 9-D, "DHCS Chart: Medi-Cal Mental Health Services."** This appendix contains a DHCS chart describing MCP and MHP financial responsibilities for mental health services for Medi-Cal patients.
- **Appendix MH 9-E, "Pertinent Legal Definitions of Emergency Psychiatric Conditions."** This appendix compares Medicaid, Medi-Cal, licensing and EMTALA definitions that apply to emergency psychiatric conditions.

II. MEDI-CAL PAYMENT FOR MENTAL HEALTH SERVICES

A. What Mental Health Services Are Covered by MHPs?

The state contracts with a MHP in each county to provide or arrange for, and pay for, all medically necessary, covered Specialty Mental Health Services (SMHS) for Medi-Cal patients who reside in that county.[3] **"Covered SMHS"** means specified health services, including psychiatric health facility services, psychiatric inpatient hospital services, and other mental health services, that meet the criteria for "medical necessity" set forth in MHP regulations at Title 9, California Code of Regulations (CCR) Sections 1820.205, 1830.205 or 1830.210. These criteria are outlined in Appendix MH 9-A, "Medical Necessity for MHP Coverage." Many counties have informational documents on their website which may be helpful to hospitals. *(See www.file.lacounty.gov/SDSInter/dmh/159129_MediCalGuide_English_July2013.pdf for an example.)*

Historically, the state contractually required MHPs to pay for "services for emergency psychiatric conditions received by a beneficiary from providers, whether or not

2 Boilerplate MCP Contract, Exh. A, Attachment 11, Provision 6.B, available at www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf (accessed May 25, 2019). Citations to the boilerplate contracts are to the two plan model contracts, but parallel provisions are found in the county operated health system and geographic managed care model boilerplate contracts.

If an MOU is not posted on the MCP or MHP's website and is not readily available upon request from the MCP, MHP or county behavioral health department, a hospital may make a formal request for it under the California Public Records Act.

3 Boilerplate MHP Contract 2017-22, Exh. A, Attachment 2, available at https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Boilerplate_2017-2022_MHP_Contract-Exhibits_A_B_and_E.pdf (accessed May 25, 2019). While this contract is identified on the DHCS website as effective July 1, 2017, through June 30, 2022, the contract was not made publicly accessible on the DHCS website until 2018. Thus, it is unclear as to when this contract actually became effective.

the provider has a subcontract" with the MHP.[4] The prior contract between the state and the MHP does not define the term "emergency psychiatric condition," but required the MHP to consider certain ICD-9 diagnosis codes as included. While not defined in the prior contract, the term **"emergency psychiatric condition"** is defined in Title 9, CCR Section 1810.216 as a condition meeting the medical necessity criteria in Title 9, CCR, Section 1820.205 when the patient, "due to a mental disorder, is a current danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services."[5] Unfortunately, there is little explanation in the contract, the regulations or other guidance that detail the precise parameters of the MHP's obligation to cover services for emergency psychiatric conditions.

As discussed in footnote 4, CHA believes that the State amended its contract with MHPs in or around 2018. That version of the contract specifies that the MHP "shall authorize out of network services when a beneficiary with an emergency psychiatric condition is admitted on an emergency basis for psychiatric inpatient hospital services or psychiatric health facility services."[6] The more recent version of the contract is silent as to what Medi-Cal payor is responsible to pay for emergency services associated with a severe mental health diagnosis in the absence of an admission to a psychiatric inpatient hospital or psychiatric health facility.[7]

California regulations also require a MHP to cover services rendered when a patient with an emergency psychiatric condition is admitted for psychiatric inpatient hospital services to the extent provided in Title 9, CCR Section 1820.225 (an "emergency admission") or admitted for psychiatric health facility services under the conditions described in Title 9, CCR Section 1830.245, whether in-network or out-of-network. Approval for payment for such services associated with an emergency psychiatric condition may be subject to the patient meeting certain medical necessity and other criteria, as well as timely notification by the hospital or psychiatric health facility to the MHP. [Title 9, CCR Sections 1820.225 and 1830.245]

DHCS has issued several plan letters, including Medi-Cal Managed Care Policy Letter (MMCD) 00-01 and All Plan Letter (APL) 13-021, excerpts of which are included in Appendices MH 9-C, "Pertinent DHCS Plan Letters" and MH 9-D, "DHCS Chart: Medi-Cal Mental Health Services," respectively. These DHCS documents attempt to clarify when the MCP is responsible for payment, and when the MHP is responsible for payment, but the documents are not entirely consistent. However, based on these letters, it is likely DHCS' position that the MHP is responsible for the following emergency, inpatient and outpatient services:

1. Emergency/inpatient services if the patient:
    a. Has an included diagnosis;
    b. Cannot be safely treated at lower level of care; and
    c. Requires inpatient hospital services due to one of the following as a result of an included mental disorder:
        - Symptoms or behaviors that represent a current danger to self or others, or significant property destruction;
        - Symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter;
        - Symptoms or behaviors that present a severe risk to the beneficiary's physical health;
        - Symptoms or behaviors that represent a recent, significant deterioration in ability to function;
        - Psychiatric evaluation or treatment can only be performed in an acute psychiatric inpatient setting or through urgent or emergency intervention provided in the community or clinic; and

4 Boilerplate MHP Contract 2013-18, Exh. A, Attachment I, Provision 3, available at https://www.dhcs.ca.gov/services/MH/Documents/2013-2018_MHP_Contract.pdf. Even though the DHCS website identifies this contract as effective July 1, 2013, through June 30, 2017, the title of the document suggests that it may have been effective through 2018, which would be consistent with the timing of the more recent contract becoming uploaded to the DHCS website.

5 As shown in Appendix E, the definition of "emergency psychiatric condition" in the MHP regulations varies from the definition of "psychiatric emergency medical condition" in the California emergency services licensing laws (Health & Safety Code Section 1317.1). The licensing laws, which govern the emergency care that a hospital must provide, do not require "medical necessity" or that a hospital maintain a psychiatric service, in order for a psychiatric condition to be deemed an "emergency condition" that the hospital must treat or effectuate a transfer.

6 Boilerplate MHP Contract 2017-22, Exh. A, Attachment 6, Provision G.

7 However, as recently as Sept. 26, 2018, DHCS issued All Plan Letter 18-043, which requires MHPs to state in their member handbooks that "prior authorization is not required for emergency services and the beneficiary has the right to use the hospital or other setting for emergency care." Pages 58-59 of the template handbook available at https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_18-043_Beneficiary_Handbook/MHP_Beneficiary_Handbook.pdf (accessed May 25, 2019) states that the MHP is required to… [p]rovide timely access to care, including making services available 24 hours a day, seven days a week, when medically necessary to treat an emergency psychiatric condition or an urgent or crisis condition." This is consistent with the statement on page 16 of the handbook that "[e]mergency services are covered 24 hours a day, seven days a week for Medi-Cal beneficiaries."

- Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.[8]

d. Facility charges for emergency services when the patient meets medical necessity criteria and is admitted for psychiatric inpatient services at the same facility that provided the emergency services.[9]

e. Facility charges directly related to the professional services of a mental health specialist provided in the ED when the services do not result in the patient's admission for psychiatric inpatient hospital services in the same or another facility.[10]

f. Professional services of a mental health specialist provided in an ED of any hospital to a patient whose condition meets medical necessity criteria or when required to assess whether medical necessity is met.[11]

2. Outpatient services if:

a. The patient has an included mental health diagnosis;

b. The patient has a significant impairment in an important area of life function, or a reasonable probability of deterioration in an important area of life function, or a reasonable probability of not progressing developmentally as individually appropriate;

c. The focus of treatment is to address impairment;

d. The expectation that proposed treatment will significantly diminish impairment, prevent significant deterioration; and

e. The condition would not be responsive to physical health care-based treatment.[12]

B. What Mental Health Services Are Covered by MCPs?

The state contracts with MCPs to provide or arrange for medically necessary covered services for Medi-Cal patients assigned to them, including outpatient mental health services. **"Outpatient mental health services"** are defined as:

> outpatient services that [the MCP] will provide for Members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.[13]

SMHS are excluded from the scope of MCP services.[14]

MCPs are required to pay for certain medically necessary mental health services, such as "[e]mergency room professional services as described in Title 22, CCR Section 53855, except services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors [now called marriage and family therapists], or other specialty mental health providers" and "[f]acility charges for emergency room visits which do not result in a psychiatric admission."[15]

DHCS has stated that the MHP is responsible for the following emergency and outpatient services:

1. Emergency Services:

a. All professional services except the professional services of a mental health specialist when required for the emergency services and care of a patient, regardless of whether the condition meets MHP medical necessity criteria[16]; and

b. All facility and professional charges for emergency services and care of a patient when such services do not result in admission. This includes patients with an excluded diagnosis or whose condition does not meet medical necessity criteria.[17]

2. Outpatient Services:

a. When the patient has been diagnosed with a mental health disorder as defined by the DSM[18] resulting in mild to moderate distress or impairment of mental, emotional or behavioral functioning.[19]

8 APL 13-021.
9 Medi-Cal Managed Care Policy Letter (MMCD) 00-01.
10 Id.
11 Id.
12 Id.
13 Boilerplate MCP Contract, Exh. E, Attachment 1.
14 Boilerplate MCP Contract, Exh. A, Attachment 11, Provision 6.
15 Boilerplate MCP Contract, Exh. A, Attachment 10, Provision 8.E.
16 MMCD 00-01.
17 MMCD 00-01; see also Dual Plan Letter 15-006, p. 5.
18 "DSM" refers to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IVE (1994), published by the American Psychiatric Association.
19 APL 13-021.

C. Must MHPs and MCPs Pay for Emergency and Post-Stabilization Services Rendered by Non-Contracted Providers?

EMERGENCY SERVICES

Under federal Medicaid law and the waivers governing the MCP and MHP programs,[20] MCPs and MHPs are required to pay for emergency services and post-stabilization services regardless of whether the provider has a contract with the plan.[21] The Centers for Medicare & Medicaid Services (CMS) has stated that this obligation applies only if the patient has an "emergency medical condition" as defined below.

If a psychiatric condition does not give rise to an "emergency medical condition" within the definition below — that is, there is no risk of serious jeopardy to the health of the patient — then the patient is not considered to have an emergency medical condition under federal law and the MCP or MHP is not required to pay. [67 Fed. Reg. 40989, 41030 (June 14, 2002)] However, DHCS has suggested that the scope of emergency services required to be covered under California law may expand to "screening, examination, and evaluation to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric medical condition, within the capability of the facility."[22]

Federal Medicaid law defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. [42 C.F.R. Section 422.113(b)(1)(i)] *(See D. "Important Definitions," page 9.6 as to variances in the definition of "emergency medical condition" in the federal Medicaid law and in the federal EMTALA regulations (42 C.F.R. Section 489.24(b)).)*

Emergency services are defined as covered inpatient and outpatient services that are rendered by a provider qualified to furnish emergency services; and needed to evaluate or stabilize an emergency medical condition [42 C.F.R. Section 422.113(b)(1)(ii)].

The most recent version of the boilerplate MHP contract appears to exempt MHPs from the requirements of 42 C.F.R. section 422.113.[23] The legal impact of this exemption for emergency services is unclear as it appears to be inconsistent with both the 1915(b) waiver and state law at California Code of Regulations, Title 9, Section 1810.345(e).

POST-STABILIZATION SERVICES

Federal Medicaid law defines **"post-stabilization services"** as covered services that are:

1. Related to an emergency medical condition;
2. Provided after an enrollee is stabilized; and
3. Provided either to maintain the stabilized condition, or under certain circumstances, to improve or resolve the enrollee's condition.

[42 C.F.R. Section 422.113(c)(1)]

The physician treating the enrollee must decide when the enrollee is considered stabilized for transfer or discharge, and that decision is binding on an MCP or MHP [42 C.F.R. Section 422.113(b)(3)].

Under the federal Medicaid regulations, a MCP or MHP is financially responsible for post-stabilization services obtained within, or outside, the plan network that meet one of the following:

1. Are pre-approved by a plan provider or other plan representative; or
2. Are not pre-approved by a plan provider or other plan representative, but are administered to maintain the patient's stabilized condition within one hour of a request to the plan for pre-approval of further post-stabilization care; or
3. Are not pre-approved by a plan provider or other plan representative, but administered to maintain, improve, or resolve the patient's stabilized condition if:
   a. The plan does not respond to a request for pre-approval within one hour;
   b. The plan cannot be contacted; or
   c. The plan representative and the treating physician cannot reach an agreement concerning the patient's care, and a plan physician is not available for consultation. In this situation, the plan must give the treating physician the opportunity to consult with a plan physician. The treating physician may continue with care of the patient

20 The MHP program is governed by the 1915(b) waiver while the MCP program is governed by the 1115 waiver. These citations are to the sections of the Social Security Act authorizing the waivers.

21 2 U.S.C. Section 1396u-2(b)(2); 42 C.F.R. Section 438.114(c); Title 9, CCR Section 1810.345(e); Boilerplate MHP Contract, Exh. A, Attachment I, Provision 3; Boilerplate MCP Contract, Exh. A, Attachment 8, Provision 13.

22 MCD Policy Letter No. 00-01 Rev., excerpted in Appendix C.

23 Boilerplate MHP Contract 2017-22, Exh. E, Provision 7.D.

until a plan physician is reached or one of the criteria below is met.

[42 C.F.R. Section 422.113(c)(2)]

If no pre-approval has been obtained, the MCP or MHP's financial responsibility for post-stabilization services ends when one of the following has occurred:

1. A plan physician with privileges at the treating hospital assumes responsibility for the patient's care; or
2. A plan physician assumes responsibility for the patient's care through transfer; or
3. A MCP or MHP plan representative and the treating physician reach an agreement concerning the patient's care; or
4. The patient is discharged.

[42 C.F.R. Section 422.113(c)(3)]

Again, the law is unsettled as to the impact of the 2018 amendment to the state MHP contract on the obligation of MHPs to cover post-stabilization care.

In summary, psychiatric emergency services are covered to the extent that a mental health diagnosis is such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part, inpatient and outpatient services needed to evaluate or stabilize the condition would constitute covered emergency services. Post-stabilization psychiatric services are covered if provided after the patient's psychiatric condition is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

D. Important Definitions

A question that frequently arises is whether the terms "emergency medical condition" and "psychiatric emergency medical condition" for Medi-Cal reimbursement purposes have the same definition as these terms as applied under EMTALA or state licensing laws for emergency psychiatric medical conditions? The answer is "no."

As shown in Appendix MH 9-E, "Pertinent Legal Definitions of Emergency Psychiatric Conditions," the definition of "emergency medical condition" in the federal Medicaid law [42 U.S.C. Section 1396u-2(b)(2)(C)] varies from the definition of "emergency medical condition" in the federal EMTALA regulations (42 C.F.R. Section 489.24(b)). The EMTALA regulations explicitly include "psychiatric disturbances" and "symptoms of substance abuse" in the definition of **"emergency medical condition"** — "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to" jeopardize the health of the patient. The federal Medicaid law does not mention psychiatric disturbances.

The mental health parity law [42 U.S.C. Section 300gg] requires a Medicaid managed care plan to provide out-of-network benefits for mental health/substance use disorders if it provides out-of-network benefits for medical/surgical conditions. However, this requirement is applied across a state's Medicaid program, and does not mean that the same plan that might be liable for the medical/surgical benefit is necessarily liable for the mental health/substance use benefit. [42 C.F.R. Section 438.920(b)]

At the state level, the definition of "psychiatric emergency medical condition" in the MHP regulations varies from the definition of "psychiatric emergency medical condition" in the California emergency services licensing law (Health and Safety Code Section 1317.1). The MHP regulations require "medical necessity" and psychiatric hospital services in order for the psychiatric condition to be deemed an "emergency condition." The licensing definition does not impose either requirement for a psychiatric condition to be deemed an emergency condition.

It is noted that all of the definitions of "emergency medical condition" and "psychiatric emergency medical condition" apply when the patient may be a danger to himself/herself, which may include grave disability; however, the Medicaid definition does not include a situation where a patient may be a danger to others, but not to himself/herself.

E. How Do MHPs and MCPs Coordinate Their Payment and Care Management Obligations?

MCPs and MHPs are required to execute memoranda of understanding (MOUs) to coordinate care between them.[24] There have been over 100 MOUs executed in the State of California.[25] Each MOU should include the following topics:

1. Basic requirements
2. Covered services and populations
3. Oversight responsibilities of the MCP and MHP
4. Screening, assessment and referral
5. Care coordination

24 Title 9, CCR Sections 1810.370, 1810.415, 1850.505, 1850.515, 1850.525; MCP Boilerplate Contracts, Exh. A, Attachment 11 and Attachment 12; All Plan Letter 13-018.

25 Lewis, K. and Coursolle, A., National Health Law Program, Mental Health Services in Medi-Cal, p. 7 (Jan. 12, 2017).

6. Information exchange
7. Reporting and quality improvement requirements
8. Dispute resolution
9. After-hours policies and procedures, and
10. Member and provider education.

However, the National Health Law Program study cited in footnote 26 reported that many MOUs fail to include some of these required topics.[26]

Review of a MOU may help a hospital understand how its local MCP and MHP have agreed to coordinate care, including screening, assessment and referral of ED patients. Accordingly, hospitals may wish to review their local MOU(s) in connection with their review of the analysis in this chapter, which does not include any analysis of the MOUs across the state. Hospitals may be able to rely on promises from MCPs and MHPs to each other in order to effectuate better care coordination for patients who present at their ED with mental health conditions.

If a MOU is not available on the Internet, a hospital may wish to request a copy of the agreement from the MHP pursuant to the California Public Records Act.

III. HOW HOSPITALS CAN GET REIMBURSED: A CASE-BY-CASE ANALYSIS

CHA has applied the general principles of the various laws and DHCS interpretations described above to the following eight scenarios to help hospitals identify which type of plan likely is responsible for reimbursing the hospital for emergency psychiatric services. However, individual circumstances may affect the outcome of each scenario. For example, a contract between a hospital and a specific plan may set forth the payment responsibilities by that plan to the hospital. If there is no contract between a hospital and a specific plan, the facts, such as whether notice of stabilization was given or whether the plan pre-approved the care, will determine whether there may be an implied contract between the hospital and the plan.

Each scenario below begins with a patient presenting to a hospital ED, either voluntarily or involuntarily. However, the scenarios differ as to whether the hospital has inpatient psychiatric beds, whether the patient has a psychiatric emergency condition, whether the patient's psychiatric condition is stabilized in the ED, whether the patient is stabilized when admitted to a psychiatric inpatient bed, whether the patient is transferred to an inpatient psychiatric facility, whether the patient is actually admitted to a psychiatric inpatient bed and whether the patient is discharged to the community.[27]

Scenario #	Hospital ED	Hospital w/Psych. Inpt.	Pt. has Psych. Emgcy[28]	Stabilized in ED	Trans-ferred to Psych Inpt.	Admitted to Psych Inpt.	Final Status
1	Yes	Either	Yes	Yes	No	No	Discharged to Comm.
2	Yes	Either	No	NA	No	No	Discharged to Comm.
3.a	Yes	Yes	Yes	Possible	Yes	No	Transferred to Another Hospital
3.b	NA	Yes	Yes	Possible	No	Yes	Admitted
4	Yes	Yes	Yes	No	No	Yes	Admitted
5.a	Yes	No	Yes	Sufficient for Transfer	Yes	See 5.b.1/ 5.b.2	Transferred to Another Hospital
5.b.1	NA	Yes	Yes	Received Transfer	No	Yes	Admitted
5.b.2	NA	Yes	Yes	Received Transfer	No	No	Discharged to Comm.

Each scenario assumes that the patient is given a medical screening examination to assess the emergent nature of the patient's medical or psychiatric condition. In most instances, the MCP is likely responsible to pay for the medical screening examination.

Scenario 1: Patient presents at the ED of a hospital with or without inpatient psychiatric services. The patient is experiencing depression and suicidal ideation. The patient is determined by a physician or other professional to have an emergency psychiatric condition. The patient's psychiatric condition is stabilized in the ED after a licensed clinical social worker consults with the patient and obtains information from family members about a recent break-up with a girlfriend. After several hours, the patient is discharged home with a referral for follow-up outpatient care.

This patient required a level of care that did not require an acute inpatient stay. Accordingly, consistent with the

26 Ibid.

27 The involvement or intervention in the emergency services process by county-designated mental health professionals does not affect which plan is responsible for payment.

28 In other words, the patient is determined by a physician or other professional to have an emergency psychiatric condition within the meaning of EMTALA and the California hospital licensing laws [Health & Safety Code Section 1317.1].

MCP-State contract, MMCD 00-01 and APL 13-021, it is likely that the MCP is responsible for paying for the ED visit, including both the facility and professional charges. The MCP will not pay for services provided by mental health specialists, such as the consult with the LCSW.[29] Instead, it is the MHP's responsibility to pay for the professional services of mental health specialists provided in the ED to patients meeting MHP medical necessity criteria or required to assess whether MHP criteria are met, and any facility charges directly related to mental health specialists' services.[30] It is likely that the MCP is responsible for mental health specialists' services required for the emergency services and care of a patient with an excluded diagnosis. Hospitals should have a billing policy in place to ensure that facility fees are not inadvertently collected from both the MHP and the MCP in those instances where both may be responsible for facility fees for professional services provided.

Scenario 2: Patient presents at the ED of a hospital without inpatient psychiatric services. Although the patient is experiencing auditory hallucinations, and it is determined by a physician or other professional that the patient has a psychiatric condition, the patient does not have an emergency psychiatric condition. The patient is provided further evaluation and treatment and is subsequently discharged without an inpatient admission.

The analysis for this scenario is likely the same as Scenario 1 because the patient's condition and level of care did not require an acute inpatient stay.

Scenarios 3.a and 3.b: Patient presents to the ED of a hospital with inpatient psychiatric services. The patient has suicidal ideation with a specific plan. The patient is determined by a physician or other professional to have an emergency psychiatric condition, and is transferred to another facility that provides acute inpatient psychiatric services due to its lack of capacity or capability to admit the patient (e.g., transfer of an adolescent or child from a psychiatric facility that does not admit minors).

3.a. Sending hospital. Both the MCP and the MHP may be responsible for reimbursement for hospital charges. More specifically, pursuant to the MMCD 00-01, the MCP may be responsible for facility charges incurred by the sending hospital. However, because the patient's condition ultimately resulted in a psychiatric admission and because the service was "for an emergency psychiatric condition," the MHP may also be responsible for the facility charges for services rendered by the sending hospital to the extent that the patient meets the medical necessity criteria. Hospitals may wish to review their contracts with the local MHP or MCP (if applicable) or the MOU between their local MHP and MCP for further clarification. Some MOUs have a gap where:

1. Patients that are admitted at the same hospital are the responsibility of the MHP,
2. Patients that are not admitted for inpatient psychiatric services are the responsibility of the MCP, and
3. No provision identifies responsibility where the patient is admitted for inpatient psychiatric services at another facility.

Our experience has indicated that there is no standard between counties as to MHP or MCP reimbursement to sending hospitals as in this scenario for services rendered in the emergency department.

With respect to professional fees, the MHP likely is responsible for professional services of mental health specialists provided in the ED to patients meeting MHP medical necessity criteria or required to assess whether MHP criteria are met.[31] The MCP is likely responsible for other professional charges, including professional services not provided by mental health specialists and services provided by mental health specialists to patients who do not meet the medical necessity criteria.

