LPS CLINICAL ASSESSMENT GUIDELINES

for Improved Assessment and Delivery of Clinical Service to Involuntarily Detained Individuals

OVERVIEW, ANALYSIS AND METHODOLOGY

Through a contract with the Mental Health Services Oversight and Accountability Commission (MHSOAC), the California Institute for Behavioral Health Solutions (CIBHS, formerly CiMH) is leading the statewide project to establish LPS Consensus Guidelines. The project is directed by legislation, to engage

counties, providers, and stakeholders to establish consensus and train to California statewide clinical assessment guidelines for involuntary detainment in various settings. These guidelines are:

- person-centered
- trauma-informed
- community-based
- family-driven/inclusive
- culturally responsive
- recovery-oriented

The ultimate purpose of this project is to improve the individual experience. More specifically, this project seeks to:

- develop standardized training and certification in consistent protocols which may reduce adverse incidences
- improve clinical assessment competencies
- identify adaptations to establish best practices for specific environments
- identify systems changes which may promote optimal care
- identify community supports and strengthen networks of care
- identify outcome and performance measures
- improve clinical/recovery outcomes through careful application of the strategies

The product of this effort will not constitute legislation, regulations, or agency policy. These guidelines will, however, become part of a set of standards by which a multifaceted community of stakeholders may evaluate the quality and accountability of California's publicly funded behavioral healthcare services that are delivered in involuntary settings. A Clinical Assessment Toolkit for Use in Involuntary Detainment based on these guidelines will provide strategies and resources those behavioral healthcare services can use to respond to and meet these standards.

CIBHS established an LPS Consensus Expert Panel comprising thirty (30) diverse members representing mental health, medical, and hospital professionals; advocacy networks, law enforcement; and CIBHS staff. The expert panel convened a strategic planning workshop on January 31, 2014. The panel endeavored to frame the issues, identify underlying factors, establish the project charter, and establish the categories of assessment for the consensus guidelines. The Clinical Assessment Guidelines were developed per the following recovery-oriented values as expressed in the CIBHS Project Charter.

Recovery Orientation

The person receiving services should inform their own treatment and support approaches whenever possible. Families may be a primary resource concerning stabilization, history, support, and discharge planning. A primary goal of assessment is to formulate a stabilization and treatment approach that does not exacerbate a person's problems despite the severity, level of risk, or chronic nature of the condition.

The recovery principles and attributes listed below were referenced in various forms and iterations during the expert panel and in regional working meetings and includes references from documents and literature from SAMHSA, Mark Ragins, MD, and Mary Ellen Copeland.

List of Recovery Principles and Attributes

- *begin* with welcoming, outreach, and engagement
- *maintain* a person-centered focus
- *encourage* self-direction
- *encourage* self-responsibility
- *strengthen* empowerment
- *promote* strengths-based interventions
- *build* responsibility
- *promote* respect
- *strive* to be culturally relevant
- *stimulate* hope
- *offer* goal-driven services
- *create* natural support networks
- *provide* community-based services
- *offer* the least restrictive environment possible
- *go beyond* professional interventions (which can occur independent of professional services)
- *focus* on quality of life goals
- *focus* on meaningful life roles
- *track* progress toward recovery and cure

Throughout this document, each Clinical Assessment Guidelines (CAG) will be explicitly associated with one or more recovery-oriented value. The sections leading up to the actual Guidelines will contain a good deal of reiteration. This reiteration and reframing is necessary to provide the context in which the guidelines were created, which will, in turn, affect their eventual implementation.

Project Scope and Charter

CIBHS was contracted by the MHSOAC to work with all fifty-eight (58) counties to develop statewide clinical assessment guidelines for involuntary detainment; research existing practices and protocols, identify best practices and provide training to counties. Due to the vast range of issues related to the involuntary detainment of individuals and the LPS Act itself, the scope of this project needed to be carefully defined. CIBHS and the expert panel developed a project charter (Table 2) to guide the project's overall design, development, implementation, and evaluation.

The CIBHS team presented a draft document during the expert panel meeting held in January 2014. The draft included a problem statement, a project charter and objectives, an aim statement and key drivers of change. The expert panel members refined the document by providing in-depth feedback on each component of the project charter, aim and objectives. CIBHS shared the revised documents with statewide stakeholders during a webinar to launch the project and with county behavioral health directors during CBHDA's monthly all-members meetings.

The next steps involved further development of the concepts outlined in the charter. This process occurred through a series of five (5) regional meetings representatives of county behavioral health departments statewide which convened between July and September 2014. The regional meeting schedule is listed below in Table 1.

Table 1. Regional Meeting Schedule

Southern Region	July 24, 2014
Los Angeles Area	July 25, 2014
Bay Area Region	August 4, 2014
Superior Region	August 7, 2014
Central Region	September 12, 2014

The Regional Meetings were led by CIBHS staff and formatted to include both dyadic presentation and small group process. The agenda outline consisted of:

- Welcome and Introduction
- Project Overview
- Framing the Issues and Identification of underlying Issues
- Clinical Assessment Guidelines
    - Components of Ideal Assessment
    - Identification of Core Competencies
- Wrap Up

During the meetings, participants provided critical analysis of the issues related to clinical assessment and involuntary holds and shaped a sound charter problem statement, project aim and project objectives.

The final project charter is presented in Table 2 below.

