Contra Costa County Emergency Medical Services 5150 Summit

After Action Summary

On February 22, 2017 Contra Costa Emergency Medical Services held the first 5150 Summit in collaboration with the Contra Costa County Emergency Medical Care Committee and Contra Costa Behavioral Health Services bringing together stakeholders, patient advocates and subject matter experts to support a greater collective awareness.
Table of Contents

General Overview............................................................................................................................................... 2

Agenda............................................................................................................................................................. 3

Summit Overview: 5150 by the Numbers.......................................................................................................... 4

Summit Overview: Legal.................................................................................................................................... 10

Summit Overview: Clinical & Tabletop Exercise.............................................................................................. 11

Summit Overview: Evolving Programs............................................................................................................. 13

Opportunities: Recommendations and Next Steps.......................................................................................... 14

Summit Evaluation: Participant Feedback........................................................................................................ 15

Website Resources........................................................................................................................................... 19

Addendum of Slides.......................................................................................................................................... 20

5150 Summit Planning Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Kacey Hansen, RN, BSN, MBA</td>
<td>Chair Emergency Medical Care Committee</td>
<td>John Muir Medical Center Walnut Creek</td>
</tr>
<tr>
<td>Derek Krause, Contra Costa Fire Chief Association Representative to EMCC</td>
<td>Assistant Chief, San Ramon Fire Protection District, EMCC Committee Member</td>
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<tr>
<td>Patricia Frost, RN, MS, PNP</td>
<td>Director Emergency Medical Services</td>
<td>Contra Costa Health Services and Staff to EMCC</td>
</tr>
<tr>
<td>Anna Roth, RN,CEO</td>
<td>Contra Costa Health Services</td>
<td>Contra Costa Regional Medical Center, Detention and Ambulatory Care</td>
</tr>
<tr>
<td>Cynthia Belon, LCSW, Director Behavioral Health Services</td>
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<td>Contra Costa Health Services</td>
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This report was compiled by the Contra Costa Emergency Medical Services. Questions and comments about the Summit may be addressed to:

Patricia Frost, RN, MS, PNP, Director
Contra Costa Emergency Medical Services
1340 Arnold Drive, Suite 126
Martinez, CA 94553
General Overview

This After Action report is a result of the first 5150 Summit held February 22, 2017 at John Muir Medical Center Walnut Creek in Walnut Creek California. The Summit was conducted on behalf of the Contra Costa County Emergency Medical Care Committee, an advisory committee for Emergency Medical Services appointed by the County Board of Directors. The Summit was hosted with the support of Contra Costa Behavioral Health and Contra Costa Health System Leadership.

The Summit was designed to support a dialogue that promotes a greater collective awareness and comprehensive understanding of 5150 related issues facing patients, families and stakeholders representing various disciplines. Individuals were invited from:

1. Fire First Responders and Ambulance Providers
2. Representatives Contra Costa Board of Supervisors
3. Contra Costa Fire Executive Chiefs
4. Patient and Family Mental Health Consumers and Advocates
5. Hospital Council Leadership
6. Contra Costa County Hospital and Nurse Executives
7. Alameda and Contra Costa County Medical Association (ACCMA)
8. Alameda EMS Agency Leadership
9. Contra Costa Health Services (CCHS) Public Health
10. Contra Costa Non-Emergency Ambulance Community
11. Emergency Department Physician and Nurse Emergency Department Directors
12. Behavioral Health Leadership and Subject Matter Experts
13. Contra Costa County Counsel
14. Contra Costa County Sheriffs and Law Enforcement Agencies
15. Emergency Ambulance Providers and Subcontractors
16. Field Paramedics and EMTs
17. Base Hospital MICNs
18. Contra Costa County Mental Health Commission Members
19. CCHS Homeless Program
20. CCHS Psychiatric Emergency Services
21. Sutter and Kaiser Local and Regional Leadership

Planning Guidance was offered by the Executive Committee of the Emergency Medical Care Committee and Contra Costa County Health Services Executive Leadership Team. Over 80 individuals registered for the event and a total of 69 attended with at least one representative from each of the invited groups.

The conference featured subject matter experts, EMS System field responders from fire, law and hospitals who addressed the summit objectives through presentations, panel discussions and group exercises exploring the barriers and opportunities to support this challenging population.

Objectives: By the end of the Summit participants will be able to:
1. Understand the countywide frequency and impact of use of 5150 holds on the community.
2. State the legal requirements and responsibilities associated with voluntary and involuntary holds.
3. Recognize the special challenges associated with 5150 of individuals with substance abuse, dementia or when youth are involved.

4. Explore how inter-disciplinary collaboration across the EMS System is important to this complex population.

### Agenda for the Day

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-8:40 am</td>
<td>Welcome and Introductions</td>
<td>Kacey Hansen RN, BSN, MBA Chair EMCC, Pat Frost RN, MSN, PNP, EMS Director</td>
</tr>
<tr>
<td>8:45-10:00 am</td>
<td>5150 by the Numbers: Brief Presentations reviewing data from the community</td>
<td>Joe Barger MD, Contra Costa Health Services, Rebecca Forbes RN, MSN, CEN, Emergency Department Director, John Muir Medical Center Concord, Kristina Serrano LMFT, Lt. Denton Carlson, San Ramon Police Department</td>
</tr>
<tr>
<td>10:10:15</td>
<td>BREAK</td>
<td></td>
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<tr>
<td>10-11 am</td>
<td>5150 Legal and Clinical Roles and Responsibilities: Speakers to describe law, review legal requirements, provide some &quot;myth busting&quot;, review challenges associated with legal, regulatory and clinical responsibilities associated with 5150 and involuntary holds</td>
<td>Steven Rettig, Contra Costa Deputy County Counsel, Anton Bland MD, Chief Psychiatrist Contra Costa Regional Medical Center</td>
</tr>
<tr>
<td>11-12 noon</td>
<td>5150 Impact Panel: Law, EMS, PES, Hospital, Patients/Family. Speakers share from various disciplines the field, provider and patient experience.</td>
<td>Lt Denton Carlson, San Ramon Police Department, Kristina Serrano LMFT, CCHS Mental Health Program Supervisor, Rebecca Forbes RN, MSN, CEN, Director of Emergency Services, John Muir Health Concord Campus</td>
</tr>
</tbody>
</table>
Summit Overview: 5150 by the Numbers

In the first presentation, Dr. Joseph Barger from Contra Costa EMS presented the historical data on the frequency of Behavioral/Psych transport to Contra Costa Regional Medical Center Psychiatric Emergency Services by EMS Ambulance Provider American Medical Response between 2008 and 2015. The data represents 92% of the 9-1-1 ambulance transport volume in Contra Costa and does not include San Ramon Valley Fire or Moraga Orinda Fire. However it is important to note that even though the overall numbers transported by those agencies may appear small they have a significant impact on ambulance deployment.

