Crisis File

Emergency response information

Mental Health and Crisis Services in orange county

NAMI
National Alliance on Mental Illness
Orange County
www.namioc.org
714-544-8488
Office Hours
M-F 9 AM - 5 PM
Education & Advocacy

24 Hour Emergency Contacts

Crisis Stabilization Unit	**714-834-6900**
College Hospital Psychiatric Emergency	**800-773-8001**
Evaluation and Treatment Services (ETS)	**714-834-6900**
OC Links	**855-625-4657**
National Suicide Prevention Hotline	**988**

the OC WarmLine
Free & Confidential phone service providing
emotional support and resources
to OC residents
714-991-6412
Text: 714-991-6412
Live Chat: namioc.org
Email: wl@namioc.org

Non emergency contacts

ORANGE COUNTY MENTAL HEALTH CLINICS

Hours: Mon.-Thurs. 8:00 am - 6:00 pm (Fri. 8:00 am - 5:00 pm) *Please call first*

Anaheim 2035 E. Ball Rd. Suite 200 → **714-517-6300**
Aliso Viejo 5 Mareblu → **949-643-6901**
Santa Ana 1200 N. Main St. Suite 200 → **714-480-6767**
Westminster 14140 Beach Blvd. Suite 223 → **714-896-7566**

General Information		
Social Security Administration **800-772-1213**	Social Services Agency **800-281-9799** ssa.ocgov.com	OC Links (info and referral to mental health services) 855-625-4657 (**855-OC LINKS**)
	Legal Assistance	
OC Public Guardian 1300 S. Grand Ave. Santa Ana, CA **714-567-7660** www.ochealthinfo.com/bhs/pg OCHCA Patient's Rights Advocacy **714-276-8145 or 800-668-4240**	Orange County Bar Assoc Lawyer Referral Service **949-440-6747** **877-257-4762**	Legal Aid Society of Orange County **800-834-5001 or 714-571-5200** Collaborative Courts 909 N. Main St. Santa Ana **657-622-5800**
	Mental Health Professional Referral Services	
OC Medical Association Physician Referral Line www.ocma.org **949-398-8100**	OC Psychiatric Society **General 949-250-3157** www.ocps.org	OC Psychological Association **888-324-7978**

Hospitals and county services

Orange County Hospitals With Psychiatric Units

Anaheim Global Medical Center (formerly Western Medical Center Anaheim)
1025 South Anaheim Blvd.
Anaheim, CA 92805
(714) 533-6220

College Hospital Costa Mesa
301 Victoria Street
Costa Mesa, CA 92627
(949) 642-2734

Evaluation and Treatment Services (ETS)
1030 West Warner Avenue
Santa Ana, CA 92707
(714) 834-6900

Huntington Beach Hospital
17772 Beach Blvd.
Huntington Beach, CA 92627
(714) 843-5020

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720
(562) 799-3234

Mission Pacific Coast Recovery (formerly Mission Hospital Laguna Beach)
31872 Coast Highway
South Laguna Beach, CA 92651
(949) 499-7501

Newport Bay Hospital
1501 East 16th Street
Newport Beach, CA 92663
(949) 650-9750

South Coast Global Medical Center (formerly Coastal Communities Hospital)
2701 South Bristol Street
Santa Ana, CA 92704
(714) 754-5454

South Coast Post Acute
1030 West Warner Avenue
Santa Ana, CA 92707
(714) 546-6450

St. Joseph Hospital
1100 West Stewart Drive
Orange, CA 92868
(714) 771-8134

UCI Medical Center, Neuropsychiatric Center
101 The City Drive South
Orange, CA 92868
(714) 456-5801

West Anaheim Medical Center
3033 West Orange Avenue
Anaheim, CA 92804
(714) 827-3000

Mental Health and Crisis Services in Your Community

Crisis team phone # _____

Local mental health agency phone # _____

Local mental health caseworker services phone # _____

Local hospital phone # _____

Local law enforcement phone # _____

State law enforcement phone # _____

Psychiatrist phone # _____

Internist phone # _____

Counselor/Therapist phone # _____

Case manager phone # _____

Other Contacts

NAMI State Organization phone # _____

NAMI Affiliate office phone # _____

Local NAMI support group facilitator phone # _____

State Department of Mental Health phone # _____

National Mental Health Crisis and Support Services

National Suicide Prevention Lifeline: (800) 273-TALK (8255)

A free national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. The Lifeline offers specialized assistance for the following: Attempt Survivors, Disaster Survivors, Deaf/Hard of Hearing, Loss Survivors, LGBTQ+, Native Americans, Veterans, Youth.

Ayuda En Español: (888) 628-9454

Lifeline ofrece 24/7, gratuito servicios en español, no es necesario hablar ingles si usted necesita ayuda.

Veterans Suicide Prevention Hotline: (800) 273-8255 and Press 1

A free 24-hour hotline and online chat available to Service Members and Veterans of all branches of the military and their loved ones in suicidal crisis or emotional distress: 1-800-273-TALK (800-273-8255) and press "1" to be routed to the Veterans Suicide Prevention Hotline. In Germany, Belgium, United Kingdom, Italy and the Netherlands call 001-800-273-8255. Individuals on military bases can access the Lifeline with a 3-digit access code (118) through their DSN system. http://www.veteranscrisisline.net

Veterans Affairs' Caregiver Support Line: (855) 260-3274

A free support line answered by licensed professionals who can tell you about the services available from VA, how you can access them and how you can reach the Caregiver Support Coordinator at a VA Medical Center near you. VA's Caregiver Support Line is toll-free Monday through Friday 8:00 am-8:00 pm ET. www.caregiver.va.gov

NAMI HelpLine: (800) 950-NAMI (6264) or info@nami.org

Staff and volunteers are available Monday through Friday, 10:00 am-6:00 pm ET to answer your questions about mental health issues.

Crisis Text Line: Text NAMI to 741-741

Connect with a trained counselor to receive free, 24/7 crisis support via text message.

National Domestic Violence Hotline: (800) 799-SAFE (7233)

Trained expert advocates are available 24/7 to provide confidential support to anyone experiencing domestic violence or seeking resources and information. Help is available in Spanish and other languages.

National Sexual Assault Hotline: (800) 656-HOPE (4673)

Connect with a trained staff member from a sexual assault service provider in your area that offers access to a range of free services. Crisis chat support is available at the Online Hotline: online.rainn.org. Free help, 24/7.

Dealing with the Criminal Justice System

When people with a mental health condition or their families interact with the criminal justice system, the pressure and intimidation can be overwhelming. This fact sheet offers basic information to help you navigate the legal system. More detail can be found on the NAMI website.

What should you know first about criminal law?

In criminal law, the outcome of a case depends as much on the facts of the case and the procedures followed in building it as it does on the actual law. It is, therefore, essential to have a good criminal lawyer to direct you through any encounter with the criminal justice system.

What is the difference between a misdemeanor and a felony?

Criminal violations come in two varieties, misdemeanors and felonies. There is no universal rule among the states to determine what is a misdemeanor and what is a felony. Generally, crimes that are punishable by incarceration of one year or less are misdemeanors, and crimes punishable by incarceration of more than one year are felonies. Beyond the maximum period of incarceration, whether a crime is a felony or a misdemeanor is significant because it will impact criminal procedures and constitutional rights.

When does an arrest take place?

An arrest occurs when the police take a person into custody in order to charge that person with a crime. To make a lawful arrest, a police officer must believe that the person to be arrested committed a crime. This is important in the context of mental illness because an arrest does not occur every time a person with a mental health condition is picked up or taken into custody by police.

What is booking?

Booking is the process of fingerprinting and photographing a person who has been arrested. In some instances, it may be important for the police to be notified quickly that they have a person with a mental health condition in custody. However, families should be cautioned that the disclosure that a person has a mental illness could make the police view the situation more seriously. Therefore, whenever possible, before family members make disclosures to the authorities concerning the psychiatric history of a family member, they should discuss it with their attorney.

What should the family do during the interrogation?

Family members should try to prevent the police from questioning a family member with a mental health condition without a lawyer present. Any person who is questioned by the police and is not free to end the questioning and leave the place where he or she is being questioned must be given a Miranda warning (the right to remain silent, etc.). The police must immediately stop questioning anyone who asks for a lawyer.

How do you find a lawyer?

Competent criminal lawyers are almost always available, even if your budget is limited. The first places to seek a lawyer if you cannot afford to pay a full fee for a private lawyer is through public defender services, court-appointed attorneys, local criminal defense lawyers' associations or local bar associations.