Table 2. Project Charter

Problem Statement	• Current involuntary detainment protocols are inconsistent and inadequate. • There is a lack of consensus and inconsistent skill of practitioners regarding assessment, intervention and discharge for involuntary detainment • Individuals and family members experience isolation—from each other (person-centered, family-inclusive care); from systems (coordination of care); and from community supports (community-based alternatives to crisis facilities). • There is insufficient focus on ongoing training and supervision assessment teams. • There is only limited focus on linguistic and cultural competence in crisis settings.
Project Aim	Over a 24-month period, CIBHS will collaborate with counties, providers, and stakeholders to establish consensus on, and train to, California statewide clinical assessment guidelines for involuntary detainment in various settings. These guidelines will be person-centered, family-inclusive, culturally responsive, and recovery-oriented to improve the individual experience.
Project Objectives	• Offer standardized training and certification in a consistent protocol which reduces adverse incidences • Improve clinical assessment competencies • Set specific adaptations to establish best practices for specific environments • Implement systems changes that promote optimal care • Identify community supports and strengthen networks of care • Identify outcome and performance measures • Improve clinical/recovery outcomes • Improve individual-based outcomes

Framing the Issues

Involuntarily detained individuals and their family members often report that the involuntary detention experience has been traumatic. They frequently report that interventions have not been person-centered, community-based, or family directed. Moreover, discharge plans and support strategies are often disconnected from the next level of care within the community.

A person-centered, trauma-informed, culturally appropriate assessment methodology can mitigate the traumatic impact of the issues listed above. This project is focused on developing consensus around assessment strategies that lead to recovery-oriented clinical interventions. Treatment options for detained persons should ideally focus on their needs rather than any competing sets of priorities that conflict with their needs.

These Consensus Assessment Guidelines are driven by the following recovery values:

- The person receiving services informs his or her treatment and support approaches if possible.
- Families *can* be a primary resource in stabilization, history, support, and discharge planning.
- A primary goal of assessment is to formulate a stabilization and treatment approach that does not *exacerbate* the person's problems despite the severity, level of risk, or chronic nature of the condition.

Key Issues

Recovery Model

- California has largely adopted the Recovery Model as its philosophical basis for behavioral health treatment for adults. However, many interpret the regulations guiding involuntary detention in an illness-based manner that is philosophically at odds with the Recovery Model.
- There has been no purposeful, consistent synergy or alignment between recovery-oriented, consumer-driven practice, crisis intervention, and emergency treatment and care across the State of California.
- A key challenge to facilitating more person-centered assessment is the fact that many detained individuals are in severe crisis and are not fully capable of collaborative interaction always during their detainment.

Statewide Inconsistencies

The State of California currently has no standardized or consistent assessment or treatment approach - either within the facility or post-detainment- for individuals who are involuntarily detained due to mental health crisis. Some of the inconsistencies that exist among California Counties include the following:

- Individuals are detained in a variety of emergency settings (hospitals, behavioral health crisis centers, jails, etc.) that have different approaches to assessment, access, familial involvement, view of capacity for treatment, etc.
- An array of treatment professionals, all of whom bring different perspectives concerning assessment, discharge planning, and care coordination, are working with detained individuals.
- Hearing officers may have varying views regarding risk, which affects detainment issues in a variety of ways.
- Access to and development of treatment resources is not uniform across counties.
- The quality of engagement between detained persons and professional staff may vary while detained persons are waiting to be assessed.
- Wait times for assessment of 24 hours or more have been reported in some instances.
- Psychiatric beds and resources continue to diminish due to the continuing heavy need for crisis psychiatric care.

Rationale for Statewide Clinical Assessment Guidelines

The establishment of these statewide guidelines creates a general practice within crisis intervention services at all levels within the State of California. The intentions behind creating these guidelines are outlined below:

- to address the many overlapping and complex factors involved in the management of behavioral emergencies in a manner that more carefully considers familial, cultural, spiritual, and community assets and strengths
- to help establish consistency of practice in a variety of clinical settings for providing the greatest benefit to detained individuals
- to provide a clinical context for structured staff training in ongoing crisis assessment (in a recovery context) which leads to improved outcomes and more effective discharge planning and care coordination for detained individuals
- to promote the adoption of new knowledge and recovery-oriented processes into the assessment, treatment, and management of behavioral emergencies.
- to facilitate elements of shared decision-making into the assessment process concerning treatment options and discharge planning; shared decision-making (SDM) is an approach in which clinicians and individuals communicate together using the best available evidence when faced with the task of making decisions and patients are supported to deliberate about the possible attributes and consequences of options. That is, SDM works to help individuals arrive at informed preferences in deciding about the best action and seeks to respect individual autonomy where this is desired, ethical, and legal.
- to encourage advance directives to promote more person-centered approaches in crisis settings and to facilitate shared decision-making whenever possible
- to promote effective community discharge and linkage, which may result in less overall crisis resource utilization

Although there is strong support for crisis treatment and intervention in the least restrictive environment, the process of reaching these goals is not without its challenges, including:

- lack of significant movement toward blending recovery-oriented processes
- increased public concerns about violence perpetrated by individuals suffering from serious mental illness (SMI) is an impetus to consider every possibly efficacious improvement to clinical assessment practice (with special attention to not “blaming the victim”)
- lack of attention to the fact that persons with SMI suffer as victims of violent crime, which may increase crisis episodes.

Key Drivers for Change in Policy and Practice

Social policy drivers are those conditions or policy decisions that cause subsequent conditions to occur. Drivers have a key effect on associated issues. They often form the root cause of a problem that prompts attention to the need for solutions.

In the context of this project, drivers are those key conditions that interfere with the provision of consistent, skillful clinical assessments of detained people. Attention to these key drivers leads to understanding the kinds of solutions that will overcome the problem and result in improved outcomes for detained individuals.

CIBHS convened five (5) regional meetings and engaged participants to complete a small group brainstorming exercise to identify the predominant drivers concerning the need to improve the process of clinical assessment.

Participants were instructed to consider what the major *impediments* might be to a quality clinical assessment process. The CIBHS project team carefully explained the scope of the project, noting that the scope of the project ***does not include policy changes to the fundamental framework or legality of LPS***. Participants were further instructed to prioritize the top three to four drivers that had the greatest impact on the current system.

