Misery Loves Company: Collaborating to Help Patients with Complex Needs Get "Unstuck"

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Children's System of Care Division, Placer County
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California Region Behavioral Health Director, CommonSpirit Health

California Hospital Association

Presenter

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Director, Children's System of Care Division

Placer County

Twylla Abrahamson has been employed by Placer County since 2007 and is currently the Deputy Director for Health and Human Services over the Children's System of Care. She is also the Behavioral Health Compliance Officer and was formerly employed as a Health Program Manager in Sacramento County Adult Behavioral Health Services. Ms. Abrahamson is a licensed psychologist and spent 16 years with a Sacramento area non-profit mental health agency while also teaching doctoral level courses at two universities.

California Hospital Association

Presenter

Brian Jensen

Regional Vice President

Hospital Council of Northern and Central California

Brian Jensen is an executive with a quarter century of public policy and government relations experience, over a decade of experience building partnerships with health care organizations, and an extensive civic leadership record. In his current role, he accomplishes local advocacy outcomes on behalf of 47 member hospitals in a 15-county territory. He has convened groups of diverse health stakeholders and facilitated efforts to improve mental health delivery, emergency medical services, and health care workforce development.

California Hospital Association

Presenter

Celeste Sweitzer, LCSW

California Region Behavioral Health Director

CommonSpirit Health

Celeste Sweitzer oversees services for 29 hospitals and numerous behavioral health units, including two EmPATH behavioral health emergency units and a freestanding behavioral health center. A licensed clinical social worker with over 20 years of experience at Dignity Health, Celeste is passionate about providing timely and efficient care to individuals in behavioral health crises. She has presented at Becker's Hospital review on the parallel process of working concurrently with the emergency room physician to get the patient's crisis behavioral health services started.

Disclosure of Relevant Financial Relationships

Twylla Abrahamson, PhD, reports no relevant financial relationships or relationships she has with ineligible companies of any amount during the past 24 months.

Brian Jensen, reports no relevant financial relationships or relationships he has with ineligible companies of any amount during the past 24 months.

Celeste Sweitzer, LCSW, reports no relevant financial relationships or relationships she has with ineligible companies of any amount during the past 24 months.

Misery Loves Company

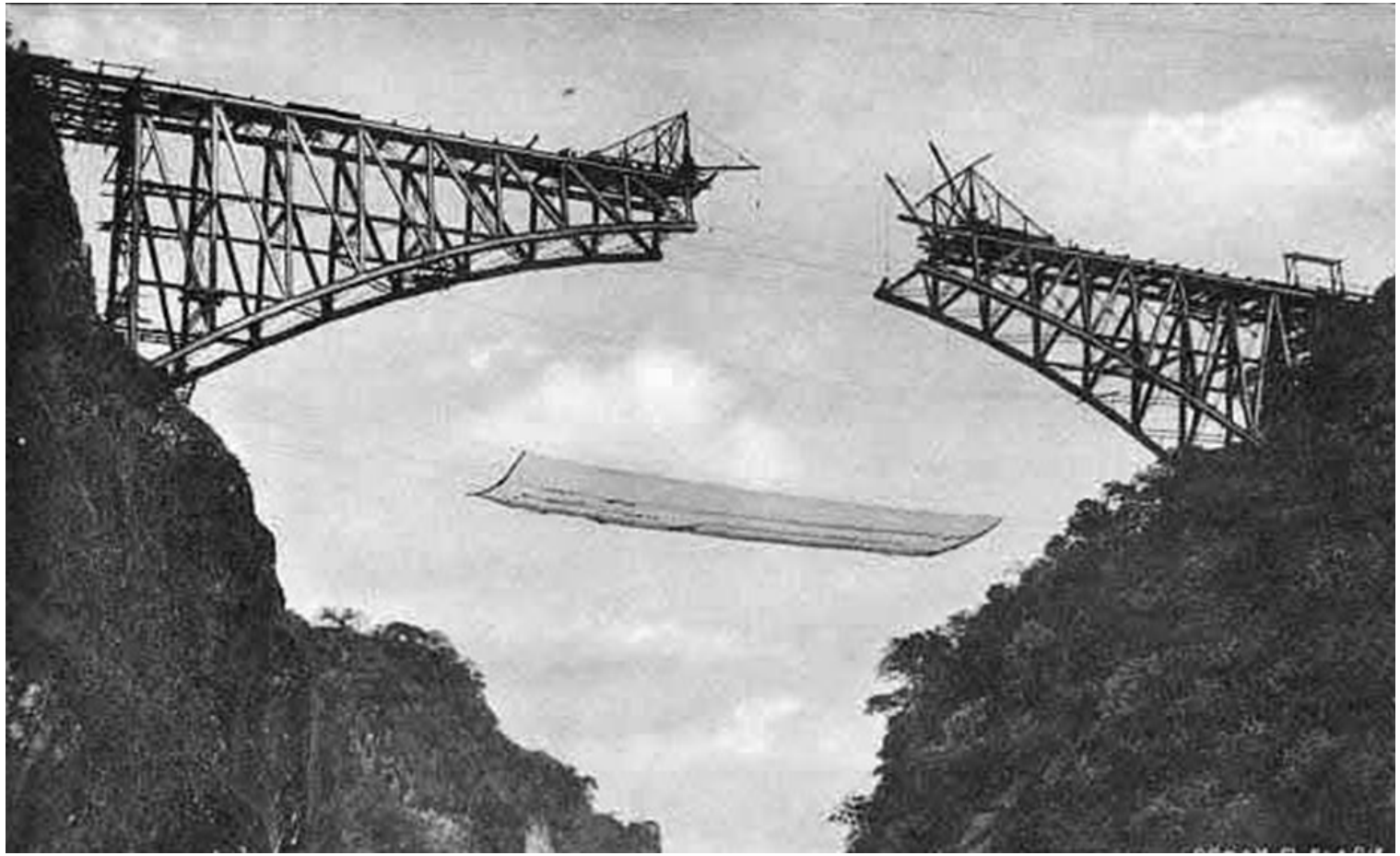
Collaborating to Help Patients with Complex Needs Get "Unstuck"

“If you want to go fast, go alone.
If you want to go far, go together.”