The United States Constitution guarantees legal representation to every defendant in a felony criminal case. Therefore, if a defendant to a felony charge cannot afford a lawyer, the state must provide him or her with one.

What are your constitutional rights?

- The Fourth Amendment guarantees the right against unreasonable searches and seizures. Usually a warrant is required. The exclusionary rule prevents the prosecution from placing into evidence any evidence that was obtained unreasonably.
- The Fifth Amendment guarantees the right against self-incrimination, which is the well-known right to remain silent.
- The Sixth Amendment guarantees the right to a speedy trial. Every defendant in a criminal case has a constitutional right to have the charges against him or her decided quickly so that he or she can move on with life. The Sixth Amendment also guarantees the right to a public trial and a jury trial. The right to confront witnesses, a compulsory process for obtaining witnesses, and the right to assistance of counsel are also protected by this amendment.
- The Eighth Amendment protects people from cruel and unusual punishment. In addition, it protects the right to treatment for acute medical problems, including psychiatric problems.

Who decides to file charges?

The decision to file charges is often made by the police and the prosecutor's office together.

What is jail diversion?

Jail diversion is a procedure in which a person with a mental health condition who has been charged with a crime agrees to participate in voluntary treatment. This treatment is generally provided in the community. In exchange for participating in treatment, the charges are either dropped or deferred, pending satisfactory compliance with treatment. Jail diversion must be distinguished from probation and a suspended sentence (which are similar), which entail a conviction being entered onto the defendant's criminal record, either by guilty plea or by a verdict.

Can a person stand trial if he or she is viewed as incompetent?

No person can be tried or sentenced for a crime if — because of a mental disease or defect — he or she cannot understand the nature of the proceedings against him or her or assist his or her lawyer in preparing a defense. A criminal found not competent to stand trial is usually subject to civil commitment for an indefinite period.

If a person is found competent to stand trial, can he or she invoke the insanity defense?

Yes. A determination of competency does not prevent a defendant from raising the insanity defense.

Other justice resources may be available for Service Members and civilians dealing with mental illness including:

- Specialty courts or dockets that address various issues and populations including: Veterans, Mental Health, Drugs/Substance Abuse and SAMI (Substance Addiction and Mental Illness).
- Diversionary programs that allow the individual who has been charged with a crime to opt into a special program that will require rigorous mental health and/or addiction treatment in order to avoid to serving time. These programs may not be available to those charged with serious crimes.
- Reentry programs that provide specialized supervision as individuals with mental health needs transition back into the community following incarceration.

Source: A Guide to Mental Illness and the Criminal Justice System (NAMI, out of print)

Take Warning Signs of Suicide Seriously

Recognize signs of suicide risk:

- Feeling like a burden
- Isolating
- Increased anxiety
- Feeling trapped or in unbearable pain
- Increased substance use
- Looking for a way to access lethal means
- Increased anger or rage
- Extreme mood swings
- Expressing hopelessness
- Sleeping too little or too much
- Talking or posting about wanting to die
- Making plans for suicide
- Change in personality — sad, withdrawn, irritable, anxious, tired, indecisive, apathetic
- Change in behavior — unable to concentrate on school, work, routine tasks
- Change in eating habits — loss of appetite and weight, or overeating
- Loss of interest in friends, sex, hobbies, and activities previously enjoyed
- Worry about money, illness (either real or imaginary)
- Fear of losing control, “going crazy” or harming self or others
- Feelings of overwhelming guilt, shame, self-hatred
- Recent loss — death, divorce, separation, broken relationship, job, money, status, self-confidence, self-esteem
- Loss of religious faith
- Agitation, hyperactivity, restlessness may indicate masked depression

Five steps to help someone at risk:

- Ask
- Keep them safe
- Be there
- Help them connect
- Follow up

Sources: Center for Disease Control & Prevention (CDC), American Foundation for Suicide Prevention (AFSP)

Preventing Suicide through Communication

A Checklist for Parents and Families of People Living with Mental Illness to Assist in Communicating with Treatment Providers**

Created by the Oregon Council of Child and Adolescent Psychiatry in 2013, national statistics added by NAMI

Purpose

Statistics from the Centers for Disease Control and Prevention (CDC) indicate that more than 47,000 people died by suicide in 2017 (the most recent year for which full data are available) making suicide the 10th leading cause of death in the U.S. The highest rates of suicide occur among people ages 45-54 years and second highest among people aged 85 and older. While unintentional injury is the leading cause of death among young people ages 10-14 years, suicide was the second leading cause of death among youth ages 15-19 years and those ages 20-34 years. In 2017 50.6% of deaths by suicide involved a firearm, 27.7% were by suffocation and 13.9% were by poisoning *(CDC website)*.

According to the American Foundation for Suicide Prevention (AFSP), no complete count is kept of suicide attempts in the U.S.; however, each year the CDC gathers data from hospitals on non-fatal injuries from self-harm. 575,000 people visited a hospital for injuries due to self-harm. This number suggests that approximately 12 people harm themselves for every reported death by suicide. However, because of the way these data are collected, we are not able to distinguish intentional suicide attempts from non-intentional self-harm behaviors. Many suicide attempts, however, go unreported or untreated. In 2017, an estimated 1.4 million people in the U.S. each year engage in intentionally inflicted self-harm. Females attempt suicide three times more often than males. As with suicide deaths, rates of attempted suicide vary considerably among demographic groups. While males are 4 times more likely than females to die by suicide, females attempt suicide 3 times as often as males. The ratio of suicide attempts to suicide death in youth is estimated to be about 25:1, compared to about 4:1 in the elderly *(AFSP website)*.

Communication between family members of persons seeking treatment for mental illness and primary care providers and/or mental health practitioners improves the quality of care provided to these persons, reduces the risk of suicide and self-harm behaviors, and encourages the use of community resources to improve overall outcomes for these persons. While confidentiality is a fundamental component of a therapeutic relationship, it is not an absolute, and the safety of the patient overrides the duty of confidentiality. Misunderstandings by clinicians about the limitations created by HIPAA, FERPA, and state laws for preserving confidentiality of patients has caused unnecessary concern regarding disclosure of relevant clinical information. Communication between family members or identified significant others and providers needs to be recognized as a clinical best practice and deviations from this should occur only in rare and special circumstances.

To address a perceived deficit of communication, the Oregon Council of Child and Adolescent Psychiatry published a checklist for health providers in 2012. This

companion checklist is designed to help family members access information that might be essential to preserving the life of their loved one.

Definitions

Person involved in treatment — a person receiving care for a mental illness, which may include a child, sibling, parent, or other person whom you wish to support in treatment services, herein abbreviated to "person."

Treatment services — may include outpatient therapy, medication management, support groups, or other treatment supports, partial hospitalization, hospitalization, or therapeutic residential treatment programs.

Provider — may include primary care providers, emergency room physicians, psychiatrists, nurse practitioners, licensed clinical social workers, licensed professional counselors, or other qualified mental health professionals.

Family — may include first-degree biological relatives, adoptive family, foster parent(s), spouse, or other individuals who occupy a similar position in the life of the person involved in treatment.

> **NOTE: If patient is a minor, parents may consult state statutes to determine when the provider may or must disclose patient's information to parents.

For all persons with mental health issues, families should request the following:

- ☐ Has the provider requested that the person sign an authorization to speak with the family? If not, why not? If yes and the person refused, did the provider explain the therapeutic value of speaking with the family?
- ☐ Has a comprehensive risk assessment including personal interview with the person, record review, and solicitation of information from the family been completed by the provider or another qualified professional?
- ☐ Has the provider or any other professional concluded that the person is at elevated risk of suicide?
- ☐ Has the provider reviewed the records of previous mental health providers, and communicated with all others who are involved with the persons' treatment and care (e.g., therapist, family physician, case manager, et al.)?
- ☐ You should offer to provide additional history to the provider and tell the provider what you already know about the family member's illness and need for treatment, especially any episode that suggests the potential for self-harm.

Where an elevated risk of suicide is identified in persons involved in treatment, families have a compelling interest to learn the following:

- ☐ What are the diagnoses and treatment recommendations? How can the family best support the provider's recommendations? Where can one learn more about the illness which has been diagnosed?