The data presented from a 2012-2016 study includes patients where the prehospital paramedic primary impression was Behavioral Emergency or involuntary transport (5150) as noted on the patient care record. Dr. Barger reported that prehospital documentation is incomplete in many cases and was not available prior to 2012 due to how data was entered into the prehospital electronic medical record.

Data includes 911 transports from field settings only involving paramedics and does not include interfacility transports (IFTs) provided by numerous private non-emergency ambulance providers. Currently no data is available for IFTs.
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Transports</td>
<td>60369</td>
<td>60423</td>
<td>63118</td>
<td>69015</td>
<td>72388</td>
<td>20%</td>
</tr>
<tr>
<td>5150 or Behavioral Emergency Transports</td>
<td>7753</td>
<td>8468</td>
<td>9477</td>
<td>10546</td>
<td>11050</td>
<td>43%</td>
</tr>
<tr>
<td>Percentage 5150 or Behavioral Emergency</td>
<td>12.8%</td>
<td>14.0%</td>
<td>15.0%</td>
<td>15.3%</td>
<td>15.3%</td>
<td></td>
</tr>
</tbody>
</table>

**Behavioral/Psych Transports to CCRMC/PES by AMR**

![Bar chart showing behavioral/psych transports over years](chart.png)
5150 Data by the Numbers: Community Hospitals

This data reflects the total impact of Mental Health and Substance-Related disorders affecting the Health Care System in Contra Costa County. The data was obtained by the Hospital Council from the Office of Statewide Health Planning and Development (OSHPD) and shared with Summit participants as a handout. Hospital and health care data to date is still unable to identify involuntary hold 5150 patients.

### Contra Costa County
#### Hospital Data 2013-2015
#### Emergency Department Usage for Mental Health and Substance-Related Disorders

<table>
<thead>
<tr>
<th>Contra Costa County ER Visits for Mental Disorders</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contra Costa Regional Medical Center</td>
<td>8,838</td>
<td>9,773</td>
<td>10,063</td>
</tr>
<tr>
<td>John Muir Medical Center - Concord Campus</td>
<td>2,185</td>
<td>2,343</td>
<td>2,479</td>
</tr>
<tr>
<td>Kaiser Foundation Hospital - Walnut Creek</td>
<td>1,453</td>
<td>1,594</td>
<td>1,611</td>
</tr>
<tr>
<td>Sutter Delta Medical Center</td>
<td>1,061</td>
<td>1,212</td>
<td>1,502</td>
</tr>
<tr>
<td>Kaiser Foundation Hospital - Antioch</td>
<td>941</td>
<td>1,096</td>
<td>1,206</td>
</tr>
<tr>
<td>John Muir Medical Center - Walnut Creek Campus</td>
<td>1,024</td>
<td>1,140</td>
<td>1,188</td>
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<tr>
<td>San Ramon Regional Medical Center</td>
<td>456</td>
<td>424</td>
<td>435</td>
</tr>
<tr>
<td>Doctors Medical Center - San Pablo</td>
<td>1,229</td>
<td>1,095</td>
<td>185</td>
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**TOTALS**: 19,200 20,691 20,684

<table>
<thead>
<tr>
<th>Contra Costa County Admits from ER for Mental Disorders</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contra Costa Regional Medical Center</td>
<td>832</td>
<td>801</td>
<td>709</td>
</tr>
<tr>
<td>Kaiser Foundation Hospital - Walnut Creek</td>
<td>103</td>
<td>115</td>
<td>122</td>
</tr>
<tr>
<td>John Muir Medical Center - Walnut Creek Campus</td>
<td>96</td>
<td>101</td>
<td>111</td>
</tr>
<tr>
<td>John Muir Medical Center - Concord Campus</td>
<td>76</td>
<td>69</td>
<td>101</td>
</tr>
<tr>
<td>Sutter Delta Medical Center</td>
<td>82</td>
<td>93</td>
<td>89</td>
</tr>
<tr>
<td>Kaiser Foundation Hospital - Antioch</td>
<td>32</td>
<td>35</td>
<td>62</td>
</tr>
<tr>
<td>San Ramon Regional Medical Center</td>
<td>51</td>
<td>64</td>
<td>32</td>
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<tr>
<td>Doctors Medical Center - San Pablo</td>
<td>38</td>
<td>35</td>
<td>4</td>
</tr>
</tbody>
</table>

**TOTALS**: 3,323 3,327 3,245
5150 Data by the Numbers: Emergency Department

In this presentation, Rebecca Forbes of John Muir Medical Center Concord Emergency Services shared data associated with the John Muir Health System experience. A summary of her data presentation follows:

True numbers of mental health patients seen in the Emergency Department (ED) proved elusive to capture. An analysis of the 5150 patients transferred from the Concord (CC) and Walnut Creek (WC) EDs was as follows:

<table>
<thead>
<tr>
<th>Campus</th>
<th>Month</th>
<th>Year</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC and WC</td>
<td>December</td>
<td>2016</td>
<td>59</td>
</tr>
<tr>
<td>CC and WC</td>
<td>November</td>
<td>2016</td>
<td>65</td>
</tr>
<tr>
<td>CC and WC</td>
<td>October</td>
<td>2016</td>
<td>85</td>
</tr>
<tr>
<td>CC and WC</td>
<td>September</td>
<td>2016</td>
<td>79</td>
</tr>
<tr>
<td>CC and WC</td>
<td>August</td>
<td>2016</td>
<td>71</td>
</tr>
<tr>
<td>CC and WC</td>
<td>July</td>
<td>2016</td>
<td>66</td>
</tr>
<tr>
<td>CC and WC</td>
<td>June</td>
<td>2016</td>
<td>67</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>492</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Campus</th>
<th>Month</th>
<th>Year</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC and WC</td>
<td>December</td>
<td>2014</td>
<td>79</td>
</tr>
<tr>
<td>CC and WC</td>
<td>November</td>
<td>2014</td>
<td>73</td>
</tr>
<tr>
<td>CC and WC</td>
<td>October</td>
<td>2014</td>
<td>76</td>
</tr>
<tr>
<td>CC and WC</td>
<td>September</td>
<td>2014</td>
<td>77</td>
</tr>
<tr>
<td>CC and WC</td>
<td>August</td>
<td>2014</td>
<td>91</td>
</tr>
<tr>
<td>CC and WC</td>
<td>July</td>
<td>2014</td>
<td>72</td>
</tr>
<tr>
<td>CC and WC</td>
<td>June</td>
<td>2014</td>
<td>58</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>526</strong></td>
</tr>
</tbody>
</table>

As the numbers show, despite a 20% increase in the number of total patients seen in the ED between 2014 and 2016, there was a slight decrease in 5150 volume. This does not mirror the trend in the Psychiatric Emergency Services (PES) numbers and explanations can vary ranging from a change in transportation practices by paramedics, a decrease in the number of 5150 holds placed on mental health patients, to an increase in admissions of 5150s (the numbers above reflect only transferred patients).