– African Proverb

Collaboration

Collaboration



"Alone we can do so little; together we can do so much."

– Helen Keller


2020

Coming Together

Collaborating Organizations

HOSPITALS

Hospital Council – Northern & Central California

Adventist Health + Rideout

Dignity Health

Heritage Oaks Hospital

Kaiser Permanente

Marshall

Sacramento Behavioral Health Hospital

Sierra Vista Hospital

St. Joseph's Behavioral Health Center

Sutter Health

UC Davis Health

COUNTIES

El Dorado County

Placer County

Sacramento County

San Joaquin County

Sutter County

Yolo County

Yuba County

OTHER PARTNERS

Alta California Regional Center

Children's Law Center

Crestwood Behavioral Health

Turning Point Community Programs

WellSpace Health

Risk Management Issues

Sacramento Region Behavioral Health Task Force

Elements of a Violence Mitigation Plan for Health Care Facilities and Outpatient Mental Health Programs

Providers of mental health services in all settings seek to maintain a safe environment to promote care and healing. This is best achieved by an organizational commitment to:

- Sponsoring and engaging in a violence prevention and mitigation program
- Understanding and addressing the root causes of violence
- Equally valuing patient and staff safety
- Mutual engagement and collaboration with all care team members: staff, patients/consumers, and their families

Actions: "THE WHAT"	Best Practices: "THE HOW"
I. SCREENING / RISK STRATIFICATION	
Screen all patients	Evidence-based violence screening tools: • The Brøset Violence Checklist (BVC) at www.riskassessment.no/ • Oregon Association of Hospitals and Health Systems Risk of Violence Assessment tool at www.oahhs.org › files › 5a WPV risk assessment tool • V-RISK-10 – Sifer at https://sifer.no/verktoy/v-risk-10/ • STAMP - Quick Safety Issue 47: De-escalation in Health Care at www.jointcommission.org/quick-safety/quick-safety-47-deescalation-in-health-care/
	Evidence-based screening tools for high-risk medical conditions linked to violent behavior: • Richmond Agitation Sedation Scale (RASS) at www.mnhospitals.org/RASS Sedation Assessment Tool.pdf
	Process and policy to implement use of the tool and audit its effectiveness
II. COMMUNICATION OF RISK	
Environmental communication	Risk communication process and policy (e.g., sign on door)
Electronic record communication	Use of records to identify risk and history of violence (e.g., alert flag), and documentation of new incidents for future violence prevention and risk management
Verbal communication	In-person communication of potential risk (e.g., huddle, report, shift change) and development of care plan

Elements of a Violence Mitigation Plan for Health Care Facilities and Outpatient Mental Health Programs

Actions: "THE WHAT"	Best Practices: "THE HOW"
III. PREVENTION / INTERVENTION / POSTVENTION	

Prevention	• Staff training in implicit bias in health care, trauma-informed care, de-escalation, situational awareness, environmental safety, appropriate limit setting, organizational policies, and processes
	• Person-centered, relationship-based care models
	• Individualized plan of care/coping agreement, including assessment of strengths and resiliency
	  • CPI – Nonviolent Crisis Intervention®
	  • Pro-ACT – Professional Assault Crisis Training
	  • https://therapeuticoptions.com/

Proactive, clinically focused intervention with de-escalation	• Establish a Behavioral Emergency Response Team/ Behavioral Escalation Support Team • Establish tiered response codes as needed • Review Psychiatric Rapid Response Team Abstract at https://pubmed.ncbi.nlm.nih.gov/31090558/
Threshold for security-focused intervention	• Understand the risks and benefits of a security-based intervention • Clearly define threshold and process: Who initiates a security-based intervention?
Post-incident debriefing for all parties involved	• Procedural debriefing • Therapeutic debriefing opportunity, peer support • Patient debriefing
IV. ONGOING QUALITY IMPROVEMENT	
Root cause analysis process	• Establish a standardized tool and process to review all events
Report	• Establish a standardized tool and process for reporting that meets both external and internal requirements
Review/Analyze	• Develop a committee to oversee the review process • Develop a committee to audit event reports and track data so trends can be analyzed and reported per Cal/OSHA requirements

PRINCIPAL CONTRIBUTORS

Dignity Health	**Rosemary Younts** **Catherine Geraty-Hoag**
Turning Point Community Programs	**Al Rowlett** **Leslie Springer**
UC Davis Health	**Jessica Vetter** **Sharon Demeter**

Sacramento Region Behavioral Health Task Force

Suicide Risk Prevention Best Practice Recommendations on The Joint Commission Standards 15.01.01

November 5, 2021

NPSG - National Patient Safety Goal
EP - Element of Performance

REQUIREMENTS	RECOMMENDATIONS
NPSG 15.01.01, EP 1	

The hospital conducts an environmental risk assessment
• Implements procedures to mitigate the risk of suicide for patients at high risk for suicide
	• Use of a standardized tool for assessment of ligature points and safety risk items in the environment
	  ◦ Conduct initial assessment
	  ◦ Conduct an annual assessment
	  ◦ Conduct an annual assessment when there is change in population served and/or alteration in the environment
	• Documentation of risk mitigation or correction
	• Staff education and training includes identified risks and mitigations in place
	• An environmental safety checklist is helpful tool

NPSG 15.01.01, EP 2	
Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool. • *Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.*	• Universal screening as best practice for 10 years old and above • Use of The Columbia-Suicide Severity Rating Scale (C-SSRS) as an evidence-based, validated tool

Suicide Risk Prevention Best Practice Recommendations on The Joint Commission Standards 15.01.01

REQUIREMENTS	RECOMMENDATIONS
NPSG 15.01.01, EP 3	
Use an evidence-based process to conduct a suicide risk assessment of patients who have screened positive for suicidal ideation. • The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. • *Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.*	• The goal is to identify high risk patients and provide appropriate level of care • Patients who "screen" high risk on C-SSRS will be "assessed" by *Behavioral health consultants/team using an evidence-based tool or process (Use an assessment tool that corresponds to the screening tool) • Patients who "screen" moderate risk on C-SSRS will be "assessed", per discretion of provider, by behavioral health consultants/team using an evidence-based process **Behavioral health consultants may include psychiatrists, psychologists, social workers, tele-psychiatry etc. per hospital policy.*
NPSG 15.01.01, EP 4	

Document patients' overall level of risk for suicide and the plan to mitigate the risk for suicide	• Overall risk is determined by the assessment (risk and protective factors are critical)
	• Mitigation as follows and documented:
	High Risk
	  ◦ 1:1 continuous observation
	  ◦ Removal of potentially harmful objects to the extent possible (use environmental safety checklist)
	Moderate Risk
	  ◦ Behavioral health consultation per provider discretion
	  ◦ Note: line of sight is not automatically required; follow hospital policy on addressing patient safety and observation levels.