- ☐ What is the provider's evaluation of suicide risk in this case? What are the particular warning signs (not the same as risk factors) for suicide in this person's situation? What steps should the family take if they see these signs occurring, such as taking the person to the hospital for reassessment? You may wish to ask the provider to help create a plan to monitor and support the family member. What protective factors exist, and how can these be expanded or enhanced for this person?
- ☐ What community resources are available to help the family and the person involved in treatment, including resources for case management, peer and family support groups, and improving mental health at home?
- ☐ What type of ongoing care is required? Who should provide that care? How can the family access that care?
- ☐ What can the family do to best help the person involved in treatment? What should the family not do?
- ☐ When the person transitions from one level of care to another or from one provider to another, how will provision of care be coordinated? You may wish to request that the provider assures that follow up is in place with a specific timely appointment, that the accepting provider has full knowledge of history and risk issues/records, and that the original provider confirms that family member has attended the follow up appointment.

Where the person is at university or similar setting, the family may wish to ask the Dean of Students:

- ☐ What systems are in place to support students living with mental illness and avoid self-harm? Is peer counseling available for the student with mental illness? Are the health service and/or counseling services on call 24/7; if not what are their hours? Is there a 24-hour number to call in case of emergency?
- ☐ Is there an office to intercede with instructors for the student who feels overwhelmed or highly stressed? Will use of these resources imperil any scholarships the student might have?

Identifying a Good Psychiatrist

Check with other families who have relatives with mental health conditions to see if they have had good experiences with a particular psychiatrist, one who:

- Will make special efforts to communicate with the family; can speak using terms you can understand.
- Won't insist that your loved one makes the first contact and recognizes that they may be in crisis and unable to do so.
- Will make special efforts to communicate. For instance, taking five minutes in the middle or at the end of a session to ask for patient's family to share their views on how things are going.
- Recognizes the condition is a no-fault brain disorder.
- Is strong enough not to be threatened by views of the family or the individual about treatment; willing to discuss openly symptoms, medications and side effects, and the limits of his/her knowledge, while remaining in command of the treatment. While psychiatrists are trained to be vigilant about boundaries, any psychiatrist who communicates the idea that there is a special mystique in psychiatry that you can't understand isn't the kind of doctor you want.
- Is flexible enough to customize treatment for your relative and to enlist families as part of the treatment team when that is indicated, e.g., as observers and reporters on the response to changes in treatment.
- Is innovative enough to consider alternative ways to engage with people who don't think they have a mental health condition.
- Is accommodating enough to schedule visits at less frequent intervals to match the family's financial ability; communicates that he/she is more concerned about finding outcomes that satisfy the entire family than about maximizing their own income.
- Takes seriously and respects the information communicated by the family regarding the status of the patient.

Modified by: Carol Howe, NAMI Threshold, Bethesda, MD

Questions to Ask the Psychiatrist

1. What is the diagnosis? What is the nature of this condition from a medical point of view?
2. What is known about how we can avoid future episodes or making this disorder worse in the future?
3. How certain are you of this diagnosis? If you're not certain, what other possibilities do you consider most likely, and why?
4. Did the physical examination include a neurological exam? If so, how extensive was it, and what were the results?
5. Are there any additional tests or exams that you would recommend at this point?
6. Would you advise an independent opinion from another psychiatrist at this point?
7. What program of treatment do you think would be most helpful? How will it be helpful?
8. Will this program involve services by other specialists (i.e., neurologist, psychologist, allied health professionals)? If so, who will be responsible for coordinating these services?
9. Who will be able to answer our questions at times when you're not available?
10. What kind of therapy do you plan to use, and what will be the contribution of the psychiatrist to the overall program of treatment?
11. What do you expect this program to accomplish? About how long will it take, and how frequently will you and the other specialists be seeing my loved one?
12. What will be the best evidence that my loved one is responding to the program, and how soon will it be before these signs appear?
13. What do you see as the family's role in this program of treatment? In particular, how much access will the family have to the individuals who are providing the treatment?
14. If your current evaluation is a preliminary one, how soon will it be before you will be able to provide a more definite evaluation of my loved one's condition?
15. What medication do you propose to use? (Ask for name and dosage level). What is the biological effect of this medication, and what do you expect it to accomplish? What are the risks associated with the medication? How soon will we be able to tell if the medication is effective, and how will we know?
16. Are there other medications that might be appropriate? If so, why do you prefer the one you have chosen?
17. Are you currently treating other patients with these symptoms? (Psychiatrists vary in their level of experience with severe or long-term mental health conditions, and it

is helpful to know how involved the psychiatrist is with treatment of the kind of problem that your relative has).

18. When are the best times, and what are the most dependable ways for getting in touch with you?
19. How do you monitor medications and what symptoms indicate that they should be raised, lowered or changed?
20. How familiar are you with the activities of NAMI and of our NAMI State Organization?

Getting Satisfactory Results: Some Dos and Don'ts

Families need to know how to be effective in getting help for a person with a mental health condition. They need to know what questions to ask, what people to see and where to go. They need to understand the various parts of the mental healthcare system and how best to interact with each part.

Frequently, when a parent, relative or close friend becomes involved — especially during the early phases of the condition — each person is so overwhelmed by the experience that vague information and "jargon" is accepted as substantive. Families, at the time, want and need honest, direct information about the disorder. They want specific, practical suggestions about how to cope during the acute as well as the stable phases of the condition. To get this kind of information, there are some things which you must do. Following are some hints to obtain positive results from the mental health system.

Things to do:

- Keep a record of everything. List names, addresses, phone numbers, etc. Nothing is unimportant. Every date, time, etc., may come in handy. Make notes of what went on during conferences. Keep all notices, letters, etc. Make copies of everything you mail. Keep a notebook or file of all contacts. Don't throw anything away.
- Be polite. Keep all conversations to the point. Ask for specific information.
- If your loved one is 18 years of age or older, request their permission to review all documents. Many places will request written permission from the person with the condition, so consider asking your relative for this before symptoms affect their ability to cooperate with signing a release of information.
- If your loved one is hospitalized, get the name of the physician who is coordinating the care. In some cases, you may have the right to request a different doctor who has privileges at that hospital. Get the name of the staff member on the unit who is working most closely with your loved one. This is usually a psychiatric nurse, but may be a therapist, a social worker, a psychiatric resident or a case manager. Ask for an appointment to meet with this person; make it at their convenience. Come prepared with a list of specific questions. Some sample questions are:
    - "What are the specific symptoms about which you are most concerned?"
    - "What do these indicate? How are you monitoring them? Who is documenting in the chart? How often is the medication being monitored? What, specifically, is he/she getting? How much? How often? Has my loved one been informed on medication side-effects? When can I look at the record book or chart? When can we meet to plan the transition back home?"
- Keep the meeting short. If you come with a list of questions you will be able to get all the information you need in less than half an hour.
- Write letters of appreciation when warranted; write letters of criticism when necessary. Send these to the head of the hospital (or unit, or both), and send copies

to anyone else who may be involved, including the Governor. Just as there are certain actions to take in order to be effective, there are some things that tend to be counter-productive. Keep in mind that most professionals want to do a good job. Most of the frontline staff (people who work directly with the patients — social workers, case managers, hospital attendants, practical nurses, doctors, nurses, therapists, etc.) are over-scheduled. Usually, there are too few staff for the number of community mental health centers, jails, etc. Thus, it is important to maintain some perspective on what one can reasonably expect.

There are, however, some specific responsibilities for which you can hold staff accountable. The following “don’ts” will help both you and the helping professionals.

- Don’t come late to appointments.
- Don’t accept repeated “cancellations.”
- Don’t make excessive demands on staff, i.e., don’t harass the staff with special requests, don’t have long phone conversations filled with unnecessary details, etc.
- Don’t accept vague answers or statements that seem confusing. If a clinician says, “we are observing your daughter carefully,” recognize that this is a statement which provides you with no information. Don’t accept it without further clarification. Ask who is doing the observing, what is being observed (exactly), how is the information being documented, when can you view the progress of the observation, etc.
- Don’t feel that you “should know” and therefore inhibit yourself from asking for substantive information.
- If your loved one is in a state psychiatric hospital and you have permission to look at the record book, set up an appointment with a staff member who can review what information they have recorded. Be clear that you are not trying to find fault with their care, and that your only goal is to make sure that they have the correct and complete information about your family member.
- Ask to review your loved one’s Individualized Treatment Plan. This is legally mandated and must be carried out. You can ask to participate in the development of the plan. As a patient, your loved one has the right to have his/her wishes considered.
- When you ask how the staff is implementing the treatment plan, don’t accept answers which imply that the patient is responsible for his/her own progress. Persist in finding out exactly what actions staff are taking, i.e., how often my loved one gets exercise or recreation time, which staff person oversees group therapy, how consistent is the treatment, i.e., does each staff member know what others are doing?
- Don’t allow yourself to be intimidated.
- If your relative is in a group home, critical care facility (CCF), individual care facility (ICF) or any facility receiving public funds, you are entitled to inquire about personnel qualifications, etc. Don’t permit unqualified personnel to continue to work

without a formal complaint to the Department of Social & Health Services.