3.b. Receiving hospital. Pursuant to the MHP-State contract and MMCD 00-01 and APL 13-021, the MHP is responsible for the inpatient acute psychiatric care rendered to this patient if the patient meets medical necessity criteria. The MCP continues to have responsibility for professional services necessary to meet the physical needs of the patient while admitted at the receiving hospital[32], although the MHP may be responsible for routine hospital services and certain ancillary services.[33] To the extent that the patient does not have a diagnosis listed in Appendix MH 9-A, "Medical Necessity for MHP Coverage," but requires inpatient acute psychiatric care,

29 Specialty mental health providers include psychiatrists, psychologists, licensed clinical social workers, and marriage and family therapists (previously called marriage, family and child counselors).

30 MMCD 00-01. This includes hospitals that provide and do not provide acute psychiatric services.

31 Ibid.

32 Ibid.

33 Welfare and Institutions Code Section 14722; Cal. Code Regs., Title 9, Section 1810.350; MMCD 00-01.

the hospital should consult its legal counsel to pursue payment options for the services rendered.

Scenario 4: Patient presents to the ED of a hospital with inpatient psychiatric services. **The patient has suicidal ideation with a specific plan.** The patient is determined by a physician or other professional to have an emergency psychiatric condition, and is admitted to the same hospital.

Pursuant to the MHP-State contract and MMCD 00-01 and APL 13-021, if the patient meets the medical necessity criteria for MHP coverage, the MHP should be responsible for the care rendered to this patient as an emergency admission. The emergency charges are likely to be incorporated into the reimbursement for the inpatient stay. However, the MCP may be responsible for professional services not rendered by a mental health specialist when required for the emergency services and care of the member.

MHPs may take the position that specific notice is required in order for emergency admissions to be reimbursable [California Code of Regulations, Title 9, Section 1820.225]. Non-contract hospitals with psychiatric lines of service should familiarize themselves with the expectations of their counties. Even if the requirements imposed by a county may not be legally valid (e.g., some of these requirements may constitute non-quantitative limitations in violation of the mental health parity law [42 U.S.C. Section 300gg]), compliance with the MHP expectations will remove a potential obstacle to claim payment.

If the patient does not have a diagnosis listed in Appendix MH 9-A, "Medical Necessity for MHP Coverage," the hospital should consult its legal counsel to pursue payment options for the services rendered.

Scenarios 5.a, 5.b.1 and 5.b.2: Patient presents to the ED of a hospital that does not provide inpatient psychiatric services. The patient has suicidal ideation with a specific plan. The patient is determined by the ED physician or other professional to have an emergency psychiatric condition and is transferred to a hospital that provides inpatient psychiatric services, with the expectation of an admission.

5.a. Sending hospital. Pursuant to the MMCD 00-01, the MCP may be responsible for facility charges incurred by the sending hospital. However, because the patient's condition may have required a psychiatric admission and because the service was "for an emergency psychiatric condition," the MHP may also be responsible for the facility charges for services rendered by the sending hospital to the extent that the patient meets the medical necessity criteria. Hospitals may wish to consult their contracts with their local MHP or MCP (if applicable) or the MOU between their local MHP and MCP for further clarification.

With respect to professional services, the MHP is responsible for professional services of mental health specialists provided in the ED to patients meeting MHP medical necessity criteria or required to assess whether MHP criteria are met.[34] The MCP is likely responsible for other professional charges, including professional services not provided by mental health specialists and services provided by mental health specialists to patients who do not meet the medical necessity criteria.

5.b.1. Receiving hospital that admits the patient. Pursuant to the MHP-State contract and MMCD 00-01 and APL 13-021, the MHP is responsible for the inpatient psychiatric services rendered if the patient meets medical necessity criteria. The MCP continues to have responsibility for professional services necessary to meet the physical needs of the patient while admitted at the receiving hospital.[35] To the extent that the patient does not have a diagnosis listed in Appendix MH 9-A, "Medical Necessity for MHP Coverage," but requires inpatient psychiatric care, the hospital may wish to consult its legal counsel to pursue payment options for the services rendered.

Receiving hospital that does not admit the patient. In some instances, the receiving hospital will determine that the patient does not require inpatient psychiatric care. In these cases, the payment responsibility for the services rendered by the receiving hospital should follow the rationale set forth in Scenarios 1 and 2.

34 MMCD 00-01.

35 Ibid.

List of Forms and Appendices

These documents are provided in English in the back of the manual. All forms, including Spanish versions, when available, can be found online for CHA members at www.calhospital.org/free-resources. "S" denotes that the form is provided in English and Spanish.

1-1S Consent to Surgery or Special Procedure*
1-2S Informed Consent to Surgery or Special Procedure*
2-1S Self-Sufficient Minor Information
2-2S Caregiver's Authorization Affidavit
2-3S Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent
2-A Decision Makers for Medical Treatment of Adults
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2-D Health Care Decisions for Unrepresented Patients
2-E Considerations for Revising the Hospital's Policy and Procedure Regarding Decision Making for Unrepresented Patients
4-7S Consent to Receive Antipsychotic Medications
8-1S Conditions of Admission
MH 9-A Medical Necessity for MHP Coverage
MH 9-B Types of MCPs and MHPs
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12-10S Notice of Certification for Second Involuntary 14-Day Period for Intensive Treatment — Suicidal Patient
12-11 Petition for Postcertification Treatment of Imminently Dangerous Person
12-12 Detention of Patient With Psychiatric Emergency in a Nondesignated Health Facility (Health and Safety Code Section 1799.111)
12-A Summary of Lanterman-Petris-Short Act's Provision for Involuntary Evaluation and Treatment and Right of Review
13-3S Aftercare Plan
13-4 Notice to Law Enforcement Agency: Release of Person From Hospital From Whom a Firearm or Other Deadly Weapon Was Confiscated
13-5S Notice to Patient: Procedure for Return of Confiscated Weapon(s)
16-1S Authorization for Use or Disclosure of Health Information*
16-2S Request to Withhold Public Release of Information
19-2 Employee Acknowledgment of Child Abuse and Neglect Reporting Obligations
19-4 Employee Acknowledgment of Elder and Dependent Adult Abuse Reporting Obligations
19-A Assault and Abuse Reporting Requirements
20-1 Adverse Event Report Form — *Sample*
21-1 Incident Report
21-2 Report to Attorney
23-1S Consent for the HIV Test
25-A Report of a Hospital Death Associated With Restraint or Seclusion

* Indicates forms that are new or revised in this edition.

FORM 1-1

Consent to Surgery or Special Procedure

1. Your doctors have recommended the following operation or procedure: _____

   _____

   and the following type of anesthesia: _____

   Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the doctor(s) performing the procedure, may be indicated due to an emergency or newly-discovered information, will be performed on you. The operations or procedures will be performed by the doctor named below (or in the event the doctor is unable to perform or complete the procedure, a qualified substitute doctor), together with associates and assistants, including anesthesiologists, pathologists, and radiologists from the medical staff of *(name of hospital)* _____ _____ to whom the doctor(s) performing the procedure may assign designated responsibilities.

2. Name of the practitioner who is performing the procedure or administering the medical treatment[1]: _____

   The hospital maintains personnel and facilities to assist your doctors in their performance of various surgical operations and other special diagnostic or therapeutic procedures. However, your doctors, surgeons, and the persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology, or pathology are not employees, representatives or agents of the hospital or of doctor(s) performing the procedure. They are independent medical practitioners.

3. All operations and procedures carry the risk of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of:

   - The nature of the operation or procedure, including other care, treatment or medications;
   - Potential benefits, risks or side effects of the operation or procedure, including potential problems that might occur with the anesthesia to be used and during recuperation;
   - The likelihood of achieving treatment goals;
   - Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment; and
   - Any independent medical research or significant economic interests your doctor may have related to the performance of the proposed operation or procedure.

   Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to give or refuse consent to any proposed operation or procedure at any time prior to its performance.

1 CMS recommends that consent forms state, if applicable, that physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, in accordance with the hospital's policies (and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner) and that qualified medical practitioners who are not physicians will perform important parts of the surgery or administration of anesthesia within their scope of practice, as determined under state law, and for which they have been granted privileges by the hospital.

4. If your doctor determines that there is a reasonable possibility that you may need a blood transfusion as a result of the surgery or procedure to which you are consenting, your doctor will inform you of this and will provide you with information concerning the benefits and risks of the various options for blood transfusion, including predonation by yourself or others. You also have the right to have adequate time before your procedure to arrange for predonation, but you can waive this right if you do not wish to wait.

   Transfusion of blood or blood products involves certain risks, including the transmission of disease such as hepatitis or Human Immunodeficiency Virus (HIV), and you have a right to consent or refuse consent to any transfusion. You should discuss any questions that you may have about transfusions with your doctor.

5. By your signature below, you authorize the pathologist to use his or her discretion in disposition or use of any cells, tissue, body part, hardware or foreign object removed from your person during the operation or procedure set forth above, subject to the following conditions (if any): _____

6. Your signature on this form indicates that:
   - You have read and understand the information provided in this form;
   - Your doctor has adequately explained to you the operation or procedure and the anesthesia set forth above, along with the risks, benefits, and alternatives, and the other information described above in this form;
   - You have had a chance to ask your doctors questions;
   - You have received all of the information you desire concerning the operation or procedure and the anesthesia; and
   - You authorize and consent to the performance of the operation or procedure and the anesthesia.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Physician Certification[2]

I, the undersigned physician, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including:

1. The risks and benefits of the procedure;
2. Any adverse reactions that may reasonably be expected to occur;
3. Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment;
4. The potential problems that may occur during recuperation; and
5. Any research or economic interest I may have regarding this treatment.

I understand that I am responsible for filling in all blanks in paragraphs 1. and 2. above. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(legal representative)

Consent to Blood Transfusion

Your signature below indicates that:

1. You have received a copy of the brochure, A Patient's Guide to Blood Transfusion.
2. You have received information from your doctor concerning the risks and benefits of blood transfusion and of any alternative therapies and their risks and benefits.
3. You have had the opportunity to discuss this matter with your doctor, including predonation.
4. Subject to any special instructions listed below, you consent to such blood transfusion as your doctor may order in connection with the operation or procedure described in this consent form.

2 The Physician Certification is not a required element of this form, but is one way of providing for physician documentation of the consent process. Other options include a progress note in the patient's medical record, a note in the patient's history and physical, or documentation provided from the physician's office (e.g., an informed consent form signed by both the patient and the physician). **NOTE:** Even if the physician provides a copy of a consent form signed in the physician's office, the patient should still be asked to sign the hospital's consent form.

Special Instructions: _____

_____

(Describe here any specific instructions for patient's blood transfusion, e.g., predonation, direct donation, etc.)

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Interpreter's Statement

I have accurately and completely read the foregoing document to *(patient or patient's legal representative)* _____ in the patient's or legal representative's primary language *(identify language)* _____. He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Date: _____ Time: _____ AM / PM

Signature: _____
(interpreter)

Print name: _____
(interpreter)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: CoP *Interpretive Guidelines*, Tags A-0466 and A-0955

FORM 1-1S

Consentimiento Para Effectuar Cirugía o Procedimiento Especial

1. Sus doctores han recomendado la siguiente operación o procedimiento: _____

   _____

   y el siguiente tipo de anestesia: _____

   Trassu autorización y consentimiento, se le realizará esta operación o procedimiento, junto con cualquier otroprocedimiento diferente o añadido que, en la opinión del médico o médicos que realizan el procedimiento pueda estar indicadodebido a una emergencia o nueva información. Las operaciones o procedimientos serán efectuados por el doctor o doctores que se nombran más abajo (o en caso de que alguno de estos doctores no pueda efectuar o completar el procedimiento, por un doctor sustituto calificado), junto a otros asociados y asistentes, entre ellos, anestesistas, patólogos y radiólogos del cuerpo médico *(nombre del hospital)* _____, a quienes el o los doctores que realicen el procedimiento podrían asignar responsabilidades designadas.

2. Nombre del médico que realiza la intervención o administra el tratamiento: _____

   _____

   El hospital mantiene personal e instalaciones para ayudar a los doctores en el desempeño de las diferentes operaciones quirúrgicas y otros procedimientos terapéuticos o diagnósticos especiales. No obstante, sus médicos, cirujanos y las personas que asisten con el fin de prestar servicios médicos especializados, tales como anestesia, radiología o patología, no son empleados, **representantes** ni agentes del hospital ni del doctor o doctores que realizan el procedimiento, sino que son profesionales médicos independientes.

3. Todas las operaciones y procedimientos conllevan el riesgo de resultados fallidos, complicaciones, lesiones o incluso la muerte, tanto por causas conocidas como imprevistas, y no se otorga ninguna garantía respecto al resultado o la curación. Usted tiene derecho a que se le informe acerca de:

   - La naturaleza de la operación o procedimiento, incluidos otros cuidados médicos, tratamientos o medicamentos;
   - Los beneficios, riesgos o efectos secundarios potenciales de la operación o procedimiento, incluidos los problemas potenciales que podrían presentarse durante la recuperación por la anestesia utilizada;
   - Las alternativas razonables y los riesgos, beneficios y efectos secundarios pertinentes relacionados con dichas alternativas, incluidos los posibles resultados de no recibir atención o tratamiento, y
   - Cualquier interés en investigaciones médicas independientes u otros intereses significativos que su doctor pueda tener en relación con la realización de la operación o procedimiento propuesto.

Excepto en casos de emergencia, las operaciones y los procedimientos no se efectúan sino hasta que usted haya tenido la oportunidad de recibir esta información y otorgar su consentimiento. Usted tiene derecho a dar o rehusar su consentimiento para toda operación o procedimiento que se proponga en cualquier momento, antes de que éstos se efectúen.

4. Si su doctor determina que existe la posibilidad razonable de que usted requerirá una transfusión de sangre como resultado de la cirugía o procedimiento para el cual está otorgando su consentimiento, se lo informará y se le proporcionará información sobre los beneficios y los riesgos de las diversas opciones de transfusión de sangre, incluida la donación adelantada realizada por usted u otras personas. Usted también tiene derecho a contar con suficiente tiempo antes de su procedimiento para gestionar la donación adelantada, pero puede renunciar a este derecho si no desea esperar.

   La transfusión de sangre o derivados sanguíneos conlleva ciertos riesgos, incluyendo la transmisión de enfermedades como la hepatitis o el virus de la inmunodeficiencia humana (VIH), y usted tiene derecho a dar o rehusar el consentimiento para cualquier transfusión. Si tiene preguntas sobre las transfusiones, debe consultarlas con su doctor.

5. Al firmar a continuación, usted autoriza al patólogo a hacer uso de su criterio en la eliminación o uso de células, tejidos, partes del cuerpo, dispositivos o cuerpos extraños extraídos de su persona durante la operación o procedimiento expuesto anteriormente, sujeto a las siguientes condiciones (si las hubiere): _____.

6. Su firma en este formulario indica que:
   - Leyó y entendió la información provista en este formulario;
   - Su doctor le explicó adecuadamente la operación o procedimiento y la anestesia que se utilizará, arriba mencionados, así como los riesgos, beneficios, alternativas y la otra información descrita en este formulario;
   - Tuvo oportunidad de hacerle preguntas a sus doctores;
   - Recibió toda la información que desea sobre la operación o procedimiento y la anestesia, y
   - Autoriza y otorga su consentimiento para la realización de la operación o procedimiento y la anestesia.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

Physician Certification

I, the undersigned physician, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including:

- The risks and benefits of the procedure;
- Any adverse reactions that may reasonably be expected to occur;
- Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment;
- The potential problems that may occur during recuperation;
- The likelihood of achieving treatment goals; and
- Any research or economic interest I may have regarding this treatment.

I understand that I am responsible for filling in all blanks in paragraphs 1. and 2. above. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

Consentimiento para Transfusión de Sangre

Su firma al pie indica que:

1. Recibió una copia del folleto "Guía de Transfusión de Sangre para Pacientes."
2. Recibió información de su doctor sobre los riesgos y beneficios de las transfusiones de sangre y de otras terapias alternativas con sus riesgos y beneficios.
3. Tuvo oportunidad de conversar con su doctor sobre este asunto, incluyendo el tema de la donación adelantada.
4. Sujeto a las instrucciones especiales que se detallan a continuación, otorga su consentimiento para cualquier transfusión de sangre que su doctor indique en relación con la operación o procedimiento que se describe en este formulario de consentimiento.

Instrucciones especiales: _____

_____

(Describa en este espacio cualquier instrucción específica relacionada con la transfusión de sangre del paciente; por ejemplo, donación adelantada, donación directa, etc.)

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

Interpreter's Statement

I have accurately and completely read the foregoing document to *(patient or patient's legal representative)* _____ in the patient's or legal representative's primary language *(identify language)* _____ _____. He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Date: _____ Time: _____ AM / PM

Signature: _____
(interpreter)

Print name: _____
(interpreter)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: CoP Interpretive Guidelines, Tags A-0466 and A-0955

FORM 1-2

Informed Consent to Surgery or Special Procedure

1. This form is called an "Informed Consent Form." It is your doctor's obligation to provide you with the information you need in order to decide whether to consent to the surgery or special procedure that your doctors have recommended. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you. You should read this form carefully and ask questions of your doctors so that you understand the operation or procedure before you decide whether or not to give your consent. If you have questions, you are encouraged and expected to ask them before you sign this form. Your doctors are not employees or agents of the hospital. They are independent medical practitioners.

2. Your doctors have recommended the following operation or procedure: _____ _____ and the following type of anesthesia: _____

   Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the doctor(s) performing the procedure, may be indicated due to an emergency or newly-discovered information, will be performed on you. The operations or procedures will be performed by the doctor named below (or, in the event the doctor is unable to perform or complete the procedure, a qualified substitute doctor), together with associates and assistants, including anesthesiologists, pathologists, and radiologists from the medical staff of *(name of hospital)* _____ _____ to whom the doctor(s) performing the procedure may assign designated responsibilities.

3. Name of the practitioner who is performing the procedure or administering the medical treatment[1]: _____

   The hospital maintains personnel and facilities to assist your doctors in their performance of various surgical operations and other special diagnostic or therapeutic procedures. However, your doctors, surgeons and the persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology, or pathology are not employees, representatives or agents of the hospital or of doctor(s) performing the procedure. They are independent medical practitioners.

4. All operations and procedures carry the risk of unsuccessful results, complications, injury or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of:

   - The nature of the operation or procedure, including other care, treatment or medications;
   - Potential benefits, risks or side effects of the operation or procedure, including potential problems that might occur with the anesthesia to be used and during recuperation;

1 CMS recommends that consent forms state, if applicable, that physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, in accordance with the hospital's policies (and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner) and that qualified medical practitioners who are not physicians will perform important parts of the surgery or administration of anesthesia within their scope of practice, as determined under state law, and for which they have been granted privileges by the hospital.

- The likelihood of achieving treatment goals;
- Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment; and
- Any independent medical research or significant economic interests your doctor may have related to the performance of the proposed operation or procedure.

Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to give or refuse consent to any proposed operation or procedure at any time prior to its performance.

5. By your signature below, you authorize the pathologist to use his or her discretion in disposition or use of any cells, tissue, body part, hardware or foreign object removed from your person during the operation or procedure set forth above, subject to the following conditions (if any): _____

6. Your doctor will discuss with you the risks and benefits of the recommended operation or procedure, including the following (the patient's doctor is responsible for the content of the information provided below):

   a. The nature of the operation or procedure and the anesthesia, including the surgical site and laterality if applicable: _____

   b. The expected benefits or effects of the operation or procedure and anesthesia: _____
   _____

   c. The possible risks and/or complications of the operation or procedure and anesthesia, including potential problems that might occur during recuperation include, but are not limited to: _____

   d. Due to the following specific medical condition(s): _____
   _____, additional risks and/or complications of the operation or procedure and anesthesia include, but are not limited to: _____

   e. Alternative methods of treatment, including the nature of such treatments, their expected benefits or effects, and their possible risks and complications include: _____
   _____

   f. Other issues discussed with the patient: _____
   _____

7. If your doctor determines that there is a reasonable possibility that you may need a blood transfusion as a result of the surgery or procedure to which you are consenting, your doctor will inform you of this and will provide you with information concerning the benefits and risks of the various options for blood transfusion, including predonation by yourself or others. You also have the right to have adequate time before your procedure to arrange for predonation, but you can waive this right if you do not wish to wait.

   Transfusion of blood or blood products involves certain risks, including the transmission of disease such as hepatitis or Human Immunodeficiency Virus (HIV), and you have a right to

consent or refuse consent to any transfusion. You should discuss any questions that you may have about transfusions with your doctor.

8. Your signature on this form indicates that:
   a. You have read and understand the information provided in this form;
   b. Your doctor has adequately explained to you the operation or procedure and the anesthesia set forth above, along with the risks, benefits, and the other information described above in this form;
   c. You have had a chance to ask your doctors questions;
   d. You have received all of the information you desire concerning the operation or procedure and the anesthesia; and
   e. You authorize and consent to the performance of the operation or procedure and the anesthesia.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate name and relationship: _____

Print name: _____
(legal representative)

Physician Certification[2]

I, the undersigned physician, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including:

- The risks and benefits of the procedure;
- Any adverse reactions that may reasonably be expected to occur;
- Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment; and
- The potential problems that may occur during recuperation; and
- Any research or economic interest I may have regarding this treatment.

I understand that I am responsible for filling in all blanks in paragraphs 2, 3 and 6. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

2 While the Physician Certification is optional for the Consent to Surgery or Special Procedure (CHA Form 1-1), CHA recommends that it be included in this Informed Consent form containing medical information for which the physician is responsible.

Consent to Blood Transfusion

Your signature below indicates that:

1. You have received a copy of the brochure, *A Patient's Guide to Blood Transfusion*.
2. You have received information from your doctor concerning the risks and benefits of blood transfusion and of any alternative therapies and their risks and benefits.
3. You have had the opportunity to discuss this matter with your doctor, including predonation.
4. Subject to any special instructions listed below, you consent to such blood transfusion as your doctor may order in connection with the operation or procedure described in this consent form.

Special Instructions: _____

_____

(Describe here any specific instructions for patient's blood transfusion, e.g., predonation, direct donation, etc.)

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Interpreter's Statement

I have accurately and completely read the foregoing document to *(patient or patient's legal representative)* _____ in the patient's or legal representative's primary language *(identify language)* _____. He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Date: _____ Time: _____ AM / PM

Signature: _____
(interpreter)

Print name: _____
(interpreter)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: CoP Interpretive Guidelines, Tags A-0466 and A-0955

FORM 1-2S

Consentimiento Informado Para Effectuar Cirugía o Procedimiento Especial

1. Este formulario se llama “Formulario de consentimiento informado”. Su doctor tiene la obligación de darle toda la información necesaria para que usted pueda decidir si quiere dar su consentimiento para la cirugía o procedimiento especial que sus doctores le recomendaron. El propósito de este formulario es verificar que usted recibió esta información y dio su consentimiento para la cirugía o procedimiento especial que le recomendaron. Debe leer este formulario detenidamente y hacerle preguntas a sus doctores para que entienda la operación o procedimiento antes de decidir si dará o no su consentimiento. Si tiene preguntas, se le anima y se espera que las haga antes de firmar este formulario. Sus doctores no son empleados ni agentes del hospital. Son profesionales médicos independientes.

2. Sus doctores han recomendado la siguiente operación o procedimiento: _____

   _____

   y el siguiente tipo de anestesia: _____

   Trassu autorización y consentimiento, se le realizará esta operación o procedimiento, junto con cualquier otroprocedimiento diferente o añadido que, en la opinión del médico o médicos que realizan el procedimiento pueda estar indicadodebido a una emergencia o nueva información. Las operaciones o procedimientos serán efectuados por el doctor o doctores que se nombran más abajo (o en caso de que alguno de estos doctores no pueda efectuar o completar el procedimiento, por un doctor sustituto calificado), junto a otros asociados y asistentes, entre ellos, anestesistas, patólogos y radiólogos del cuerpo médico *(nombre del hospital)* _____, a quienes el o los doctores que realicen el procedimiento podrían asignar responsabilidades designadas.