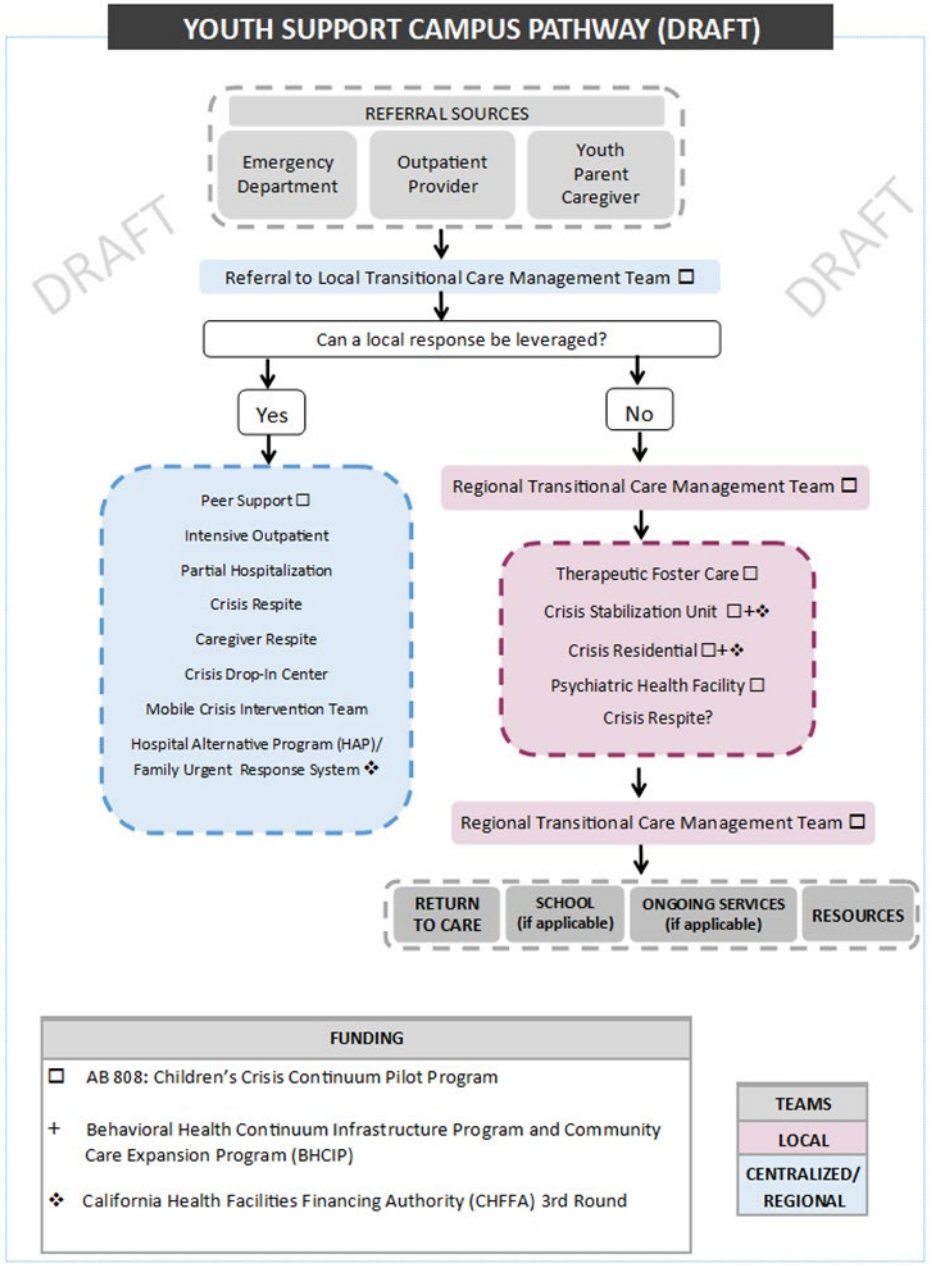
NPSG 15.01.01, EP 5	

Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following:
• Training and competence assessment of staff who care for patients at risk for suicide
• Guidelines for reassessment
• Monitoring patients who are at high risk for suicide
CMS: Hospitals must provide the appropriate level of education and training to staff regarding the identification of patients at risk of harm to self or others, the identification of environmental patient safety risk factors and mitigation strategies. CMS recommends initial training and then ongoing training at least every two years thereafter.
	• Policy to address
	  ◦ Training and competence assessment of staff who care for patients at risk for suicide
	  ◦ Guidelines for reassessment
	  ◦ Monitoring patients who are at high risk for suicide
	• Training frequency done during initial orientation, when there is a change in the policy and no less than every 2 years
	• Training content is addressed outside of the policy
	• *Examples of content:* Environmental risk and mitigation, 1:1 continuous observation training for sitters, screening, and assessment (training/competency varies depending on role, licensure etc.)