5150 Impact Panel: ED Provider

Boarding 5150 patients in the ED occurs very rarely. Juxtaposing our experience with an academic, 66-bed ED in Sacramento County where 8,000 patient-care hours are spent on 5150 holds per month, I feel we are fortunate to be in this county with a PES that does not refuse transfers at any time. The biggest impact to the ED in Concord is the emotional and spiritual strain the 5150 patient population places on staff. ED staff do not feel they are equipped to provide optimal psychological care and are challenged to
provide a therapeutic environment while caring for their other patients. Staff members also feel unsafe at times when patients manifest verbal abuse and violent outbreaks.

**Summit Overview: Legal Roles and Responsibilities**

In the first presentation, County Counsel Steven Rettig reviewed the law and legal aspects of 5150 emphasizing the legislative intent of the Lanterman-Petris-Short (LPS) Act was to end the inappropriate, indefinite and involuntary commitments of people with mental health disorders and provide them with prompt evaluation and treatment. Each county is responsible for implementing this 5150 process within the resources of the community. The law requires time-specific legal hold periods and some measure of due process.

**Under the LPS Act the following persons are authorized to detain under 5150:**

- Peace officers
- Professional person in charge of a facility designated by the county for evaluation and treatment or a member of attending staff
  - Designated Treatment and Evaluation Facilities in Contra Costa County
    - Contra Costa Regional Medical Center
    - John Muir Behavioral Health Center
- Professional staff of a private medical facility as designated by the Local Mental Health Director
  - Designated staff include ED physicians, psychiatrists, psychologists and LCSWs who have been authorized by the facility approved by the Mental Health Director and received 5150 training.
  - The medical facility must have a Memorandum of Understanding with the Mental Health Director on file.

**Criteria for 5150 Detention Upon Probable Cause:** When a person as a result of a mental health disorder is a danger to others, danger to self or gravely disabled. Danger to self or others are not defined nor are these terms clearly defined in the law; however, in order to find probable cause that a person is a danger to self or others, there is no legal requirement that the person have an intent to harm themselves or others. Case law in this area has supported the use of 5150 based on information that would lead any person of ordinary care and prudence to believe that the individual as a result of a mental disorder was a danger to themselves.

**Criteria for 5150 Associated with Grave Disability** is defined 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. However, a person is not gravely disabled if that person can survive safely without involuntary detention with the help of responsible family, friends or others who are both willing and able to help provide for the persons basic personal needs for food, clothing or shelter. A distinction is made for minors who as a result of a mental disorder are unable to use the elements of life which are essential to health safety and development, including food, clothing and shelter even though provided to the minor by others.
5150 statutory and liability issues were also reviewed. Each organization must consult with their legal counsel for guidance on liability issues related to 5150. Information presented at the Summit is for educational purposes only.

**Summit Overview: Clinical Roles and Responsibilities**

In this presentation, participants were introduced to the clinical responsibilities and requirements associated with 5150 detainment. The phases of Involuntary Psychiatric evaluation were reviewed as follows:

- Application completion and review by the designated receiving facility e.g. PES
- Evaluation and Treatment in PES (5152)
  - Interview and assessment by psychiatrist
  - Offer for medications and/or therapy as needed
- Decision to Admit, Transfer or Discharge

The importance of field and law enforcement documentation was emphasized and examples of probable cause were presented. Participants were then given information on what occurs during a 5150 patient care encounter at PES. The following important points were then summarized:

- Evaluation does NOT require one to involuntarily hold the individual for 72 hours and the 5152 process (referring to the required mental health evaluation) can be discontinued anytime within the first 72 hours.
- The 5152 evaluation is not predictive of what the patient will do.
- Despite suffering from signs of mental illness consumers have the right to refuse treatment or be treated in a less restrictive setting.
- Patient documentation provided by Law and EMS is important to the PES evaluation for patients placed on an involuntary hold.

Slides from both of these presentations are available as an addendum to this report.

**Summit Overview: Tabletop Discussion**

The tabletop discussion involved three cases that were designed to stimulate discussion between stakeholders. The cases captured elements associated with potential 5150 patients that are known to be challenging to address. Each table of stakeholders representing various points of view were asked to discuss each case and answer the following three questions:

**Questions**

Is this in the best interest of the patient?
What alternatives were available for those involved?
Who benefits from having the patient 5150 and why?
15 y/o male with Autism

Developmentally delayed 15 year old boy with a diagnosis of Autism; Lives in a group home setting with four other adolescents. Followed by Case Worker from Regional Center. Verbal but with moderate communication challenges. Suffers from anxiety as well as sensory sensitivities to noise and touch. Tends to bite arm when agitated and can be verbally loud when over stimulated but generally compliant with directions from staff and amenable to redirection. Attends a special education day program during the day. No medical issues, no history of seizures. Takes Risperdone daily and Ativan as needed.

Today, new staff member did not know patient's routine around access to video game console. Patient became increasingly agitated and began biting himself. Staff member attempted to restrain patient from self injury which precipitated increasing agitation. Staff felt physically at risk and called 911. Police responded and became concerned that patient's behavior was unsafe. 5150 place for danger to self and others. Patient transported by EMS to Psychiatric Emergency Department without incident.

42 y/o male intoxicated at BART

Patient discovered in Antioch BART station at 1AM 'asleep' on a bench. Police ask him to leave. Patient becomes belligerent and after brief physical altercation is placed in hand cuffs. Patient admits to alcohol use. Unstable on his feet. Denies medical problems. States most recently resides in shelter in San Francisco as well as living on the street. No family available. Patient tells BART police he wants to kill himself. 5150 placed, transported by EMS to Sutter Delta Emergency Department as patient is clinically intoxicated and 'unable to walk'. Patient ultimately cleared medically after 6 hours of observation, reaches clinical sobriety with stable gait, and persists in expressing suicidal thoughts. He transferred by ambulance to Contra Costa County PES in Martinez for further evaluation of Suicidal Ideation and 5150.

77 y/o female with Dementia

Per patient's husband, patient has been increasingly agitated and difficult to manage over the last several months. Awake at night roaming the house. Has been agitated, yelling at spouse, occasionally violent. Has left the house and become lost wandering in the neighborhood, returned by police and neighbors on two occasions in the last month. Increasingly fearful of taking her medications and no longer recognizing family friends. Husband with chronic medical conditions and recently more ill making it difficult to take patient to doctor's appointments. Physician has recommended placement in a memory care facility but husband has been resistant and financial resources are an issue.

Diagnosed with Alzheimer's Dementia two years prior. Baseline with short term memory challenges and episodic agitation. History of Hypertension, Coronary Artery Disease, n multiple medications.