- Don’t be afraid or ashamed to acknowledge that you are related to a person with brain disorder.
- Keep your loved one informed about everything you plan to do. He/she might disapprove of your action or may wish to modify your plan.
- Be assertive! As a taxpayer, you are entitled to information, respect, and courtesy. Your taxes go to public employees. You’re not asking for freebies. You are simply helping to get the job done.

Source: Eleanor Owen, NAMI Washington Connections

Co-occurring Disorders

Co-occurring disorder (also referred to as dual diagnosis) is a term for when someone experiences a mental illness and a substance use disorder simultaneously. Either disorder — substance use or mental illness — can develop first. People experiencing a mental health condition may turn to alcohol or other drugs as a form of self-medication to improve the mental health symptoms they experience. However, research shows that alcohol and other drugs worsen the symptoms of mental illnesses.

The professional fields of mental health and substance use recovery have different cultures, so finding integrated care can challenging. A national effort led by psychiatrist Ken Minkoff helps systems integrate these cultures and services on every level of care.

How Common are Co-occurring disorders?

According to a 2014 National Survey on Drug Use and Health, 7.9 million people in the U.S. experience both a mental disorder and substance use disorder simultaneously. More than half of those people — 4.1 million to be exact — are men.

Symptoms

Because many combinations of co-occurring disorders can occur, the symptoms vary widely. Mental health clinics are starting to use alcohol and drug screening tools to help identify people at risk for drug and alcohol abuse. Symptoms of substance use disorder may include:

- Withdrawal from friends and family
- Sudden changes in behavior
- Using substances under dangerous conditions
- Engaging in risky behaviors
- Loss of control over use of substances
- Developing a high tolerance and withdrawal symptoms
- Feeling like you need a drug to be able to function

Symptoms of a mental health condition can also vary greatly. Warnings signs, such as extreme mood changes, confused thinking or problems concentrating, avoiding friends and social activities and thoughts of suicide may be reason to seek help.

How Are Co-occurring Disorders Treated?

The best treatment for co-occurring disorders is integrated intervention, when a person receives care for both their diagnosed mental illness and substance use disorder. The idea that “I cannot treat your depression because you are also drinking” is outdated — current thinking requires *both* issues be addressed.

You and your treatment provider should understand the ways each condition affects the other and how your treatment can be most effective. Treatment planning will not be the same for everyone, but here are the common methods used as part of the treatment plan:

Detoxification. Inpatient detoxification is generally more effective than outpatient for initial sobriety and safety. During inpatient detoxification, trained medical staff monitor a person 24/7 for up to seven days. The staff may administer tapering amounts of the substance or its medical alternative to wean a person off and lessen the effects of withdrawal.

Inpatient Rehabilitation. A person experiencing a mental illness and dangerous/dependent patterns of substance use may benefit from an inpatient rehabilitation center where they can receive medical and mental health care 24/7. These treatment centers provide therapy, support, medication and health services to treat the substance use disorder and its underlying causes.

Supportive Housing, like group homes or sober houses, are residential treatment centers that may help people who are newly sober or trying to avoid relapse. These centers provide some support and independence. Sober homes have been criticized for offering varying levels of quality care because licensed professionals do not typically run them. Do your research when selecting a treatment setting.

Psychotherapy is usually a large part of an effective dual diagnosis treatment plan. Cognitive behavioral therapy (CBT) helps people with dual diagnosis learn how to cope and change ineffective patterns of thinking, which may increase the risk of substance use.

Medications are useful for treating mental illnesses. Certain medications can also help people experiencing substance use disorders ease withdrawal symptoms during the detoxification process and promote recovery.

Self-Help and Support Groups. Dealing with a dual diagnosis can feel challenging and isolating. Support groups allow members to share frustrations, celebrate successes, find referrals for specialists, find the best community resources and swap recovery tips. They also provide a space for forming healthy friendships filled with encouragement to stay clean. Here are some groups NAMI likes:

- Double Trouble in Recovery is a 12-step fellowship for people managing both a mental illness and substance abuse.
- Alcoholics Anonymous and Narcotics Anonymous are 12-step groups for people recovering from alcohol or drug addiction. Be sure to find a group that understands the role of mental health treatment in recovery.
- Smart Recovery is a sobriety support group for people with a variety of addictions that is *not* based in faith.

Source: nami.org

Limit Setting

Behaviors that shouldn't be tolerated:

Even if they are a result of the mental health condition, the following behaviors shouldn't be tolerated:

- Physical abuse
- Sexual abuse
- Destruction of property (example: punching holes in walls)
- Setting fires or creating fire hazards (example: smoking in bed)
- Stealing
- Abuse of illegal and/or prescription drugs
- Severely disruptive or tyrannical behaviors (examples: walking around the house with a weapon, blasting the stereo, intolerably loud screaming)

Allowing yourself or other members of your family to become a victim of any of these behaviors not only poses danger but sets up an atmosphere that is extremely stressful for everyone, especially your loved one.

Behaviors that are typical symptoms of a mental health condition:

- Trying to stop any of the following behaviors in someone with a mental health disorder can be like trying to stop someone with a cold from sneezing:
  - Periodic departure from normal eating habits
  - Unusual sleep/wake cycles (example: sleeping all day and staying up all night)
  - Delusions or disordered thinking
  - Hallucinations
  - Withdrawal to a quiet, private place
  - Exhibiting behaviors that fall outside social norms
- The reasons for these behaviors are much more complicated than attempts to manipulate. They are symptoms of a disorder or attempts to cope with symptoms in which manipulation may play only a small role, if any.
- Even if a behavior is a symptom or attempt to cope with a symptom, you shouldn't tolerate it if it's destructive or severely disruptive (see above), or if it is driving you or someone else in the house to absolute distraction.

What you can do to manage violent or disruptive behavior:

- When you and your relative are BOTH calm, explain to him/her what kinds of behaviors you will not tolerate, as well as the specific consequences upon which you (and other family members) have decided (and agreed) for specific violent or disruptive behaviors.

  Example: "Next time you threaten to harm any of us, law enforcement will be called."

- Get to know and recognize cues that your relative is becoming violent or disruptive (your own uneasiness or fear is usually a good cue).
- Tell your relative that his/her behavior is scaring you or upsetting you. This feedback can defuse the situation but proceed with the next suggestion if it doesn't. Saying you are scared doesn't mean you act scared.
- If you (and other family members) have made a limit-setting plan, now is the time to carry out the consequences. If you haven't already warned your relative of the consequences when he/she was calm, use your judgment and past experience to decide whether to warn him/her or to just go ahead with the plan without saying anything.
- Give your relative plenty of space, both physical and emotional. Never corner a person who is agitated or whose symptoms are escalating unless you can safely restrain them. Verbal threats or hostile remarks constitute emotional cornering and should be avoided.
- Give yourself an easy exit and leave the scene immediately if they are scaring you or becoming violent.
- Get help! Bringing in other people, including law enforcement if necessary, can quickly defuse the situation.
- If you or someone else has witnessed your relative recently committing or planning a violent or dangerous act, that is grounds for involuntary commitment.

What you should NOT do:

- Don't ignore violent or disruptive behavior. Ignoring only leads your loved one to believe that this kind of behavior is acceptable and "repeatable."
- Don't give your loved one what they want if they are bullying you. Giving in reinforces this bullying behavior and makes it likely that your loved one will use it again. Give in if it is the ONLY way out of a dangerous situation.
- Don't try to lecture or reason with your loved one when they are agitated or losing control.
- NEVER be alone with someone you fear.

  Example: Don't drive them to the hospital by yourself

Source: The Training and Education Center Network, Mental Health Association of Southeastern Pennsylvania, Philadelphia, Pennsylvania

Draft of Important Medical History Summary under WIC 5008.2 (AB 1424)*

This summary is being provided by a family member, relative or friend who knows the person named below very well.