Suicide Risk Prevention Best Practice Recommendations on The Joint Commission Standards 15.01.01

REQUIREMENTS	RECOMMENDATIONS
NPSG 15.01.01, EP 6	
Follow written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide	• Include National Suicide Prevention Lifeline and/or other resources on the after-visit summary (AVS) for all patients • High Risk
NPSG 15.01.01, EP 7	
Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and take action as needed to improve compliance.	• Partner with quality/risk department on process to monitor effectiveness of the policy • Includes data/metrics being monitored • Develop improvement plan where indicated • *Examples*: % of high, moderate, low risk, compliance rate, 1:1 utilization, patient events, suicide, action taken

Youth Crisis Continuum Expansion



Care Transitions for Complex Patients

Sacramento Region Behavioral Health Task Force

Caring for System-Involved Youth in Acute Hospital Settings

Step-by-Step Guide for Hospital Personnel

Youth is taken to a hospital emergency department

Determine who is authorized to sign consent for medical treatment

Non-system involved:

- If parent, no additional authorization is required
- If legal guardian with letter of guardianship, no additional authorization is required
- If "qualified relative" presenting with a caregiver affidavit, no additional authorization is required

System involved:

- If the youth has a probation officer
- If the youth has a child protective services worker
- If there is a foster parent, group home, or short-term residential treatment administrator

Obtain local form (e.g., JC/E 365 in Sacramento County) or a minute order or confirm that parents retain rights to make medical decisions.

Determine who is authorized to sign consent for psychotropic medication

Non-system involved:

- If parent/legal guardian, no additional authorization is required

System involved:

- If the youth has a probation officer
- If the youth has a child protective services worker
- If there is a foster parent, group home, or short-term residential treatment administrator

Obtain JV 220 and 223 or confirm that parents retain rights to make psychotropic medication decisions. See JV 217 for additional information on psychotropic medication forms.

Determine insurance status: Medi-Cal, private, or self-pay

If it is Medi-Cal, identify county of behavioral health responsibility (usually it is in the same county of residence).

Questions to ask:

1. What county is responsibile when the child is in hospital?

2. What county is responsible when the child is discharged?

Identify which county's juvenile court placed the child (dependency court or juvenile justice)

Foster parent, relative caregiver, or group home administrator should have this information. If not, see below.*

Notify the county of jurisdiction (child protective services or probation) that placed the child via 24/7 call line to ensure it is notified that the youth is in the emergency department**

System-involved youth will have an attorney. County social worker/ probation officer must notify child's attorney to let them know the youth is in hospital.

County social worker/ probation officer to determine if there is an existing behavioral health services provider. If so, contact the provider to coordinate care.

Develop a transition/safety plan for inpatient hospitalization or release into the community in the event that hospitalization is not possible

Determine if there is an existing behavioral health services provider and if there is a care plan in place

If yes, notify them that youth is in the hospital.

If no, provide referral to access and linkage to outpatient service provider as appropriate to insurance type.

If the child is in the emergency department for 24 hours without a clear plan, a care conference may be appropriate.

A care conference should happen as early as possible (in person, virtual, telephonic) for all youth who will be transitioning from the hospital to another setting/placement. The care team may include:

- Acute care hospital representatives
- County social worker and/or probation officer
- Family/friends as appropriate — determined by county social worker and/or probation officer, and/or attorney
- Attorney
- A clinician from the current facility
- Therapeutic team members (i.e., ongoing therapist, flexible integrated therapy)
- Representative from an identified authorized placement (check with county social worker)

Conference goals should include:

- Identifying the least restrictive placement possible, as permitted by court order
- Identifying anticipated time frames
- Planning for safety and security
- Planning for ongoing medical needs after care, including medications
- Planning for ongoing mental health care, including psychiatric medications and authorizations
- Assessing the appropriateness and desirability of voluntary hospitalization during follow-up with attorney

Placement *per current court order* upon discharge if/when the application/voluntary hold is discontinued:

- Home with parents or legal guardian
- Home of relative or family friend
- Foster care home
- Short-term residential therapeutic program

*Note: This list **could apply** to non-minor dependents*

* **County mental health points of contact for presumptive transfer of foster care youth:**
https://www.cdss.ca.gov/inforesources/foster-care/presumptive-transfer/county-points-of-contact

** **CPS Emergency Response Hotline Numbers:**
https://www.hwcws.cahwnet.gov/countyinfo/county_contacts/hotline_numbers.asp

County Probation Department Contacts:
https://www.cpoc.org/post/find-my-county-probation-department

Family Urgent Response System (FURS) hub to information and resources:
https://www.cdss.ca.gov/inforesources/cdss-programs/foster-care/furs

FURS outreach materials: https://www.cdss.ca.gov/inforesources/cdss-programs/foster-care/family-urgent-response-system/outreach-materials

Sacramento Region Behavioral Health Task Force

Placement of System-Involved Youth Discharged from a Psychiatric Hold

Step-by-Step Guide for Psychiatric Facility, Child Welfare Agency/Probation, and Child's Attorney

Youth involuntarily hospitalized pursuant to Welfare and Institutions Code 5150/5585.50, 5250, 5260, or 5270.15

Upon admission, psychiatric hospital staff contacts child welfare agency/probation regarding date of admission and type of hold

Child welfare agency/probation case carrying social worker:

Maintains contact with facility to determine recommended course of action and anticipated discharge date

A care conference should happen as early as possible (in-person, virtual, telephonic) for all youth who will be transitioning from the hospital to another setting/placement. The care team may include:

- Acute care hospital representatives
- County social workers and/or probation officer
- Family/friends as appropriate — determined by county social worker and/or probation officer, and/or attorney
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- Home of relative or family friend
- Foster care home
- Short-term residential therapeutic program

*Note: This list **could apply** to non-minor dependents*

72-Hour Involuntary Hold

Child Welfare Agency/ Probation Case Carrying Social Worker

Contact facility to determine:

- Diagnosis
- Current symptoms
- Legal basis for hold
- Recommended medications
- Day/time involuntary hold will expire
- If further involuntary mental health treatment is recommended

14-Day Involuntary Hold

Child Welfare Agency/ Probation Case Carrying Social Worker

Maintain contact with facility to determine:

- Legal basis for continued hospitalization (gravely disabled, danger to self/ others)
- Recommended course of treatment
- Anticipated discharge date