No known substance abuse. No hallucinations. No acute medical complaints.

Today, 911 called by neighbor who witnessed patient striking her husband. When police arrived husband resisted their attempts to intervene and denied event. Patient became agitated and began yelling at officers to leave her alone and swung a fist at the officer.

Patient placed on 5150 for Danger to Others, Gravely Disabled and transported by EMS to the Medical Emergency Department in Martinez at CCRMC for Evaluation.
Summit Overview: Options for 5150 and Evolving Programs

In this session, presentations highlighting various new and pilot programs were featured. All programs emphasized the importance of collaborative partnerships between behavioral health, law, homeless programs, Public Health and EMS.

CORE Outreach: The CORE Outreach Program stands for Coordinated, Outreach, Referral and Engagement, and is the newest program to be implemented in our homeless system of care. CORE provides day time and evening outreach Monday through Saturday in small multidisciplinary teams that work collaboratively to engage and stabilize homeless individuals and families who are living outside. CORE delivers health and basic need services with the ultimate goal of linking chronically homeless individuals to permanent housing.

Currently we have two day time teams and one evening team that cover the entire geography of Contra Costa County, from west county to far east county. Services and support include but is not limited to delivering basic needs supplies such as socks, hygiene kits, and emergency food. CORE teams will also complete housing assessments, facilitate the completion and submission of benefits applications (CalFresh, MediCal) as well as link consumers to shelters and other housing programs. In addition, CORE works in collaboration with Healthcare for the Homeless (HCH) to ensure that we are providing a direct linkage to services for those accessing their care who are in need of housing.

The central access point for CORE is 211, and once calls are transferred from 211 to our CORE line, dispatch staff screen and assess each call to determine the most appropriate and timely response. Stay tuned for a formal communication launch from the Health, Housing and Homeless (H3) Division that will provide additional information and details regarding CORE, as well as other significant changes in our county's homeless system of care.

San Ramon Police Department PES Pilot: The San Ramon Police Department has partnered with Contra Costa County Health Services to create and implement a 5150 Pilot Program. As a community based law enforcement agency, we felt service from the San Ramon Police Department should not stop when the ambulance doors close and the patient is transported to the County P.E.S. facility in Martinez. As a result, we have implemented a 5150 Pilot Program, which began on January 1st, 2017.

This program ensures the patient and/or family members associated with any incident involving someone being placed under a 5150 hold for evaluation are contacted within a few days by an Officer from the San Ramon Police Department. Our goal is to provide additional resources and possible avenues for further care to the family and patient. They need support after this type of incident, and our goal is to provide that support. By working side-by-side with County Health Services, we are able to recommend the most applicable and helpful resources for those who need further assistance and treatment.
**Assisted Outpatient Program (AOT):** Information on Contra Costa Assisted Outpatient program established under Laura’s Law was presented. The program is for people with severe and persistent mental illness to prevent substantial deterioration of their condition and who may pose a risk to themselves or others. It was emphasized that this program is voluntary and allows counties to use the civil court system to supervise care. The honorable Judge Stephen Austin presented information on his role in the program. AOT is not for crisis intervention. More information about the program is available on the county health services website at https://cchealth.org/mentalhealth/lauras-law.php.

**Community Connect:** The session ended with an overview of Community Connect, the new Contra Costa Health Services Whole Person Care Program designed to support wrap around services for those requiring intensive case management due to homelessness, mental illness, substance abuse, two or more chronic health conditions, multiple hospital/ED visits. Community Connect will also target foster youth being treated with psychiatric medications and adults on probation or scheduled for release from jail. The Whole Person Care presentation is included as an addendum to this after-action.

**Opportunities for Improvement and Next Steps**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Responsible Agency</th>
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<tbody>
<tr>
<td>Establish consistent Way of Capturing 5150 data across the EMS and Health Care System</td>
<td>Hospitals, Behavioral Health, EMS, Public Health, Law, PES</td>
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<tr>
<td>Repeat the Summit periodically</td>
<td>EMS, EMCC</td>
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<tr>
<td>Establish Sobering Centers</td>
<td>Hospitals, Behavioral Health, EMS, Public Health, Law, PES</td>
</tr>
<tr>
<td>Educate field providers on mechanisms to alert and address frequent 5150 9-1-1 users</td>
<td>EMS, Law, Behavioral Health, Hospitals</td>
</tr>
<tr>
<td>Promote training of field providers e.g Crisis Intervention</td>
<td>EMS, Law, Behavioral Health, Hospitals</td>
</tr>
<tr>
<td>Promote partnerships to increase efficiency between providers involved in serving the 5150 population</td>
<td>Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families</td>
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<tr>
<td>Improve coordination of care for 5150 frequent users</td>
<td>Behavioral Health, H3, Public Health, EMS, Hospitals</td>
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<tr>
<td>Improve access to 9-1-1 and other educational resources for patients and families e.g. NAMI, Discovery Center</td>
<td>Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families, NAMI</td>
</tr>
<tr>
<td>Recognize that regional center and schools may need to be included in mitigating 5150 with youth</td>
<td>Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families</td>
</tr>
<tr>
<td>Increase partnerships with families through outreach and engagement. Recognize the importance of family in assisting in mitigation of 5150.</td>
<td>Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families, NAMI</td>
</tr>
<tr>
<td>Recognize the role of housing to support stability of at risk 5150 populations who are homeless</td>
<td>H3, Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families, NAMI</td>
</tr>
<tr>
<td>Increase awareness of the role of Mental Health</td>
<td>Behavioral Health, Law, EMS</td>
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### Crisis Teams in the Field

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make NAMI resources more widely available</td>
<td>NAMI, EMS, Behavioral Health</td>
</tr>
<tr>
<td>Integrate families in supporting case management through follow-up</td>
<td>Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families</td>
</tr>
<tr>
<td>Clarify role of 5150 for EMS providers after Law leaves the scene</td>
<td>EMS, County Counsel</td>
</tr>
<tr>
<td>Consider adding more designated individuals to support 5150 evaluation in non CCHS setting such as community emergency departments in the EMS System.</td>
<td>Hospitals, Behavioral Health, EMS, Public Health, Law, PES</td>
</tr>
<tr>
<td>Explore 5150 Designation for EMS</td>
<td>EMS, County Counsel, EMS Medical Director, Behavioral Health</td>
</tr>
</tbody>
</table>

### Summit Evaluation Summary and Comments

#### Summit Evaluation Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructor Presentation</td>
<td></td>
<td>2</td>
<td>12</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Instructor Communication</td>
<td></td>
<td>1</td>
<td>10</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Instructor Knowledgeable</td>
<td></td>
<td>2</td>
<td>8</td>
<td>22</td>
<td></td>
</tr>
</tbody>
</table>

#### Course Satisfaction

<table>
<thead>
<tr>
<th>Category</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course Format</td>
<td>4</td>
<td>12</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Course Content</td>
<td>5</td>
<td>10</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pace of class</td>
<td>4</td>
<td>14</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Course Satisfaction</td>
<td>4</td>
<td>12</td>
<td>16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Not all participants completed their evaluations.
**Comment Summary:** “Comments reflected significant engagement.”