Analysis of the responses revealed the following five overlapping and interrelated conditions which define the Key Drivers for Change in policy and practice:

- Environmental/Attitudinal

  These are issues such as public perceptions or geographic location. For example, certain individuals' lack of insight into the nature of their illness, the need for staff self-protection from dangerous behavior, problematic ER environments, eccentricities or political tensions in the local community, stigmatizing public perceptions of mental illness, and staff fear of being held responsible for negative individual outcomes, as well as related liability concerns.

- Policy and Practice

  These are issues generated by the local behavioral health authority, either by formal policy or by established routines. Even when they are influenced by external mandates, local policies may not always take advantage of alternative means of compliance.

  Problems also sometimes result from inconsistent implementation and/or enforcement of policies. For example, delays between the time of detention and the time when treatment begins; giving priority to insurance requirements over individual needs when the two are in conflict; insufficient communication and coordination of assessment standards between practitioners, authorization reviewers, police, and others; lack of familiarity with the portability provisions of HIPAA with an

overemphasis on the confidentiality provisions; inadequately resourced emergency room (ER) and hospital staff; and insufficient resistance to pressure from certain sectors of the community invested in hospitalizing individuals can all contribute to issues with implementation and practice.

Examples of potentially traumatic experiences associated with service delivery include:

- transportation in a police vehicle by officers in uniform
- being held behind locked doors
- seclusion and restraint
- forced use of medication in emergency situations
- inadequate post-discharge transportation home

- Clinical (Skill/Training)

  These problems were attributed to the level, type, intensity, and array of skills possessed by those who interact with involuntarily detained persons. Examples include a need for better skills related to evidence-based approaches to individual care, recovery orientation, and engagement during crisis; recognition and assessment of "co-occurring conditions;" collaborative discharge planning; and care coordination acumen.

  Such problems were attributed to lack of training, a generally slow adoption of a recovery orientation in public behavioral healthcare systems, variations in skills and practice principles across the various service professions, and a lack of available clinical assessment protocols pertaining to emergency/involuntary detention.

- Resources

  These issues are specifically related to the lack of access to available tools, people, and processes, usually as a direct result of lack of funding or access to personnel. These issues vary per regional concerns, size and "wealth" of administrative entities, and community infrastructure and supports (hospitals, trained law enforcement entities, etc.). Examples include lack of local community aftercare resources (e.g., food, clothing, shelter, healthcare), especially for those whose hospitalization was triggered as a way of temporarily addressing such needs; lack of communication between ER/inpatient staff and community providers; high volume of admissions with a resulting pressure to free up beds; insufficient funds to hire staff; insufficient availability of alternatives to hospitalization; and high staff turnover in crisis facilities making it difficult to maintain an "institutional residue" of the benefits of prior training.

- Insufficient Collaboration

  These issues address insufficient collaboration on the part of all the entities participating in services to involuntarily detained persons, such as emergency facility staff, both medical and behavioral health staff, law enforcement, patients' rights staff, families, consumers, and judicial partners. For example, individual staff approach the individual with varying perspectives, goals, and

objectives, with only LPS regulations as a common ground; “overreaction” from first responders limits the effectiveness of subsequent behavioral health intervention or care coordination; staff often fail to partner with individuals and family members, perhaps because of a lack of methodology or models for partnership in crisis care situations; lack of availability for coordination with community professionals who primarily want to “get people off the street” limits post-care effectiveness; lack of information sharing among service providers within a system of care as well as across systems of care reduces overall support; and insufficient peer involvement or use of advance directives limits person-centered care.

It was recognized that conditions such as these could be positively affected by ***improved inclusion, shared decision-making, and policy-making*** among professional entities, families, consumers, and peer advocacy groups. In other words, *insufficient collaboration* is a fundamental key driver for problems raised in all five of the key driver categories.

The CIBHS project team found a remarkable consistency across regions concerning the most salient issues. There was also a great deal of synergy and similarity between the drivers mapped out in the regional meetings and the drivers mapped out in the expert panel meeting. This indicates that there is a gathering consensus in California concerning the need to improve the assessment process during an involuntary detainment, as well as similarities in understanding about factors that make practice improvement a difficult—but not impossible—proposition.

Core Competencies

This section identifies a set of core competencies needed by service providers to implement the Clinical Assessment Guidelines. These competencies are also relevant for supervisors, middle managers, and administrators who will provide leadership, support, and direction to those service providers.

The desired core competencies for implementing the LPS Clinical Assessment Guidelines were identified by regional meeting participants representing California county mental/behavioral health organizations and their contractors. The methodology utilized to facilitate the "Identifying Core Competencies" exercise included small break-out groups for brainstorming, followed by report-outs and discussion with the entire audience. The instructions for the exercise explained that "competencies" refer to a set of knowledge, skills, and abilities necessary to successfully perform job duties and responsibilities. Each participant was asked to identify competencies across four broad categories—skill sets, personal attributes, knowledge/expertise, and role in the community—that are needed to successfully conduct the clinical assessment process with detained individuals.

The four categories of feedback are as follows: 1) skill sets, 2) personal attributes, 3) knowledge/expertise, and 4) role in the community. The project team provided the following definitions of each of the four categories:

- Skill sets were defined as specific proficiencies and techniques that enable individual members of the clinical assessment team to successfully perform their jobs.

- Personal attributes were described as one's perspective and personal qualities, which may support the clinical assessment process.

- Knowledge/expertise was described as the facts, principles, and other *need to know* traits of the members of the clinical assessment team.

- Role in the community was described as the effective collaboration required for the clinical team to provide the appropriate resources and supports to an individual who is involuntarily detained.