Subsequent 14-Day Involuntary Hold for Suicidal Person

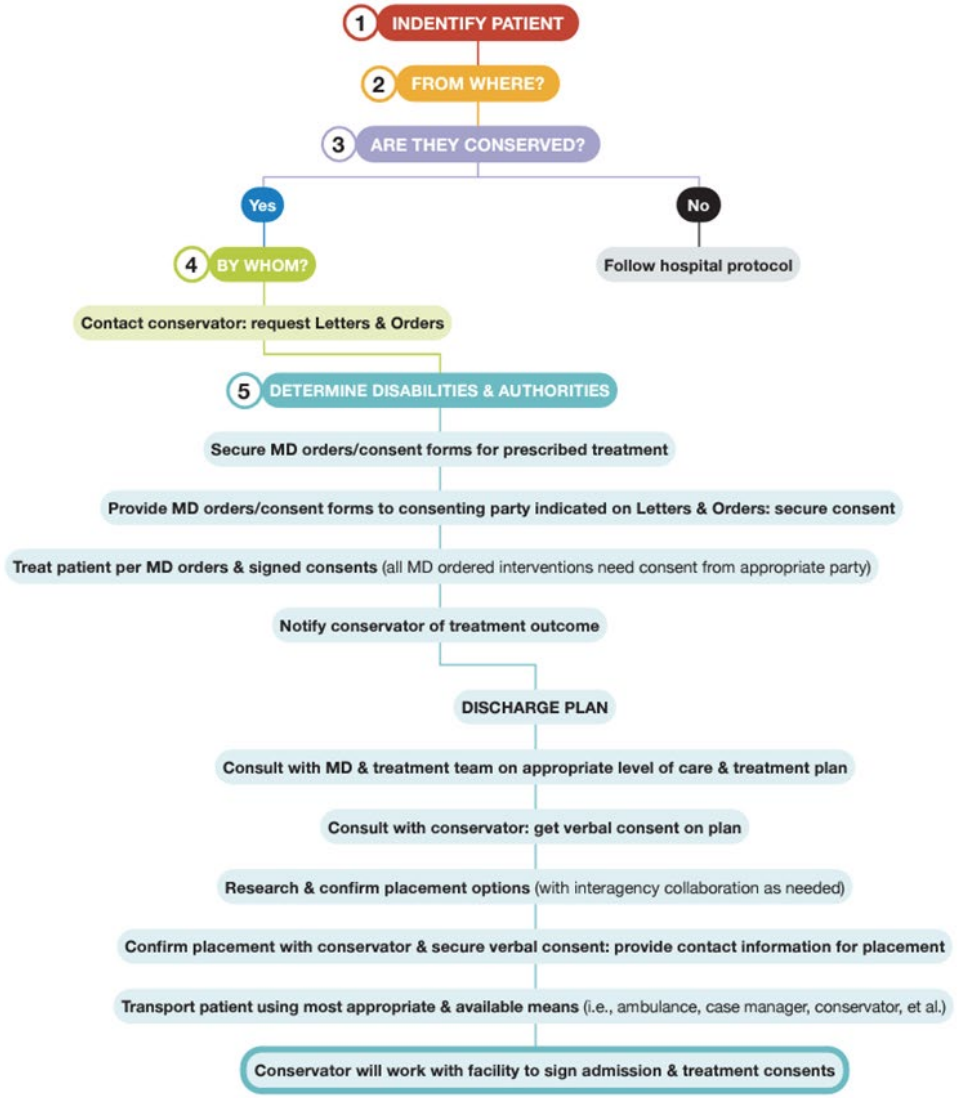
NOTE: Child must be released after subsequent 14-day hold expires unless under Lanterman-Petris-Short (LPS) Act conservatorship.

30-Day Hospitalization of Gravely Disabled Child

NOTE: Child must be released after the 30-day hold expires unless a petition for appointment of LPS Act conservatorship is established (accepted and filed with probate court).

Sacramento Region Behavioral Health Task Force

Conserved Patient Process



Sacramento Region Behavioral Health Task Force

Conserved Patient Investigation Process

1 INDENTIFY PATIENT

Confirm the patient's identity with the party who brought in the patient (i.e., ambulance, law enforcement, friends, family, care provider, et al.). Search their wallet/purse, clothing, personal effects (e.g., backpacks, etc.).

Consult with your peers. It is not uncommon for hospital staff to be very familiar with some patients due to a history of multiple admits.

2 FROM WHERE?

Where did the patient come from? (i.e., homelessness, independent living, board and care, mental health residential center, chronic psychiatric facility, acute-psychiatric facility, etc.)

3 ARE THEY CONSERVED?

Consult with collateral contacts who may have transported (i.e., ambulance, care provider, friend, et al.) or been accompanying the patient. The setting in which the patient lives may be a clue as to their conservatorship status (i.e., a person must be conserved to be placed in a chronic psychiatric facility). If they came in on a 5150 hold, information needed to remediate the crisis is allowed to be shared under HIPAA, so a crisis worker or psychiatric facility staff making the referral for medical clearance may know the person's conservatorship status and could legally share that during a crisis. There may be an indication of conservatorship status in the contents of the patient's wallet, purse, or personal effects, like a business card from the conservator or representative payee. A payee is not a guarantee of conservatorship status, though they would likely know if the person is conserved and who the conservator is. Prior admit hospital records at your facility may indicate a conservatorship and contact person. A county or private mental health provider may not be willing or able to provide you information during a cold call, but may be able to direct you to someone who can help (e.g., the person answering the phone may not have the authority to disclose HIPAA protected information, but the conservator they refer you to almost certainly can).

4 BY WHOM?

The conservatorship is typically held by either a private party (i.e., family, private conservator, et al.) or the county public guardian/conservator from the patient's county of residence. However, placement location is not a good indicator of conservatorship location (e.g., a Placer County conservatee may be placed in a facility in Sacramento County, but the person is still a Placer County conservatee). The collateral contacts or other methods used in No. 3 above will get you to the identification of the conservator if there is one. Once you identify the conservator, contact them, and request the "letters and orders of conservatorship (L & Os)" provided by the court that outline what rights the conservatee retained and/or what rights were transferred to the conservator.