Summary of Mental Health History for our family member (Name)
_____

_____

Summary submitted on (date): _____

D.O.B. _____

Social Security Number: _____

Medical Insurance Company _____

Medical Record Number or ID#_____

Doctor or Care Coordinator: _____
Phone Number: _____

Medical Diagnosis: (Psychiatric diagnosis)
_____

Medications Prescribed:
_____

Medications presently taking:
_____

Medications given in the past that were **not tolerated well**:
_____

Adverse reactions:
_____

History of medical condition starting with most recent past:
(include the follow information)

- State whether loved one is or ever was a danger to self or others, and gravely disabled
- State any homelessness, hospitalizations, diagnosis, medications, incarcerations
- State what frightens and calms your loved one
- Keep it brief, concise and dramatic. Write no more than one page.
- State education, work history

End with information about yourself, spouse or other persons close to family member and describe the relationship with your loved one. Give names and contacts if applicable. State that you are a member of:

Note: List health and religious organizations including National Alliance on Mental Illness Orange County and/or California Treatment and Advocacy Coalition.

- Sign with names of self, spouse and other support persons mentioned above.

Summary reported and submitted by:

Name: _____ Phone: _____ Fax: _____

Address: _____ E-mail: _____

(Print this very clearly)

* **WIC 5008.2** (**AB 1424**) A copy of is attached. That law requires that the historical course of an individual's illness shall be considered when a person is taken into custody under WIC 5150. It also requires that facilities shall make every reasonable effort to make information provided by the patients' family, including parents, children, spouses, significant others, and consumer-identified natural resource system available to the court.

BILL NUMBER: AB 1424 CHAPTERED (WIC 5008.2)

BILL TEXT

CHAPTER 506
FILED WITH SECRETARY OF STATE OCTOBER 4, 2001
APPROVED BY GOVERNOR OCTOBER 4, 2001
PASSED THE ASSEMBLY SEPTEMBER 6, 2001
PASSED THE SENATE SEPTEMBER 4, 2001
AMENDED IN SENATE AUGUST 28, 2001
AMENDED IN SENATE JULY 18, 2001
AMENDED IN ASSEMBLY MAY 1, 2001
AMENDED IN ASSEMBLY APRIL 18, 2001
AMENDED IN ASSEMBLY APRIL 16, 2001
AMENDED IN ASSEMBLY MARCH 29, 2001

INTRODUCED BY Assembly Member Thomson
(Coauthors: Assembly Members Aroner and Koretz)
(Coauthor: Senator Kuehl)

FEBRUARY 23, 2001
An act to add Section 1374.51 to the Health and Safety Code, to add Section 10144.6 to the Insurance Code, and to amend Sections 5008.2, 5328, and 5332 of, and to add Sections 5012, 5150.05, and 14021.8 to, the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1424, Thomson. Mental health: involuntary treatment.

Existing law, the Lanterman-Petris-Short Act, provides that when applying the definition of mental disorder for specified purposes, the historical course of the person's mental disorder, as determined by available relevant information about the course of the person's mental disorder, shall be considered when it has a direct bearing on the determination of whether the person is a danger to others or to himself or herself or is gravely disabled as a result of a mental disorder. Existing law authorizes the hearing officer, court, or jury to exclude from consideration evidence it deems to be irrelevant because of remoteness of time or dissimilarity of circumstances.

This bill would instead require the hearing officer, court, or jury to exclude from consideration evidence it deems to be irrelevant because of remoteness of time or dissimilarity of circumstances, and would broaden the types of information that are required to be included within the historical course of a person's mental disorder to include the patient's medical records and psychiatric records. It would also require that relevant information, including information provided by the patient's family or the patient about the historical course of a patient's mental disorder, be considered when determining whether probable cause exists to involuntarily detain a person for 72-hour treatment and evaluation.

This bill would provide that the fact that a person has been taken into custody under the Lanterman-Petris-Short Act may not be used in the determination of that person's eligibility for payment or reimbursement for mental health or other health care services for which he or she has applied or received under the Medi-Cal program, any health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975, or any insurer providing health coverage doing business in the state.

Existing law authorizes the administration of antipsychotic medication by an agency or facility providing treatment to any person subject to detention, if that person does not refuse that medication following disclosure of the right to refuse medication as well as information required to be given to persons pursuant to specified provisions.

This bill would require the agency or facility providing treatment to any person to acquire the person's medication history, if possible, if the person is subject to detention for 72 hours on the basis he or she is a danger to himself or herself or others or is gravely disabled, or to extended periods of detention pursuant to professional evaluations of the person that he or she remains a danger to himself or herself or others or is gravely disabled or has suicidal tendencies.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health services.

This bill would prohibit a health care service plan, disability insurer, or, under the Medi-Cal program, the State Department of Health Services, from utilizing any information regarding whether a person's psychiatric inpatient admission was made on a voluntary or involuntary basis for the purpose of determining eligibility for claim reimbursement. Since a willful violation of the provisions applicable to health care service plans is a crime, this bill would impose a state-mandated local program.

This bill would incorporate additional changes to Section 5328 of the Welfare and Institutions Code proposed by AB 213, to be operative only if AB 213 and this bill are both chaptered and become effective on or before January 1, 2002, and this bill is chaptered last. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(a) Many families of persons with serious mental illness find the Lanterman-Petris-Short Act system difficult to access and not supportive of family information regarding history and symptoms.

(b) Persons with mental illness are best served in a system of care that supports and acknowledges the role of the family, including parents, children, spouses, significant others, and consumer-identified natural resource systems.

SEC. 2. It is the intent of the Legislature that the Lanterman-Petris-Short Act system procedures be clarified to ensure that families are a part of the system response, subject to the rules of evidence and court procedures.

SEC. 3. Section 1374.51 is added to the Health and Safety Code, to read:

1374.51. No plan may utilize any information regarding whether an enrollee's psychiatric inpatient admission was made on a voluntary or involuntary basis for the purpose of determining eligibility for claim reimbursement.

SEC. 4. Section 10144.6 is added to the Insurance Code, to read:

10144.6. No disability insurer may utilize any information regarding whether a beneficiary's psychiatric inpatient admission was made on a voluntary or involuntary basis for the purpose of determining eligibility for claim reimbursement.

SEC. 5. Section 5008.2 of the Welfare and Institutions Code is amended to read:

5008.2. (a) When applying the definition of mental disorder for the purposes of Articles 2 (commencing with Section 5200), 4 (commencing with Section 5250), and 5 (commencing with Section 5275) of Chapter 2 and Chapter 3 (commencing with Section 5350), the historical course of the person's mental disorder, as determined by available relevant information about the course of the person's mental disorder, shall be considered when it has a direct bearing on the determination of whether the person is a danger to others, or to himself or herself, or is gravely disabled, as a result of a mental disorder. The historical course shall include, but is not limited to, evidence presented by persons who have provided, or are providing, mental health or related support services to the patient, the patient's medical records as presented to the court, including psychiatric records, or evidence voluntarily presented by family members, the patient, or any other person designated by the patient. Facilities shall make every reasonable effort to make information provided by the patient's family available to the court. The hearing officer, court, or jury shall exclude from consideration evidence it determines to be irrelevant because of remoteness of time or dissimilarity of circumstances.

(b) This section shall not be applied to limit the application of Section 5328 or to limit existing rights of a patient to respond to evidence presented to the court.

SEC. 6. Section 5012 is added to the Welfare and Institutions Code, to read:

5012. The fact that a person has been taken into custody under this part may not be used in the determination of that person's eligibility for payment or reimbursement for mental health or other health care services for which he or she has applied or received under the Medi-Cal program, any health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), or any insurer providing health coverage doing business in the state.

SEC. 7. Section 5150.05 is added to the Welfare and Institutions Code, to read:

5150.05. (a) When determining if probable cause exists to take a person into custody, or cause a person to be taken into custody, pursuant to Section 5150, any person who is authorized to take that person, or cause that person to be taken, into custody pursuant to that section shall consider available relevant information about the historical course of the person's mental disorder if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a danger to others, or to himself or herself, or is gravely disabled as a result of the mental disorder.

(b) For purposes of this section, "information about the historical course of the person's mental disorder" includes evidence presented by the person who has provided or is providing mental health or related support services to the person subject to a determination described in subdivision (a), evidence presented by one or more members of the family of that person, and evidence presented by the person subject to a determination described in subdivision (a) or anyone designated by that person.

(c) If the probable cause in subdivision (a) is based on the statement of a person other than the one authorized to take the person into custody pursuant to Section 5150, a member of the attending staff, or a professional person, the person making the statement shall be liable in a civil action for intentionally giving any statement that he or she knows to be false.

(d) This section shall not be applied to limit the application of Section 5328.