Skill Sets

The following is a list of the skill sets described by the experts in the regional meetings:

- de-escalation techniques
- individual engagement; establishing trust and rapport
- engaging families
- listening to a person in crisis (i.e., being involuntarily detained)
- motivational interviewing
- trauma-informed care
- shared decision-making
- emotional CPR
- open, unbiased, and clear communication, both verbally and in written form

- creative thinking about a person's strengths and challenges
- focused and consistent problem solving
- flexible identification of a range of solutions
- forming relationships and resource coordination with community resources
- respecting a person's culture
- use of structured assessment instruments

Knowledge/Expertise

The following list describes the necessary knowledge and expertise required for the clinical assessment team. Per the experts in the regional meetings, the team must have knowledge of:

- motivational interviewing
- trauma-informed care
- shared decision-making
- emotional CPR
- peer navigator services
- advance directives
- wellness recovery action planning
- LPS law
- Health Insurance Portability and Accountability Act (HIPAA)
- Media-Cal billing requirements
- recovery principles
- common ground between Media-Cal billing requirements and recovery principles
- how the involuntarily detained are affected by stressors and unmet needs such as:
    - poverty
    - homelessness
    - trauma
    - compromised physical health
    - lack of community resources for child care, transportation, etc.
- local resources
- interactive effects of co-occurring mental health and substance-related disorders
- interactive effects of co-occurring mental health and physical health disorders
- potential contributions of people with lived experience; principles, programs and practices related to:
    - peer support networks
    - family-centered service models

Personal Attributes

Although knowledge and skills are critical in the implementation of effective services for anyone being involuntarily detained, they cannot be the only competency elements used. Personal attributes influence staff members' behavior as they apply their knowledge and skills.

The following is a list of personal attributes described by the experts in the regional meetings:

- demonstrate respect and empathy for:

    - different cultural backgrounds
    - varied lived experience
- show a desire/motivation to:
    - eliminate stigma
    - be a positive role model
    - work collaboratively with colleagues and professionals from other disciplines
    - learn and grow
- value and express:
    - empathic understanding
    - warmth
    - non-judgmental acceptance
    - authenticity (genuineness)
    - compassion
    - support
    - humility
    - sensitivity
- practice:
    - patience
    - flexibility
    - adaptability
- recognize the value of:
    - peer support
    - family as an asset
- maintain optimism
- recognize one's own limitations regarding knowledge, skills, experience, biases, and training
- recognize one's own strengths regarding knowledge, skills, experience, objectivity, and training

Role in the Community

The following is a list of community roles as described by the experts during the regional meetings:

- Use strength-based approaches to create a safe, supportive environment (strengths-based)
- Coordinate and collaborate with health/medical and other service providers regarding issues specific to the individual who has been involuntarily detained (community-based services)
- Provide appropriate referrals (empowerment, community-based services)
- Provide or link individuals with local information and services (empowerment, community-based services)
- Assist the individual in communicating effectively *themselves* with other mental health or health care providers (e.g., preparing a list of questions, listening, taking notes, asking for written information) (empowerment, self-responsibility)
- Understand the various priorities, goals, and challenges of collaborating agencies (community-based services)
- Motivate collaborators to consistently follow up on issues of recovery from mental health and/or substance use conditions/disorders
- Convey hope (hopeful)

The experts in each regional meeting were charged with identifying competencies of the clinical team as they perform clinical assessments of involuntarily detained individuals.

Planning for the Implementation of Competencies

Experts in each of the five regions noted that *existing training and educational entities do not necessarily have the knowledge, skills, or expertise to develop and implement policies and programs for clinical teams.* The competencies described in this section may serve as a resource for developing more effective training programs and other professional development resources. They can also serve as a guide to standardizing a set of competencies to use in job descriptions, certifications, staff evaluations, and the development of assessment tools.

The expert panel began the process of mapping components for an ideal clinical assessment. The draft set of components were introduced at the regional meetings and the participants formed small workgroups to clarify, enhance and define the essential elements of the ideal clinical assessment for individuals who are involuntarily detained.

The CIBHS team compiled the data collected from the regional meetings, and established eleven core components of the clinical assessment. The components can also be defined as core staff competencies. The components/ competencies were share with the stakeholders (expert panel members, regional meeting participants and behavioral health directors) for review, comment and approval. The list was approved and a twelfth component was added- Pre-Detainment Assessment Process.

Developing these core competencies is only the first step to establishing an effective workforce ready to address the clinical needs of individuals who have been involuntarily detained.

How these competencies are utilized will vary depending on the individual needs and resources of each institution and community, as well as their scope of services, populations, and methods of service delivery. Some educators, credentialing bodies, administrators, and policymakers may be able to utilize the list to operationalize these competencies within their setting.

COMPONENTS OF THE IDEAL ASSESSMENT

Through the expert panel meeting, held in January 2014, the CIBHS project team identified eleven categories in the ideal clinical assessment process.

These categories are meant to capture the clinical assessment process at each stage of the intervention. The eleven categories are as follows:

1. Stabilization and De-Escalation
2. Engagement
3. Initial Clinical Assessment
4. Admission

5. Ongoing Assessment
6. Formulation/Narrative Summary
7. Treatment (Decision-Making and Intervention)
8. Discharge Planning
9. Care Coordination
10. Discharge
11. Support for Wellness and Recovery

* Pre-Detainment Assessment

Pre-Detainment Assessment was consistently addressed by stakeholders, even though it was not presented to them as one of the categories of an Ideal Assessment Process. Thus, Pre-Detainment Assessment was added to the component list.

Referring to the list, regional meeting participants engaged in small group discussions to brainstorm essential elements for the ideal assessment as well as identify gaps in the current assessment process. The categories, including pre-detainment assessment, were used as an outline for the small group discussions; one significant finding was that the categories of assessment recommendations were similar across the five regions.