5 DETERMINE DISABILITIES & AUTHORITIES

It is usually a good idea to have your legal team give the L & Os a quick read and provide you with their interpretation of who has the authority to consent for what kinds of treatment or interventions. For instance, the term "health care" typically refers to physical health care, not "mental health care." A family conservator may not be clear on the limitations of their authority, and you may unwittingly provide a treatment intervention authorized by someone who did not have authority to do so. In the face of conflicting information (e.g., L & Os say one thing, family conservator says another), follow the advice of your legal team.

Developed 12.8.22

Guiding Youth and Families Through Crisis

Handout for Adolescent Patients in Hospital ERs

What to expect now that you are at the hospital

We are here to help make sure you are safe. Our team of caregivers will ask questions to help us support you. It is important for you to know what may happen today.

- You may meet nurses, counselors, or doctors.
- You may be taken to a room to speak privately.
- You may receive a check-up.

We encourage you to ask questions at any time. You have a right to call someone.

RESOURCES

- You can also call Disability Rights California at (800) 776-5746 or TTY (800) 719-5798 to find the local Office of Patient Rights. You or a caregiver can also find the local office online.
- National Alliance on Mental Illness (NAMI): (800) 950-6264

*Scan the QR code to access an educational guide on **"Supporting Youth in Mental Health Crisis"***

Hospital Council
Northern & Central California

Notes:

Guide for Families and Caregivers of Youth

Brought to you in collaboration with:

Hospital Council Northern & Central California

El Dorado County California

County of Placer

Sacramento County

San Joaquin County — Greatness grows here.

Sutter County

Yuba County

Table of Contents

The Purpose of This Guide

You are reading this because you are a parent, guardian, caregiver, or another supporter of a young person experiencing a mental health crisis. This is likely a stressful and confusing time. You have an important role in the care and recovery of your loved one. The purpose of this tool is to make things a little easier.

First, please know that your young person is not alone. Globally, one in seven 10 to 19 year olds experiences a mental disorder, according to the World Health Organization. Closer to home, we have seen an increase in the number of children and adolescents needing mental health care, particularly since the onset of the COVID-19 pandemic in early 2020.

This guide is designed to assist you in supporting youth during and following a mental health crisis. It includes information about how to recognize the signs of a mental health crisis, what resources are available to you, options for treatment, what to expect in the process, and more.

Your loved one may choose to access a variety of services, including temporary psychiatric hospitalization. Depending on the severity of individual circumstances, they may also require involuntary care. In California, the Welfare & Institutions Code provides guidance on when a person — including youth — can be taken into custody, initially for a period of up to 72 hours, for crisis intervention, assessment, safety, and discharge planning.

This document will guide you in making informed decisions involving your youth's mental health needs, prepare you for what might come next, and equip you with knowledge of minor consent and confidentiality laws, patient rights, and possible recourse if there is a problem with patient care.

This guide is designed to assist you in supporting youth during and following a mental health crisis. It includes information about how to recognize the signs of a mental health crisis, what resources are available to you, options for treatment, what to expect in the process, and more.

What Does a Mental Health Crisis Look Like?

While evidence of mental health crisis can vary from person to person, it often shows as changes in behavior that include:

- Rapid mood swings
- Agitation
- Aggressive behavior
- Confused thinking or irrational thoughts
- Verbally stating, writing, or insinuating they'd like to hurt themselves or someone else
- Talking about death or dying
- Giving away belongings
- Texting, posting, or saying goodbye
- Extreme energy or lack of energy
- Changes in the completion of daily tasks
- Withdrawing from typically attended social situations
- Changes in diet, not eating, or eating all the time
- Hallucinations, delusions, or paranoia
- Losing touch with reality

Help During an Urgent Mental Health Crisis

If your youth is struggling with how they are feeling or thinking and needs to talk with someone, contact local crisis programs for help. There is no crisis that is too big or too small, so do not hesitate to reach out for help.

- Talk to a counselor at your child's school.
- Contact your insurance company for a list of covered providers who work with children and adolescents.
- For youth with Medi-Cal, contact your county behavioral health department.

Local Resources

El Dorado County
- **Crisis Hotline:** Placerville West Slope, (530) 622-3345 and South Lake Tahoe, (530) 544-2219
- **988 Suicide & Crisis Lifeline:** Call, text, or chat

Placer County
- **Placer County Intake and Mobile Crisis Team:** (916) 787-8860
  In-person response is available Monday-Friday, 9 a.m.-7 p.m. for all youth; and Saturdays, 10 a.m.-7 p.m. for youth ages 16 and older
- **Call 211:** A 24-hour hotline that connects you to help and resources; information is also available online

Sacramento County
- **The Source:** Call or text 916-SUPPORT (916-787-7678) or chat 24/7 online
- **Mental Health Urgent Care Walk-in Clinic:** 2130 Stockton Blvd., Building 300, Sacramento or call (916) 520-2460

San Joaquin County
- **24-hour crisis line:** (209) 468-8696
- **Prevention services:** (209) 468 2005

Sutter-Yuba counties
- **24-hour crisis/warm line:** (530) 673-8255 or (888) 923-3800
- **Psychiatric Emergency Services Clinic:** 7 a.m.-11 p.m., 1965 Live Oak Blvd., Yuba City
- **Adventist-Rideout emergency department, 24/7 if it's a life-threatening emergency:** 726 Fourth St., Marysville

Yolo County
- **2-1-1 Yolo County:** Information hub linking residents to vital health and human services resources and highly trained specialists — 24/7
- **Yolo County Mental Health Crisis and Access Line:** (888) 965-6647, available 24/7 for individuals who have a mental health crisis or who are seeking to access mental health treatment

State and National Resources

Behavioral Health California
- Find and access quality behavioral health care providers in California.

Disability Rights California
- Disability Rights California serves as California's advocacy system for human, legal, and service rights for individuals with disabilities.
  (916) 504-5800

National Alliance on Mental Illness (NAMI) & NAMI California

National Suicide Prevention Lifeline
(800) 273-8255

Crisis Text Line
Text 741-741 to connect with a trained crisis counselor to receive free, 24/7 support via text message

Seeking Care for a Mental Health Emergency

When other local resources are not enough, your child or adolescent may need more intensive, more immediate care.