SEC. 8. Section 5328 of the Welfare and Institutions Code is amended to read:

5328. All information and records obtained in the course of providing services under Division 4 (commencing with Section 4000), Division 4.1 (commencing with Section 4400), Division 4.5 (commencing with Section 4500), Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7100), to either voluntary or involuntary recipients of services shall be confidential. Information and records obtained in the course of providing similar services to either voluntary or involuntary recipients prior to 1969 shall also be confidential. Information and records shall be disclosed only in any of the following cases:

(a) In communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. The consent of the patient, or his or her guardian or conservator shall be obtained before information or records may be disclosed by a professional person employed by a facility to a professional person not employed by the facility who does not have the medical or psychological responsibility for the patient's care.

(b) When the patient, with the approval of the physician, licensed psychologist, or social worker with a master's degree in social work, who is in charge of the patient, designates persons to whom information or records may be released, except that nothing in this article shall be construed to compel a physician, psychologist, social worker, nurse, attorney, or other professional person to reveal information which has been given to him or her in confidence by members of a patient's family.

(c) To the extent necessary for a recipient to make a claim, or for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which he or she may be entitled.

(d) If the recipient of services is a minor, ward, or conservatee, and his or her parent, guardian, guardian ad litem, or conservator designates, in writing, persons to whom records or information may be disclosed, except that nothing in this article shall be construed to compel a physician, psychologist, social worker, nurse, attorney, or other professional person to reveal information which has been given to him or her in confidence by members of a patient's family.

(e) For research, provided that the Director of Mental Health or the Director of Developmental Services designates by regulation, rules for the conduct of research and requires the research to be first reviewed by the appropriate institutional review board or boards. The rules shall include, but need not be limited to, the requirement that all researchers shall sign an oath of confidentiality as follows:

_____
Date

As a condition of doing research concerning persons who have received services from _____ (fill in the facility, agency or person), I, _____, agree to obtain the prior informed consent of persons who have received services to the maximum degree possible as determined by the appropriate institutional review board or boards for protection of human subjects reviewing my research, and I further agree not to divulge any information obtained in the course of research to unauthorized persons, and not to publish or otherwise make public any information regarding persons who have received services so that the person who received services is identifiable.

I recognize that the unauthorized release of confidential information may make me subject to a civil action under provisions of the Welfare and Institutions Code.

(f) To the courts, as necessary to the administration of justice.

(g) To governmental law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families.

(h) To the Committee on Senate Rules or the Committee on Assembly Rules for the purposes of legislative investigation authorized by the committee.

(i) If the recipient of services who applies for life or disability insurance designates in writing the insurer to which records or information may be disclosed.

(j) To the attorney for the patient in any and all proceedings upon presentation of a release of information signed by the patient, except that when the patient is unable to sign the release, the staff of the facility, upon satisfying itself of the identity of the attorney, and of the fact that the attorney does represent the interests of the patient, may release all information and records relating to the patient except that nothing in this article shall be construed to compel a physician, psychologist, social worker, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family.

(k) Upon written agreement by a person previously confined in or otherwise treated by a facility, the professional person in charge of the facility or his or her designee may release any information, except information that has been given in confidence by members of the person's family, requested by a probation officer charged with the evaluation of the person after his or her conviction of a crime if the professional person in charge of the facility determines that the information is relevant to the evaluation. The agreement shall only be operative until sentence is passed on the crime of which the person was convicted. The confidential information released pursuant to this subdivision shall be transmitted to the court separately from the probation report and shall not be placed in the probation report. The confidential information shall remain confidential except for purposes of sentencing. After sentencing, the confidential information shall be sealed.

(l) Between persons who are trained and qualified to serve on "multidisciplinary personnel" teams pursuant to subdivision (d) of Section 18951. The information and records sought to be disclosed shall be relevant to the prevention, identification, management, or treatment of an abused child and his or her parents pursuant to Chapter 11 (commencing with Section 18950) of Part 6 of Division 9.

(m) To county patients' rights advocates who have been given knowing voluntary authorization by a client or a guardian ad litem. The client or guardian ad litem, whoever entered into the agreement, may revoke the authorization at any time, either in writing or by oral declaration to an approved advocate.

(n) To a committee established in compliance with Sections 4070 and 5624.

(o) In providing information as described in Section 7325.5. Nothing in this subdivision shall permit the release of any information other than that described in Section 7325.5.

(p) To the county mental health director or the director's designee, or to a law enforcement officer, or to the person designated by a law enforcement agency, pursuant to Sections 5152.1 and 5250.1.

(q) If the patient gives his or her consent, information specifically pertaining to the existence of genetically handicapping conditions, as defined in Section 341.5 of the Health and Safety Code, may be released to qualified professional persons for purposes of genetic counseling for blood relatives upon request of the blood relative. For purposes of this subdivision, "qualified professional persons" means those persons with the qualifications necessary to carry out the genetic counseling duties under this subdivision as determined by the genetic disease unit established in the State Department of Health Services under Section 309 of the Health and Safety Code. If the patient does not respond or cannot respond to a request for permission to release information pursuant to this subdivision after reasonable attempts have been made over a two-week period to get a response, the information may be released upon request of the blood relative.

(r) When the patient, in the opinion of his or her psychotherapist, presents a serious danger of violence to a

reasonably foreseeable victim or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies as the psychotherapist determines is needed for the protection of that person or persons. For purposes of this subdivision, "psychotherapist" means anyone so defined within Section 1010 of the Evidence Code.

(s) To persons serving on an interagency case management council established in compliance with Section 5606.6 to the extent necessary to perform its duties. This council shall attempt to obtain the consent of the client. If this consent is not given by the client, the council shall justify in the client's chart why these records are necessary for the work of the council.

(t) (1) To the designated officer of an emergency response employee, and from that designated officer to an emergency response employee regarding possible exposure to HIV or AIDS, but only to the extent necessary to comply with provisions of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (P.L. 101-381; 42 U.S.C. Sec. 201).

(2) For purposes of this subdivision, "designated officer" and "emergency response employee" have the same meaning as these terms are used in the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (P.L. 101-381; 42 U.S.C. Sec. 201).

(3) The designated officer shall be subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV results. Further, the designated officer shall inform the exposed emergency response employee that the employee is also subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV test results.

(u) (1) To a law enforcement officer who personally lodges with a facility, as defined in paragraph (2), a warrant of arrest or an abstract of such a warrant showing that the person sought is wanted for a serious felony, as defined in Section 1192.7 of the Penal Code, or a violent felony, as defined in Section 667.5 of the Penal Code. The information sought and released shall be limited to whether or not the person named in the arrest warrant is presently confined in the facility. This paragraph shall be implemented with minimum disruption to health facility operations and patients, in accordance with Section 5212. If the law enforcement officer is informed that the person named in the warrant is confined in the facility, the officer may not enter the facility to arrest the person without obtaining a valid search warrant or the permission of staff of the facility.

(2) For purposes of paragraph (1), a facility means all of the following:

(A) A state hospital, as defined in Section 4001.
(B) A general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, solely with regard to information pertaining to a mentally disordered person subject to this section.
(C) An acute psychiatric hospital, as defined in subdivision (b) of Section 1250 of the Health and Safety Code.
(D) A psychiatric health facility, as described in Section 1250.2 of the Health and Safety Code.
(E) A mental health rehabilitation center, as described in Section 5675.
(F) A skilled nursing facility with a special treatment program for chronically mentally disordered patients, as described in Sections 51335 and 72445 to 72475, inclusive, of Title 22 of the California Code of Regulations.

(v) The amendment of subdivision (d) enacted at the 1970 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the preexisting law.

(w) This section shall not be limited by Section 5150.05 or 5332.

SEC. 8.5. Section 5328 of the Welfare and Institutions Code is amended to read:

5328. All information and records obtained in the course of providing services under Division 4 (commencing with Section 4000), Division 4.1 (commencing with Section 4400), Division 4.5 (commencing with Section 4500), Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7100), to either voluntary or involuntary recipients of services shall be confidential. Information and records obtained in the course of providing similar services to either voluntary or involuntary recipients prior to 1969 shall also be confidential. Information and records shall be disclosed only in any of the following cases:

(a) In communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. The consent of the patient, or his or her guardian or conservator shall be obtained before information or records may be disclosed by a professional person employed by a facility to a professional person not employed by the facility who does not have the medical or psychological responsibility for the patient's care.

(b) When the patient, with the approval of the physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist, who is in charge of the patient, designates persons to whom information or records may be released, except that nothing in this article shall be construed to compel a physician, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family. Nothing in this subdivision shall be construed to authorize a licensed marriage and family therapist to provide services or to be in charge of a patient's care beyond his or her lawful scope of practice.