The exercise to identify components of an ideal assessment was meant to capture *existing best practices* utilized within county programs for conducting a clinical assessment to determine the need for involuntary detainment, as well as continuing assessment of ongoing care during detention and for discharge and care coordination.

The groups generated lists of assessment tasks, training recommendations, and best practices for each category, with an explicit interest in:

- individual satisfaction surveys
- decreased use of restraints/seclusion
- reduction in repeat hospitalizations
- decreased occurrence of adverse events

The small groups reported their findings to the larger gathering for comments and edits.

A sizable amount of data was collected from the five regional meetings was analyzed and compiled by CIBHS team to create the Clinical Assessment Guidelines(CAG) for involuntarily detained individuals. The consensus component of the process was achieved through a CIBHS facilitated presentation of the draft document via webinar to the expert panel members and regional meeting participants for their review comment and approval. Each member also received an electronic copy of the draft the final edit included the webinar feedback and the final version of Clinical Assessment Guidelines was approved.

THE CLINICAL ASSESSMENT GUIDELINES FOR INVOLUNTARILY DETAINED INDIVIDUALS

The following Clinical Assessment Guidelines are fully informed by the stakeholder input gathered during the expert panel and regional meetings. Considering the fundamental recovery orientation of this project, each Guideline is followed by a parenthetical reference to the relevant recovery-oriented value(s) and/or practice principle(s).

Stabilization and De-Escalation

Immediate and effective stabilization and de-escalation is essential to the safety of both the assessor and the individual in crisis. This step commonly involves law enforcement or other first responders and requires appropriate communication skills, cultural knowledge and responsiveness, knowledge of resources, and engagement of family and other important affected persons as defined by individuals. Depending on the acuity of the crisis, stabilization and de-escalation of the individual may be required at other levels of intervention. Stakeholders recognized the need for stabilization and de-escalation skill development for all crisis intervention providers. The ability to quickly and effectively de-escalate and stabilize a given situation to the degree that the individual understands what is happening and is able, as much as possible, to comply with the instructions offered can significantly decrease the risk of adverse incidents and increase the level of safety for all involved in the crisis.

The Brose Violence Checklist was proposed as a possible standardized assessment tool for stabilization and de-escalation.

The group identified five county sources for best practice models for stabilization and de-escalation. These are:

- Certified Officer responder programs in Los Angeles, San Diego- PERT, and Long Beach
- Mobile Crisis Units in the City of Berkeley and Alameda County

The group also identified the importance of understanding the individual's relationships with family and significant others prior to the crisis as a means of stabilization and de-escalation (person-centered)

GUIDELINES

1.01 Both first responders and behavioral health service staff should identify and document:

1.01 (a) the specific factors that led the officer to declare a need for involuntary hold (least restrictive environment)

1.01 (b) input from family members, when possible (person-centered)

1.01 (c) the individual's disposition, location, and history, if known (person-centered)

1.01 (d) indicators of medical, psychiatric, and physical needs, if known (person-centered)

Engagement

The engagement component describes the process of effectively communicating with the individual and any significant others to work together for desired outcomes. Note that engagement is not something that fully occurs at a single point in time. It is an ongoing process, which often has a "two steps forward, one step back" progression pattern.

The quality of information that can be obtained from the detained individual in the subsequent stages of the assessment will largely depend on the extent to which that individual has been engaged in a relationship in which the service provider has come to be trustworthy, warm, accepting, competent, and reliable. Few people will readily reveal information about sensitive, private, and personal issues to someone perceived as a distant, judgmental, uncaring, or hostile inquirer.

GUIDELINES

2.01 Exercise clear and effective communication skills (relationship-based)

2.02 Validate the individual's perspective on the situation (person-centered)

2.03 Create non-judgmental, supportive environments (respectful)

2.04 Create environments that feel safe (e.g., question the necessity of each phase of the process, such as whether to use handcuffs or to transport in a police car or an ambulance) (respectful)

2.05 Inquire about the individual's comfort (e.g., dry, warm clothing, food, water) prior to making assessment inquiries (respectful)

2.06 Address individual concerns about personal effects (e.g., cars, bikes, pets, personal belongings, home) (respectful)

2.07 Develop and implement an action plan to secure personal effects (respectful)

2.08 Include family members and significant others as identified by the individual (self-direction); focus the engagement process on discharge (goal-driven services)

2.09 Practice a recovery orientation.

Note: Although law enforcement may utilize some of the guidelines listed above, It is important to consider other possible engagement skills law enforcement as first responders may employ

Initial Clinical Assessment

GUIDELINES

Initial Clinical Assessment Process by Behavioral Health Staff

3.01 Use a "team or collaborative process" whereby the mental health clinician references the information from the first responder, including information about prior law enforcement contact (not limited to professional interventions, natural support networks)

3.02 Access behavioral health records to the extent possible (person-centered, respectful)

3.03 Draw out the individual's own experience of the situation through "inquiry, not accusation" (person-centered)

3.04 Conduct a systematic review of interventions that have previously benefited the detained individual.

3.05 Inform the first responder regarding the disposition of the involuntary hold and status of the individual following the assessment (community-based)

Initial Clinical Assessment Content

3.06 Assess for medical necessity for involuntary hold (least restrictive environment)

3.07 Include information about history of care (person-centered, respectful)

3.08 Identify alternatives to the hold, such as community and family supports, and reasons for using or not using these alternatives (least restrictive environment, natural support networks)

3.09 Identify the individual's needs regarding securing personal property, pets, cars, other family members (e.g., children), safety, medical/physical needs, etc. (respectful, focus on meaningful life roles)

3.10 Identify strengths (e.g., problem-solving capacities, capacity to engage others, interests and motivations, awareness of strengths and limitations, symptom management abilities) (strengths-based)

3.11 Include information about involvement with support systems (e.g., family, friends, agencies) (strengths-based, community-based, natural support networks, meaningful roles, recovery can occur independent of professional interventions)

3.12 Address issues relevant to the individual's ethnicity, social class, religion, gender, sexual orientation, generation, or other cultural considerations and be linguistically appropriate (culturally relevant, respectful)

3.13 Address any ongoing assessment content that is logistically feasible in view of time constraints and the individual's ability to communicate such information

Admission

This component refers to **admission** to any program of care for the benefit of the individual.