- **If they are at risk of suicide, call 988.**
- **For other mental health emergencies call 911, or you may take them to the hospital emergency room.**
- **If someone wants to hurt themselves or others, SEEK HELP RIGHT AWAY.**

What Can You Expect at the Hospital?

If your youth is experiencing a mental health emergency, going to your hospital emergency department is the right next step. If eligible, they may agree to voluntary hospitalization. You may also consent to voluntary hospitalization on their behalf. While there, your youth's health care team (doctors, nurses, social workers, et. al) will determine your youth's medical needs and short-term mental health recommendations. The team will help your youth get the appropriate urgent medical treatment and will make recommendations for follow-up medical care. During this time, your youth may receive a medical assessment, including vital signs, diagnostic tests, lab tests, etc.

The team will help your youth get the appropriate urgent medical treatment and will make recommendations for follow-up medical care.

Many young patients will not need to go into an inpatient psychiatric hospital, but for those who do, the transfer process can take anywhere from several hours to several days. Various factors affect how long your youth may stay at the hospital while waiting to be transferred to a psychiatric hospital, including:
- Treatment of a critical medical condition or injury
- Assessment of the cause of your youth's crisis, which may be due to a mental illness
- Insurance

Planning for Discharge

A member of the treatment team, who could be a social worker, therapist, counselor, nurse, or other hospital staff, will speak with you prior to discharge to discuss the family's goals, preferences, and needs to begin developing a discharge plan for when your youth leaves the hospital. The primary provider overseeing your youth's care will also be involved to ensure that this plan aligns with your family's goals for the care and treatment.

The following elements will be used to develop your youth's plan and connect you to providers who can offer support after discharge:

- Your youth's diagnosis and treatment needs
- Medical issues and past medical history
- Your insurance company's provider list
- Ongoing needs after discharge
- Any safety risks that may require inpatient treatment
- Your social, family, psychological, employment, food, housing, and transportation needs
- Communication needs, language barriers, diminished eyesight or hearing, and literacy

When the member of the treatment team meets with you and your youth, they will help you select a provider. You and your youth should be involved in the development of the discharge plan so that you can prepare for the next steps after discharge.

Discharge options may include:

- Releasing youth to you or another family member, guardian, or caregiver
- Having your youth continue treatment in the hospital on a voluntary basis (and the hold may be released if applicable)*
- Transferring your youth to a psychiatric hospital — you have the right to request a specific location depending on availability

*You may have concerns about releasing the hold (if applicable) — these concerns can be discussed with the treatment team to identify options.

When the member of the treatment team meets with you and your youth, they will help you select a provider. You and your youth should be involved in the development of the discharge plan so that you can prepare for the next steps after discharge.

Youth Mental Health Hold Overview

Types of Mental Health Holds

5150 and 5585: According to state law (Welfare & Institutions Code 5150 and 5585), when there is probable cause that a youth — as a result of a mental health disorder— is a danger to themselves or others or is gravely disabled, they may be taken into custody for an initial period of up to 72 hours for crisis intervention, assessment, and safety and discharge planning by the following individuals:

- A peace or probation officer
- A professional person in charge of a facility designated by the county for mental health evaluation and treatment
- A member of the attending staff of a facility designated by the county for mental health evaluation and treatment
- A designated member of a mobile crisis team or a professional person designated by the county

1799 or 1799.11: These sections in California's Health and Safety code permit emergency department physicians to involuntarily detain a patient for a psychiatric evaluation, if they believe that the patient is a danger to self, others, or gravely disabled as a result of a mental health condition. A 1799 hold is different from a 5150 hold because it only allows a patient to be held for 23 hours. A 5150 hold lasts for 72 hours on admission to a designated acute psychiatric hospital. 5150 holds are intended for county-designated psychiatric facilities and 1799 holds are for non-designated facilities (like an emergency department). The 1799 hold gives the emergency department time for qualified and credentialed staff to conduct an assessment for 5150 eligibility.

What Happens While on a Mental Health Hold?

If your youth has been placed on a Welfare & Institutions Code 5150 hold, they will be taken to a medical hospital for a medical clearance evaluation, or you may take them to the emergency room.

Medical Clearance: Prior to admission to an acute inpatient psychiatric hospital, medical clearance is often needed to determine if a patient would be physically safe and stable enough to receive treatment in that facility. Medical clearance or a medical examination involves evaluation of the patient by a physician, nurse practitioner, or physician's assistant to identify specific health needs and medical conditions that may require stabilization, follow-up, and/or monitoring. Before being discharged from a medical setting, the patient's medical condition must have resolved or they must be stable enough to be medically treated as an outpatient. The scope of most acute inpatient psychiatric hospitals is limited to basic life support, so they are unable to treat ongoing medical conditions.

How Long Can a Mental Health Hold Last?

Under **Welfare & Institutions Code 5150,** the initial assessment, evaluation, and crisis intervention hold can last up to 72 hours.

Under **Welfare & Institutions Code 5250,** a youth can be detained longer if:

- The professional staff of the agency or facility has analyzed the person's mental health condition and has found the youth is a danger to self or others or is gravely disabled
- The facility providing intensive treatment is designated by the county to provide intensive treatment, and agrees to admit the youth
- The youth has been advised of the need for but has not been willing or able to accept treatment on a voluntary basis

The youth has the opportunity to contest the hold. A hearing will be set **within four days** to determine whether the youth meets the criteria to be certified (held) for **not more than 14 days** of intensive treatment related to the mental health disorder.

For more information, contact Disability Rights California at (916) 504-5800.

Note: Under Welfare & Institutions Code 5585.25, a "gravely disabled minor" means that as a result of a mental health condition a minor is unable to meet the basic needs that are essential to health, safety, and development. This includes food, clothing, and shelter, even though it may be provided to the minor by others. Intellectual disability, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not — by themselves — constitute a mental condition.