3. Nombre del médico que realiza la intervención o administra el tratamiento: _____

   _____

   El hospital mantiene personal e instalaciones para ayudar a los doctores en el desempeño de las diferentes operaciones quirúrgicas y otros procedimientos terapéuticos o diagnósticos especiales. No obstante, sus médicos, cirujanos y las personas que asisten con el fin de prestar servicios médicos especializados, tales como anestesia, radiología o patología, no son empleados, **representantes** ni agentes del hospital ni del doctor o doctores que realizan el procedimiento, sino que son profesionales médicos independientes.

4. Todas las operaciones y procedimientos conllevan el riesgo de resultados fallidos, complicaciones, lesiones o incluso la muerte, tanto por causas conocidas como imprevistas, y no se otorga ninguna garantía respecto al resultado o la curación. Usted tiene derecho a que se le informe acerca de:

   - La naturaleza de la operación o procedimiento, incluidos otros cuidados médicos, tratamientos o medicamentos;
   - Los beneficios, riesgos o efectos secundarios potenciales de la operación o procedimiento, incluidos los problemas potenciales que podrían presentarse durante la recuperación por la anestesia utilizada;

- La probabilidad para lograr las metas del tratamiento;
- Las alternativas razonables y los riesgos, beneficios y efectos secundarios pertinentes relacionados con dichas alternativas, incluidos los posibles resultados de no recibir atención o tratamiento, y
- Cualquier interés en investigaciones médicas independientes u otros intereses significativos que su doctor pueda tener en relación con la realización de la operación o procedimiento propuesto.

Excepto en casos de emergencia, las operaciones y los procedimientos no se efectúan sino hasta que usted haya tenido la oportunidad de recibir esta información y otorgar su consentimiento. Usted tiene derecho a dar o rehusar su consentimiento para toda operación o procedimiento que se proponga en cualquier momento, antes de que éstos se efectúen.

5. Al firmar a continuación, usted autoriza al patólogo a hacer uso de su criterio en la eliminación o uso de células, tejidos, partes del cuerpo, dispositivos o cuerpos extraños extraídos de su persona durante la operación o procedimiento expuesto anteriormente, sujeto a las siguientes condiciones (si las hubiere): _____

6. Su doctor conversará con usted sobre los riesgos y beneficios de la operación o procedimiento recomendando, incluidos los siguientes puntos (El médico del paciente es responsable del contenido de la información proporcionada abajo):

   a. La naturaleza de la operación o procedimiento y la anestesia, incluyendo el lugar y lado del cuerpo donde se realizará la operación, si corresponde: _____
   _____

   b. Los beneficios o efectos esperados de la operación o procedimiento y de la anestesia: _
   _____

   Entre los posibles riesgos y complicaciones de la operación o procedimiento y de la anestesia, incluyendo los problemas potenciales que podrían presentarse durante la recuperación, están los siguientes (sin limitarse a ellos): _____

   c. Debido a la o las siguientes afecciones médicas especiales: _____
   _____ otros riesgos y complicaciones adicionales de la operación o procedimiento y de la anestesia, incluyen, sin limitarse a ellos: _____
   _____

   d. Entre los métodos alternativos de tratamiento, incluyendo la naturaleza de dichos tratamientos, sus beneficios o efectos esperados y sus posibles riesgos y complicaciones, están los siguientes: _____

   e. Otros asuntos que se discutieron con el paciente: _____
   _____

7. Si su doctor determina que existe la posibilidad razonable de que usted requerirá una transfusión de sangre como resultado de la cirugía o procedimiento para el cual está otorgando su consentimiento, se lo informará y se le proporcionará información sobre los beneficios y los riesgos de las diversas opciones de transfusión de sangre, incluida la

donación adelantada realizada por usted u otras personas. Usted también tiene derecho a contar con suficiente tiempo antes de su procedimiento para gestionar la donación adelantada, pero puede renunciar a este derecho si no desea esperar.

La transfusión de sangre o derivados sanguíneos conlleva ciertos riesgos, incluyendo la transmisión de enfermedades como la hepatitis o el virus de la inmunodeficiencia humana (VIH), y usted tiene derecho a dar o rehusar el consentimiento para cualquier transfusión. Si tiene preguntas sobre las transfusiones, debe consultarlas con su doctor.

8. Su firma en este formulario indica que:
   - Leyó y entendió la información provista en este formulario;
   - Su doctor le explicó adecuadamente la operación o procedimiento y la anestesia que se utilizará, arriba mencionados, así como los riesgos, beneficios, alternativas y la otra información descrita en este formulario;
   - Tuvo oportunidad de hacerle preguntas a sus doctores;
   - Recibió toda la información que desea sobre la operación o procedimiento y la anestesia; y
   - Autoriza y otorga su consentimiento para la realización de la operación o procedimiento y la anestesia.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

Physician Certification

I, the undersigned physician, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including:

- The risks and benefits of the procedure;
- Any adverse reactions that may reasonably be expected to occur;
- Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment; and
- The potential problems that may occur during recuperation;
- The likelihood of achieving treatment goals; and
- Any research or economic interest I may have regarding this treatment.

I understand that I am responsible for filling in all blanks in paragraphs 2, 3 and 6 above. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

Consentimiento para Transfusión de Sangre

Su firma al pie indica que:

- Recibió una copia del folleto *Guía de Transfusión de Sangre para Pacientes*.
- Recibió información de su doctor sobre los riesgos y beneficios de las transfusiones de sangre y de otras terapias alternativas con sus riesgos y beneficios.
- Tuvo oportunidad de conversar con su doctor sobre este asunto, incluyendo el tema de la donación adelantada.
- Sujeto a las instrucciones especiales que se detallan a continuación, otorga su consentimiento a cualquier transfusión de sangre que su doctor indique en relación con la operación o procedimiento que se describe en este formulario de consentimiento.

Instrucciones especiales: _____

_____

(Describa en este espacio cualquier instrucción específica relacionada con la transfusión de sangre del paciente; por ejemplo, donación adelantada, donación directa, etc.)

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

Interpreter's Statement

I have accurately and completely read the foregoing document to *(patient or patient's legal representative)* _____ in the patient's or legal representative's primary language *(identify language)* _____. He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Date: _____ Time: _____ AM / PM

Signature: _____
(interpreter)

Print name: _____
(interpreter)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: CoP *Interpretive Guidelines*, Tags A-0466 and A-0955

FORM 2-1

Self-Sufficient Minor Information

For the purposes of obtaining diagnosis or treatment at the *(name of hospital)* _____ _____ or by any physician, surgeon or dentist associated with it, the undersigned certifies the following facts are true:

1. I am 15 years of age or older, having been born on _____ .
   (insert date as mm/dd/yy)

2. I am living separate and apart from my parents or legal guardian.

   _____ _____
   (place of residence of patient) *(phone)*

   _____ _____
   (place of residence of parents or guardian) *(phone)*

3. I am managing my own financial affairs.

   _____
   (place of employment)

   _____
   (other source of financial support — explain)

4. I understand that I will be financially responsible for the charges for my medical, dental, or hospital diagnosis, treatment and care and that I may not disaffirm this contract on the grounds that I am a minor.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient)

Print name: _____
(patient)

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Family Code Section 6922

FORM 2-1S

Formulario de Informacion para el Menor de Edad Autosuficiente

Con el fin de obtener un diagnóstico o tratamiento en el hospital *(nombre del hospital)* _____ _____ o por cualquier médico, cirujano o dentista asociado con dicho hospital, el suscrito da fe que la siguiente información es verídica:

1. Tengo 15 años de edad o más y nací el _____
   (escriba la fecha de la siguiente forma: mes/día/año)

2. Mi domicilio es distinto y separado del de mis padres o de mi tutor.

   _____ _____
   (domicilio del paciente) *(teléfono)*

   _____ _____
   (domicilio de los padres o del tutor) *(teléfono)*

3. Manejo mis propios asuntos financieros.

   _____
   (lugar de empleo)

   _____
   (otras fuentes de ayuda financeria—explique)

4. Entiendo que tendré la responsabilidad financiera de los gastos que resulten del diagnóstico, atención y tratamiento médico, dental, o del hospital que se me proporcionen, y que no podré negar el presente consentimiento por ser menor de edad.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente)

Nombre en letra de imprenta: _____
(paciente)

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(testigo)

Nombre en letra de imprenta: _____
(testigo)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Family Code Section 6922

FORM 2-2

Caregiver's Authorization Affidavit

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions:
Completion of items 1-4, inclusive, and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. School-related medical care means medical care that is required by state or local governmental authority as a condition for school enrollment, including immunizations, physical exams and medical exams conducted in schools. Completion of items 5-8, inclusive, is additionally required to authorize any other medical care. Please print clearly.

☐ I am requesting enrollment of the minor in school and to authorize school-related medical care. Completion of items 1-4 only is required.

☐ I am requesting to authorize medical care not school-related. Completion of items 1-8 is required.

The minor named below lives in my home, and I am 18 years of age or older.

1. Name of minor: _____
2. Minor's birth date: _____
3. My name (adult giving authorization): _____
4. My home address: _____
5. I am a grandparent, aunt, uncle, or other qualified relative of the minor *(see back of this form for a definition of "qualified relative")*.
6. Check one or both (for example, if one parent was advised and the other cannot be located):
   - ☐ I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.
   - ☐ I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.
7. My date of birth: _____
8. My California driver's license or ID card number: _____

WARNING: DO NOT SIGN THIS FORM IF ANY OF THE STATEMENTS ABOVE ARE INCORRECT, OR YOU WILL BE COMMITTING A CRIME PUNISHABLE BY A FINE, IMPRISONMENT OR BOTH.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: _____ Time: _____ AM / PM

Signature: _____
(legal representative)

Print name: _____
(legal representative)

Please **NOTE:**

- This declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the caregiver has legal custody of the minor.
- A person who relies on this affidavit has no obligation to make any further inquiry or investigation.

IMPORTANT INFORMATION

To Caregivers

"Qualified relative," for purposes of item 5, means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great," or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

The law may require you, if you are not a relative or currently licensed, certified, or approved foster parent, to obtain resource family approval pursuant to Health and Safety Code Section 1517 or Welfare and Institutions Code Section 16519.5 in order to care for a minor. If you have any questions, please contact your local department of social services.

If the minor stops living with you, you are required to notify any school, health care provider, or health care service plan to which you have given this affidavit. The affidavit is invalid after the school, health care provider or health care service plan receives notice that the minor no longer lives with you.

If you do not have the information requested in item 8 (California driver license or identification card), provide another form of identification such as your social security number or Medi-Cal number.

To School Officials

Section 48204(a)(5) of the Education Code provides that this affidavit constitutes a sufficient basis for determination of residency of the minor, without the requirement of a guardianship or other custody order, unless the school district determines from actual facts that the minor is not living with the caregiver.

The school district may require additional reasonable evidence that the caregiver lives at the address provided in item 4.

To Health Care Providers and Health Care Service Plans

A person who acts in good faith reliance upon a Caregiver's Authorization Affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit, is not subject to criminal liability or to civil liability to any person, and is not subject to professional disciplinary action, for that reliance if the applicable portions of the form are completed.

This affidavit does not mean that the minor is automatically a dependent for health care coverage purposes.

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: Family Code Sections 6550 to 6552

FORM 2-2S

Declaracion Jurada de Autorizacion de una Persona Que Cuida a un Menor de Edad

El uso de esta declaración jurada está autorizado por la Parte 1.5 (a partir de la sección 6550) de la División 11 del Código de Familia de California.

Instrucciones:
Para autorizar la matrícula y la atención médica en la escuela de un menor de edad basta con completar los puntos del 1 al 4 y firmar la declaración jurada. La atención médica en la escuela se refiere a los cuidados médicos que las autoridades gubernamentales locales o estatales exigen como condición de la matrícula escolar, incluyendo inmunizaciones, exámenes físicos y exámenes médicos realizados en las escuelas. Para autorizar cualquier otro tipo de atención médica se deben completar además los puntos del 5 al 8. Por favor escriba claramente en letra de molde.

☐ Solicito inscripción del menor de edad en la escuela y autorizo la atención médica relacionada con la escuela. Sólo se requiere llenar los puntos 1 a 4.

☐ Solicito autorizar atención médica no relacionada con la escuela. Se requiere llenar los puntos 1 a 8.

El menor de edad nombrado a continuación reside en mi domicilio y tengo 18 años de edad o más.

1. Nombre del menor de edad:
2. Fecha de nacimiento del menor de edad:
3. Mi nombre:(adulto que presta autorización)
4. Dirección de mi domicilio:
5. Soy abuelo, tía, tío u otro pariente calificado del menor de edad (para una definición de “pariente calificado” sírvase consultar el dorso de este formulario).
6. Marque un casillero o ambos (por ejemplo, si le avisaron a un padre y el otro no se puede localizar):
   - ☐ He avisado al/los padre(s) u otra(s) persona(s) con custodia legal del menor de edad de mi intención de autorizar atención médica y no he recibido ninguna objeción.
   - ☐ No he podido ponerme en contacto con el/los padre(s) u otra(s) persona(s) con custodia legal del menor de edad en el presente para notificarles que propongo prestar autorización.
7. Mi fecha de nacimiento:
8. El número de mi licencia de conducir o tarjeta de identificación de California:

ADVERTENCIA: NO FIRME ESTE FORMULARIO SI ALGUNA DE LAS DECLARACIONES QUE ANTECEDEN SEA INCORRECTA O SI ESTARÁ COMETIENDO UN DELITO SUJETO A MULTAS, ENCARCELAMIENTO O AMBOS

Declaro bajo pena de perjurio bajo las leyes del Estado de California que lo que antecede es verdadero y correcto.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(representante legal)

Nombre en letra de imprenta: _____
(representante legal)

Sírvase NOTAR:

- Esta declaración no afecta los derechos de los padres o tutores legales del menor de edad acerca del cuidado, custodia y control del menor, y no significa que el que cuida a dicho menor de edad tenga custodia legal del menor de edad.
- Una persona que se base en esta declaración jurada no tiene ninguna obligación de realizar ninguna otra averiguación o investigación.

INFORMACION IMPORTANTE

A los Que Cuidan a Menores de Edad

Para los objetivos del punto 5, "familiar calificado" significa un cónyuge, padre, padrastro, hermano, hermana, hermanastro, hermanastra, medio hermano, media hermana, tío, tía, sobrina, sobrino, primo hermano, abuelo, abuelo, bisabuelo, bisabuela o el cónyuge de las personas especificadas en esta definición, incluso después de que el matrimonio haya finalizado a causa de fallecimiento o disolución.

Si usted no es pariente o actualmente padre de crianza con licencia, certificado o aprobado, la ley puede requerir que obtenga la aprobación de recursos familiar en virtud del Código de Salud y Seguridad de California, seccion 1517 o el Código de Bienestar e Instituciones, sección 16519.5 para poder cuidar de un menor de edad. Si tiene preguntas, póngase en contacto con su departamento local de servicios sociales.

Si el menor deja de vivir con usted, usted debe notificar a la escuela, proveedor de atención médica o plan de servicios médicos a los que les haya entregado esta declaración jurada. La declaración jurada expirará en cuanto la escuela, proveedor de atención médica o plan de servicios médicos reciba notificación de que el menor ya no reside con usted.

Si no tiene la información requerida en el punto 8 (licencia de conducir o tarjeta de identificación de California), provea alguna otra forma de identificación, como su número del Seguro Social o de Medi-Cal.

A Los Funcionarios de las Escuelas

La Sección 48204 del Código de Educación estipula que esta declaración jurada constituya un fundamento suficiente para determinar la residencia del menor de edad, sin el requisito de una orden de tutela o de algún otro orden de custodia, a menos que el distrito escolar determine mediante hechos concretos que el menor no está viviendo con la persona que lo cuida.

El distrito escolar podrá requerir pruebas adicionales razonables de que la persona que cuida al menor de edad vive en la dirección provista en el punto 4.

A los Proveedores de Servicios de Salud y a los Planes de Servicios de Atencion de la Salud

Una persona que actúe de buena fe con base en una Declaración Jurada de Autorización del Encargado del Menor y proporcione atención médica o dental sin tener conocimiento real de hechos contrarios a los que establece la declaración jurada no estará sujeta a cargos penales ni civiles por ningún tercero, ni tampoco estará sujeta a acciones disciplinarias profesionales por sus actos si todas las partes aplicables del formulario se completan.

Esta declaración jurada no significa que el menor de edad es automáticamente un dependiente para fines de la cobertura de la atención de la salud.

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: Family Code Sections 6550 to 6552

FORM 2-3

Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent

I am the ☐ Parent

☐ Guardian

☐ Other person having legal custody _____
(describe legal relationship)

of *(name of minor)* _____, a minor.

I hereby authorize *(name of agent)* _____, to act as my agent to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of, any licensed doctor or dentist, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor or dentist recommends.

This authorization is given pursuant to the provisions of Family Code Section 6910.

I hereby authorize any hospital providing treatment to the above-named minor pursuant to the provisions of Family Code Section 6910 to surrender physical custody of the minor to the above-named agent upon the completion of treatment. This authorization is given pursuant to Health and Safety Code Section 1283.

These authorizations shall remain effective until *(month and day)* _____, 20_____, unless sooner revoked in writing delivered to the agent named above.

Date: _____ Time: _____ AM / PM

Signature: _____

Print name: _____

(over)

Medically Relevant Information

Minor's Name: _____

Minor's date of birth: _____

Allergies to drugs or food: _____

Conditions for which minor is currently being treated: _____

_____

Current medications: _____

Restrictions on activity: _____

Primary care physician *(name and telephone number)*: _____

_____

Insurance Company: _____

Mother's name: _____

Mother's address: _____

Mother's telephone numbers: _____ _____ _____
(work) *(home)* *(other)*

Father's name: _____

Father's address: _____

Father's telephone numbers: _____ _____ _____
(work) *(home)* *(other)*

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

FORM 2-3S

Autorización para que un Tercero Pueda dar su Consentimiento al Tratamiento de un Menor de Edad

Yo soy ☐ El padre o la madre

☐ El tutor

☐ Otra persona que tiene la custodia legal _____
(describa la relación legal)

de *(nombre del menor)* _____, menor de edad.

Por medio del presente autorizo a *(nombre del representante)* _____, a actuar como mi representante y dar consentimiento para todo estudio de radiografías, diagnóstico o tratamiento anestésico, médico, quirúrgico o dental y atención hospitalaria que sea recomendada por cualquier médico o dentista con licencia quien prestará supervisión general o especial del mismo, ya sea que dicho diagnóstico o tratamiento se brinde en el consultorio del médico o en un hospital.

Entiendo que esta autorización se otorga antes de cualquier diagnóstico, tratamiento o atención hospitalaria que se requiera, pero se otorga a fin de dar autoridad al representante nombrado anteriormente a dar consentimiento para todo y cualquiera de dichos diagnósticos, tratamientos u atención hospitalaria que recomiende un médico o dentista con licencia.

Esta autorización se otorga en conformidad con las disposiciones del Artículo 6910 del Código de Familia.

Por medio del presente autorizo a todo hospital que brinde tratamiento al menor de edad nombrado anteriormente en conformidad con las disposiciones del Artículo 6910 del Código de Familia a entregar la custodia física del menor al representante nombrado anteriormente al finalizar el tratamiento. Esta autorización se otorga en conformidad con el Artículo 1283 del Código de Salud y Seguridad.

Estas autorizaciones tendrán vigencia hasta *(mes y día)* _____del 20_____ a menos que sea antes revocada por escrito entregada al representante nombrado anteriormente.

Fecha: _____ Hora: _____ AM / PM

Firma: _____

Nombre en letra de imprenta: _____

(sobre)

Informacíon Médica Pertinente

Nombre del menor: _____

Fecha de nacimiento del menor: _____

Alergias a medicamentos o alimentos: _____

Padecimientos por los cuales el menor está recibiendo tratamiento: _____

_____

Medicamentos actuales: _____

Restricciones de las actividades: _____

Médico de atención primaria *(nombre y teléfono)*: _____

_____

Compañía de seguros: _____

Nombre de la madre: _____

Dirección de la madre: _____

Teléfonos de la madre: _____ _____ _____
(trabajo) *(casa)* *(otro)*

Nombre del padre: _____

Dirección del padre: _____

Teléfonos del padre: _____ _____ _____
(trabajo) *(casa)* *(otro)*

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Consent Requirements for MEDICAL TREATMENT OF ADULTS

(Special rules apply to mental health commitment, convulsive therapy, psychosurgery, sterilization, abortion and experimental treatment)

Person who can consent to treatment	Definition
The following hierarchy must be followed:	
1. Adult patient with capacity	Able to understand the nature and consequences of the decision; adult is a person age 18 or older
2. Surrogate decision maker	Oral or written appointment by the patient, for duration of stay or illness; maximum 60 days
3. Agent	Appointed in an Advance Health Care Directive or Power of Attorney for Health Care
4. Conservator	Appointed by a court
5. Court-appointed surrogate decision maker	Court appoints a surrogate to make health care decisions
6. Closest available relative	*See "Closest Available Relative" table, below*
7. Multi-disciplinary committee	*See "Adults Lacking Capacity and Not Under a Conservatorship" for important information*

Emergency Exception When a patient lacks capacity to make a health care decision and treatment is immediately necessary to prevent death or permanent disability, or to alleviate severe pain, and a surrogate decision maker cannot be contacted, treatment may proceed because it is an emergency. The treatment is limited to that which is necessary to treat the emergency and cannot include treatment that has previously been validly refused.

Closest Available Relative

Health Care Decisions	Autopsy	Anatomical Gifts	Disposition of Remains
No statutory hierarchy[1] • Spouse/domestic partner • Adult child • Either parent • Adult sibling • Grandparent • Adult aunt/uncle • Adult niece/nephew	***No statutory hierarchy*** • Spouse/domestic partner • Adult child or parent • Adult sibling • Any other kin or person who has the right to control disposition of remains • Public administrator • Coroner or other official, such as the California Curator of the Unclaimed Dead	***In the order listed*** 1. An agent who could have made an anatomical gift immediately before decedent's death 2. Spouse/domestic partner 3. Adult child 4. Either parent 5. Adult sibling 6. Adult grandchildren 7. Grandparent 8. An adult who exhibited special care and concern for the decedent during the decedent's lifetime 9. Guardian or conservator of the decedent at the time of death 10. Any other person authorized to dispose of the remains of the unclaimed dead provided that reasonable effort has been made to locate and inform persons listed above	***In the order listed*** 1. An agent named in an advance directive 2. Spouse/domestic partner 3. Adult child or majority of children 4. Parent 5. Adult sibling or majority of siblings 6. Surviving adults in degree of kinship or a majority of the same degree 7. Conservator of person 8. Conservator of estate 9. Public administrator, if the patient has assets
	Reference: Health and Safety Code Section 7113	Reference: Health and Safety Code Section 7150.40	Reference: Health and Safety Code Section 7100

[1]For general medical decisions, case law (not a statute) authorizes decisions by the "closest available relative" and there is no specific hierarchy/order given. It is wise to select the person who seems most familiar with the patient's values, demonstrates concern for the patient, had regular contact prior to the illness, is available to visit and make decisions, and is able to understand the information and engage in meaningful contact. Agreement with the doctor's recommendations is not a proper criterion for selection.