Ongoing Assessment

This component refers to daily assessments to inform diagnosis, medications, discharge plans, and aftercare resources, maintaining a focus on discharge and recovery/wellness planning. Whereas the Initial Clinical Assessment may need to focus on the immediate crisis, the Ongoing Assessment offers greater opportunity to gather a fuller range of recovery-oriented information about the individual, especially if the depth of engagement has progressed.

GUIDELINES

Ongoing Assessment Process

5.01 Use a "team or collaborative process."

5.01 (a) Use an "assessment team" including friends, family members, etc. as requested by the individual; inclusion of family members can provide significant information about individual history, daily routines, etc. that could influence the assessment and intervention plan (not limited to professional interventions, natural support networks)

5.01 (b) Make individual aware of the option of including family members and significant others in the assessment process, and the potential benefits of doing so (empowerment, natural support networks)

5.01 (c) Respect the individual's decisions about engaging others (self-direction, self-responsibility, person centered, respectful)

5.01 (d) Access behavioral health records, including a review of the individual's own crisis related perspectives and preferences as expressed in documented pre-detainment assessments. (person centered, respectful)

5.01 (e) Draw out the individual's own experience of the situation through "inquiry, not accusation" (person-centered)

5.01 (f) Use motivational interviewing principles, as relevant (person-centered)

5.01 (g) Facilitate the individual's communication with individuals and resources with whom he or she chooses to communicate to obtain information about his/her history, status, and post-discharge options. (self-responsibility)

5.01 (h) Facilitate the individual's communication with those individuals and resources whom he or she chooses to invite as participants in the discharge planning process (self-responsibility)

Ongoing Assessment Content

5.02 The Ongoing Assessment should inform Discharge Planning decisions and occurs simultaneously with the Discharge Planning process (not yet a concluded Discharge Plan).

5.03 To inform Discharge Planning, the Ongoing Assessment should include content that informs:

5.03 (a) decisions regarding restoration of role functioning and/or introduction to new roles (focus on life roles)

5.03 (b) the individual's stage of change so that Discharge Plan goals and objectives can be linked to the individual's stage of change (person-centered)

5.03 (c) a determination of the kinds of goals and objectives that would be realistic, achievable, meaningful to the individual, and either initiated by the individual or acceptable to the individual (person-centered, self-determination)

5.04 Include information about history of care that may be available from other sources (person-centered)

5.05 Identify the individual's needs regarding securing personal property, pets, cars, other family members (e.g., children), safety, medical/physical needs, etc. (respectful)

5.06 Identify strengths (e.g., problem-solving capacities, capacity to engage others, interests and motivations, awareness of strengths and limitations, symptom management abilities) (strengths-based)

5.07 Include information about the individual's involvement with support systems (e.g., family, friends, agencies) (focus on meaningful life roles, not limited to professional interventions)

5.08 Address issues relevant to the individual's ethnicity, social class, religion, gender, sexual orientation, generation, or other cultural considerations and be linguistically appropriate (culturally relevant, person-centered, respectful)

5.09 Evaluate the individual's role functioning (e.g., employment, raising children, participation in training or education, neighborhood participation) (focus on meaningful life roles)

5.10 Identify those individuals and resources that the individual chooses to communicate with during the detainment (self-direction)

5.11 Identify those individuals and resources whom the individual chooses to invite to participate in the discharge planning process (self-direction, not limited to professional interventions)

Formulation/Narrative Summary

The Formulation is a key component of the assessment process that integrates all significant assessment findings to create a concise, narrative "story." The formulated information provides the rationale for the diagnosis and the goals/objectives that are still under consideration by both the individual and staff. The diagnosis and goals/objectives under consideration are stated at the end of the Formulation.

GUIDELINES

6.01 The Formulation should clearly convey:

6.01 (a) that the documented diagnosis/diagnoses is/are valid

6.01 (b) which problems are primarily due to the symptoms of the diagnosed mental disorder

6.01 (c) which problems are primarily due to factors other than symptoms of the diagnosed mental disorder

6.01 (d) which strengths are relevant to solving each major problem

6.01 (e) which resources are available for solving each major problem

Treatment (Decision-Making and Intervention)

The assessment at this phase relates to individual response to intervention strategies, stabilization and ongoing care, assessment, appropriate resources, and family and community supports.

GUIDELINES

7.01 The Assessment of Treatment includes:

7.01 (a) recommendations made to the individual during the hold

7.01 (b) the individual's response to recommendations (person-centered)

7.01 (d) therapeutic interventions provided to the individual during the hold

7.01 (d) the individual's response to therapeutic interventions provided (person-centered)

7.01 (e) contacts with significant others during the hold (not limited to professional interventions)

7.01 (f) the individual's response to contacts with significant others (person-centered)

7.01 (g) an evaluation of the individual's potential and willingness to engage in outpatient care and supports (self-direction)

7.01 (h) staff communication and collaboration with potential outpatient follow-up service providers (community-based services)

7.01 (I) individual communication with potential outpatient follow-up service providers (self-responsibility)

7.01 (j) access to centralized information within a system of care, fully implementing the "portability" purpose of HIPAA while remaining within the confidentiality and security provisions of HIPAA (community-based services)