(c) To the extent necessary for a recipient to make a claim, or for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which he or she may be entitled.

(d) If the recipient of services is a minor, ward, or conservatee, and his or her parent, guardian, guardian ad litem, or conservator designates, in writing, persons to whom records or information may be disclosed, except that nothing in this article shall be construed to compel a physician, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family.

(e) For research, provided that the Director of Mental Health or the Director of Developmental Services designates by regulation, rules for the conduct of research and requires the research to be first reviewed by the appropriate institutional review board or boards. The rules shall include, but need not be limited to, the requirement that all researchers shall sign an oath of confidentiality as follows:

_____
Date

As a condition of doing research concerning persons who have received services from _____ (fill in the facility, agency or person), I, _____, agree to obtain the prior informed consent of such persons who have received services to the maximum degree possible as determined by the appropriate institutional review board or boards for protection of human subjects reviewing my research, and I further agree not to divulge any information obtained in the course of such research to unauthorized persons, and not to publish or otherwise make public any information regarding persons who have received services such that the person who received services is identifiable.

I recognize that the unauthorized release of confidential information may make me subject to a civil action under provisions of the Welfare and Institutions Code.

(f) To the courts, as necessary to the administration of justice.

(g) To governmental law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families.

(h) To the Committee on Senate Rules or the Committee on Assembly Rules for the purposes of legislative investigation authorized by the committee.

(i) If the recipient of services who applies for life or disability insurance designates in writing the insurer to which records or information may be disclosed.

(j) To the attorney for the patient in any and all proceedings upon presentation of a release of information signed by the patient, except that when the patient is unable to sign the release, the staff of the facility, upon satisfying itself of the identity of the attorney, and of the fact that the attorney does represent the interests of the patient, may release all information and records relating to the patient except that nothing in this article shall be construed to compel a physician, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family.

(k) Upon written agreement by a person previously confined in or otherwise treated by a facility, the professional person in charge of the facility or his or her designee may release any information, except information that has been given in confidence by members of the person's family, requested by a probation officer charged with the evaluation of the person after his or her conviction of a crime if the professional person in charge of the facility determines that the information is relevant to the evaluation. The agreement shall only be operative until sentence is passed on the crime of which the person was convicted. The confidential information released pursuant to this subdivision shall be transmitted to the court separately from the probation report and shall not be placed in the probation report. The confidential information shall remain confidential except for purposes of sentencing. After sentencing, the confidential information shall be sealed.

(l) Between persons who are trained and qualified to serve on "multidisciplinary personnel" teams pursuant to subdivision (d) of Section 18951. The information and records sought to be disclosed shall be relevant to the prevention, identification, management, or treatment of an abused child and his or her parents pursuant to Chapter 11 (commencing with Section 18950) of Part 6 of Division 9.

(m) To county patients' rights advocates who have been given knowing voluntary authorization by a client or a guardian ad litem. The client or guardian ad litem, whoever entered into the agreement, may revoke the authorization at any time, either in writing or by oral declaration to an approved advocate.

(n) To a committee established in compliance with Sections 4070 and 5624.

(o) In providing information as described in Section 7325.5. Nothing in this subdivision shall permit the release of any information other than that described in Section 7325.5.

(p) To the county mental health director or the director's designee, or to a law enforcement officer, or to the person designated by a law enforcement agency, pursuant to Sections 5152.1 and 5250.1.

(q) If the patient gives his or her consent, information specifically pertaining to the existence of genetically handicapping conditions, as defined in Section 341.5 of the Health and Safety Code, may be released to qualified professional persons for purposes of genetic counseling for blood relatives upon request of the blood relative. For purposes of this subdivision, "qualified professional persons" means those persons with the qualifications necessary to carry out the genetic counseling duties under this subdivision as determined by the genetic disease unit established in the State Department of Health Services under Section 309 of the Health and Safety Code. If the patient does not respond or cannot respond to a request for permission to release information pursuant to this subdivision after reasonable attempts have been made over a two-week period to get a response, the information may be released upon request of the blood relative.

(r) When the patient, in the opinion of his or her psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies as the psychotherapist determines is needed for the protection of that person or persons. For purposes of this subdivision, "psychotherapist" means anyone so defined within Section 1010 of the Evidence Code.

(s) To persons serving on an interagency case management council established in compliance with Section 5606.6 to the extent necessary to perform its duties. This council shall attempt to obtain the consent of the client. If this consent is not given by the client, the council shall justify in the client's chart why these records are necessary for the work of the council.

(t) (1) To the designated officer of an emergency response employee, and from that designated officer to an emergency response employee regarding possible exposure to HIV or AIDS, but only to the extent necessary to comply with provisions of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (P.L. 101-381; 42 U.S.C. Sec. 201).

(2) For purposes of this subdivision, "designated officer" and "emergency response employee" have the same meaning as these terms are used in the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (P.L. 101-381; 42 U.S.C. Sec. 201).

(3) The designated officer shall be subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV results. Further, the designated officer shall inform the exposed emergency response employee that the employee is also subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV test results.

(u) (1) To a law enforcement officer who personally lodges with a facility, as defined in paragraph (2), a warrant of arrest or an abstract of such a warrant showing that the person sought is wanted for a serious felony, as defined in Section 1192.7 of the Penal Code, or a violent felony, as defined in Section 667.5 of the Penal Code. The information sought and released shall be limited to whether or not the person named in the arrest warrant is presently confined in the facility. This paragraph shall be implemented with minimum disruption to health facility operations and patients, in accordance with Section 5212. If the law enforcement officer is informed that the person named in the warrant is confined in the facility, the officer may not enter the facility to arrest the person without obtaining a valid search warrant or the permission of staff of the facility.

(2) For purposes of paragraph (1), a facility means all of the following:

(A) A state hospital, as defined in Section 4001.

(B) A general acute care hospital, as defined in subdivision of Section 1250 of the Health and Safety Code, solely with regard to information pertaining to a mentally disordered person subject to this section.

(C) An acute psychiatric hospital, as defined in subdivision (b) of Section 1250 of the Health and Safety Code.

(D) A psychiatric health facility, as described in Section 1250.2 of the Health and Safety Code.

(E) A mental health rehabilitation center, as described in Section 5675.

(F) A skilled nursing facility with a special treatment program for chronically mentally disordered patients, as described in Sections 51335 and 72445 to 72475, inclusive, of Title 22 of the California Code of Regulations.

(v) The amendment of subdivision (d) enacted at the 1970 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the preexisting law.

(w) This section shall not be limited by Section 5150.05 or 5332.

SEC. 9. Section 5332 of the Welfare and Institutions Code is amended to read:

5332. (a) Antipsychotic medication, as defined in subdivision (l) of Section 5008, may be administered to any person subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15, if that person does not refuse that medication following disclosure of the right to refuse medication as well as information required to be given to persons pursuant to subdivision (c) of Section 5152 and subdivision (b) of Section 5213.

(b) If any person subject to detention pursuant to Section 5150,5250, 5260, or 5270.15, and for whom antipsychotic medication has been prescribed, orally refuses or gives other indication of refusal of treatment with that medication, the medication shall be administered only when treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient, and upon a determination of that person's incapacity to refuse the treatment, in a hearing held for that purpose.

(c) Each hospital in conjunction with the hospital medical staff or any other treatment facility in conjunction with its clinical staff shall develop internal procedures for facilitating the filing of petitions for capacity hearings and other activities required pursuant to this chapter.

(d) When any person is subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15, the agency or facility providing the treatment shall acquire the person's medication history, if possible.

(e) In the case of an emergency, as defined in subdivision (m) of Section 5008, a person detained pursuant to Section 5150, 5250, 5260, or 5270.15 may be treated with antipsychotic medication over his or her objection prior to a capacity hearing, but only with antipsychotic medication that is required to treat the emergency condition, which shall be provided in the manner least restrictive to the personal liberty of the patient. It is not necessary for harm to take place or become unavoidable prior to intervention.

SEC. 10. Section 14021.8 is added to the Welfare and Institutions Code, to read:

14021.8. The department may not utilize any information regarding whether a beneficiary's psychiatric inpatient admission was made on a voluntary or involuntary basis for the purpose of determining eligibility for Medi-Cal claim reimbursement.

SEC. 11. Section 8.5 of this bill incorporates amendments to Section 5328 of the Welfare and Institutions Code proposed by both this bill and AB 213. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2002, (2) each bill amends Section 5328 of the Welfare and Institutions Code, and (3) this bill is enacted after AB 213, in which case Section 8 of this bill shall not become operative.