<table>
<thead>
<tr>
<th>Question</th>
<th>Participants Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name one fact that you learned today about 5150 issues.</td>
<td>• That there are several arrest challenges with 5150s. Placement and lack of resources continues to be an issue. Need a sobering center for those that are appropriate  &lt;br&gt; • PD impact  &lt;br&gt; • There is no easy way to collect 5150 data points across all stakeholders  &lt;br&gt; • Other stakeholder roles  &lt;br&gt; • A complete overall vision of 5150  &lt;br&gt; • Core Teams  &lt;br&gt; • Legal definition of 5150  &lt;br&gt; • Other patient rights  &lt;br&gt; • Not so much a single fact but I did not realize some of the legal and other issues shared by ambulance crews during 5150  &lt;br&gt; • Complexity  &lt;br&gt; • Judge involved in AOPT program, sobering center  &lt;br&gt; • Need for sobering center  &lt;br&gt; • EMS staff are not designated staff (to authorize 5150)  &lt;br&gt; • During one of the case studies (tabletop portion) understanding the diagnosis of certain illnesses and conditions can be helpful to first responders when responding (ie: autism, epilepsy etc)  &lt;br&gt; • 85-90% of 5150 holds are created via law enforcement  &lt;br&gt; • Resources available  &lt;br&gt; • Recommend speaker from NAMI on family to family. Cross over with domestic violence. Bay area crisis nursery: where children can go if caregiver is hospitalized  &lt;br&gt; • I learned to appreciate different perspectives concerning roles and county resources  &lt;br&gt; • Learned the incredible value that county resources add to our system  &lt;br&gt; • Challenge that EMS has with 5150 holds if law enforcement leaves the scene  &lt;br&gt; • 3rd party assist  &lt;br&gt; • Patient family perspective  &lt;br&gt; • Clarification of criteria to qualify for 5150 detention  &lt;br&gt; • 5150 transfers are on the rise  &lt;br&gt; • Mental disorder alone is not sufficient for 5150 under gravely disabled  &lt;br&gt; • Clearer understanding of requirement for a legal 5150  &lt;br&gt; • EMS challenge if police leave the scene  &lt;br&gt; • The definition of section 5150, legal aspects, who has authority to determine 5150, procedure and process  &lt;br&gt; • Over impact of jails  &lt;br&gt; • Increase in 5150, decrease in voluntary 5150</td>
</tr>
<tr>
<td>Question</td>
<td>Participants Comments</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Name one fact that you learned today about 5150 issues.                 | • Every perspective brings value and sheds light on our seemingly broken system. Can we do this better?  
• Concern of EMD regarding transporting individual on 5150 holds after peace officer has left the scene  
• Crash course NAMI Contra Costa  
• That the county is implementing MHET team in order to provide resources for those that don’t always require 5150 hold |
| Name a program that could help support solutions associated with 5150 patients. | • Need more strong family support programs  
• MHET program  
• Field ready crisis intervention teams  
• Share the ideas, conclusions and concerns with county BOS. Call for annual goals and summits  
• Training across all Health Services  
• Sobering center vs PES-4C admission  
• Increased opportunity for treatment. From 911 side process to transport to alternative destinations. Expand San Ramon follow-up program  
• Family advocacy representatives provided great resources from the community perspective  
• San Ramon Community resource division  
• Mobile Health Evaluation Teams (MHET)  
• More connection between EMS and MHET, Sobering Centers  
• County mobile crisis unit  
• MHET  
• MHET, Information to provide family members with contact information and resources available  
• NAMI  
• Sobering Center, San Ramon Pilot Project  
• 5150 Pilot project and core team, MHET and Whole Person Care  
• Laura’s Law  
• EMS triage of patients  
• Whole Person Care Community Connect  
• Assistive Outpatient Treatment (AOPT)  
• I would love to see more outreach team response to potential 5150  
• Community Connect may assist with case management for medical patients (sobering facility)  
• MHET, sobering center with evaluation capabilities.  
• Psychiatric Emergency Services (PES)  
• They are multifactorial, high cost, high resource consumers |
<table>
<thead>
<tr>
<th>Question</th>
<th>Participants Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>What comments if any do you have about the summit positive or negative?</td>
<td>• Awesome. Please continue to have this summit periodically until we improve the challenges discussed today.</td>
</tr>
<tr>
<td></td>
<td>• Sobering centers</td>
</tr>
<tr>
<td></td>
<td>• Excellent. I think it achieved its goal of making all stakeholders aware of the issues and impacts of each other’s perspectives</td>
</tr>
<tr>
<td></td>
<td>• This forum provided a great opportunity for different agencies and disciplines to come together with a primary goal to not only highlight overall gaps in 5150 cases but to also provide solutions and educational awareness</td>
</tr>
<tr>
<td></td>
<td>• Very good start to an important conversation</td>
</tr>
<tr>
<td></td>
<td>• Good source of information to raise current issues and to consider future action to be taken</td>
</tr>
<tr>
<td></td>
<td>• Poor execution of break out session. Should not herd all groups together</td>
</tr>
<tr>
<td></td>
<td>• MHET and CIT (Crisis Intervention Training)</td>
</tr>
<tr>
<td></td>
<td>• Please add the consumer impact. There was no consumer representation and little discussion of the role</td>
</tr>
<tr>
<td></td>
<td>• Excellent. Very organized, very informative, interesting to hear challenges faces by other branches of the system</td>
</tr>
<tr>
<td></td>
<td>• We have a long road ahead of us. Together we must certainly improve the care to our 5150 patients</td>
</tr>
<tr>
<td></td>
<td>• Great way to develop more awareness</td>
</tr>
<tr>
<td></td>
<td>• This was a great way to open the discussion on a problem that needs more funding and field direction</td>
</tr>
<tr>
<td></td>
<td>• Great opportunity to bring a 360 perspective to one room so that all</td>
</tr>
<tr>
<td></td>
<td>• Great Job, Nicely done</td>
</tr>
<tr>
<td></td>
<td>• Stakeholders can gain new perspective and begin to develop new strategies</td>
</tr>
<tr>
<td></td>
<td>• Need to do this yearly. System very fragmented. A summit like this helps to network and increase access</td>
</tr>
<tr>
<td></td>
<td>• Excellent summit, speakers are fantastic</td>
</tr>
<tr>
<td></td>
<td>• I’m very pleased to see the number of disciplines working on this</td>
</tr>
<tr>
<td></td>
<td>• Excellent collaboration</td>
</tr>
<tr>
<td></td>
<td>• More police presence. San Ramon is small represents a very small portion of the county. Police are indeed still using 5150 inappropriately. More advocacy at state level to change.</td>
</tr>
<tr>
<td></td>
<td>• I valued networking with the county individuals</td>
</tr>
<tr>
<td></td>
<td>• It was a great forum. Perspectives from all sides was very critical, tabletop discussion was great. Thank you for putting this summit on. It was very helpful</td>
</tr>
<tr>
<td></td>
<td>• A little too long consider half day program next time</td>
</tr>
<tr>
<td></td>
<td>• I would have like the presented stat’s and numbers in PowerPoint form. A lot of great info was presented that I would have like to take with me</td>
</tr>
<tr>
<td></td>
<td>• PowerPoint over paper of all presentations</td>
</tr>
<tr>
<td>Question</td>
<td>Participants Comments</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| What comments if any do you have about the summit positive or negative? | • Should do annual  
• Great Start  
• Good first step  
• Dialogue is vital to partner with all entities involved in the process: therefore finding the best solutions for patient care |