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See chapter 2, "Who May Give Consent," of CHA's Consent Manual *for additional information.*
See chapter 11, "Patient Deaths," of CHA's Consent Manual *for additional information regarding autopsies, anatomical gifts, and disposition of remains.*

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Consent Requirements for MEDICAL TREATMENT OF MINORS

IF MINOR IS:	*Is parental consent required?*	*Are parents responsible for costs? †*	*Is minor's consent sufficient?*	*May M.D. inform parents of treatment without minor's consent?*
Unmarried, no special circumstances	Yes	Yes	No	Yes
Unmarried, emergency care and parents not available [Business and Professions Code § 2397]	No	Yes	Yes, if capable	Yes
Currently or previously married or in a domestic partnership [Family Code § 7002]	No	No	Yes	No
Emancipated (declaration by court, identification card from DMV) [Family Code §§ 7002, 7050, 7140]	No	Probably Not[1]	Yes	No
Self-sufficient (15 or older, not living at home, manages own financial affairs) [Family Code § 6922]	No	No	Yes	[1]
Not married, care related to prevention or treatment of pregnancy, except sterilization [Family Code § 6925]	No	No	Yes	No
Not married, seeking abortion [Family Code § 6925]	No	No	Yes	No
Not married, pregnant, care not related to prevention or treatment of pregnancy and no other special circumstances	Yes	Yes	No	Yes
On active duty with Armed Forces [Family Code § 7002]	No	No	Yes	No
12 or older, care related to diagnosis or treatment of a communicable reportable disease or to prevention of an STD [Family Code § 6926]	No	No	Yes	No
12 or older, care for rape[1] [Family Code § 6927]	No	No	Yes	Yes, usually
Care for sexual assault or intimate partner violence[1] [Family Code §§ 6928 and 6930]	No	No	Yes	Yes, usually
12 or older, care for alcohol or drug abuse[1] [Family Code § 6929]	No[2]	Only if parents are participating in counseling	Yes	Yes, usually
12 or older, care for mental health treatment, outpatient only[1] [Family Code § 6924; Health and Safety Code § 124260]	No	Only if parents are participating in counseling	Yes	Yes, usually
17 or older, blood donation only [Health and Safety Code § 1607.5]	No	No	Yes	Probably not

[1] Special requirements or exceptions may apply. See *Chapter 4* of the *Consent Manual* or *Chapter 3* of *Minors & Health Care Law.*

[2] Parental consent *is* required for a minor's participation in replacement narcotic abuse treatment (such as methadone, LAAM or buprenorphine products) in a program licensed pursuant to Health and Safety Code § 11875 (now codified at § 11839 *et. seq.* [Family Code § 6929(e)]

Note: Notwithstanding the above information, a psychotherapist may not disclose mental health information to a parent who has lost physical custody of a child in a juvenile court dependency hearing unless the parent has obtained a court order granting access to the information.

† Reference: Welfare and Institutions Code § 14010

Minors are defined as all persons under 18 years of age.

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APPENDIX 2-D

Health Care Decisions for Unrepresented Patients

Model Policy for General Acute Care Hospitals

The purpose of this policy is to provide a process for making ethically and medically appropriate treatment decisions on behalf of persons who lack health care decision-making capacity and for whom there is no surrogate decision maker.

Preamble

This policy guides health care professionals through a process to make medical treatment decisions on behalf of an incapacitated patient who lacks a surrogate decision maker and when there is no known family member who is willing and able to make medical treatment decisions on behalf of the patient. Despite their incapacity, such "unrepresented" patients are entitled to have ethically and medically appropriate medical decisions made on their behalf and to have these decisions made in their best interest. The process set forth in this policy is intended to meet these goals. This policy is considered necessary since no clear- cut legal guidelines exist that cover these circumstances. This policy is designed to provide uniformity and consistency within the institutional setting of California's general acute care hospitals[1] on the process to make medical treatment decisions for unrepresented patients.

Decisions made without clear knowledge of an unrepresented patient's specific treatment preferences must be made in the patient's best interest, taking into consideration the patient's personal history, values and beliefs to the extent that these are known. Decisions about treatment should be based on sound medical advice and should be made without the influence of material conflicts of interest. These decisions must be made with a focus on the patient's interests, and not the interests of providers, the institutions, or other affected parties. In this regard, appropriate health care decisions include both the provision of needed medical treatment and the avoidance of nonbeneficial or excessively burdensome treatment, or treatment that is medically ineffective or contrary to generally-accepted health care standards.[2]

This policy is procedural in nature and applies to most medical decisions for which informed consent is usually required. This policy is meant to support the institution's underlying consent policy.

Adoption of this policy does not preclude any party from seeking judicial intervention. Appropriate judicial remedies may include a timely court order authorizing the provision, withdrawing, or withholding of treatment or appointment of a conservator; however, courts are not necessarily the proper forum in which to make health care decisions.[3]

When Use of This Policy is Appropriate

This policy may be used when all of the following conditions are met:

1. The patient has been determined by the primary physician (with assistance from appropriate consulting physicians if necessary) to lack capacity to make health care decisions. Capacity means a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate

a health care decision. Conditions for which psychiatric or psychological treatment may be required do not, in and of themselves, constitute a lack of capacity to make health care decisions.

2. No agent, conservator, or guardian has been designated to act on behalf of the patient.
3. There is no individual health care directive or instruction in the patient's medical record or other available sources that would eliminate the need for a surrogate decision maker.
4. No surrogate decision maker or family member can be located who is reasonably available[4] and who is willing and able to serve. Efforts to locate a surrogate should be diligent and may include contacting the facility from which the patient was referred, and contacting public health or social service agencies known to have provided treatment for the patient.

This policy does not address the criteria for determining and appointing an appropriate decision maker when one or more are available and willing to serve. And finally, this policy is not meant to be applied in emergency medical situations.

Policy

When use of this policy is appropriate (as outlined above), medical decisions will be made by a multi- disciplinary team whose members shall include, but not be limited to, individuals directly involved with the care of the patient. It is recommended that the multi-disciplinary team include an attending physician, nurse familiar with the patient, social worker familiar with the patient, chair or vice-chair of the ethics committee, non-medical (community) member of the ethics committee or other appropriate committee and, if available and appropriate, consulting clinicians and pastoral care staff.[5] It is very important to include on the multi-disciplinary team a person who will represent the patient's interests. Some patients may have a family member or friend who is unable or unwilling to take full responsibility for making health care decisions on behalf of the patient, but who is willing to serve as part of this team. If no such person exists, the hospital may consider including an ombudsman, patient advocate, bioethicist, community member, or other person whose role is to protect the patients' interests. If it is not practicable to include such a person on the IDT in a particular case, document the reasons therefore.

In order to determine the appropriate medical treatment for the patient, the multi-disciplinary team should:

1. Review the diagnosis and prognosis of the patient and assure itself of the accuracy thereof.
2. Determine appropriate goals of care by weighing the following considerations:
    a. Patient's previously-expressed wishes, if any and to the extent known
    b. Relief of suffering and pain
    c. Preservation or improvement of function
    d. Recovery of cognitive functions
    e. Quality and extent of life sustained
    f. Degree of intrusiveness, risk or discomfort of treatment
    g. Cultural or religious beliefs, to the extent known

3. Establish a care plan based upon the patient's diagnosis and prognosis and the determination of appropriate goals of care. The care plan should determine the appropriate level of care, including categories or types of procedures and treatments.
4. Notify the patient that:
    a. He or she has been determined incapacitated;
    b. It has been determined that he or she lacks a surrogate decision maker;
    c. Medical intervention has been prescribed; and
    d. He or she has the opportunity to seek judicial review of the above determinations.
5. A sample notification form is attached. Health care providers should modify it to fit their circumstances.
6. If the patient will be administered antipsychotic drugs, consider obtaining the review of an independent physician.
7. Limit end-of-life decisions (such as withholding or withdrawing life-sustaining treatment, or ordering hospice care) to patients who are terminally ill.

Except to the extent that such a factor is medically relevant, any medical treatment decision made pursuant to this policy shall not be biased based on the patient's age, sex, race, color, religion, ancestry, national origin, disability, marital status, sexual orientation (or any other category prohibited by law), the ability to pay for health care services, or avoidance of burden to family/others or to society.

Under the terms of this policy, the multi-disciplinary team may make the same treatment decisions, and will have the same limitations, as does an agent appointed pursuant to a power of attorney for health care specified under current law.[6,7] However, this policy shall not apply to decisions pertaining to disposition of remains, autopsies, or anatomical gifts; specific laws apply to these procedures.[8]

The multi-disciplinary team must assure itself that the medical decision is made based on sound medical advice, is in the patient's best interest and takes into account the patient's values, to the extent known. In determining the best interest of the patient, it is not required that life support be continued in all circumstances, where treatment is otherwise nonbeneficial or is medically ineffective or contrary to generally-accepted health care standards, when the patient is terminally ill and suffering, or where there is no reasonable expectation of the recovery of cognitive functions.

Agreement on Treatment

1. If all members of the multi-disciplinary team agree to the appropriateness of providing treatment, it shall be provided.
2. If all members of the multi-disciplinary team agree to the appropriateness of withholding or withdrawing treatment, it shall be withdrawn or withheld. Any implementation of a decision to withhold or withdraw life-sustaining medical treatment will be the responsibility of the primary treating physician.[9]

Disagreement on Treatment

If the members of the multi-disciplinary team disagree about the care plan, the ethics committee, ethics resource expert(s) or other resource experts will meet with the team to explore their disagreement and facilitate resolution.

1. If agreement is reached either to provide or to forgo treatment, the decision of the multi-disciplinary team then becomes final.
2. If agreement still is not reached, current treatments will be continued and any other medically necessary treatments provided, until such time that the issue is resolved through court intervention or the disagreement is otherwise resolved.[10] Court-imposed legal remedies should be sought only in extreme circumstances and as a last resort.[3]

In all cases, appropriate pain relief and other palliative care shall be continued.

Exceptional Circumstances

Legal counsel should be consulted if a decision to withdraw or withhold treatment is likely to result in the death of the patient and the situation arises in any of the following circumstances:

1. The patient's condition is the result of an injury that appears to have been inflicted by a criminal act.
2. The patient's condition was created or aggravated by a medical incident.
3. The patient is pregnant.
4. The patient is a parent with sole custody or responsibility for support of a minor child.

Documentation

Signed, dated and timed medical record progress notes will be written for the following:

1. The findings used to conclude that the patient lacks medical decision-making capacity.
2. The finding that there is no advance health care directive, no conservator, guardian or other available decision maker, and no health care instructions in the patient's medical record or other available sources.
3. The attempts made to locate surrogate decision makers and/or family members and the results of those attempts.
4. Notification to the patient that he or she has been determined to be incapable of making medical decisions, that there is no substitute decision maker available, the nature of the prescribed medical intervention, and how to seek review.
5. The bases for the decision to treat the patient and/or the decision to withhold or withdraw treatment.
6. Any information from the ethics committee or other consult, should it be convened.

End Notes

1 This policy is intended for use in general acute care hospitals. California Health and Safety Code Section 1418.8 sets forth a statutory decision-making process for patients in a skilled nursing facility or intermediate care facility.

2 California Probate Code Section 4735 states that: "A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution."

3 California Probate Code Section 4650(c) states that: "In the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment."

4 California Probate Code Section 4717 states that:

> (a) Notwithstanding any other provision of law, within 24 hours of the arrival in the emergency department of a general acute care hospital of a patient who is unconscious or otherwise incapable of communication, the hospital shall make reasonable efforts to contact the patient's agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient. A hospital shall be deemed to have made reasonable efforts, and to have discharged its duty under this section, if it does all of the following:
>
> > (1) Examines the personal effects, if any, accompanying the patient and any medical records regarding the patient in its possession, and reviews any verbal or written report made by emergency medical technicians or the police, to identify the name of any agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient.
> >
> > (2) Contacts or attempts to contact any agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient, as identified in paragraph (1).
> >
> > (3) Contacts the Secretary of State directly or indirectly, including by voice mail or facsimile, to inquire whether the patient has registered an advance health care directive with the Advance Health Care Directive Registry, if the hospital finds evidence of the patient's Advance Health Care Directive Registry identification card either from the patient or from the patient's family or authorized agent.
>
> (b) The hospital shall document in the patient's medical record all efforts made to contact any agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient.
>
> (c) Application of this section shall be suspended during any period in which the hospital implements its disaster and mass casualty program, or its fire and internal disaster program.

5 California Probate Code Section 4736 states that:

> A health care provider or health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following: (a) Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient. (b) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision. (c) Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care shall be continued.

Institutions should designate by policy the particular types and numbers of providers who may constitute the multi-disciplinary team, and should ensure that non-medical/community representatives are properly prepared to serve on the multi-disciplinary team.

6 California Probate Code Section 4617 states that:

> **"Health care decision"** means a decision made by a patient or the patient's agent, conservator, or surrogate, regarding the patient's health care, including the following: (a) Selection and discharge of health care providers and institutions. (b) Approval or disapproval of diagnostic tests, surgical procedures, and programs of

medication. (c) Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

California Probate Code Section 4683 states that: "Subject to any limitations in the power of attorney for health care: (a) An agent designated in the power of attorney may make health care decisions for the principal to the same extent the principal could make health care decisions if the principal had the capacity to do so."

7 California Probate Code Section 4652 states that: "This division does not authorize consent to any of the following on behalf of a patient: (a) Commitment to or placement in a mental health treatment facility. (b) Convulsive treatment (as defined in Section 5325 of the Welfare and Institutions Code). (c) Psychosurgery (as defined in Section 5325 of the Welfare and Institutions Code). (d) Sterilization. (e) Abortion."

8 Health and Safety Code Sections 7100 (disposition of remains), 7113 (autopsy), and 7150 *et seq.* (anatomical gift).

9 California Probate Code Section 4734 states that:

> (a) A health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience.
>
> (b) A health care institution may decline to comply with an individual health care instruction or health care decision if the instruction or decision is contrary to a policy of the institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.

10 California Probate Code Section 4736 states that:

> A health care provider or health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following: (a) Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient. (b) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision. (c) Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care shall be continued.

Sample Notification Form for Unrepresented Patients

Patient Name: _____

Your doctor, Dr. _____, has carefully evaluated your physical, medical and cognitive condition and concluded that you don't have the ability to make decisions about your medical treatment.

The hospital has tried to find a family member or friend of yours to make health care decisions for you. The hospital hasn't been able to find anyone to do that. If you have a family member or friend who you want to make health care decisions for you, please tell us.

Your doctor has recommended the following treatment, believing that this is the best treatment for you under the circumstances:

_____

_____

_____

A team of health care professionals, including your doctor and nurses and others, agrees that this is the best treatment for you.

Unless your doctor receives direction otherwise, your doctor intends to proceed with this treatment. You can ask a judge to stop this treatment. You can also ask a judge to let you make your own health care decisions. You can contact a judge at:

[Hospital to insert contact information for local Superior Court]

Here are some people who might be able to help you contact a judge:

[Hospital to list any local resources, such as an ombudsman, law school legal assistance clinic, Adult Protective Services, any assistance the local Superior Court offers, etc.]

Hospital Employee to Complete:

I gave a copy of this form to the above-named patient on _____ *[date]* at _____ *[time]* a.m./p.m.

Signature: _____

Print name: _____

ORIGINAL TO PATIENT
COPY IN MEDICAL RECORD

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

APPENDIX 2-E

Considerations for Revising the Hospital's Policy and Procedure Regarding Decision Making for Unrepresented Patients

Hospitals that have adopted the CMA/CHA/Alliance model policy, "Health Care Decisions for Unrepresented Patients," may wish to revise their policy & procedure to address the deficiencies in state law identified in the recent Superior Court case, *California Advocates for Nursing Home Reform v. Chapman*. Hospitals may wish to consider the suggestions outlined below.

☐ 1. Your policy should require that the hospital or physician notify the patient that:

a. He or she has been determined incapacitated;

b. It has been determined that he or she lacks a surrogate decision maker;

c. Medical intervention has been prescribed; and

d. He or she has the opportunity to seek judicial review of the above determinations.

The hospital may wish to develop a notification form to give to the patient (see the sample form at the end of the revised CMA/CHA Alliance Model Policy). A copy of the form can be put in the medical record to document that notice was given. This form should include the name of the physician who determined that the patient lacks capacity to make health care decisions, confirmation that the information identified in a. through d. was provided, and the type of treatment that the physician has recommended. The form may also include the address of the county Superior Court and contact information for any resources that might assist the patient if he or she wishes to contest the determinations. Resources might include a local ombudsman, law school legal assistance clinic, Adult Protective Services, any assistance the local Superior Court offers, etc.

The notification should be given to the patient sufficiently in advance of treatment to allow the patient to contest the determinations, to the extent possible. If it is inadvisable to delay treatment, this fact should be documented. How far in advance of treatment a patient should be notified will depend upon what is reasonable given all the facts and circumstances. There is no one-size-fits-all answer to this question. (Remember that the law implies consent in emergency situations, and this notification process is thus not required in emergencies.)

If the patient does not speak English sufficiently well to understand the form, an interpreter should be used. If the patient has impaired vision, appropriate auxiliary aids should be used.

If a patient is comatose, in a persistent vegetative state, or otherwise so obviously unable to comprehend this information, these circumstances should be documented.

(continued on next page)

☐ 2. Include a patient representative on the hospital's interdisciplinary team (IDT), when practicable.

Some patients may have a family member or friend who is unable or unwilling to take full responsibility for making health care decisions on behalf of the patient, but who is willing to serve as part of the IDT. If no such person exists, the hospital may consider including on the IDT an ombudsman, patient advocate, bioethicist, community member, or other person whose role is to protect the patients' interests.

If it is not practicable to include such a person on the IDT in a particular case, document the reasons therefore.

☐ 3. If the patient will be administered antipsychotic drugs, consider obtaining the review of an independent physician. There is no legal definition of "independent" — it is unclear whether the court meant that the second physician should be independent from the hospital, or from the prescribing physician, or both. Hospitals that choose to adopt a policy for independent review should make their best efforts to secure a physician that seems independent to a reasonable judge or jury.

☐ 4. Limit end of life decisions (such as withholding or withdrawing life-sustaining treatment, or ordering hospice care) to patients who are terminally ill.

☐ 5. The hospital's policy should clearly state that the patient's wishes will be taken into account when making health care decisions, to the extent those wishes are known.

☐ 6. Consider obtaining the review of an independent physician in difficult cases.

FORM 4-7

Consent to Receive Antipsychotic Medications

To: _____
(name of patient)

Your attending physician, *(physician name)* _____, has recommended that you be treated with this antipsychotic medication: _____

_____

The hospital needs to maintain a written record of your decision to consent to the administration of this medication. You may be treated with antipsychotic medications only after you have been informed of your right to accept or refuse such medications. In order to allow you to make an informed decision, you must be provided with sufficient information by the physician prescribing such medications, which must include the following:

1. The nature of your mental condition;
2. The reasons for your taking the medication, including the likelihood of your improving or not improving without such medication;
3. The reasonable alternative treatments available, if any;
4. The name and type, range of frequency of administration, range of dosage amount (including use of PRN or "as needed" order), method of administration (oral or injection), and duration of taking the medications;
5. The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur in your particular case;
6. The possible additional side effects which may occur if you take such medication longer than three months. You should have been advised that such side effects may include persistent involuntary movement of the face or mouth or might at times include similar movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued (your doctor will tell you if this possible side effect does not apply to the medication recommended for you).
7. You may refuse the medication. If you consent, you may withdraw it at any time by your stating such intention to any member of the treating staff.

Your physician is not the employee or agent of the hospital. He or she is an independent medical practitioner.

Your signature below constitutes your acknowledgment: (1) that you have read and agree to the foregoing; (2) that the medications listed above have been adequately explained and/or discussed with you by your supervising physician, and that you have received all of the information you desire concerning such medication and treatment; and (3) that you authorize and consent to the administration of such medications and treatment.

(over)

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Notations by physicians (if applicable): _____

_____

_____

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Title 9, California Code of Regulations, Sections 850-856

FORM 4-7S

Consentimiento para Recibir Medicamentos Antipsicóticos

Para: _____
(nombre del/de la paciente)

El médico que lo/la atiende *(nombre del médico)* _____, ha recomendado que usted reciba tratamiento con esta medicación antipsicótica: _____

El hospital debe mantener un registro escrito de su decisión de autorizar la administración de este medicamento. Puede recibir tratamiento con los medicamentos antipsicóticos únicamente después de que se le haya informado acerca de su derecho de aceptar o rechazar estos medicamentos. Para permitirle que tome una decisión informada, el médico que le receta estos medicamentos debe brindarle toda la información necesaria, la cual debe incluir lo siguiente:

1. La naturaleza de su enfermedad mental;
2. Los motivos por los cuales debe tomar los medicamentos, incluso la posibilidad de presentar una mejora o no sin estos medicamentos;
3. Los tratamientos alternativos razonables disponibles, si los hubiera;
4. El nombre y tipo de medicamento, la frecuencia de la administración, cantidad de dosis (incluido el uso de un pedido “según sea necesario” o PRN), método de administración (por vía oral o inyectable) y duración del tratamiento con el medicamento;
5. Los posibles efectos secundarios que habitualmente se presentan con estos medicamentos y cualquier otro efecto secundario que pueda presentarse en su caso en particular;
6. Los posibles efectos secundarios adicionales que pueden presentarse si toma este medicamento por más de tres meses. Es importante que le hayan informado que tales efectos secundarios pueden incluir: movimiento involuntario persistente en el rostro o en la boca o, en ocasiones, puede incluir movimientos similares en las manos y pies. También se le debe haber informado que estos síntomas de discinesia tardía posiblemente sean irreversibles y que pueden aparecer después de haber suspendido el tratamiento con el medicamento (su médico le dirá si este posible efecto secundario no se aplica al medicamento que le recomendaron).
7. Puede negarse a recibir el medicamento. Si da su consentimiento, puede retirarlo en cualquier momento. Para ello, debe avisarle a cualquier miembro del personal que lo atiende.

Su médico no es empleado o agente del hospital. Es un profesional de la salud independiente

Su firma a continuación confirma lo siguiente: (1) que leyó y está de acuerdo con lo que se menciona anteriormente; (2) que el médico que lo supervisa le explicó de manera adecuada todo sobre los medicamentos que se mencionan anteriormente, y que recibió toda la información relacionada con dicho medicamento y el tratamiento; y (3) que autorizó y dio su consentimiento para la administración de estos medicamentos y para el tratamiento.

(sobre)

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente/representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

Anotaciones del médico (si corresponde): _____

_____

_____

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Title 9, California Code of Regulations, Sections 850-856

FORM 8-1

Conditions of Admission

Patient's Name: _____

Consent to Medical and Surgical Procedures

I consent to the procedures that may be performed during this hospitalization or while I am an outpatient. These may include, but are not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, telehealth services, anesthesia, or hospital services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in this hospital.

Nursing Care

This hospital provides only general nursing care and care ordered by the physician(s). If I want a private duty nurse, I agree to make such arrangements. The hospital is not responsible for failure to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide this additional care.

Legal Relationship Between Hospital and Physicians

All physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist and others, are not employees, representatives or agents of the hospital. They have been granted the privilege of using the hospital for the care and treatment of their patients, but they are not employees, representatives or agents of the hospital. They are independent practitioners.

Patient initials: _____

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

Maternity Patients

If I deliver an infant(s) while a patient of this hospital, I agree that these same Conditions of Admission apply to the infant(s).

Personal Belongings

As a patient, I am encouraged to leave personal items at home. The hospital maintains a fireproof safe for the safekeeping of money and valuables. The hospital is not liable for the loss or damage to any money, jewelry, documents, eyeglasses, dentures, hearing aids, cell phones, laptops, other personal electronic devices, or other articles that are not placed in the safe. Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars ($500) unless I receive a written receipt for a greater amount from the hospital.