SEC. 12. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIB of the California Constitution.

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My Family Member Has Been Arrested. What Do I Do?

A step-by-step guide to help families cope with the criminal justice system in Orange County, California when a family member who suffers from a brain disorder (mental illness) is arrested.

STEP ONE: SUPPORT YOUR RELATIVE

- If your family member/friend calls you and says that he/she has been arrested, help him/her stay calm and let him/her know you are there to help.
- If your relative is being held in a city jail, remind him/her that he/she has a right to have an attorney present when being questioned by police officers or detectives.
- If your mentally ill relative is already at the Orange County Sheriff Department Central Jail Complex, **he/she can expect to be interviewed by the Mental Health Evaluation Team**. If the Medical Evaluation Team determines that there are mental health issues, your relative will be referred to Correctional Mental Health.
- It is OK for your mentally ill family member to discuss his/her physical and mental condition, diagnosis, medications, etc. with Medical Evaluation Team members. It is important that he/she feels safe and to speak openly with mental health screeners.

STEP TWO: CONTACT THE JAIL

- If your family member is being held in a city jail, call that jail (not the County Jail) and ask for the Watch Commander. Notify the jail that your family member suffers from a mental illness and describe the diagnosis and any other concerns you might have. Inquire about the family member's status and estimated length of stay at this facility. Ask if he/she is expected to be released directly from the city jail. If he/she is going to be released directly from the city jail (which sometimes occurs for minor offenses), ask for the time and place so that you can be there to pick him/her up. If your relative is severely ill, request the city police to take him/her to a psychiatric hospital for a "5150" involuntary three day hold for evaluation and treatment.
- Be sure to ask for the following information:
  - The expected date and time of departure from the City Jail.
  - The court arraignment date and address.

- Medication probably will not be accessible until your relative arrives at County Jail, but you might inquire if the holding facility can secure needed medication.

STEP THREE: <u>COUNTY JAIL INFORMATION</u>

- Upon arrival of your mentally ill relative at the Intake and Release Center of the Orange County Jail, call 714-647-4666 and ask for the following information:
  - Booking number.
  - County jail in which the person is being held.
  - Charges.
  - Court Date.
  - Visiting Hours.
- This information also is available on the Internet at www.ocsd.org. Click on "Services"; then click on "Who's in Jail". Enter the mentally ill family member's complete legal name to bring up the booking number. Note the information for future reference.

(Tip: Inmates sometimes are booked with/without a middle name. If you are unable to locate him/her, try any names your relative has used.)

STEP FOUR: <u>SEND A FAX TO MEDICAL RECORDS - (714) 647-7010</u>

- Immediately prepare a fax requesting that your relative be evaluated for mental health treatment. Head this fax with your relative's:
  - Full legal name.
  - Date of birth.
  - Booking number.
  - Location.
- In the body of the fax:
  - State his/her diagnosis.
  - Provide his/her psychiatrist's name, telephone number, and address.
  - **Indicate the medications that are prescribed for your family member by name, dosage, and the time of day to be administered.**
  - Note if a particular medication has proven to be ineffective or has dangerous and/or uncomfortable side effects.
  - Caution if a suicide attempt is a possibility or if you have other serious concerns.
  - Describe any other urgent medical conditions that might require immediate attention such as diabetes, high blood pressure, seizures, heart problems, etc. and note the necessary medications to be given. Include his/her medical doctor's name, address, and phone number for verification purposes.
  - List (to the best of your recollection) in chronological order:
    - When he/she first became ill.
    - Any "5150" detainments.

- Hospitalizations.
- Prior psychiatric evaluations.
- Prior arrests.

- **IMPORTANT: Do NOT address any impending charges against your family member in this fax. Provide only medical information!**
- Keep a copy of this fax for future reference. If your family member is transferred to a different facility you will need to fax this information again.
- Fax the document to 714-647-7010. **This number is for mental health information only.** Faxes can be sent 24 hours a day.
- Without a signed release of information form, confidentiality requirements prevent Correctional Medical Health staff from providing you any information. This release of information form must be signed by your mentally ill relative while he/she is at the facility. Correctional Mental Health staff routinely ask an inmate if he/she wants to sign a release form.
- Communication with staff can be improved by designating one person or family member as the contact person.

STEP FIVE: DECIDING ON LEGAL REPRESENTATION

- Your family member may want to retain a private attorney or use the **Public Defender's Office.** 714-834-2144 Or you may email them at: PDinfo@pubdef.ocgov.com
- **Provide information.** Provide the attorney with an extensive medical/psychiatric/social/educational history of your family member. This information presented in writing will be very useful in pursuing the best outcome for your loved one.
- **Private Attorney.**
  - If your relative has a private attorney, contact him/her and provide him/her pertinent information regarding your relative's case and mental health condition.
  - If your family member decides to retain a private attorney, be sure to select one that is well versed in helping people with mental illness. He/she must understand not only the law, but also how to access the treatment facilities and mental health services that are available.
  - A private attorney will grant you more time, but remember you are paying for that access.
- **Public Defenders Office.**
  - If your relative does not have, or cannot afford an attorney, a **Public Defender** will be assigned to him/her at the arraignment.
  - Do not be afraid to use the Public Defender. Public Defenders often have knowledge of "the system' as it pertains to those who need mental health services, as the Public Defender's Office also represents individuals in LPS, Probate and AOT Proceedings. In addition, the Public Defender's Office staffs a variety of mental health-oriented Collaborative Courts, where the focus is on addressing mental health issues and linking clients with mental health services and other resources. Some of the

Collaborative Courts include: Opportunity Court, Recovery Court, "Whatever It Takes" Court (WIT Court), and Assisted Intervention Court. For further information, please visit http://www.collaborativecourtsfoundation.org.

- At the arraignment you can provide to the Public Defender pertinent information concerning both the legal issues and mental health matters.
- This should be a brief statement (preferably written) concerning the current circumstances, diagnosis, and relevant history of your relative's mental illness.
- The more information the better- but be concise and to the point.
- Public Defenders are extremely busy and do not have much time for telephone calls. He/she will appreciate written or faxed correspondence. Remember, it is the inmate, not you, who is the attorney's client.

- Bail.
  - Carefully consider the posting of bail for your family member. No one wants a loved one to remain in jail.
  - Being in jail is an unpleasant experience for them as well as the family. However, you must ask yourself the following question: Will my family member be able to comply with the terms of the bail and appear in court when required?
  - Also, jail may be a safer place for a person with severe mental illness who is in crisis rather than having him/her wandering the streets with no help at all. At least in jail he/she will be fed, will have shelter and will be given access to medication treatments.

STEP SIX: ALTERNATIVE COMMUNITY TREATMENT PROGRAM

The Alternative Community Treatment Program may be able to provide additional case management to your mentally ill relative. For more information, call the Telecare WIT Program at 714-361-7950. They are a Full-Service Partnership and provide medication management by a Psychiatrist or a Nurse Practitioner, therapy, case management, and assistance *Nth employment and housing. They participate in the Collaborative Court program. To participate in this program, they must be 18 or older and referred through the court. They are located at: 1910 North Bush Street, Santa Ana, 92706.

STEP SEVEN: FAMILY SUPPORT

The Office of Consumer & Family Affairs with the Orange County Health Care Agency is available to assist you with consultation, education, and support. Please call: 714-834-5917. Office hours are Monday - Friday from 8 AM - 5 PM.

CONCLUSION

Supporting and coping with a loved one who suffers from a brain disorder can be extremely challenging and stressful. Knowledge, as well as your love and fortitude, will be instrumental in helping you to provide strong and effective support to your

family member. For information about support groups and educational programs provided free of charge in your Orange County contact NAMI Orange County, the Community's Voice on Mental Illness, at 714-544-8488 or on the internet at www.namioc.org or via email to info@namioc.org.

This guide is based on a draft prepared for the Los Angeles County Jail System by Mark Gale and Jim Randall of the Los Angeles NAMI Criminal Justice Committee. Carla Jacobs deserves special thanks for her help with this project.

The specific procedures to help families navigate the "system" in Orange County were prepared by NAMI Orange County Coordinator of Family Education and Support William Benton Harwood, Ed.D. with the assistance of NAMI Orange County Criminal Justice System Mentor Howard Black, M.A. We are not attorneys. This paper is not intended as a substitute for professional legal advice. Please assist your family member in obtaining proper legal representation.