List of Web Resources related to Behavioral Health and Emergency Medical Services


Assisted Outpatient Treatment: [https://cchealth.org/mentalhealth/lauras-law.php](https://cchealth.org/mentalhealth/lauras-law.php)

Homeless Program: [https://cchealth.org/homeless/](https://cchealth.org/homeless/)

Mental Health Crisis Services: [https://cchealth.org/mentalhealth/crisis-services.php](https://cchealth.org/mentalhealth/crisis-services.php)


Whole Person Care: Community Connect: [https://cchealth.org/care/](https://cchealth.org/care/)

Contra Costa Emergency Medical Services: [http://cchealth.org/ems/](http://cchealth.org/ems/)

Mental Health Services: [http://cchealth.org/mentalhealth/#simpleContained6](http://cchealth.org/mentalhealth/#simpleContained6)


Alcohol and Other Drugs: [http://cchealth.org/aod/](http://cchealth.org/aod/)
Detention Upon Probable Cause
Welfare and Institutions Code § 5150

Steven P. Rettig
Assistant County Counsel

5150 in a nutshell:

“When a person, as a result of mental disorder, is a
danger to others, or to himself or herself, or gravely disabled, a
peace officer, member of the attending staff, as defined by
regulation, of a facility designated by the county for evaluation
and treatment, designated members of a mobile crisis team, or
professional person designated by county may, upon probable
cause, take, or cause to be taken, the person into custody for a
period of up to 72 hours for assessment, evaluation and crisis
intervention, or placement for evaluation and treatment in a
facility designated by the county for evaluation and treatment
and approved by the State Department of Health Care Services.”
W & I Code § 5150 (a).

Legislative Intent of the
Lanterman-Petris-Short (LPS) Act

• To end the inappropriate, indefinite and
  involuntary commitments of people with mental
  health disorders and to provide them with
  prompt evaluation and treatment. W & I Code
  5001 (a) and (b).

In order to achieve this, the LPS Act includes time-specific
legal hold periods with some measure of due process
attached to each type of hold. Section 5150 is the first of
these legal holds and can last up to 72 hours.

Persons authorized to detain under § 5150

• Peace officers

• Professional person in charge of a facility
designated by the county for evaluation and
treatment or a member of attending staff.

Contra Costa County’s designated treatment and
evaluation facilities are the Contra Costa Regional
Medical Center at 2500 Alhambra Avenue in
Martinez and the John Muir Behavioral Health
Center at 2740 Grant Street in Concord.

Persons authorized to detain under § 5150

• Professional staff of the Contra Costa Health
  Services Department as designated by the
  Local Mental Health Director

‘Professional staff’ includes: licensed psychiatrists, licensed
psychologists, LCSW’s (licensed clinical social workers), MFT’s
(marriage and family therapists), RN’s, psychiatric technicians
and ambulatory care psychiatrists. Their authority to detain is
limited to their role and responsibilities as a county employee at
the specific service site where the employee is located.

Persons authorized to detain under § 5150

• Professional staff of a private medical facility
  as designated by the Local Mental Health
  Director.

Designated professional staff include emergency department
physicians, psychiatrists, psychologists, and LCSW’s who have
been authorized by the facility, approved by the Mental Health
Director, and have received 5150 training.
The medical facility must have a Memorandum of Understanding
with the Mental Health Director on file.
Criteria for a § 5150 detention upon probable cause

- When a person, as a result of a mental health disorder is a:
  1. Danger to others;
  2. Danger to self; or

Probable cause defined:

- A state of facts must be known that would lead a person of ordinary care and prudence to believe, or to entertain a strong suspicion, that the person to be detained is mentally disordered and is a danger to self, others, or is gravely disabled.

- In justifying the detention, the officer (or other authorized person) must be able to point to specific facts which, together with rational inferences, reasonably warrant the belief or suspicion. *(People v. Triplett (1983) 144 Cal. App. 3d 283, 288.)*

Mental health disorder:

- The term “mental health disorder” is defined in the California Administrative Code as any of the mental disorders set forth in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (“DSM”).

- The peace officer or other authorized person is not required to make a medical diagnosis of mental disorder. "It is sufficient if the officer, as a lay person, can articulate behavioral symptoms of mental disorder, either temporary or prolonged ... mental health disorder might be exhibited if a person's thought process, as evidenced by words or actions or emotional affect, are bizarre or inappropriate for the circumstances." *(People v. Triplett (1983) 144 Cal. App. 3d 283, 288.)*

Information about the historical course of a person’s mental disorder shall be considered:

- "When determining if probable cause exists to take a person into custody ... [the authorizing person] shall consider available relevant information about the historical course of the person's mental disorder if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a danger to others, or to himself or herself, or is gravely disabled as a result of the mental disorder." *(Welfare and Institutions Code Section 5150.05, subdivision (a).)*

Danger to self or others

- Section 5150 does not define danger to self or danger to others, nor are these terms clearly defined in case law; however, in order to find probable cause that a person is a danger to self or others, there is no legal requirement that the person have an intent to harm himself or others.

Examples of possible danger to self or others

Danger to others:
- Acts or attempts to harm others.
- Statements of intent or plan to harm others.
- Behaviors that are dangerous to others.
- Symptoms that create the likelihood of dangerousness.

Danger to self:
- Acts or attempts to harm self.
- Statements of intent or plan for self-harm.
- Behaviors that place a person in harms way.
- Symptoms that increase the likelihood of dangerousness.
Sufficient evidence of danger to self:

- "In the case before us, it was reasonable for the officer to infer from appellant’s intoxication and tearful condition that she was at least temporarily disordered. Her intoxication and weeping standing alone would not justify a detention under section 5150. But these symptoms coupled with obvious physical signs of a recent suicide attempt would lead any person of ordinary care and prudence to believe that appellant as a result of mental disorder was a danger to herself." (People v. Triplett (1983) 144 Cal. App. 3d 283, 288.)