Financial Agreement

I agree to promptly pay all hospital bills in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. I understand that I may review the hospital's charge description master before (or after) I receive services from the hospital. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

Patient initials: _____

Assignment of All Rights and Benefits

I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurer or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by, this hospital to perfect, confirm, or validate this assignment.

Health Plan Contracts

This hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from the financial office. All physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services. It is my responsibility to determine if the hospital or the physicians providing services to me contract with my health plan.

I certify that I have read the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Signature: _____
(witness)

Print name: _____
(witness)

Financial Responsibility Agreement by Person Other Than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Contracts provisions above.

Date: _____ Time: _____ AM / PM

Signature: _____
(financially responsible party)

Print name: _____
(financially responsible party)

Address: _____

_____

Phone number: _____

Signature: _____
(witness)

Print name: _____
(witness)

A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT.

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

FORM 8-1S

Condiciones para la Admision

Nombre del Paciente: _____

Consentimiento a Procedimientos Médicos y Quirúrgicos

Doy mi consentimiento a los procedimientos que podrían efectuarse durante esta hospitalización o mientras sea paciente externo. Estos podrían incluir, entre otros, tratamiento o servicios de emergencia, procedimientos de laboratorio, rayos X, tratamientos o procedimientos médicos o quirúrgicos, servicios de salud telefónicos, anestesia, o servicios de hospital que se me proporcionen, sin limitarse a éstos, bajo las instrucciones generales y especiales de mi médico o cirujano. Entiendo que la práctica de la medicina y la cirugía no constituyen ciencias exactas y que el diagnóstico y tratamiento pueden conllevar riesgo de lesión y hasta de muerte. Reconozco que no se han hecho garantías respecto al resultado del examen o tratamiento en este hospital.

Atención de Enfermería

Este hospital suministra únicamente atención de enfermería general, y atención solicitada por el(los) médico(s). Si deseo un(a) enfermero(a) privado(a), estoy de acuerdo en hacer los arreglos necesarios. El hospital no es responsable en caso de que no se proporcionara un(a) enfermero(a) privado(a) y por medio del presente queda eximido de cualquier y toda responsabilidad que se origine a partir del hecho de que el hospital no proporciona esta atención adicional.

Los Médicos Son Practioners Medicos Independientes

Todos los médicos y cirujanos que me proporcionen servicios, incluido el radiólogo, patólogo, médico de emergencias, anestesiólogo y otros, no son empleados, representantes ni agentes del hospital. Se les ha otorgado el privilegio de utilizar el hospital para la atención y el tratamiento de sus pacientes, pero no son empleados, representantes o agentes del hospital. Son profesionales independientes.

Iniciales del paciente: _____

Entiendo que estoy bajo la atención y supervisión de mi médico. El hospital y su personal de enfermería son responsables del cumplimiento de las instrucciones de mi médico. Es la responsabilidad de mi médico o cirujano obtener el consentimiento informado del paciente, en caso necesario, para el tratamiento médico o quirúrgico, los procedimientos diagnósticos o terapéuticos especiales, o los servicios de hospital que me proporcionen bajo las instrucciones generales y especiales de mi médico.

Pacientes de Maternidad

Si diera a luz a mi bebé como paciente de este hospital, estoy de acuerdo en que estas mismas Condiciones de Admisión se aplicarán al bebé.

Objetos Personales

Como paciente, se me aconseja que deje mis artículos personales en casa. El hospital tiene una caja fuerte a prueba de incendios para el depósito de dinero y objetos de valor. El hospital no se hace responsable por el daño o por la pérdida de dinero, joyas, documentos, anteojos, dentaduras, audífonos para la sordera, teléfonos celulares, computadoras portátiles, otros dispositivos electrónicos personales o artículos no depositados en la caja fuerte. La responsabilidad del hospital por la pérdida de bienes personales depositados en la caja fuerte del hospital para su protección se limita a quinientos dólares ($500) a menos que el hospital me entregue un recibo por una cantidad mayor.

Acuerdo Sobre la Responsabilidad Financiera

Estoy de acuerdo en pagar puntualmente todas las factures del hospital según los cargos que aparezcan en el detalle de cargos de la factura principal del hospital y, en caso aplicable, las políticas del programa de atención médica de caridad y pago con descuento, y las leyes estatales y federales. Entiendo que puedo revisar el archivo maestro de descripción de cargos del hospital antes (o después) de recibir los servicios de esta institución. Entiendo que todos los médicos y cirujanos, incluido el radiólogo, patólogo, médico de emergencias, anestesiólogo y otros, facturarán sus servicios por separado. En caso de que la cuenta se entregue a un abogado o a una agencia de cobranzas para conseguir la liquidación, pagaré los honorarios del abogado y los costos de la cobranza. Todas las cuentas vencidas acumularán intereses a la tasa legal a menos de que la ley lo prohíba.

Asignación de Todos los Derechos y Beneficios

Irrevocablemente asigno y transfiero al hospital todos los derechos, beneficios y demás intereses en relación con cualquier plan de seguros, plan de beneficios de salud u otra fuente de pago para mi atención. Esta asignación incluirá la asignación y autorización del pago directo al hospital de todos los beneficios del seguro y del plan de salud pagaderos por esta hospitalización o por los servicios de paciente externo. Estoy de acuerdo con que el pago de la compañía de seguros o el plan de pagos al hospital según lo acordado en esta autorización deberá cubrir las obligaciones de la compañía de seguros o del plan hasta donde abarque dicho pago. Entiendo que soy financieramente responsable de cargos que no se paguen de acuerdo con esta asignación, en la medida que lo permita la ley estatal o federal. Acepto cooperar con el hospital, y realizar todo lo que este solicite de manera razonable, para perfeccionar, confirmar o validar esta asignación.

Contratos del Plan de Atención Médica

Este hospital mantiene una lista de los planes de atención médica con los que tiene contrato. A petición, se encuentra disponible una lista de estos planes en la oficina de finanzas. Todos los médicos y cirujanos, incluido el radiólogo, patólogo, médico de emergencias, anestesiólogo y otros, facturarán sus servicios por separado. Es mi responsabilidad determinar si el hospital o los médicos que me proporcionan servicios tienen algún contrato con mi plan de salud.

Doy fe de que he leído lo anterior y que he recibido una copia del documento. Soy el paciente, el representante legal del paciente o estoy autorizado por el paciente para firmar este documento y aceptar sus términos y condiciones en su nombre.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

Firma: _____
(testigo)

Nombre en letra de imprenta: _____
(testigo)

Acuerdo de Responsabilidad Financiera por Parte de una Persona que no Sea el Paciente ni el Representante Legal del Paciente

Estoy de acuerdo en aceptar la responsabilidad financiera por los servicios prestados al paciente y en aceptar las condiciones del Acuerdo sobre la Responsabilidad Financiera, de la Asignación de Beneficios de Seguro, y de las disposiciones de la Obligación de un Plan de Atención Médica expuestos anteriormente.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(persona con responsabilidad financiera)

Nombre en letra de imprenta: _____
(persona con responsabilidad financiera)

Dirección: _____

_____

Teléfono: _____

Firma: _____
(testigo)

Nombre en letra de imprenta: _____
(testigo)

A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT.

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

MH APPENDIX 9-A

Medical Necessity for MHP Coverage

For MHP coverage as a **psychiatric inpatient service or an emergency psychiatric condition**, the patient must meet the following:	
Has one of the following diagnoses in the DSM-IVE: • Pervasive development disorders; • Disruptive behavior and attention deficit disorders; • Feeding and eating disorders of infancy or early childhood; • Tic disorders; • Elimination disorders; • Other disorders of infancy, childhood, or adolescence, cognitive disorders (dementia with delusions or depressed mood); • Substance induced disorders (with psychotic, mood, or anxiety disorder); • Schizophrenia and other psychotic disorders; • Mood disorders; • Anxiety disorders; • Somatoform disorders; • Dissociative disorders; • Eating disorders; • Intermittent explosive disorder; • Pyromania; • Adjustment disorders; • Personality disorders.	Cannot be safely treated at a lower level of care and Requires psychiatric inpatient hospital services as the result of a mental disorder as the result of one of the following: • Has symptoms or behaviors due to a mental disorder that: — Represent a current danger to self or others, or significant property destruction; — Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter; — Present a severe risk to the beneficiary's physical health; or — Represent a recent, significant deterioration in ability to function. • Requires admission for one of the following: — Further psychiatric evaluation; — Medication treatment; or — Other treatment that can reasonably be provided only if the patient is hospitalized.

[Title 9, California Code of Regulations, Section 1820.205]

For MHP coverage for **outpatient specialty mental health services**, the patient and/or service must meet the following:

Has one of the following diagnoses in the DSM-IVE:

- Pervasive developmental disorders, except autistic disorders
- Disruptive behavior and attention deficit disorders
- Feeding and eating disorders of infancy and early childhood
- Elimination disorders
- Other disorders of infancy, childhood, or adolescence
- Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition
- Mood disorders, except mood disorders due to a general medical condition
- Anxiety disorders, except anxiety disorders due to a general medical condition
- Somatoform disorders
- Factitious disorders
- Dissociative disorders
- Paraphilias
- Gender identity disorder
- Eating disorders
- Impulse control disorders not elsewhere classified
- Adjustment disorders
- Personality disorders, excluding antisocial personality disorder
- Medication-induced movement disorders related to other included diagnoses

Have one of the following impairments as a result of the mental disorder(s) on the left:

- A significant impairment in an important area of life functioning
- A reasonable probability of significant deterioration in an important area of life functioning
- Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years

and the service meets each of the following criteria:

- The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.
- The expectation is that the proposed intervention will:
  - Significantly diminish the impairment, or
  - Prevent significant deterioration in an important area of life functioning, or
  - Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
  - For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).
- The condition would not be responsive to physical health care-based treatment.

[Title 9, California Code of Regulations, Section 1830.205]

For MHP coverage for **outpatient specialty mental health services for eligible beneficiaries under 21 years of age**, the patient and/or service must meet the following:	
Has one of the following diagnoses in the DSM-IVE: • Pervasive developmental disorders, except autistic disorders • Disruptive behavior and attention deficit disorders • Feeding and eating disorders of infancy and early childhood • Elimination disorders • Other disorders of infancy, childhood, or adolescence • Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition • Mood disorders, except mood disorders due to a general medical condition • Anxiety disorders, except anxiety disorders due to a general medical condition • Somatoform disorders • Factitious disorders • Dissociative disorders • Paraphilias • Gender identity disorder • Eating disorders • Impulse control disorders not elsewhere classified • Adjustment disorders • Personality disorders, excluding antisocial personality disorder • Medication-induced movement disorders related to other included diagnoses	The beneficiary has a condition that would not be responsive to physical health care-based treatment, and The services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services with respect to the mental disorder.[1]

[Title 9, California Code of Regulations, Section 1830.210]

1 Other standards apply for eligibility for targeted case management.

APPENDIX MH 9-B

Types of MCPs and MHPs

Identifying the Players and Governing Authorities

Medi-Cal Managed Care Plans

There are three main models of Medi-Cal managed care plans, including county-operated health systems (COHS), geographic managed care plans and two-plan model/regional model plans. The COHS serve beneficiaries in Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura and Yolo Counties. Geographic managed care serves beneficiaries in Sacramento and San Diego Counties. All other counties, with the exception of San Benito that has a unique Medi-Cal managed care program, are served through a two-plan, modified two-plan or regional model.

Non-COHS Medi-Cal managed care plans are subject to a myriad of rules: federal Medicaid laws, the 1115 waiver, state Medi-Cal laws, the contracts between the non-COHS Medi-Cal plans and the state and the Knox-Keene Act. The state has adopted laws governing non-COHS Medi-Cal managed care plans.

Unlike non-COHS Medi-Cal managed care plans, COHS Medi-Cal managed care plans are subject to few state laws and are exempt from certain federal requirements. They are also exempt from Knox-Keene licensure with respect to their Medi-Cal lines of business. However, they continue to be subject to the 1115 waiver and certain legal requirements are made applicable to them pursuant to their contracts with the state.

Cal MediConnect Plan

Cal MediConnect plans operate in seven counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara) and administer the Medi-Cal and Medicare benefits for dual-eligible beneficiaries enrolled in the Cal MediConnect program.

Cal MediConnect plans are subject to the plans' three-way contracts with CMS and DHCS, the memorandum of understanding between DHCS and CMS and state and federal laws governing dual demonstration projects. In addition, non-COHS Cal MediConnect plans are subject to the Knox-Keene Act. In some areas, the Cal MediConnect plans apply Medicare Advantage rules when the patient is receiving services that would have otherwise been covered by Medicare if the patient was not enrolled in Cal MediConnect. In these situations, if the patient is receiving care that would have otherwise been covered by Medi-Cal, then the plans apply Medi-Cal rules.

County Mental Health Plan

County mental health plans operate as prepaid inpatient health plans under federal law. They are subject to the state's 1915(b) Medi-Cal Specialty Mental Health Services Waiver, their contracts with the state, federal laws governing prepaid inpatient health plans and applicable state law. They are not health care service plans subject to the Knox- Keene Act.

Pertinent DHCS Plan Letters

MMCD 00-01 Excerpt *(Redlines from Revised Guidance from DHCS)*

Emergency Services and Care

The assignment of financial responsibility to the Plan or the MHP for charges resulting from ~~emergency~~ services to determine whether a psychiatric emergency exists under the conditions provided in Title 9, CCR, Section 1820.225~~, and the care and treatment necessary to relieve or eliminate the emergent condition~~ is generally determined by:

- The diagnosis assigned to the emergent condition;
- The type of professional performing the services; and
- Whether such services result in the admission of the Plan member for psychiatric inpatient hospital services at the same or a different facility.

It is suggested that the assignment of financial responsibility for emergency room facility charges and professional services be addressed as a component of the MOU.

Emergency Room Facility Charges and Professional Services

Financial responsibility for charges resulting from the emergency services and care of a Plan member whose condition meets the medical necessity criteria for coverage by the MHP is contractually assigned as follows:

- The Plan shall cover and pay for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility.
- The MHP ~~shall cover and pay~~ is responsible for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do result in the admission of the member for psychiatric inpatient hospital services at the same facility. The facility charge is not paid separately, but is included in the per diem rate for the inpatient stay.
- ~~The Plan shall cover and pay for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria at a hospital that does not provide psychiatric inpatient hospital services, when such services and care do result in the transfer and admission of the member to a hospital or psychiatric health facility that does provide psychiatric inpatient hospital services. The Plan is not responsible for the separately billable facility charges related to the professional services of a mental health specialist at the hospital of assessment. The MHP may pay this charge, depending on its arrangement with the hospital.~~

- The MHP is responsible for facility charges directly related to the professional services of a mental health specialist provided in the emergency room when these services do not result in an admission of the member for psychiatric inpatient hospital services at that facility or any other facility.
- ~~The Plan shall cover and pay for the medical professional services required for the emergency services and care of a member whose condition meets MHP medical necessity criteria when such services and care~~ do not result in the admission ~~of the member for psychiatric inpatient hospital services.~~
- The MHP shall cover and pay for the professional services of a mental health specialist ~~required for the emergency services and care of~~ provided in an emergency room to a Plan member whose condition meets MHP medical necessity criteria or when mental health specialist services are required to assess whether MHP medical necessity is met ~~when such services and care~~ do result in the admission ~~of the member for psychiatric inpatient hospital services~~.
- The Plan shall cover and pay for all professional services except the professional services of a mental health specialist, when required for the emergency services and care of a member whose condition meets MHP medical necessity criteria.

Payment responsibility for charges resulting from the emergency services and care of a Plan member with an excluded diagnosis or for a plan member whose condition does not meet MHP medical necessity criteria shall be assigned as follows:

- The plan shall cover and pay for the facility charges and the medical professional services required for the emergency services and care of a Plan member with an excluded diagnosis or a Plan member whose condition does not meet MHP medical necessity criteria and such services and care do not result in the admission of the member for psychiatric inpatient hospital services.
- Payment for the professional services of a mental health specialist required for the emergency services and care of a Plan member with an excluded diagnosis is the responsibility of the Medi-Cal FFS system.

NOTE: Effective Jan. 1, 2000, SB 349 (Chapter 544, Statutes of 1999), redefines the definition of emergency services and care as it applies only to health care service plans where coverage for mental health is included as a benefit. SB 349 redefines the Health and Safety Code definition of emergency services and care to include an additional screening, examination, and evaluation to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric medical condition, within the capability of the facility. The provisions of SB 349 are a clarification of the definition of emergency services and care and a clarification of an existing responsibility and not the addition of a new responsibility. SB 349 does not change the assigned responsibilities of the Plan and the MHP to pay for emergency services as described above.

Matrix of Managed Care Plan, Mental Health Plan Responsibilities — Sample

Responsibility	Type of Service	Included Diagnosis and Meets MHP Impairment and Intervention Criteria	Excluded Diagnosis	Included Diagnosis, But Does Not Meet MHP Impairment and Intervention Criteria
Emergency Departments	Facility Charges	MCP for initial triage and medical services MHP for any facility charges related to a covered psychiatric service **NOTE:** When a beneficiary is admitted to a psychiatric bed at the same facility, there is no separate payment for the ER by the MHP or the MCP	MCP	MCP
	Psychiatric Professional Services	MHP	EDS	No MHP, MCP, or EDS payment
	Medical Professional Services	MCP	MCP	MCP

DHCS Chart: Medi-Cal Mental Health Services

DIMENSION	MEDI-CAL[1]	MHP[2] OUTPATIENT	MHP INPATIENT
ELIGIBILITY	Mild to Moderate Impairment in Functioning A member is covered by the MCP for services if he or she is diagnosed with a mental health disorder as defined by the current DSM[3] resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning: • Primary care providers identify the need for a mental health screening and refer to a specialist within their network. Upon assessment, the mental health specialists can assess the mental health disorder and the level of impairment and refer members that meet medical necessity criteria to the MHP for a Specialty Mental Health Services (SMHS) assessment. • When a member's condition improves under SMHS and the mental health providers in the MCP and MHP coordinate care, the member may return to the MH provider in the MCP network. **NOTE:** Conditions that the current DSM identifies as relational problems are not covered, i.e., couples counseling or family counseling.	Significant Impairment in Functioning A member is eligible for services if he or she meets all of the following medical necessity criteria: 1. Has an included mental health diagnosis;[4] 2. Has a significant impairment in an important area of life function, or a reasonable probability of significant deterioration in an important area of life function, or a reasonable probability of not progressing developmentally as individually appropriate; 3. The focus of the proposed treatment is to address the impairment(s) described in #2; 4. The expectation that the proposed treatment will significantly diminish the impairment, prevent significant deterioration in an important area of life function, and 5. The condition would not be responsive to physical health care-based treatment. **NOTE:** For members under age 21 who meet criteria for EPSTD specialty mental health services, the criteria allow for a range of impairment levels[5] and include treatment that allows the child to progress developmentally as individually appropriate.	Emergency and Inpatient A member is eligible for services if he or she meets the following medical necessity criteria: 1. An included diagnosis; 2. Cannot be safely treated at a lower level of care; 3. Requires inpatient hospital services due to one of the following which is the result of an included mental disorder: a. Symptoms or behaviors which represent a current danger to self or others, or significant property destruction; b. Symptoms or behaviors which prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter; c. Symptoms or behaviors which present a severe risk to the beneficiary's physical health; d. Symptoms or behaviors which represent a recent, significant deterioration in ability to function; e. Psychiatric evaluation or treatment which can only be performed in an acute psychiatric inpatient setting or through urgent or emergency intervention provided in the community or clinic; and f. Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.

DIMENSION	MEDI-CAL[1]	MHP[2] OUTPATIENT	MHP INPATIENT
SERVICES	Mental health services when provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license: • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient services for the purposes of monitoring medication therapy • Outpatient laboratory, medications, supplies, and supplements • Psychiatric consultation	Medi-Cal Specialty Mental Health Services: • Mental Health Services — Assessment — Plan development — Therapy — Rehabilitation — Collateral • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential • Adult Crisis Residential • Crisis Intervention • Crisis Stabilization • Targeted Case Management	• Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital

1 Medi-Cal Managed Care Plan.

2 County Mental Health Plan Medi-Cal Specialty Mental Health Services.

3 Current policy is based on DSM IV and will be updated to DSM 5 in the future.

4 As specified in Title 9, CCR, Sections 1820.205 and 1830.205 for adults and 1830.210 for those under age 21.

5 See footnote 4

Pertinent Legal Definitions of Emergency Psychiatric Conditions

FEDERAL DEFINITIONS			CALIFORNIA DEFINITIONS	
EMTALA Definition	**Medicaid Definition**		**California Hospital Licensing Definition**	**Medi-Cal MHP Definition**
"Emergency medical condition"	"Emergency medical condition"		"Psychiatric emergency medical condition"	"Emergency psychiatric condition"
a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in	a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in		a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following —	a condition that meets the criteria in Section 1820.205[1] when the beneficiary with the condition, due to a mental disorder —
(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;	(i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child, or		(i) an immediate danger to himself or herself or to others, or	(i) is a current danger to self or others, or
(ii) serious impairment to bodily functions; or	(ii) serious impairment to bodily functions; or		(ii) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.	(ii) immediately unable to provide for or utilize, food, shelter or clothing, and
(iii) Serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions (i) that there is inadequate time to effect a safe transfer to another hospital before delivery; or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.	(iii) serious dysfunction of any bodily organ or part.			(iii) requires psychiatric inpatient hospital or psychiatric health facility services.

1 Title 9, CCR Section 1820.205 defines the term "medical necessity." See Appendix A.

FORM 12-1

Request for Voluntary Admission and Authorization for Treatment

Psychiatric Unit: _____

I hereby request admission to the above-named psychiatric unit and consent to the care and treatment ordered by my attending physician or his or her associates. I understand that these physicians are independent contractors and are not employees or agents of the hospital.

If my request is granted, I agree to conform to all the rules and regulations of the unit. If I wish to leave the hospital, I will give notice of my desire to leave to a hospital staff member and will complete all usual discharge or temporary absence procedures.

I understand that the hospital may inventory my personal belongings and possessions and remove items it considers potentially dangerous to my safety and welfare, or to the safety and welfare of other patients, visitors, or hospital staff.

I understand that my attending physician may wish to permit me the maximum amount of freedom of action commensurate with my condition, as this may be an important factor in my treatment program. This freedom of action may lead to possible self-injury and I release the hospital, its employees and agents, as well as my attending physician or his or her associates, from any and all responsibility in case such freedom leads to injury, except where the injury was the proximate result of negligence on the part of the hospital, its employees and agents, or my attending physician and his or her associates.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

(over)

Certificate of Attending Physician

I hereby certify that I am the attending physician of the above-named patient, that I have examined the patient with reference to mental condition and, based on that examination, it is my opinion that the patient understands the nature of the admission to the psychiatric unit of this hospital and the care and treatment to be rendered, and that the patient was mentally competent at the time of the examination to make this application for admission.

Additional comments: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

FORM 12-1S

Solicitud de Admisión Voluntaria y Autorización Para el Tratamiento

Unidad psiquiátrica: _____

Por la presente, solicito la admisión a la unidad psiquiátrica mencionada anteriormente y doy mi consentimiento para la atención y el tratamiento que ordenó el médico que me atiende o sus colaboradores. Entiendo que estos médicos son contratistas independientes y que no son empleados ni agentes del hospital.

Si se concede mi solicitud, me comprometo a cumplir con todas las normas y los reglamentos de la unidad. En el caso de que desee dejar el hospital, informaré sobre mi deseo de irme a un miembro del personal del hospital y llevaré a cabo todos los procedimientos normales para que me den de alta o la ausencia temporal.

Entiendo que el hospital puede hacer un inventario de mis efectos personales y pertenencias, y quitarme los elementos que considere potencialmente peligrosos para mi seguridad y bienestar, o para la seguridad y el bienestar de otros pacientes, visitantes o miembros del personal del hospital.