Discharge Planning

GUIDELINES

8.01 Discharge decisions should be informed by a validated instrument whenever possible

8.02 Discharge decisions should be based on a documented, systematic review of interventions that have previously benefited the detained individual

8.03 Exercise clear and effective communication skills (relationship-based)

8.04 Validate the individual's perspective of the situation (person-centered)

8.05 Include family members and significant others as identified by the individual (self-direction)

8.06 Focus the discharge process on post-discharge follow-through (goal-driven services)

8.07 Discharge procedures should express a recovery orientation; therefore, discharge plans must:

8.07 (a) be person-centered

8.07 (b) reflect the individual's self-direction and build self-responsibility

8.07 (c) empower the individual with information and links to supportive resources

8.07 (d) be strengths-based

8.07 (e) be respectful

8.07 (f) be culturally relevant (e.g., identify and respect the ethnicity, religion, social class, gender, sexual orientation, and other cultural considerations that are meaningful to the individual)

8.07 (g) be hopeful; stimulate hope

8.07 (h) identify relevant community-based services and natural support networks

8.07 (I) not be limited to professional interventions

8.07 (j) focus on quality of life goals and meaningful life roles

8.07 (k) express goals/objectives that are sufficiently clear and specific to enable valid and reliable outcome evaluation

Care Coordination

If discharge planning began at the time of the initial and ongoing clinical assessment, then the individual and staff will have substantial information about markers for the appropriate conditions for actual discharge, as well as specific follow-up supports and outpatient resources.

GUIDELINES

9.01 Confirm that the planned follow-up resources are in place and ready to engage with the individual (respectful)

9.02 Confirm that the individual remains committed to his or her decisions about use of chosen follow-up resources and remains willing to follow through (self-direction, self-responsibility)

9.03 Confirm that the individual's basic needs (e.g., housing, meals, adequate clothing, access to medications) can and will be met if the individual and designated resources follow through on their commitments (respectful, meaningful life roles)

Discharge

Discharge is an event that can contain an element of crisis, to the extent that the individual may feel that he or she is leaving circumstances and relationships that have become familiar and/or meaningful during the hold.

GUIDELINES

10.01 Provide the individual with an opportunity to say goodbye to staff and peers to the extent possible (respectful)

10.02 Assess, with the individual, progress that was accomplished during the hold (strengths-based)

10.03 Convey a realistic sense of the individual's positive course of resolution that can be projected into the future, and assess the individual's awareness of these positive developments (strengths-based, self-responsibility)

10.04 Assess, with the individual, how the present experience of stabilizing and resolving the crisis state may be helpful in coping with future crises (strengths-based, self-responsibility)

Supports for Wellness and Recovery

GUIDELINES

11.01 A post-crisis management team should be provided for this phase of support.

11.01 (a) The post-crisis management team should function as a multidisciplinary support planning group that considers holistic individual needs following the crisis and provides a "warm hand-off" to aftercare services, including outpatient community and family supports.

11.01 (b) The post-crisis management team should follow up with individuals after discharge to ensure that they connect with outpatient services.

11.01 (c) The post-crisis management team should engage peer support organizations to participate on the team as aftercare and resource educators, liaisons, and aftercare case managers as a best practice.

11.01 (d) The post-crisis management team should use best practices such as Emotional CPR (National Empowerment Center).

11.02 Whether construction of a post-crisis management team as a standalone resource is possible, increased care coordination amongst disparate agencies ultimately serving the same individuals should serve this function in a de facto manner.

11.03 Engage the supportive efforts of peer navigators.

PRE-DETAINMENT ASSESSMENT

Clearly a mentally ill individual will be much better able to receive, consider, communicate, and deliberate about options and arrive at informed preferences over the course of many months of outpatient services while stable, in contrast to the hectic turmoil of a 5150 crisis. Of course, the individual being involuntarily held still has the right to make and change decisions at that time, but effective planning in anticipation of a possible 5150 hold provides the individual in crisis with the benefit of reflecting on his or her own previously expressed decisions.

Although the stakeholder groups set out to focus on events commencing with the imposition of a 5150 hold, many comments and suggestions by the groups related to actions that might have been taken prior to detainment which have a major effect on events that may occur during the detainment. For example:

- The expert panel report explicitly called for "pre-detainment assessment, which could refer to the initial 5150 documentations."
- The expert panel report stated that: "A key challenge to facilitating more person-centered assessment is the fact that many detained individuals are in severe crisis and not fully capable of collaborative interaction."
- Although it is understood that not everyone is connected with a full service partnership (FSP), The expert panel members stated that "The best managed involuntary hold is the one that has been prevented. Therefore, effective management of involuntary holds depends largely on how well the FSP 'whatever it takes' model has been implemented."
- Both the expert panel and regional meeting participants made many references to the benefits of Advance Directives and Wellness Recovery Action Planning.
- Panel participants frequently described the clinical assessment as dynamic and should be regarded as ongoing process from the pre-detainment phase through discharge and aftercare or referral.
- "Insufficient collaboration" was identified during the regional meetings as one of the five "key drivers" for change in policy and practice. This issue includes insufficient collaboration between outpatient service providers and emergency room/inpatient service providers.
- The planning groups identified the importance of understanding the individual's relationships with family and significant others prior to the crisis as a means of stabilization and de-escalation. Of course, such historical information can be developed at the time of the crisis, but it can be done much more thoroughly and accurately before the crisis, with findings documented for availability during a possible future crisis.

Many of the guidelines suggested by the stakeholder panels are directly affected by the way in which outpatient services were provided prior to the 5150 hold. For example, whenever the suggested guidelines call for "engagement of family and others," it is followed by the phrase "as defined by individual." Clearly, the individual's ability to distinguish between supportive others and stressful others might be very different during a stable period prior to the 5150 hold than it would be during the psychiatric crisis.