Grave disability defined:

- “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.” (Welfare and Institutions Code Section 5008, subdivision (h)(1)(A).)

- Exception: Third party assist. A person is not gravely disabled if that person can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to help provide for the person’s basic personal needs for food, clothing, or shelter. (Welfare and Institutions Code Section 5250, subdivision (d)(1).)

Examples of grave disability:

- In making the determination of grave disability, it is not necessary that a person be unable to provide for all three basic needs. Inability to provide for one of the three basic needs—food, clothing, or shelter—is sufficient.
- Signs of malnourishment/dehydration.
- Inability to articulate plan for food, clothing, or shelter.
- Irrational beliefs about food, clothing, or shelter. i.e. food is poisoned, clothing is bugged.

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 which are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others.” (Welfare and Institutions Code Section 5585.25.)

Statutory requirements upon detaining individual:

- Safeguarding personal belongings. (Welfare and Institutions Code Section 5150, subdivision (f).)
- Advisement upon being detained. (Welfare and Institutions Code Section 5150, subdivision (g)(1).)
- Advisement upon being detained at home. (Welfare and Institutions Code Section 5150, subdivision (g)(2).)
- Documentation of factual basis for detention. (Welfare and Institutions Code Section 5150.2.)

Personal belongings: safeguarding

- “At the time a person is taken into custody for evaluation, or within a reasonable time thereafter, unless a responsible relative or the guardian or conservator of the person is in possession of the person’s personal property, the person taking him or her into custody shall take reasonable precautions to preserve and safeguard the personal property in the possession of or on the premises occupied by the person ...” (Welfare and Institutions Code Section 5150, subdivision (f).)
Advisements upon being detained:
Section 5150, subdivision (g)(1)
- At the time of detention, the person authorizing the detention must provide verbally or in writing, in a language or modality accessible to the person, the advisement: My name is _______________. I am a (peace officer, mental health professional, doctor, nurse). You are not under criminal arrest, but I am taking you for an examination by mental health professionals at _______________ (name of designated facility). You will be told your rights by the mental health staff." (Welfare and Institutions Code Section 5150, subdivision (g)(1).)

Advisements upon being detained at home: Section 5150, subdivision (g)(2)
- “If taken into custody at his or her own residence, the person also shall be provided the following information: You may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken.” (Welfare and Institutions Code Section 5150, subdivision (g)(2).)

Documentation of factual basis for detention:
- “The documentation shall 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 section 5105 (sic—should read 5150).” (Welfare and Institutions Code Section 5150.2.)

Liability for detaining person: non-LPS facility.
- Health and Safety Code Section 1799.111, provides immunity from civil or criminal liability under specific circumstances, when a person is detained at a non-designated LPS facility. The specific circumstances include that the person is not detained beyond 24 hours and there is probable cause for the detention. (Health and Safety Code Section 1799.111.)
- If transferred to a LPS facility the amount of time detained under section 1799.111 is deducted from the 72 hours allowed for evaluation and treatment.

Liability for persons exercising authority:
- Welfare and Institutions Code Section 5278 provides that “Individuals authorized under this part to detain a person for 72-hour treatment and evaluation ... shall not be held either criminally or civilly liable for exercising this authority in accordance with the law.” (Welfare and Institutions Code Section 5278.)

Maximum period for detention: Section 5151
- “If the facility designated by the county for evaluation and treatment admits the person, it may detain him or her for evaluation and treatment for a period not to exceed 72 hours. ... the professional person in charge of the facility or his or her designee shall assess the individual in person to determine the appropriateness of the involuntary detention.” (Welfare and Institutions Code Section 5151.)
Clinical Aspects of the 5150 Referral
D. Anton Bland, M.D.
Chief Psychiatrist
Contra Costa Regional Medical Center

Disclosures
• I have no commercial interests to disclose.

Objectives
• Describe the process of evaluation and management of individuals on a legal hold.
• Identify the signs/symptoms of a mental disorder required for involuntary detention.
• Discuss the conditions for release from a legal hold.

This is NOT an Objective

The Phases of Involuntary Psychiatric Evaluation
• Application Completed and Reviewed
  • Evaluation and Treatment in PES (5152)
    — Interview and Assessment Completed by Psychiatrist
    — Offer for medications and/or therapy as needed
  • Decision to Admit/Transfer/Discharge

Essential Components of 5150 Legal Documentation
• Legible Names/Signatures/Date
• Statements made on the form need to be anchored in observable, describable behavior that substantiate a finding of probable cause to believe the person is a DTS, DTO, or is GD because of a mental disorder.
Example:
Statements of Probable Cause
- “Called by person’s brother to assess a client that was running naked in the street,”
- “Call from patient’s mother saying son was suicidal, isolating, and hasn't slept in 3 days”
- “Called by school principal to assess student who stated she is cutting herself and said she didn't care if she died to her school counselor,”

Example:
Statements of Probable Cause
- “Called by roommate because client threatened him to stop projecting his thoughts into client’s mind,”
- “Told by therapist at County mental health clinic that well-known client just called saying 'it was all over, and people were going to be sorry.'”

The Phases of Involuntary Psychiatric Evaluation
- Application Completed and Reviewed
- **Evaluation and Treatment in PES (5152)**
  - Interview and Assessment by Psychiatrist
  - Clinical Observation
  - Offer for medications and/or therapy as needed
- Decision to Admit/Transfer/Discharge

What happens in the PES?
- Evaluation consist of multidisciplinary analyses of a person’s medical, psychological, social, financial and legal conditions as may appear to constitute a problem
- Focus is on relieving the acute crisis, not comprehensive psychiatric evaluation – much like medical emergency departments, treat the presenting problem.

The Mental Status Examination
- A multifaceted analyses of a person’s medical, psychological, social, financial and legal conditions as may appear to constitute a problem.
  - Emphasis on assessment for hallucinations, delusions, impaired judgment.

Clinical Consideration
- Danger to self or others without a mental disorder does not meet the standard.
  - Mental retardation, epilepsy, or other developmental disabilities, alcoholism or other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental health disorder.
- Likewise, inability to provide food, clothing and shelter without a mental disorder is not enough.

1. W&I Code section 5455.35
Clinical Consideration

- **Assessing Hallucinations**
  - Are they commanding the person?
  - Are they telling the person to hurt self or others?
  - Has the person heard the voices in the past?
  - If so, did the person act on the voices or did the voices cause the person to do anything?

- **Assessing Delusions**
  - How do you know that it is a delusion?
  - Is the delusion such that it would lead the person to cause harm to self or others?
  - Has the person had the delusion in the past and has it caused the person to do anything?
  - Does the delusion prevent the person from providing for food, clothing and/or shelter? If so, how?