Entiendo que el médico que me atiende puede considerar conveniente permitirme la máxima cantidad de libertad de acción que sea acorde a mi enfermedad, ya que esto puede ser un factor importante en mi programa de tratamiento. Esta libertad de acción podría conducirme a posibles autolesiones, y eximo al hospital, a sus empleados y agentes, y al médico que me atiende o a sus colaboradores de toda responsabilidad en caso de que tal libertad me conduzca a lesiones, excepto si la lesión fuera consecuencia inmediata de la negligencia por parte del hospital, sus empleados y agentes, o del médico que me atiende y sus colaboradores.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente/representante legal)

En caso de que lo firmase una persona que no sea el paciente, indique la relación: _____

Nombre en letra de imprenta: _____
(representante legal)

(sobre)

Certificate of Attending Physician

I hereby certify that I am the attending physician of the above-named patient, that I have examined the patient with reference to mental condition and, based on that examination, it is my opinion that the patient understands the nature of the admission to the psychiatric unit of this hospital and the care and treatment to be rendered, and that the patient was mentally competent at the time of the examination to make this application for admission.

Additional comments: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

FORM 12-2

Statement of Professional Person Responsible for Minor's Admission

(To be placed in minor's medical record.)

Minor's Name: _____

I affirm that the above-named minor meets the following criteria:

1. The minor has a mental health disorder, or a mental health disorder and a substance abuse disorder.
2. Inpatient treatment in this facility is reasonably likely to be beneficial to the minor's mental health disorder.
3. Inpatient treatment in this facility is the least restrictive, most appropriate available setting in which to treat the minor, within the constraints of reasonably available services, facilities, resources, and financial support.

I have provided the minor's admitting parent or guardian with a full explanation, both orally and in writing, of the facility's treatment philosophy, including, where applicable, the use of seclusion, restraints, medications, and the extent of family involvement.

Date: _____ Time: _____ AM / PM

Signature: _____
(hospital representative)

Print name: _____
(hospital representative)

Title: _____

Reference: Welfare & Institutions Code Sections 6002.10 and 6002.15(a) and (b)

FORM 12-3

Notice to Minors

You are entitled to an independent clinical review of your continued inpatient treatment at this facility. This review must be requested within 10 days of your admission. If you request such a review, the patients' rights advocate will provide you with information and assistance related to this review.

You will be provided a booklet published by the California Department of Health Care Services describing the rights of minors in mental health facilities. The booklet will include the telephone number of the patients' rights advocate and the hours that the advocate may be reached.

Please sign below indicating your receipt of this Notice to Minors.

I have received the Notice to Minors.

Date: _____ Time: _____ AM / PM

Signature: _____
(minor)

Print name: _____
(minor)

Witness by Facility Representative (required):

Date: _____ Time: _____ AM / PM

Signature: _____
(facility representative)

Print name: _____
(facility representative)

Title: _____
(facility representative)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Welfare and Institutions Code Section 6002.15(c)

FORM 12-3S

Aviso a los Menores de Edad

Usted tiene derecho a una revisión clínica independiente respecto a su tratamiento continuado como paciente interno de esta institución. Esta revisión deberá ser solicitada dentro de los díez días siguientes a su admisión. Si usted solicita dicha revisión, el defensor de los derechos de los pacientes le proporcionará la información y asistencia relativas a esta revisión.

Usted recibirá un folleto publicado por el Departamento de Servicios de Salud del estado, describiendo los derechos de los menores de edad en las instituciones de salud mental. El folleto incluirá el teléfono del defensor de los derechos de los pacientes y el horario en que usted puede comunicarse con dicho defensor.

Por favor firme al calce, indicando que ha recibido este Aviso a los Menores de Edad.

He recibido el Aviso a los Menores de Edad.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(menor)

Nombre en letra de imprenta: _____
(menor)

Witness by Facility Representative (required):

Date: _____ Time: _____ AM / PM

Signature: _____
(facility representative)

Print name: _____
(facility representative)

Title: _____
(facility representative)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Welfare and Institutions Code Section 6002.15(c)

FORM 12-4

Certification of Admitting Physician

The undersigned does hereby certify that he/she:

1. Is a physician and surgeon licensed to practice in the State of California,
2. Is a member of the attending staff or is otherwise authorized by a facility designated by the county and approved by the California Department of Health Care Services as a facility for 72-hour treatment and evaluation,
3. Has made a physical and mental examination of the patient, considered the historical course of the patient's mental disorder, if that information was available, and
4. Believes that there is probable cause to believe that the patient is, as a result of mental health disorder:

   ☐ A danger to others ☐ A danger to himself/herself ☐ Gravely disabled

And for that reason requires hospital admission for evaluation or treatment on other than a voluntary inpatient or outpatient basis.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

Reference: Welfare and Institutions Code Section 5150

FORM 12-5

Application for Involuntary Admission — Inebriates

Pursuant to Welfare and Institutions Code Section 5170 *et seq.*

I, the undersigned, being one of the following persons:

☐ Staff member of a designated facility ☐ Other designated professional person

☐ A peace officer

State that as a result of my personal observations, there is probable cause to believe that (name of patient) _____, as a result of inebriation, is:

☐ A danger to others ☐ A danger to himself/herself ☐ Gravely disabled

I have advised the patient of his/her rights: ☐ Yes ☐ No

The patient's condition was brought to my attention by the following circumstances:

_____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(staff member/peace officer/other)

Print name: _____
(staff member/peace officer/other)

Certificate of Admitting Physician

The undersigned does hereby certify that he/she: (1) is a physician and surgeon licensed to practice in the State of California, (2) is a member of the attending staff (or is otherwise authorized by) a facility designated by the county and approved by the California Department of Alcohol and Drug Programs as a facility for 72-hour treatment and evaluation of inebriates, (3) has made a physical and mental examination of the patient, and (4) believes that there is probable cause to believe that the patient is, as a result of inebriation, is:

☐ A danger to others ☐ A danger to himself/herself ☐ Gravely disabled

and for that reason requires hospital admission for evaluation or treatment on other than a voluntary inpatient or outpatient basis.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

FORM 12-6

Notice of Certification for Intensive Treatment

Pursuant To: *(Check applicable box)*

- ☐ ***Welfare and Institutions Code 5250 (Additional 14 days of intensive treatment)***
- ☐ ***Welfare and Institutions Code 5270.15 (Additional 30 days of intensive treatment)***

The authorized agency providing evaluation services in the County of _____ has evaluated the condition of:

Name: _____ Age: _____ Sex: ____ Marital Status: _____

Address: _____

_____

We, the undersigned, allege that the above-named person is, as a result of mental health disorder or impairment by chronic alcoholism *(check all applicable boxes)*:

- ☐ A danger to others
- ☐ A danger to himself/herself
- ☐ Gravely disabled as defined in Welfare and Institutions Code Section 5008(h)(1)

The specific facts which form the basis for our opinion that the above-named person meets one or more of the classifications indicated above are as follows *(certifying persons to detail facts)*: _____

_____

_____

The above-named person has been informed of this evaluation, and has been advised of the need for, but has not been able or willing to accept treatment on a voluntary basis, or to accept referral to, the following services: _____

_____

Therefore we certify the above-named person to receive intensive treatment related to the mental health disorder or impairment by chronic alcoholism beginning this ____ day of *(month)* _____, 20_____, in the intensive treatment facility named: _____.

We hereby state that we delivered a copy of this notice this day to the above-named person. We informed him or her that unless judicial review is requested, a certification review hearing will be held within four days of the date on which the person is certified for a period of intensive treatment to determine whether or not probable cause exists to detain him or her for intensive treatment related to the mental health disorder or impairment by chronic alcoholism. We informed the above-named person that an attorney or advocate will visit him or her to provide assistance in preparing for the hearing or to answer questions regarding his or her commitment or to provide other assistance. The court has been notified of this certification on this day.

(over)

Also, on this day the above-named person has been informed of his/her legal right to a judicial review by habeas corpus, and the term "habeas corpus" has been explained to him/her, and that he/she has been informed of his/her right to counsel, including court-appointed counsel pursuant to Welfare and Institutions Code Section 5276.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician/staff member of facility)

Print name: _____
(physician/staff member of facility)

Date: _____ Time: _____ AM / PM

Signature: _____
(representing intensive treatment facility)

Print name: _____
(representing intensive treatment facility)

Date: _____ Time: _____ AM / PM

Signature: _____
(countersignature)

Print name: _____
(countersignature)

COPIES:

Patient: _____

Patient's attorney or representative: _____

Other person designated by patient: _____

Superior Court (to be submitted with the psychiatric certification review hearing decision)

Reference: Welfare and Institutions Code Section 5252 to 5254.1

FORM 12-6S

Aviso de Certificación Para Tratamiento Intensivo

Conforme Al: *(Marque la casilla que corresponda)*

- ☐ ***Código de Instituciones y Bienestar 5250 (14 días adicionales de tratamiento intensivo)***
- ☐ ***Código de Instituciones y Bienestar 5270.15 (30 días adicionales de tratamiento intensivo)***

El organismo autorizado que brinda los servicios de evaluación en el Condado de _____ _____ha evaluado el estado de salud de:

Nombre: _____ Edad: _____ Sexo: ___ Estado civil: ____

Dirección: _____

_____

Nosotros, los suscritos, declaramos que la persona antes mencionada es así, como resultado de un trastorno de salud mental o deterioro por alcoholismo crónico (marque todas las casillas correspondientes):

- ☐ Representa un peligro para los demás
- ☐ Representa un peligro para sí mismo/misma
- ☐ Presenta una discapacidad grave según lo define la sección 5008(h)(1) del Código de Instituciones y Bienesta

Los hechos específicos que fundamentan nuestra opinión de que la persona que se menciona anteriormente cumple con una o más de las clasificaciones antes indicadas son los siguientes *(personas certificadas para detallar los hechos)*: _____

_____

La persona mencionada anteriormente fue informada sobre esta evaluación y se le notificó sobre la necesidad de recibir los siguientes servicios, pero no puede o no está dispuesto a aceptar la derivación ni el tratamiento de manera voluntaria: _____

_____

Por lo tanto, certificamos para que la persona antes mencionada reciba un tratamiento intensivo relacionado con trastorno de salud mental o deterioro por alcoholismo crónico que comenzará el día _____ de *(mes)*_____ de 20_____, en el centro de tratamiento intensivo llamado: _____.

Por la presente declaramos que hemos entregado una copia de este aviso el día de la fecha indicada a la persona antes mencionada. Le informamos a él o a ella que a menos que se solicite una revisión judicial, se realizará una audiencia de revisión de la certificación dentro de los cuatro días a partir de la fecha en la que la persona se certifique para un período de tratamiento intensivo, para determinar si existe o no una causa probable para detenerlo a él o ella para tratamiento intensivo relacionado con un trastorno de salud mental o deterioro por alcoholismo crónico.

(sobre)

Hemos informado a la persona antes mencionada que un abogado o defensor lo visitará a él o ella para brindar asistencia en la preparación de la audiencia o para responder preguntas sobre su compromiso o proporcionar otro tipo de asistencia. La corte ha sido notificada de esta certificación el día de la fecha indicada.

Además, en el día de la fecha, la persona mencionada anteriormente fue notificada sobre su derecho legal a una revisión judicial mediante el hábeas corpus, se le explicó el significado del término "hábeas corpus", y se le informó acerca de su derecho a recibir asesoramiento, lo que incluye la asignación de un abogado por parte del tribunal según la sección 5276 del Código de Instituciones y Bienestar.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(médico/miembro del personal del establecimiento médico)

Nombre en letra de imprenta: _____
(médico/miembro del personal del establecimiento médico)

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(establecimiento de tratamiento intensivo que representa)

Nombre en letra de imprenta: _____
(establecimiento de tratamiento intensivo que representa)

Fecha: _____ Hora: _____ AM / PM

Signature: _____
(contrafirma)

Nombre en letra de imprenta: _____
(contrafirma)

COPIAS:

Paciente: _____

Abogado o representante del paciente: _____

Otra persona designada por el paciente: _____

Tribunal Superior (para presentar con la decisión de la audiencia de revisión de la certificación psiquiátrica)

Reference: Welfare and Institutions Code Section 5252 to 5254.1

FORM 12-7

Advisement of Rights — Involuntary Patient

This is to certify that on *(date)* _____, the undersigned advised *(name of patient)* _____, a patient at *(name of hospital)* _____, of the following:

1. That the patient is being certified for not more than 14 days of involuntary intensive treatment for:

   ☐ Mental health disorder

   ☐ Impairment by chronic alcoholism

   ☐ Use of narcotics or restricted dangerous drugs

   And I have personally delivered a copy of the certification notice to him/her.

2. His/her legal rights to designate any person whom he/she wishes informed regarding his/her certification or judicial review (the patient understands that he/she has the right to request that this information not be provided), and the patient has designated the following person(s): *(names, relationships and address)* _____ _____;

3. His/her legal right to a certification review hearing or a habeas corpus hearing by the superior court to review this certification for involuntary treatment in order to determine whether he/she is a danger to others or to himself/herself or is gravely disabled; whether he/she has been advised of, but has not accepted voluntary treatment; and whether the facility providing intensive treatment is equipped and staffed to provide treatment, is designated by the county to provide intensive treatment, and has agreed to admit him/her; and

4. His/her legal right to assistance of an advocate at a certification review hearing or to counsel, including court-appointed counsel at no cost to him/her if he/she is unable to pay for such legal services, to prepare for and represent him/her at a writ of habeas corpus hearing.

I believe as a result of my own personal observation that *(name of patient)* _____ _____ has the capacity to comprehend the nature of the notice of certification and of the right to counsel to a certification review hearing and habeas corpus hearing.

Date: _____ Time: _____ AM / PM

Signature: _____
(hospital representative)

Print name: _____
(hospital representative)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Welfare and Institutions Code Sections 5253 and 5254.1

FORM 12-7S

Adviso de Derechos a los Pacientes Involuntarios

El presente es para certificar que el suscrito firmante ha informado en esta fecha a *(nombre del paciente)* _____, un/a paciente en *(nombre del hospital)* _____:

1. Que el/la paciente se certifica por no más de 14 días de tratamiento intensivo involuntario por:

   ☐ Trastorno de salud mental

   ☐ Incapacidad por alcholismo crónico

   ☐ Uso de estupefacientes o de drogas peligrosas restringidas

   Y que ha entregado personalmente una copia de la certificación a dicho/a paciente;

2. Acerca de sus derechos legales para designar a cualquier persona que desee para que se le informe acerca de su certificación o reconsideración judicial (el/la paciente entiende que él/ella tiene derecho a solicitar que no se provea esta información), y que él/la paciente ha designado a la(s) siguiente(s) persona(s): *(nombres, relación y direcciones)* _____ _____;

3. Acerca de su derecho legal a que se celebre una audiencia para la revisión de la certificación o de hábeas corpus ante el Tribunal Superior para reconsiderar esta certificación de tratamiento involuntario, a fin de determinar si él/ella representa un peligro para los demás o para sí mismo/a o si está seriamente incapacitado/a; si se le ha informado acerca de, pero no ha aceptado tratamiento voluntario; y si la institución que proveyó el tratamiento intensivo está equipada y cuenta con personal idóneo para proveer ese tipo de tratamiento, si ha sido designada por el condado para proveer tratamiento intensivo, y si ha acordado ingresarlo/a; y,

4. Acerca de su derecho legal a que lo/la asista un abogado durante la audiencia para la reconsideración de la certificación, o para asesorarlo/a, incluyendo abogados nombrados por el tribunal sin costo alguno para él/ella si no puede pagar dichos servicios, y para prepararlo/a para que lo/la represente durante una audiencia para el mandamiento de hábeas corpus.

Creo como resultado de mis observaciones personales que *(nombre del paciente)* _____ _____ tiene la capacidad de entender el contenido del aviso de certificación y el derecho a contar con un abogado durante una audiencia para la reconsideración de la certificación y para el mandamiento de hábeas corpus.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(representante del hospital)

Nombre en letra de imprenta: _____
(representante del hospital)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: Welfare and Institutions Code Sections 5253 and 5254.1

FORM 12-8

Leave of Absence from Psychiatric Service

Patient's Name: _____

Date: _____

The above-named patient may be placed on a temporary leave of absence from the psychiatric service of *(name of hospital)* _____
at *(time and date)* _____
to *(responsible person)* _____.

Address of responsible person: _____

_____

Telephone: _____

To be readmitted at: _____
(time and date)

Signature: _____
(attending psychiatrist)

Patient readmitted at: _____
(time and date)

By: _____

If, during the patient's absence, there is any need to contact the hospital, the following number should be called: _____

PREPARE IN DUPLICATE
ONE COPY TO PATIENT, ONE COPY TO MEDICAL RECORD

FORM 12-8S

Permiso Para Ausentarse de Servicios Psiquiatricos

Nombre del Pacente: _____

Fecha: _____

El paciente arriba mencionado podrá ausentarse temporalmente del servicio psiquiátrico de *(nombre del hospital)* _____ _____ a las *(hora y fecha)* _____ bajo la responsabilidad de *(persona responsible)* _____.

Dirección de la persona: _____

_____

Teléfono: _____

El paciente ingresará nuevamente el: _____
(hora y fecha)

Firma: _____
(psiquíatra del caso)

El paciente ingresó nuevamente el: _____
(hora y fecha)

Por: _____

Si durante la ausencia del paciente fuera necesario ponerse en contacto con el hospital, llamar al siguiente teléfono: _____

PREPARE IN DUPLICATE
ONE COPY TO PATIENT, ONE COPY TO MEDICAL RECORD

FORM 12-9

Request for Release From Involuntary Treatment

Date: _____

I, *(member of treatment staff or person delivering copy of certification notice)* _____

_____,

have today received a request for the release of *(name of patient)* _____ from the undersigned patient on his/her own behalf or from the undersigned person on behalf of the patient.

Signature (or mark): _____
(patient making request for release)

Print name: _____
(patient making request for release)

Signature (or mark): _____
(patient making request for release)

Print name: _____
(person making request on behalf of patient)

Signature: _____
(member of treatment staff or person delivering copy of certification notice)

Print name: _____
(member of treatment staff or person delivering copy of certification notice)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: Welfare and Institutions Code Section 5275

FORM 12-9S

Peticion Para Dar de Alta del Tratamiento Involuntario

Fecha: _____

Yo, *(miembro del personal de tratamiento o la persona que haya entregado la copia del aviso de certificación)* _____, he recibido hoy la petición para dar de alta a *(nombre del paciente)* _____ por parte del paciente suscrito a nombre propio o de la persona suscrita a nombre del paciente.

Firma (o marca): _____
(paciente que hace la petición para de alta)

Nombre en letra de imprenta: _____
(paciente que hace la petición para de alta)

Firma (o marca): _____
(persona que hace la petición a nombre del paciente)

Nombre en letra de imprenta: _____
(persona que hace la petición a nombre del paciente)

Firma: _____
(miembro del personal de tratamiento o persona que entrega la copia del aviso de certificación)

Nombre en letra de imprenta: _____
(miembro del personal de tratamiento o persona que entrega la copia del aviso de certificación)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: Welfare and Institutions Code Section 5275

FORM 12-10

Notice of Certification for Second Involuntary 14-Day Period for Intensive Treatment — Suicidal Patient

To the Superior Court of the State of California for the County of _____.

The authorized agency providing 14-day intensive treatment, County of _____, has custody of:

Name: _____

Address: _____

Date of birth: _____ Sex: _____Marital Status: _____

Religious Affiliation: _____

The undersigned allege that the above-named person presents an imminent threat of taking his/her own life. This allegation is based upon the following facts: _____

_____

_____

This allegation is supported by the accompanying affidavits signed by: _____

_____

The above-named person has been informed of this allegation and has been advised of, but has not been able or willing to accept referral to, the following services: _____

_____

_____

Therefore we certify the above-named person to receive additional intensive treatment for no more than 14 days beginning this _____day of *(month)* _____, 20_____, in the intensive treatment facility herein named: _____.

We hereby state that a copy of this notice has been delivered this day to the above-named person and that he/she has been clearly advised of his/her continuing legal right to a judicial review by habeas corpus, that the term "habeas corpus" has been explained to him/her, and his/her right to counsel, including court-appointed counsel pursuant to Welfare and Institutions Code Section 5276.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician/staff member of facility)

Date: _____ Time: _____ AM / PM

Countersignature: _____
(representing intensive treatment facility)

(over)

COPIES:

Patient: _____

Patient's attorney or representative: _____

Other person designated by patient: _____

Superior Court (to be submitted with the psychiatric certification review hearing decision)

District Attorney

Facility Providing Intensive Treatment

Reference: Welfare and Institutions Code Sections 5262, 5263 and 5276

FORM 12-10S

Aviso de Remision a un Segundo Periodo Involuntario de 14-Dias para Tratamiento Intensivo — Paciente Suicida

Al Tribunal Superior del Estado de California para el Condado de _____.

La dependencia autorizada que proporciona tratamiento intensivo de 14 días, Condado de _____ _____ tiene la custodia de:

Nombre: _____

Dirección: _____

Fecha del nacimiento: _____ Sexo: _____ Estado Civil: _____

Afiliación religiosa: _____

Los suscritos afirman que la persona arriba nombrada presenta la amenaza inminente de suicidarse. La presente afirmación se basa en los siguientes hechos: _____

_____

_____

Se apoya a la presente afirmación con las declaraciones juradas firmadas por: _____

_____

Se le ha notificado a la persona arriba nombrada de dicha afirmación, y se le ha informado de los siguientes servicios, pero no ha querido o no ha sido capaz de aceptar ser referido a los mismos:

_____

En tal virtud, remitimos a la persona antes mencionada para recibir tratamiento intensivo adicional por un plazo no mayor de 14 días a partir de este día _____ de *(mes)* _____ _____de 20_____, en la institución e tratamiento intensivo nombrada a continuación: _____.

We hereby state that a copy of this notice has been delivered this day to the above-named person and that he/she has been clearly advised of his/her continuing legal right to a judicial review by habeas corpus, that the term “habeas corpus” has been explained to him/her, and his/her right to counsel, including court-appointed counsel pursuant to Welfare and Institutions Code Section 5276.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician/staff member of facility)

Date: _____ Time: _____ AM / PM

Countersignature: _____
(representing intensive treatment facility)

(sobre)

COPIES:

Patient: _____

Patient's attorney or representative: _____

Other person designated by patient: _____

Superior Court (to be submitted with the psychiatric certification review hearing decision)

District Attorney

Facility Providing Intensive Treatment

Reference: Welfare and Institutions Code Sections 5262, 5263 and 5276

FORM 12-11

Petition for Postcertification Treatment of Imminently Dangerous Person

Attorney's Name: _____ Telephone: _____

Address: _____

SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF _____

In the Matter of:	Case No:
	) PETITION FOR POSTCERTIFICATION TREATMENT
_____,	) OF A DANGEROUS PERSON
	)
	) Date: _____
	)
_____	) Time: _____
	)
	) Dept: _____

I, _____, *(the professional person in charge of the* _____ *intensive treatment facility) (the designee of* _____*, the professional person in charge of the treatment facility)*, in which _____ (hereinafter referred to as "patient") has been under treatment pursuant to the certification by _____ _____ and _____, hereby petition the court for an order requiring the patient to undergo an additional period of treatment, not to exceed 180 days, pursuant to the provisions of Article 6 (commencing with Section 5300) of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code. This petition is based upon my allegation that:

1. The patient named above has attempted, or 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 that, by reason of mental health disorder, presents a demonstrated danger of inflicting substantial physical harm upon others; or that
2. The patient named above has attempted or inflicted physical harm upon the person of another, that act having resulted in his/her being taken into custody, and that he/she presents, as a result of mental health disorder, a demonstrated danger of inflicting substantial physical harm to others; or that
3. The patient named above 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/her being taken into custody, and that he/she presents, as a result of mental health disorder, a demonstrated danger of inflicting substantial physical harm upon others.