Under Welfare & Institutions Code 5270.15, upon the completion of a 14-day period of intensive treatment resulting from the 5250 hold, the youth may be certified for an additional period of not more than 30 days of intensive treatment under both of the following two conditions:

- The professional staff of the agency or facility treating the person has found that the person remains gravely disabled as a result of a mental disorder or chronic alcoholism
- The youth remains unwilling or unable to accept treatment voluntarily

The youth has the opportunity to contest the hold. A hearing will be set within four days to determine whether the youth meets the criteria to be certified (held) for not more than 14 days of intensive treatment related to the mental health disorder.

Frequently Asked Questions

Every effort should be made to provide treatment in the least restrictive setting in your community; however, psychiatric hospitalization may be necessary in circumstances where a youth cannot keep themselves safe.

What Does Inpatient Treatment Include?

Treatment starts with an evaluation that includes talking to you and your youth about why they are in the hospital, reviewing current and past mental health symptoms, getting information from people who know them, and any records from doctors and hospitals that have served them in the past. In some facilities it may also consist of a physical exam and laboratory tests to find out if there are medical conditions or medications that may be affecting the way your youth is feeling or acting.

The treatment team will use the evaluation findings to diagnose any mental health conditions. They will get input from you and your youth to develop a plan for treatment and discharge. While at the hospital, activities may include individual and/or group therapy and taking medications orally or via injection.

What is a Typical Inpatient Day Like?

Each day, the youth follow a structured schedule that may include assessment and treatment planning, group therapy, individual therapy, recreational activities, family sessions, vitals checks, medication evaluations, and private time for reflection and working on written assignments.

Are Families Involved?

Yes! It is extremely important that family members participate in treatment. This requires your youth to sign a Release of Information form. Family members and other supporters are essential members of each youth's treatment team and assist in healing. It is also very helpful for families to understand and participate in the discharge and after-care plans in order to have a smooth transition back to home, school, and the community. Your encouragement can help your youth continue practicing the skills they have learned. Your support makes a difference.

What if I Don't Have Insurance to Pay for Treatment?

There are several options for those who do not have insurance but need mental health treatment. Hospital staff will work with you to ensure your youth get the care they need. The following options are available:

- Many young people are eligible for Medi-Cal, which will allow you to access private hospitals that offer inpatient mental health services at no cost to you. Ask your social worker or hospital staff how to access.
- If you have private insurance, hospital staff may contact your insurance provider to discuss options and eligibility for inpatient hospitalization.

Preparing for the Next Steps

Every family's situation is unique, and you may need to explore different providers to find the right fit for ongoing services after discharge. It is essential to work with your discharge planner and insurance provider for coordinating care to find out what affordable and helpful options are available.

Safety Planning

Safety planning is about brainstorming ways to stay safe that may also help reduce the risk of future harm. It can include planning for a future crisis, considering options, and making decisions about the next steps. This sample safety plan can be used when working with your treatment team to develop a safety plan that is tailored to your youth's specific needs.

Sample Safety Plan

STEP 1: Warning Signs (thoughts, images, mood, situation, behavior) that a crisis may be coming
1.
2.
3.
STEP 2: Coping Skills – Things I can do to take my mind off my problems without talking to another person (examples: relaxation, music, exercise, breathing)
1.
2.
3.
STEP 3: People and social settings that distract me
1.
2.
3.
STEP 4: People I can ask for help
1.
2.
3.
New providers' names, contact information and appointment details
1.
2.
3.
Other helpful resources
1.
2.
3.

Appendix

California Minor Confidentiality and Consent Laws

Generally, if the minor did not and could not have consented to care, a parent or guardian has the right to access the minor's medical information pursuant to Civil Code section 56.10.

However, under Health and Safety Code section 123115(a)(2), the parent or guardian of a minor shall not be entitled to inspect or obtain copies of the minor's patient records where the health care provider determines that access to the patient records requested by the parent or guardian 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 as to whether a minor's records are available for inspection under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith.

Under this section, the health care provider shall make a written record, to be included with the mental health records requested, noting the date of the request and explaining the health care provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted.

Patient Rights

During hospitalization, the hospital will provide you with information on patient rights.

The California Department of Health Care Services is required to ensure that mental health laws, regulations, and policies for the rights of mental health service recipients are observed in licensed mental health facilities.

- Patients' rights
- County Offices to Apply for Health Coverage, Medi-Cal, and Other Benefits

The California Association of Mental Health Patients' Rights Advocates (CAMHPRA) is a statewide organization comprised of county patients' rights advocates mandated by state law, private and public interest attorneys, consumers of mental health services, and representatives from other advocacy organizations. CAMHPRA is dedicated to protecting and advancing the legal rights and treatment interests of individuals with mental health disabilities.

What if I'm Not Happy with the Care My Youth is Receiving?

Hospitals strive to provide the best care possible. However, there may be times when you are not satisfied with the care your youth is receiving. If you believe you or your youth's rights have not been observed, the following actions may help:

- Discuss your concern with any staff member in person and/or in writing.

- Request to speak to a patient advocate at the hospital, who can help you navigate the hospital's complaint and grievance process. This person serves as an advocate for those admitted to the hospital. The patient advocate is available to both young people and their families, and can assist in clarifying information, supporting your rights, and connecting people to the right resources. The patient advocate can also help with grievances and can pass along complaints regarding your rights and the quality of care and service at the hospital.
- If you have a concern about your rights, you may discuss your concerns with your attorney.

Complaints and Grievances

- California Department of Health Care Services, Behavioral Health Care Compliance
  (888) 466-2219
- Department of Managed Health Care
- Department of Insurance

Preparing for SB 43 Implementation

Unresolved Challenges

- Care transitions for developmentally disabled patients
- Care transitions for youth who default into child welfare when their families can no longer cope, not due to abuse

Lessons Learned

Reach Outside of Your Own Organization
Ask: Who else should be here?

Relationships Matter
Make the effort to stay connected

Think Regionally & Dream Big
Imagine what would solve the problem … then try it!

Do What You Can
Take baby steps; don't wait for everything to align before starting

Celebrate Small Wins
Build momentum to keep going

Misery loves company, so let's climb the behavioral health mountain together… we might even have some fun!

Questions

Thank you

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