Danger to Self

- Words or actions showing intent to commit suicide or bodily harm.
- Words or actions indicating gross disregard for personal safety.
- Words or actions indicating a specific plan to suicide.
- Means available to carry out suicide plan (i.e. pills, firearms present or available).

Danger to Others

- Threats against particular individuals.
- Attempts to harm certain individuals.
- Means available to carry out threats or to repeat attempts (i.e. firearms, or other weapons).
- Expressed intention or attempts to engage in dangerous activity

Gravely Disabled

- Signs of malnourishment or dehydration.
- Inability to articulate a plan for obtaining food.
- No food available in the house or at hand if not in a house.
- Irrational beliefs about food that is available (i.e. it's poisoned, inedible, etc.).

Gravely Disabled

- Destruction or giving away of clothing to the point where the person cannot clothe themselves.
- Inability to formulate a reasonable plan to obtain shelter.
- Homelessness alone does NOT constitute GD.
  - Skills/abilities test, not means test.
Treatment during Involuntary Detention
- Process should be collaborative, non-coercive care involving a therapeutic alliance when possible, with voluntary treatment in the least-restrictive setting as the goal.
- Consumers may be offered medication management during the evaluation process. However, they have the right to refuse all medical interventions.

The Phases of Involuntary Psychiatric Evaluation
- Application Completed and Reviewed
- Evaluation and Treatment in PES
  - Interview and Assessment Completed by Psychiatrist
  - Offer for medications and/or therapy as needed
- Decision to Admit/Transfer/Discharge

What happens afterward?
- A 5152 can be discontinued by a psychiatrist or psychologist at any time within the first 72 hours.
- The 5152 Evaluation is not a predictive process. Most experienced clinicians are “moderate” at best at predicting violence.

What happens afterward?
- Treatment occurs in the PES with discharge in first 24 hours for 75% or more of patients.
  - A significant proportion of consumers (1 in 2) may suffer with an addictive disorder which leads to involuntary detention during intoxication that is not sustainable post-intoxication.
- Referrals can be made for follow up appointment with ongoing provider of the client’s choice, primary care provider, or mental health professionals.

Summary
- The 5150 offers an opportunity for a humane approach to the assessment of individuals with mental health issues for safety in the community.
- Clinicians are observing for evidence of how a consumer with mental illness continues to meet criteria for involuntary detention due to DTS, DTO, and/or GD.
- Despite suffering signs of mental illness, consumers have a right to refuse treatment and to be treated in the least restrictive setting.

Questions?
D. Anton Bland, M.D.
Overview

Whole Person Care is a Medi-Cal waiver pilot program
- Overall goal is to increase coordination of health, behavioral health and social services for vulnerable Medi-Cal recipients such to address underlying social & behavioral determinants of health.
- Focus on reduction of inappropriate utilization & improved health outcomes
- CCHS received approval in October 2016 for $40M annually over 5 years
  - Program duration 2016-2020
  - One of 19 CA County Systems participating
- CCHS has termed the program "CommunityConnect"
  - DHCS grant is termed "Whole Person Care"

Target Population for WPC

- Approximately 28,000 of the ~257K Medi-Cal members in Contra Costa County, divided into two tiers, based on level of need. We have planned for ~ 1/2 to participate. Participation in entirely voluntary.
- Eligibility Criteria includes:
  - Experiencing homelessness
  - Multiple hospital/ED visits in the last year
  - On probation or scheduled for release from jail
  - Serious Mental Illness and/or Substance Use Disorder
  - Two or more chronic health conditions
  - Foster Youth being treated with psych meds.

Patient Eligibility & Risk Stratification

- Developed data-driven risk model to identify target population
  - Pulled data from 5 different systems into data warehouse to develop algorithm
  - Compared with current programs (Substance Abuse, Targeted Case Management) to validate data
  - Applied Risk model to all Medi-Cal patients (~257k)
    - Threshold of 11 on 100pt scale for initial program eligibility
    - 28,000 patients met criteria, of which 1982 cared for by network providers
    - Assigned to Tier I or Tier II based on – assessment of how medically & socially fragile the individual presents as.

Risk Model Domains

Medical Disease
- 20% of risk score
- Patients received 5 pts per chronic disease in chart

Social / Behavioral Determinants
- 40% of total score
  - Points allotted for homelessness, foster status, encounters with detention, AOD, MH, etc

Utilization
- 40% of total score
  - Points allotted for number of ED, PES visits, Ambulance transport, long-term LOS, etc

Current Risk Model Definition

*Will continue to refine model as data collection continues and improves*
Program Organization

- Three core areas
  - Direct Services
  - Data Projects
  - Sobering Center

1. Direct Services
- Eligible patients enrolled in one of two tiers
  - Tier 1 ~ 4,000
    - Medical Case Management
    - Managed by PHN
  - Tier 2 ~ 10,400
    - Social Case Management
    - Managed by Non-RN Case Manager
- Managed by interdisciplinary teams, hiring ~150 new staff members
- Additional services available to team members and beneficiaries:
  - Sobering Center Services, Legal Support, Peer mentoring services through NAMI, Payee services, Transportation vouchers, PATCH funding to support transition to board and care facilities

2. Data Projects
- Large investment in data integration to provide infrastructure across CCHS to best serve patient population
- Expansion of existing systems and new systems
  - All Data Projects to be completed in 2017

3. Sobering/Restoration Center
- New short-stay facility for intoxicated clients
  - ~24-27 bed facility or possibly two smaller 12-14 bed facilities
  - Anticipate opening mid summer-early fall, 2017
  - Location siting underway.
  - Additional services will be available onsite: transportation, counseling
- FFS Reimbursement Model
CommunityConnect Program Oversight

- **Steering Committee**
  - Metric Tracking
  - Program Guidance
  - Review Workgroups Progress
  - Meet Weekly

- **Workgroups**
  - Program Implementation
  - Metric Tracking
  - Support/Advocacy for Steering Committee
  - Recommend need to meet

- **Community Advisory Committee**
  - Quarterly updates and engagement with community partners
  - Kaiser, Lifelong, La Clinica
  - Meeting schedule TBD

- **Responsible**
  - Program Partners
    - Shared patients with Kaiser, Lifelong and La Clinica
  - Increased service contracts with NAMI, HealthLeads, Re-Entry Success Center, Bay Area Legal
  - Establishing Community Advisory Board

Community Partners

Program Administration Team

- Sue Crosby RN, CommunityConnect Director
  - Responsible for overall program success and implementation

- Rachael Birch, Administrative Manager

- Emily Parmenter, Program Manager
  - Responsible for program organization and structure, data project tracking

- Ashley Carrion, Quality Improvement Manager
  - Responsible for tracking of quality measures and workgroup implementation