(over)

My allegation is based upon the following facts: _____

_____

_____

The allegation is supported by the accompanying affidavits signed by: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____

NOTE: Copies of the petition and supporting affidavits must be served upon the patient named above the same day as they are filed with the clerk of the superior court.

FORM 12-12

Detention of Patient With Psychiatric Emergency in a Nondesignated Health Facility

(Health and Safety Code Section 1799.111)

A licensed general acute care or psychiatric hospital (that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code), licensed professional staff of those hospitals, and physicians, providing emergency medical services in any department of those hospitals will not be held civilly or criminally liable for detaining a patient if all of the following conditions exist during the detention.

Name of Patient: _____

1. The law requires probable cause for detaining the patient/believing the patient is, as a result of a mental disorder, a danger to self or others or gravely disabled. Describe the patient's behavior and/or statements, and circumstances under which the patient was detained (use direct quotes from the patient, law enforcement officers, and/or others when appropriate).

   _____

   _____

   _____

2. Based upon the above information, I believe that the patient named above cannot be safely released from the hospital because he or she is, as a result of a mental disorder, one or more of the following:

   ☐ A danger to self

   ☐ A danger to others

   ☐ Gravely disabled (for purposes of a detention under Health and Safety Code Section 1799.111, **"gravely disabled"** means an inability of the patient to provide for his or her basic personal needs for food, clothing, or shelter)

Signature of treating physician and surgeon (or clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Health and Safety Code Section 1316.5*)

Name: _____

Signature: _____

Date: _____ Time: _____ AM / PM

(over)

The hospital staff, treating physician and surgeon, or appropriate licensed mental health professional must make and document repeated unsuccessful efforts to find appropriate mental health treatment for the detained patient. Required telephone calls or other contacts must commence at the earliest possible time when the treating physician and surgeon has determined the time at which the patient will be medically stable for transfer. The hospital may not wait until after the time when the patient becomes medically stable for transfer to start making these contacts. Document efforts to find appropriate mental heath treatment for the patient:

Date/Time	Person/Facility Contacted	Results of Contact:
_____	_____	_____
_____	_____	_____
_____	_____	_____

The patient may not be detained beyond 24 hours. Date and time patient first detained: _____

If the patient is detained beyond eight hours, but less than 24 hours, both of the following additional conditions must be met:

1. A discharge or transfer for appropriate evaluation or treatment for the patient has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.

   Describe the care, observation, or treatment the hospital is providing in the lines below or in the medical record.

   _____

   _____

2. The patient named above continues to be, as a result of a mental disorder, one or more of the following:

   ☐ A danger to self

   ☐ A danger to others

   ☐ Gravely disabled (for purposes of a detention under Health and Safety Code Section 1799.111, **"gravely disabled"** means an inability of the patient to provide for his or her basic personal needs for food, clothing, or shelter)

Signature of treating physician and surgeon (or clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Health and Safety Code Section 1316.5*)

Name: _____

Signature: _____

Date: _____ Time: _____ AM / PM

To receive immunity from civil or criminal liability for any actions of the patient after release, all of the following conditions must exist during the detention:

1. The patient was not been admitted to a licensed general acute care hospital or a licensed acute psychiatric hospital for evaluation and treatment pursuant to Section 5150 of the Welfare and Institutions Code.
2. The release from the hospital is authorized by a physician and surgeon or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, who determines, based on a face-to-face examination of the patient detained, that the patient does not present a danger to himself or herself or others and is not gravely disabled. In order for this paragraph to apply to a clinical psychologist, the clinical psychologist must have a collaborative treatment relationship with the physician and surgeon. The clinical psychologist may authorize the release of the patient from the detention, but only after he or she has consulted with the physician and surgeon. In the event of a clinical or professional disagreement regarding the release of a patient subject to the detention, the detention must be maintained unless the hospital's medical director overrules the decision of the physician and surgeon opposing the release. Both the physician and surgeon and the clinical psychologist must enter their findings, concerns, or objections in the patient's medical record.

NOTE: A patient detained under this law must be credited for the time detained, up to 24 hours, in the event he or she is placed on a subsequent 72-hour hold pursuant to Section 5150 of the Welfare and Institutions Code in a designated facility.

*Health and Safety Code Section 1316.5 states that state owned and operated health facilities that offer services within the scope of practice of a psychologist must establish rules and procedures for consideration of an application for medical staff membership and clinical privileges submitted by a clinical psychologist. Private health facilities may enable the appointment of clinical psychologists on such terms and conditions as the facility may establish. If a particular service is offered by a health facility which permits clinical psychologists on its medical staff which both physicians and clinical psychologists are authorized by law to perform, such service may be performed by either, without discrimination.

Reference: Health and Safety Code Sections 1316.5 and 1799.111

SUMMARY OF LANTERMAN-PETRIS-SHORT ACT'S PROVISION FOR INVOLUNTARY EVALUATION AND TREATMENT AND RIGHT OF REVIEW

LANTERMAN-PETRIS-SHORT ACT Section 5000 *et seq.* Welfare and Institutions Code ("W&I")	72 HOURS Evaluation and intensive treatment W&I 5150	14 DAYS CERTIFICATION Intensive treatment W&I 5250	14 DAYS CERTIFICATION Additional Intensive treatment - suicide risk W&I 5260	30 DAYS ADDITIONAL CERTIFICATION Intensive treatment W&I 5270.15	180 DAYS POSTCERTIFICATION Renewable W&I 5300	30 DAYS (1-6 MONTHS) Temporary letter of conservatorship W&I 5353	1 YEAR CONSERVATORSHIP W&I 5350	ONCE WITHIN EVERY 6-MONTH PERIOD Rehearing W&I 5364	REAPPOINTMENT OF CONSERVATOR Annually if the conservator petitions W&I 5361
DANGER TO SELF		Writ or Certification Review Hearing	Writ						
DANGER TO OTHERS		Writ or Certification Review Hearing			Court or Jury				
GRAVELY DISABLED		Writ or Certification Review Hearing	3 Additional Days W&I 5352.3	Writ or Certification Review Hearing	3 Additional Days W&I 5352.3	Writ	Hearing and Jury	Court or Jury	Court or Jury

W&I = Welfare and Institutions Code

FORM 13-3

Aftercare Plan

Patient's Name: _____

Patient Number: _____

Nature of the illness: _____

_____

Recommended follow-up: _____

_____

_____

Medications prescribed and side effects and dosage schedules *(a signed informed consent form for medications, if attached to this form, may satisfy this requirement)*: _____

_____

_____

Patient's expected course of recovery: _____

_____

_____

Recommendations regarding treatment that are relevant to the patient's care: _____

_____

_____

If the patient is a minor being released from involuntary treatment, address education or training needs, if necessary, for the minor's well-being: _____

_____

_____

Other information/instructions: _____

_____

_____

(over)

Referrals

Name/Agency: _____

Address: _____

Phone: _____

Comments: _____

_____

Name/Agency: _____

Address: _____

Phone: _____

Comments: _____

_____

Name/Agency: _____

Address: _____

Phone: _____

Comments: _____

_____

(**NOTE:** If any item listed above is not completed, it must be explained why.)

Date: _____

Signature of person preparing this aftercare plan: _____

I have received a copy of this aftercare plan. I have also been advised that I may designate another person to receive a copy of this aftercare plan, and I designate the following person:

_____

(If patient declines to designate another person, this should be noted)

Date: _____ Time: _____ AM / PM

Signed: _____
(patient)

Print name: _____
(patient)

Date: _____ Time: _____ AM / PM

Signed: _____
(legal representative)

Print name: _____
(legal representative)

Date: _____ Time: _____ AM / PM

Signed: _____
(designated recipient of aftercare plan)

Print name: _____
(designated recipient of aftercare plan)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Health and Safety Code Section 1262; Welfare and Institutions Code Sections 5585.57, 5622 and 5768.5

FORM 13-3S

Plan de Cuidados Posteriores

Nombre del paciente: _____

Número de paciente: _____

Naturaleza de la enfermedad: _____

_____

Seguimiento recomendado: _____

_____

_____

Medicamentos recetados, efectos secundarios y cronograma de dosis *(un formulario de consentimiento informado firmado para los medicamentos, si se adjunta a este formulario, puede satisfacer este requisito)*:

_____

_____

Período de recuperación previsto para el paciente: _____

_____

_____

Recomendaciones con respecto al tratamiento que sean pertinentes para la atención del paciente: _

_____

_____

Si el paciente es un menor al que se da de alta de un tratamiento involuntario, aborde las necesidades de educación o capacitación, si fuera necesario, para el bienestar del menor: _____

_____

_____

Otra información/instrucciones: _____

_____

_____

(sobre)

Derivaciones

Nombre/Agencia: _____

Dirección: _____

Teléfono: _____

Comentarios: _____

_____

Nombre/Agencia: _____

Dirección: _____

Teléfono: _____

Comentarios: _____

_____

Nombre/Agencia: _____

Dirección: _____

Teléfono: _____

Comentarios: _____

_____

(**OBSERVACIÓN:** Si no se completa alguno de los puntos indicados anteriormente, se debe explicar el motivo).

Fecha: _____

Firma de la persona que prepara este plan de atención posterior a la hospitalización:

_____

He recibido una copia de este plan de atención posterior a la hospitalización. También se me ha advertido que puedo designar a otra persona para que reciba una copia de este plan de atención posterior a la hospitalización, y designo a la siguiente persona:

_____

(Se debe indicar si el paciente se rehúsa a designar a otra persona)

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente)

Nombre en letra de imprenta: _____
(paciente)

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(representante legal)

Nombre en letra de imprenta: _____
(representante legal)

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(destinatario designado del plan de atención posterior a la hospitalización)

Nombre en letra de imprenta: _____
(destinatario designado del plan de atención posterior a la hospitalización)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Health and Safety Code Section 1262; Welfare and Institutions Code Sections 5585.57, 5622 and 5768.5

FORM 13-4

Notice to Law Enforcement Agency: Release of Person From Hospital From Whom a Firearm or Other Deadly Weapon Was Confiscated

Name of Law Enforcement Agency which confiscated the weapon(s):

Address of Law Enforcement Agency which confiscated the weapon(s):

This notice is given to you as required by Welfare and Institutions Code Section 8102(b).

(name of patient) _____ was released on *(date)* _____.

This patient was provided the required notice regarding the procedure to obtain return of a confiscated weapon(s).

Date: _____ Time: _____ AM / PM

Signature: _____
(patient)

Print name: _____
(patient)

A COPY OF THIS FORM MUST BE PLACED IN THE MEDICAL RECORD.

FORM 13-5

Notice to Patient: Procedure for Return of Confiscated Weapon(s)

Name of Patient: _____

This notice is given to you as required by Welfare and Institutions Code Section 8102(b).

You had one or more firearms or other deadly weapons confiscated from you by a law enforcement officer pursuant to Welfare and Institutions Code Section 8102. The procedure for the return of your weapon is found in Penal Code Section 33850 and Welfare and Institutions Code Section 8102.

The law enforcement agency which confiscated your weapon(s) has 30 days (longer in certain cases) to initiate a petition in the superior court for a hearing to determine whether the return of the weapon(s) would be likely to result in endangering you or others. The confiscating law enforcement agency must also send you a notice of your right to a hearing on this issue. The law enforcement agency may ask the court to extend the time to file a petition; however, the petition must be filed within 60 days of your discharge from the facility even if the court grants an extension. You will have 30 days to respond to the court clerk to confirm your desire for a hearing. If you do not respond, a default order forfeiting your weapon(s) will be issued. If you request a hearing, it must be set within 30 days of your request. The court clerk will notify you and the district attorney of the date, time, and place of the hearing.

If the law enforcement agency does not file a petition, it must make your weapon(s) available for return to you. If you fail to respond to a petition, your weapon may be forfeited.

I certify by my signature below that I have been given the information above related to the procedure for the return of a confiscated weapon(s).

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

Print name: _____
(patient/legal representative)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

A COPY OF THIS FORM MUST BE GIVEN TO THE PATIENT.
THE ORIGINAL MUST BE PLACED IN THE MEDICAL RECORD.

FORM 13-5S

Aviso al Paciente: Procedimiento Para la Devolucion de Una o Mas Armas Confiscadas

Nombre del Paciente: _____

Este aviso se le entrega en conformidad con los requisitos del Código de Bienestar Social e Instituciones, Sección 8102(b).

En conformidad con la Sección 8102 del Código de Bienestar Social e Instituciones, un agente de la ley le confiscó una o más armas de fuego u otras armas mortíferas. El procedimiento para la devolución de su arma se encuentra en la sección 33850 del Código Penal y en la sección 8102 del Código de Instituciones y Bienestar.

La agencia de la ley que le confiscó el arma (las armas) tendrá 30 días (en ocasiones más tiempo) para presentar una petición ante el tribunal superior para que se realice una audiencia con el fin de determinar si la devolución del arma (de las armas) podría resultar en poner a usted o a otras personas en peligro. La agencia de la ley que haya confiscado el arma también deberá enviarle un aviso explicándole su derecho a que se realice una audiencia sobre este asunto. La agencia de la ley podrá solicitar al tribunal que prologue el plazo para presentar una petición. Sin embargo, la petición se deberá presentar dentro de los 60 días de la fecha en que sea dado de alta de la institución, aunque el tribunal otorgue una prórroga. Usted tendrá 30 días para responder al actuario del tribunal confirmando que desea que se celebre la audiencia. Si no responde, se emitirá una orden de incumplimiento y de confiscación de su arma (sus armas). Si solicita una audiencia, la misma deberá fijarse dentro de los 30 días de su solicitud. El actuario del tribunal notificará a usted y al procurador de distrito la fecha, la hora y el lugar de la audiencia.

Si la agencia de la ley no presenta una petición, deberá poner a su disposición el arma (las armas) para su devolución. Si no responde a la petición, su arma puede ser confiscada.

Certifico con mi firma a continuación que se me ha proporcionado la información que antecede relativa al procedimiento para la devolución de arma(s) confiscada(s).

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Nombre en letra de imprenta: _____
(paciente o representante legal)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

A COPY OF THIS FORM MUST BE GIVEN TO THE PATIENT.
THE ORIGINAL MUST BE PLACED IN THE MEDICAL RECORD.

FORM 16-1

Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____

Use and Disclosure of Health Information

I hereby authorize _____
(name of hospital or other provider)

to release to:

_____
(Persons/Organizations authorized to receive the information)

_____
(Address — street, city, state, zip code)

The following information:

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received; OR

☐ Only the following records or types of health information (including any dates):

_____

_____

b. I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information _____ (initial)

☐ HIV test results _____ (initial)

☐ The following substance use disorder treatment information:

_____

_____

_____

_____

_____ (initial)

(over)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.[1]

Purpose

Purpose of requested use or disclosure: ☐ Patient request OR ☐ Other:

_____

_____

_____

Limitations, if any: _____

_____

_____

Expiration

This authorization expires on *(date)*: _____

My Rights

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2]
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing[3] and submit it to the following address: _____

  _____.

  My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

1 Health care providers that do not maintain psychotherapy notes as defined in HIPAA may wish to delete this sentence.

2 If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

3 Patients of federally-assisted substance abuse programs and patients whose records are covered by LPS may revoke an authorization verbally.

- I have a right to receive a copy of this authorization.[4]
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Signature

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by a person other than the patient, indicate relationship: _____

Print name: _____
(legal representative)

Notes for Providers that Use this Form:

- If the purpose of the authorization is to use the information for marketing by a third party that remunerates the provider, a statement to this effect must be included in this authorization form.
- If the purpose of the authorization is for the sale of protected health information (PHI), this form must state whether the PHI can be further exchanged for remuneration by the initial recipient.
- A provider that discloses health information pursuant to an authorization must communicate any limitation contained in the authorization to the recipient [Civil Code Section 56.14]. The required notification may be accomplished by giving the recipient a copy of the authorization form.

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

4 Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 C.F.R. Section 164.508(c)(4))*.

FORM 16-1S

Autorización Para Utilizar o Divulgar Información Médica

Al completar este documento autoriza la divulgación y el uso de su información médica. Esta autorización puede perder su validez si no proporciona toda la información solicitada.

Nombre del paciente: _____

Uso y Divulgación de Información Médica

Por medio del presente autorizo a: _____
(nombre del hospital o del proveedor)

a divulgar a:

_____
(Personas u organizaciones autorizadas a recibir la información)

_____
(Domicilio — calle, ciudad, estado, código postal)

la siguiente información:

a. ☐ Toda la información médica referente a mi historia médica, estado mental o físico y tratamiento recibido; O

   ☐ Sólo los siguientes expedientes o tipo de información (incluso las fechas):

   _____

b. Autorizo específicamente la divulgación de la siguiente información (marque donde corresponde):

   ☐ Información sobre tratamiento de salud mental _____ (inicial)

   ☐ Resultados de análisis de VIH _____ (inicial)

   ☐ La siguiente información sobre uso de la substancia para el tratamiento del trastorno:

   _____

   _____

   _____

   _____

   _____ (inicial)

(sobre)

Se requiere una autorización adicional para permitir la divulgación o el uso de notas de psicoterapia, según se define en las regulaciones federales de la Ley de Portabilidad y Responsabilidad de Seguros Médicos.

Objetivo

Objetivo del uso o divulgación solicitados: ☐ Solicitud de paciente O ☐ Otro:

_____

_____

_____

Limitaciones, si existen: _____

_____

_____

Vencimiento

Esta autorización vence el *(fecha)*: _____

Mis Derechos

- Puedo negarme a firmar esta autorización. Mi negativa no afectará mi calificación para obtener tratamiento o pago ni mi calificación para obtener beneficios.
- Puedo inspeccionar u obtener una copia de la información médica cuyo uso o divulgación se me solicita que autorice.
- Puedo revocar esta autorización en cualquier momento, pero debo hacerlo por escrito y presentar mi revocación en este domicilio: _____

  _____.

  Mi revocación tendrá vigencia cuando se reciba, excepto en la medida en que otras personas hayan actuado basados en esta autorización.
- Tengo el derecho de recibir una copia de esta autorización.
- El destinatario de la información divulgada en virtud de esta autorización puede volver a divulgarla. Dicha nueva divulgación en algunos casos no es +prohibido por la ley del Estado de California, y puede no estar protegida por la ley federal de confidencialidad (HIPAA). Sin embargo, la ley de California prohíbe que la persona que recibe la información sobre mi salud la revele, a menos que yo autorice dicha revelación o que ésta sea requerida por la ley o permitida por ésta.

Firma

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

Notes for Providers that Use this Form:

- If the purpose of the authorization is to use the information for marketing by a third party that remunerates the provider, a statement to this effect must be included in this authorization form.
- If the purpose of the authorization is for the sale of protected health information (PHI), this form must state whether the PHI can be further exchanged for remuneration by the initial recipient.
- A provider that discloses health information pursuant to an authorization must communicate any limitation contained in the authorization to the recipient [Civil Code Section 56.14]. The required notification may be accomplished by giving the recipient a copy of the authorization form.

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

FORM 16-2

Request to Withhold Public Release of Information

Name of Patient: _____

- ☐ I do not want any information about me, including my general medical condition and my location within the hospital, to be made available to the public. I understand the hospital cannot effectively screen the identity of persons making inquiries, so this prohibition extends to all callers, which may include family, friends and clergy.
- ☐ I do not want my name or religious affiliation given to a member of the clergy, such as a priest or rabbi, if they do not ask for me by name.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by other than patient, indicate relationship: _____

Print name: _____
(legal representative)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

FORM 16-2S

Solicitud Para Prohibir la Divulgación de Información al Público

Nombre del Paciente: _____

☐ No deseo que ninguna información acerca de mí, incluso mi condición médica general y mi ubicación dentro del hospital esté a disposición del público. Entiendo que el hospital no puede efectuar una identificación sistemática eficaz de las personas que hacen indagaciones, por lo tanto esta prohibición se extiende a todas las personas que llamen, lo cual puede incluir a mis familiares, amigos y clero.

☐ No deseo mi nombre o afiliación religiosa dada a un miembro del clero, tal como un sacerdote o un rabbi, si él no pide mí por nombre.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

FORM 19-2

Employee Acknowledgment of Child Abuse and Neglect Reporting Obligations

Penal Code Sections 11165.7, 11166 and 11167 require specified health care practitioners and other persons who have knowledge of or observe a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse or neglect to report the known or suspected instance of child abuse immediately or as soon as practicably possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

You are a person who is required to report known or suspected child abuse or neglect. The reporting obligations that you must fulfill are described in Penal Code Sections 11165.7, 11166 and 11167 attached to this form. You must read this attachment.

The identity of all persons who make child abuse reports is confidential and disclosed only among agencies receiving or investigating mandated reports, to the prosecutor in a criminal prosecution or in an action initiated under Welfare and Institutions Code Section 602 arising from alleged child abuse, or to counsel appointed to represent the child pursuant to Welfare and Institutions Code Section 317(c), or to the county counsel or prosecutor in a proceeding under Family Code Section 7800 *et seq.* or Welfare and Institutions Code Section 300 *et seq.*, or to a licensing agency when abuse or neglect in out-of-home care is reasonably suspected, or when those persons waive confidentiality, or by court order. No such agency or person may disclose the identity of any person who makes a child abuse report to that person's employer, except with the employee's consent or by court order. [Penal Code Section 11167(d)]

NOTE: The hospital may wish to supplement this form by providing the new employee a copy of chapter 17 of CHA's *Consent Manual*, which describes the child abuse reporting requirements. If this approach will be used, this form should indicate:

> *We have attached a copy of the portion of CHA's* Consent Manual *that describes the California Child Abuse and Neglect Reporting Act. You should read this material carefully. If you have any questions regarding your reporting obligations, please discuss your questions with [insert the name and title of the person who should answer questions].*

NOTE: The hospital may supplement this form by discussing any special policy it has regarding notifying supervisors and administration about reports that will be or are made, and how the reporting is coordinated when several employees become aware of the same instance of suspected child abuse or neglect. Such a discussion could, for example, include the following statement:

> *Your supervisor and administration should be notified whenever you believe that you may be required to report suspected child abuse or neglect. In addition, usually several hospital employees and medical staff members will learn about the same instance of suspected abuse or neglect. The patient's attending physician (or other designated person) shall be responsible for making the reports or for identifying the member of the health care team who shall assume this responsibility.*

(over)

I have read the attached information regarding child abuse and neglect reporting obligations under California law. I understand that I must comply with these legal requirements, and I agree to do so.

Date: _____ Time: _____ AM / PM

Signature: _____
(employee)

Print name: _____
(employee)

NOTE: The employer is required by law to attach a copy of Penal Code Sections 11165.7, 11166 and 11167 to this form.

Reference: Penal Code Sections 11165.7, 11166 and 11167

FORM 19-4

Employee Acknowledgment of Elder and Dependent Adult Abuse Reporting Obligations

The Elder Abuse and Dependent Adult Civil Protection Act (Welfare and Institutions Code Sections 15600-15659) requires specified health care practitioners, clergy members, care custodians and other persons who have knowledge of or reasonably suspect abuse or neglect of an elder or dependent adult to report by telephone or through a confidential Internet reporting tool (if available and appropriate). If the initial report is made by phone, a follow-up written report or an Internet report must later be sent. The reporting time frames are described in the attached document.

You are a person who is required to report known or suspected abuse or neglect of an elder or dependent adult. The reporting obligations you must fulfill are described in Welfare and Institutions Code Section 15630, attached to this form. You must read this attachment.

NOTE: The hospital may wish to supplement this form by providing the new employees a copy of chapter 17 of CHA's *Consent Manual*, which describes the elder and dependent adult abuse reporting requirements. If this approach will be used, this form should indicate:

> *We have attached a copy of the portion of the California Hospital Association's* Consent Manual *that describes the California elder and dependent adult abuse and neglect reporting law. You should read this material carefully. If you have any questions regarding your reporting obligations, please discuss your questions with* [insert the name and title of the person who should answer questions].

NOTE: The hospital may supplement this form by discussing any special policy it has regarding notifying supervisors and administration about reports that will be or are made, and how the reporting is coordinated when several employees become aware of the same instance of suspected elder or dependent adult abuse. Such a discussion could, for example, include the following statement:

> *Your supervisor and administration should be notified whenever you believe that you may be required to report suspected elder or dependent adult abuse or neglect. In addition, usually several hospital employees and medical staff members will learn about the same instance of suspected abuse or neglect. The patient's attending physician (or other designated person) shall be responsible for making the reports or for identifying the member of the health care team who shall assume this responsibility.*

The identity of persons who report elder or dependent adult abuse or neglect is confidential and may be disclosed only among the following agencies or persons representing an agency:

1. An adult protective services agency.
2. A long-term care ombudsperson program.
3. A licensing agency.
4. A local law enforcement agency.
5. The office of the district attorney.

(over)

6. The office of the public guardian.
7. The probate court.
8. The bureau.
9. The Department of Consumer Affairs, Division of Investigation.
10. Counsel representing an adult protective services agency.

In addition, the identity of a person who reports elder or dependent adult abuse or neglect may be disclosed under the following circumstances:

1. To the district attorney in a criminal prosecution.
2. When the reporter waives his or her confidentiality rights.
3. By court order.

[Welfare and Institutions Code Section 15633.5]

I have read the attached information regarding elder and dependent adult abuse reporting obligations under California law. I understand that I must comply with these legal requirements, and I agree to do so.

Date: _____ Time: _____ AM / PM

Signature: _____
(employee)

Print name: _____
(employee)

NOTE: The employer is required by law to attach a copy of Welfare and Institutions Code Section 15630 to this form.

Reference: Welfare and Institutions Code Sections 15633.5 and 15659

A Quick Reference Guide to

ASSAULT AND ABUSE REPORTING REQUIREMENTS

	Child Abuse and Neglect	Elder/Dependent Adult Abuse	Injury by Firearm or Assaultive/ Abusive Conduct
Reporting Trigger	Mandated reporter has observed or has knowledge of a child whom he or she knows or reasonably suspects has been the victim of child abuse or neglect. May also report serious emotional damage or risk thereof (not required) **Includes:** non-accidental physical injury that was not self-inflicted; sexual abuse; neglect; willful harm, injury or endangerment; unlawful corporal punishment or injury; abuse or neglect in out-of-home care **Applies to:** minors under age 18 **Note:** reporting of a minor's sexual activity varies with age and circumstances	Mandated reporter has observed or has knowledge of (including being told by the elder/dependant adult) an incident that reasonably appears to be abuse **Includes:** physical abuse, neglect, financial abuse, abandonment, isolation, abduction or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering **Applies to:** elder persons age 65 or older; dependent adults ages 18 to 64 with physical or mental limitations; adult inpatients (age 18 to 64) in an acute care hospital or other 24-hour health facility	Health practitioner and physician providing medical services to a patient whom they reasonably suspect has a *physical* condition resulting from: 1. A wound or injury by a firearm (self-inflicted or by another person) or 2. A wound or injury resulting from assaultive or abusive conduct (as defined by Penal Code 11160(d)) **Includes:** murder, mayhem, assault, rape, battery, abuse of spouse or cohabitant and additional offenses as defined by Penal Code 11160(d) Duty to report applies even if treating a condition not related to the assault, abuse or firearm injury
To Whom to Report	Local law enforcement, designated county probation department or county welfare department	Varies depending on where the suspected/alleged abuse occurred: **1. Long-term care facility, physical abuse:** report to local ombudsman, local law enforcement, and corresponding licensing agency (CDPH or DSS) **2. Long-term care facility, abuse other than physical:** report to local ombudsman or local law enforcement **3. State mental health hospital or state development center:** report to designated investigators at California Department of State Hospitals, California Department of Developmental Services, and local law enforcement **4. Anywhere other than the above:** report to adult protective services agency or local law enforcement	Local law enforcement
Time Frame	1. Immediate telephone report 2. Follow up with written report by mail, fax or email within 36 hours	1. Immediate report by telephone or confidential Internet reporting tool (if available) 2. If initially reported by phone, follow up with written report or Internet report within two working days **NOTE:** If the abuse occurred in a long-term care facility, quicker reporting is required (sometimes within 2 hours of learning of the incident). See Welfare and Institutions Code Section 15630(b).	1. Immediate telephone report 2. Follow up with written report within two working days
Required Form	"Suspected Child Abuse Report," Department of Justice, Form SS 8572. Obtain from local social services or child protective services agency or download at www.ccfmtc.org	"Report of Suspected Dependent Adult/Elder Abuse," California Department of Social Services, Form SOC 341, download at www.ccfmtc.org	"Suspicious Injury Report," Office of Emergency Services (OES), Form CalOES 2-920, download at www.ccfmtc.org

Sexual Assault/Rape In addition to the above reporting requirements, each county must designate at least one general acute care hospital to perform forensic examinations on victims of sexual assault, including child molestation. Examination requires the consent of the patient. Local law enforcement must be notified by telephone prior to beginning the forensic examination. Forensic report forms may be downloaded at www.ccfmtc.org.

See chapter 19, "Assault and Abuse Reporting Requirements," of CHA's Consent Manual *for additional information.*

CALIFORNIA HOSPITAL ASSOCIATION

1215 K Street, Suite 800 • Sacramento, CA 95814 • (916) 443-7401 • www.calhospital.org

FORM 20-1

Adverse Event Report Form — *Sample*

[HOSPITAL LETTERHEAD]

(Must include hospital name and address elsewhere if this form is not reproduced on hospital letterhead)

[Date of report]

State of California, Department of Public Health
Licensing and Certification District Office
[Street Address]
[City], CA [ZIP]

To Whom It May Concern:

This hospital believes it may have detected the adverse event indicated below as defined in Health and Safety Code Section 1279.1, and is hereby reporting pursuant to Health and Safety Code Section 1279.1.

Due to the short time frame required for reporting in the law, the information this hospital has may be incomplete. If further investigation shows that no adverse event as defined in this law took place, you will be notified. However, in order to comply with the law's short time frame, this hospital is taking a precautionary measure and reporting accordingly.

This hospital may have detected the adverse event checked below:

- ☐ 1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. This does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
- ☐ 2. Surgery performed on the wrong patient.
- ☐ 3. The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. This does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
- ☐ 4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
- ☐ 5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

☐ 6. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

☐ 7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but it not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

☐ 8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

☐ 9. An infant discharged to the wrong person.

☐ 10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision making capacity.

☐ 11. A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for the admission to the health facility.

☐ 12. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

☐ 13. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

☐ 14. A maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

☐ 15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.

☐ 16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 miligrams per deciliter.

☐ 17. A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

☐ 18. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.

☐ 19. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.

☐ 20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

☐ 21. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.

☐ 22. A patient death associated with a fall while being cared for in a health facility.

☐ 23. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

☐ 24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

☐ 25. The abduction of a patient of any age.

☐ 26. The sexual assault of a patient within or on the grounds of a health facility.

☐ 27. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility. [Note: if this item is checked because a staff member suffered death or significant injury due to a physical assault on the grounds of the facility, please indicate the staff member's name at the bottom of the form, rather than a patient's name.]

☐ 28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor. [Note: An "adverse event" is defined as the incidents described in items 1. through 27., above. Thus, this category probably does not capture any additional adverse events not described in items 1. through 27. above. If for some reason an adverse event report is made about an event not listed in items 1. through 27. above, a brief description of the event should be included on this form. If a hospital has an adverse event that causes the death or serious disability of a patient, personnel, or visitor but is not listed above in items 1. through 27., legal counsel should be consulted to determine whether it should be reported. A different reporting requirement may apply.]

Hospital's code to link this report to its file regarding this potential adverse event:

_____

_____

_____

Date hospital detected the adverse event: _____

Please contact me at [insert phone number] or at [insert fax number] if you require further information.

Sincerely,

[Name]

[Title]

(over)

NOTE: "Serious disability" means:

a. A physical or mental impairment that substantially limits one or more of the major life activities of an individual, if the impairment lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or

b. The loss of bodily function, if the loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or

c. The loss of a body part.

**Generally, this report must be made within five days of detection. However, if the adverse event is an ongoing or urgent threat to the welfare, health, or safety of patients, personnel or visitors, a report must be made within 24 hours of detection.*

FORM 21-1

Incident Report

(Complete Immediately for Every Incident and Send to Administrator)

_____ _____

(Hospital Name) *(For Addressograph Plate)*

_____

(City)

Administrator:
Please forward to Hospital Attorney

Confidential Report of an Incident
(Not a Part of the Medical Record)

Patient: _____ Age: _____ Sex: _____ Room: _____
(Last Name, First Name) *(M / F)*

Admitting Diagnosis: _____ Date of Admission: _____

If Outpatient, Date of Visit: _____ Reason for Visit: _____

Attending Physician: _____

Date of Incident: _____ Time: _____ AM / PM

Were Bed Rails Up? _____ Was Safety Belt In Use? _____

Was Patient Rational? _____ Hi/Lo Bed Position: _____

Drugs Given Within 12 Hours Prior to Incident:

Sedatives: _____ Dose: _____ Time: _____ AM / PM

Narcotics: _____ Dose: _____ Time: _____ AM / PM

Dr. _____ Notified By: _____

At Time: _____ AM / PM Time Doctor Responded: _____ AM / PM

Nurse's Account of the Incident (Include Exact Location):

_____

_____

_____

List Witnesses or Persons Familiar With Details of Incident and Other Patients in the Same Room:

Name: _____

Address: _____

_____

Phone: _____

Name: _____

Address: _____

_____

Phone: _____

Name: _____

Address: _____

_____

Phone: _____

History of Incident as Related By the Patient: _____

_____

Immediate Actions (and their outcomes): _____

_____

_____

Notifications:

a. Will/was report made under the Safe Medical Devices Act? Yes No (circle one)

b. Will/was report made to the California Department of Public Health as an adverse event or unusual occurrence? Yes No (circle one)

c. Will/was patient or legal representative notified of any unexpected outcome? Yes No (circle one)

d. Will/was attending physician notified? Yes No (circle one)

Doctor's Report of Patient's Condition (From Progress Notes): _____

_____

_____

_____

Date of Report: _____ Time: _____ AM / PM

Signature: _____

(Nurse or Supervisor Reporting)

FORM 21-2

Report to Attorney

This Report is Confidential—
Not Part of the Medical Record

Date of Report: _____ / _____ / _____ Time: _____ AM / PM
MM DD YY

Name of Patient or Person Involved: _____

Medical Record Number or Other Identifying Information: _____

Check One:

☐ Inpatient Admitting Diagnosis: _____

☐ Outpatient/ER Reason for Visit: _____

☐ Visitor/Volunteer

Sex: ☐ Male ☐ Female

Age: _____ Yrs.

If under 1 year, circle one: 0-14 days 15-29 days 1-6 months 7-11 months

Newborn Problems:

☐ Not Applicable ☐ Apgar less than 5 at 5 minutes

☐ Coma ☐ Gestation less than 35 weeks

☐ Convulsion

Date/time of admission: _____ / _____ / _____ _____ AM / PM *(circle one)*
MM DD YY

Date/time of event or effect: _____ / _____ / _____ _____ AM / PM *(circle one)*
MM DD YY

Description of what happened (include exact location): _____

_____

If drug, IV infusion, treatment or equipment involved, specify name: _____

Description of immediate actions and outcome: _____

_____

Lost/damaged property: _____

Severity of outcome:

- ☐ **Minor outcome:** Medical review, extra observations or monitoring
- ☐ **Moderate outcome:** Minor diagnostic investigations or treatments (e.g. blood test, urinalysis, first aid treatment)
- ☐ **Moderate/Significant outcome:** Treatment with another drug, surgical intervention/ cancellation, transfer to another area with no increased length of stay
- ☐ **Significant outcome:** Hospital admission or increased length of stay/morbidity which continued at discharge
- ☐ **Severe outcome:** Permanent disability or contributed to the patient's death

Notifications:

a. Will/was report made under the Safe Medical Devices Act? Yes No (circle one)

b. Will/was report made to the California Department of Public Health as an adverse event or unusual occurrence? Yes No (circle one)

c. Will/was patient or legal representative notified of any unexpected outcome? Yes No (circle one)

d. Will/was attending physician notified? Yes No (circle one)

Witnesses to event or effect:

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

This report completed by:

Name: _____

Title: _____

Phone: _____

FORM 23-1

Consent for the HIV Test

Patient's Name: _____

I am consenting to be tested to see whether I have been infected with the Human Immunodeficiency Virus (HIV), which is the probable causative agent of Acquired Immune Deficiency Syndrome (AIDS).

The Meaning of the Test

This test is not a test for AIDS but only for the presence of HIV. Being infected with HIV does not mean that I have AIDS or that I will have AIDS or other related illnesses in the future. Other factors must be reviewed to determine whether I have AIDS.

Most test results are accurate, but sometimes results can be wrong or uncertain. Test results could indicate that I am infected with HIV when I am not (false positive) or they could fail to detect that I am infected with HIV when I really am (false negative). Sometimes, the test cannot tell whether or not I am infected at all. If I have been recently infected with HIV, it may take some time before a test will detect the infection. For these reasons, I may have to repeat the test.

Confidentiality

California law limits the disclosure of my HIV test results. As a general rule, the law states that no one but my doctor and other caregivers may be told about the test results unless I give specific written consent to let other people know. However, in some cases, my test results could be disclosed to my spouse, any sexual partner(s) or needle-sharing partner(s), the county health officer, to a health care worker who has had a substantial exposure to my blood or other potentially infectious material or to some other persons as required or authorized by law. Information relating to my test results is kept in my medical record.

Benefits and Risks of the Test

The test results can help me make better decisions about my health care and my personal life. The test results can help me and my doctor make decisions concerning medical treatments. There are numerous treatment options available for persons who test positive for HIV. If the results are positive, I know that I can infect others and that I can act to prevent this.

Potential risks of the test include psychological stress while awaiting the results and distress if the results are positive.

Obligations of Ordering Medical Care Providers

A doctor or other medical care provider who orders an HIV test is required to:

- Inform the patient that an HIV test is planned;
- Provide information to the patient about the HIV test;
- Inform the patient that there are numerous treatment options available for a person who tests positive for HIV and that a person who tests negative for HIV should continue to be routinely tested; and

- Advise the patient that he or she has the right to decline the HIV test.

I understand that if I am pregnant, my doctor will give me additional information about HIV and the HIV test as it applies to my condition.

More Information

I understand that before I decide to take this test I should be sure that I have asked my doctor any questions I may have about the test, its meaning, its risks and benefits, and any alternatives to the test.

Consent for HIV Test

By my signature below, I confirm that:

- I have read and understood the information in this form and I understand it;
- I have been given all of the information I desire concerning the HIV test, its meaning, expected benefits, possible risks, and any alternatives to the tests, and I have had my questions answered;
- I understand that I have the right to decline an HIV test; and
- I give my consent for the performance of a test to detect HIV.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship*: _____

Print name: _____
(legal representative)

**This consent may be signed by a person other than the patient only under the following circumstances:*

1. The patient is under twelve (12) years of age or, as a result of his/her physical or mental condition, is incompetent to consent to the HIV antibody blood test; and
2. The person who consents to the test on the patient's behalf is lawfully authorized to make health care decisions for the patient, e.g., an agent appointed by the patient in a power of attorney for health care; the parent or guardian of a minor; an appropriately authorized conservator; or, under appropriate circumstances, the patient's closest available relative *(see chapters 2 and 23 of CHA's* Consent Manual*)*; and
3. It is necessary to obtain the patient's HIV antibody test results in order to render appropriate care to the patient or to practice preventative measures.

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: Health and Safety Code Section 121020

FORM 23-1S

Consentimiento para la Prueba del Anticuerpo Contra el VIH

Nombre del Paciente: _____

Por el presente doy mi consentimiento para hacer una prueba que determine si he sido infectado(a) con el Virus de Inmunodeficiencia Humana (VIH), el cual es probablemente el agente causante del Síndrome de Inmunodeficiencia Adquirida (SIDA).

Elsignificado de la Prueba

Esta prueba no se usa para detectar el SIDA, sino solamente la presencia del VIH. El estar infectado(a) con el VIH no significa que tenga SIDA o que voy a tener SIDA, u otras enfermedades relacionadas en el futuro. Para determinar si tengo SIDA, deberán considerarse otros factores.

La mayoría de los resultados de la prueba son exactos, pero algunas veces los resultados pueden ser erróneos o inciertos. Los resultados de las pruebas podrían indicar que estoy infectado(a) con el VIH, cuando en realidad no lo estoy (positivo falso) o podrían no detectar que estoy infectado(a) con el VIH cuando sí lo estoy (negativo falso). Otras veces el examen no puede determinar si una persona está infectada o en realidad no lo está. Si he sido infectado(a) recientemente con el VIH, puede pasar algún tiempo antes de que una prueba detecte la infección. Por estos motivos, es posible que deba repetir la prueba.

Confidencialidad

La ley de California limita la divulgación de los resultados de mi prueba VIH. Por lo general, la ley indica que nadie, con la excepción de mi médico y de otros proveedores de servicios de atención de la salud, puede obtener los resultados de la prueba, a menos que yo consienta específicamente por escrito que otras personas conozcan dichos resultados. Sin embargo, en algunos casos los resultados de mi prueba podrían ser divulgados a mi cónyuge, a mi(s) compañero(s) sexual(es) o a la(s) persona(s) con quien(es) haya compartido agujas, al funcionario de salud del condado o a un proveedor de servicios de atención de la salud que haya estado expuesto en forma considerable a mi sangre o a otros materiales potencialmente infecciosos o a otras personas, según lo requiera o autorice la ley. La información relacionada con los resultados de mi prueba se conserva en mi expediente médico.

Beneficios y Riesgos de la Prueba

Los resultados de la prueba pueden ayudarme a tomar mejores decisiones en cuanto al cuidado de mi salud y mi vida personal. Los resultados de la prueba pueden ayudarnos a mí y a mi médico a tomar decisiones con respecto a mi tratamiento médico. Existen numerosas opciones de tratamiento disponibles para las personas que presentan resultados positivos a las pruebas de detección de VIH. Si los resultados son positivos, sé que puedo infectar a otras personas y que puedo tomar acción para evitarlo.

Los posibles riesgos de la prueba incluyen tensión sicológica, mientras espero los resultados y ansiedad, si los resultados son positivos.

Obligaciones Para los Proveedores de Atención Médica Que Solicitan las Pruebas

Un médico u oto proveedor de atención médica que solicita una prueba de detección de VIH debe:

- Informar al paciente que se planea realizar una prueba de detección de VIH.
- Proporcionar al paciente información sobre la prueba de detección de VIH.
- Informar al paciente que existen numerosas opciones de tratamiento disponible para las personas que presentan resultados positivos a las pruebas de detección de VIH y que una persona que presenta resultados negativos en una prueba de detección de VIH debería seguir sometiéndose a pruebas periódicamente, e
- Informar al paciente que tience el derecho de rechazar la prueba de detección de VIH.

Entiendo que, si estuviera embarazada, mi médico me proporcionará información adicional sobre el VIH y sobre la prueba de detección de VIH en relación a mi estado.

Más Información

Entiendo que antes de que decida tomar esta prueba, debo asegurarme de que he haber hablado con mi médico sobre cualquier pregunta que tenga sobre la prueba, su significado, sus riesgos y beneficios, así como cualesquiera alternativas a dicha prueba.

Consentimiento Para la Prueba de Detección del VIH

Al firmar abajo, confirmo que:

- He leído y comprendido la información en este formulario y la entiendo;
- Se me ha proporcionado toda la información que deseo con respecto a la prueba del VIH, su significado, los beneficios esperados, los posibles riesgos y cualesquiera alternativas a la prueba y que se me han contestado mis preguntas;
- Entiendo que tengo el derecho de rechazar una prueba de detección de VIH; y
- Doy mi consentimiento para que se realice el examen para detectar el VIH.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste*: _____

Nombre en letra de imprenta: _____
(representante legal)

**Este formulario de consentimiento solamente podrá ser firmado por otra persona que no sea el paciente bajo las siguientes circunstancias:*

1. El paciente tiene menos de doce (12) años de edad o, como resultado de su condición física o mental, es incompetente para consentir a la prueba de sangre para detectar el anticuerpo contra el VIH; y
2. La persona que consiente a esta prueba a favor del paciente está legalmente autorizada para tomar decisiones relacionadas con la atención médica del paciente; por ej., un representante nombrado por el paciente en un poder notarial para la atención de la salud; el padre o tutor de un menor; un conservador debidamente autorizado; o, en circunstancias adecuadas, el familiar disponible más cercano al paciente *(véase el* Manual de Consentimiento *de CHA, capítulos 2 y 23)*; y
3. Es necesario obtener del paciente los resultados de la prueba del anticuerpo contra el VIH a fin de prestarle la debida atención médica o de tomar medidas preventivas.

**This consent may be signed by a person other than the patient only under the following circumstances:*

1. The patient is under twelve (12) years of age or, as a result of his/her physical or mental condition, is incompetent to consent to the HIV antibody blood test; and
2. The person who consents to the test on the patient's behalf is lawfully authorized to make health care decisions for the patient, e.g., an agent appointed by the patient in a power of attorney for health care; the parent or guardian of a minor; an appropriately authorized conservator; or, under appropriate circumstances, the patient's closest available relative *(see chapters 2 and 23 of CHA's* Consent Manual*)*; and
3. It is necessary to obtain the patient's HIV antibody test results in order to render appropriate care to the patient or to practice preventative measures.

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: Health and Safety Code Section 121020

APPENDIX 25-A

Report of a Hospital Death Associated With Restraint or Seclusion

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1210

REPORT OF A HOSPITAL DEATH ASSOCIATED WITH RESTRAINT OR SECLUSION

A. Hospital Information:

Hospital Name	CCN

Address

City	State	Zip Code

Person Filing the Report	Filer's Phone Number

B. Patient Information:

Name	Date of Birth

Primary Diagnosis(es)

Medical Record Number	Date of Admission	Date of Death

Cause of Death

C. Restraint Information *(check only one)*:

☐ While in Restraint, Seclusion, or Both
☐ Within 24 Hours of Removal of Restraint, Seclusion, or Both
☐ Within 1 Week, Where Restraint, Seclusion or Both Contributed to the Patient's Death

Type *(check all that apply)*:
☐ Physical Restraint ☐ Seclusion ☐ Drug Used as a Restraint

If Physical Restraint(s), Type *(check all that apply)*:

☐ 01 Side Rails
☐ 02 Two Point, Soft Wrist
☐ 03 Two Point, Hard Wrist
☐ 04 Four Point, Soft Restraints
☐ 05 Four Point, Hard Restraints
☐ 06 Forced Medication Holds
☐ 07 Therapeutic Holds
☐ 08 Take-downs
☐ 09 Other Physical Holds (specify): _____
☐ 10 Enclosed Beds
☐ 11 Vest Restraints
☐ 12 Elbow Immobilizers
☐ 13 Law Enforcement Restraints

If Drug Used as Restraint:

Drug Name	Dosage

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