The following Guidelines for Pre-Detainment Assessment would directly facilitate implementation of the stakeholders' recommendations for Post-Detainment Assessment. All the information called for in this Pre-Detainment Assessment is directly relevant to a person-centered, strengths-based, recovery-oriented course of outpatient services and, therefore, does not require additional time or effort beyond that already committed to by California's public behavioral healthcare services.

GUIDELINES

Pre-Detainment Assessment Process

12.01 Whenever this information can be gathered during pre-detainment service contacts within a service system, those issues involving decisions (e.g., to identify individual preferences) will be made using a process of Shared Decision-Making in which:

> 12.01 (a) service provider and individual communicate together using the best available evidence (collaborative, empowerment)
>
> 12.01 (b) individuals are supported to deliberate about the possible attributes and consequences of options (empowerment)
>
> 12.01 (c) informed preferences are determined based on a choice of the best action that respects individual autonomy to the extent this is desired, ethical, and legal (self-determined)

12.02 Individuals should be made aware of the option of including family members and significant others in the assessment process, and the potential benefits of doing so

> 12.02 (a) Those individuals who have considered and made decisions about including family and significant others during the outpatient service assessment process will be best able to formulate such decisions during their detainment-based assessments.

12.03 Conduct the Pre-Detainment Assessment in a way that strengthens the individual's decision-making capacity

12.04 Use a Shared Decision-Making process. A systematic approach to decision-making is a skill. Most people need to practice systematic approaches to decision-making, just as we need to practice any skill. The individual who has had repeated opportunities to practice these skills during a course of outpatient services will be best empowered to do so when presented with a Shared Decision-Making approach during an involuntary hold. To support the development of decision-making skills, during Pre-Detainment Assessments, staff should implement the following guidelines:

> 12.04 (a) If the individual brings up a cluster of issues, see if it helps to separate and prioritize the issues with the individual (empowerment)
>
> 12.04 (b) The individual's subjective experience and response to each issue should be identified and clarified (respectful, empowerment)
>
> 12.04 (c) Weigh alternative options by "trying them out" hypothetically in discussion. For example, "What do you like best about…? What do you like least about…?" (empowerment)

12.04 (d) Ask the individual to choose preferences, but don't limit choices to only one primary preference unless the individual chooses to do so (self-direction, self-responsibility)

12.04 (e) Help the individual identify the steps that were taken in identifying preferences (empowerment)

(Note: The above five guidelines all involve a person-centered, strengths-based approach to supporting individual empowerment.)

12.05 Make Pre-Detainment Assessment findings accessible during detainment. Whenever information can be gathered during pre-detainment service contacts within a service system, the information should:

12.05 (a) be documented in a record that is accessible to psychiatric emergency and inpatient services within the same service system (community-based)

12.05 (b) be accessible to psychiatric emergency and inpatient services within the same service system (community-based)

12.05 (c) be accessed by psychiatric emergency and inpatient services within the same service system (community-based)

12.05 (d) be made available to collateral service providers in accordance with the portability provisions of HIPAA and the coordination of care provisions of the Welfare and Institutions Code section 5328

12.05 (e) be accessible to the individual by using language the individual can understand and is likely to recognize (culturally relevant, self-responsibility)

Pre-Detainment Assessment Content

12.06 Identify the individual's preferences regarding:

12.06 (a) language for communicating about strengths, symptoms, problems, and service preferences (culturally relevant)

12.06 (b) family members from whom the individual does and does not want to receive support (self-direction, not limited to professional interventions)

12.06 (c) friends, peers, staff, agencies, and others from whom the individual does and does not want to receive support (self-direction, not limited to professional interventions)

12.06 (d) clinical intervention strategies, intervention techniques, medications, and style of relationship with behavioral health service providers (self-direction)

12.07 Identify the individual's conception of:

12.07 (a) his/her problems

12.07 (b) possible solutions to problems

12.07 (c) barriers to achieving solutions

12.07 (d) his/her strengths

12.07 (e) the causes of his/her problems

12.07 (f) how significant others view his/her problems as being

12.07 (g) the types of resources that he/she sees as supportive

12.07 (h) the types of entities that he/she sees as stressful

12.07 (I) the communities with which he/she identifies

12.07 (j) the communities in which he/she prefers to participate

12.07 (k) aspects of life that support solutions to his/her problems

12.07 (l) aspects of life that exacerbate his/her problems

12.07 (m) treatments, advice, help, or healing efforts that have been sought out in the past

12.07 (n) the value of treatments, advice, help or healing efforts that have been sought out in the past

12.07 (o) what he/she has done in the past to deal with the problem that he/she perceived to be effective

12.07 (p) what he/she has done in the past to deal with the problem that he/she perceived to be ineffective or which made the problem worse

(Note: All the above constitute a person-centered approach.)

The Emergency Response Plan (ERP) developed by San Diego PERT Program is a useful resource for early assessment.

GENERAL CONSIDERATIONS FOR THE CLINICAL ASSESSMENT GUIDELINES

Stakeholder responses to the components of the ideal assessment were generally compatible with the assumptions and recommendations made by the expert panel. The regional meeting responses summarily indicated that the proposed categories of assessment were accurate and complete. Participants frequently described the clinical assessment as dynamic and noted that it should be regarded as an ongoing process from the pre-detainment phase through discharge and aftercare or referral.

Beyond the explicit Clinical Assessment Guidelines listed above, other recommendations for the ideal clinical assessment process included the following:

- The assessment should be a dynamic and continuous process from the initial contact through discharge and aftercare supports.

- Collaborative planning between mental health, emergency rooms, and law enforcement is necessary; such planning should focus particularly on developing protocols for 5150 documentation and training in the use of these protocols. A team approach to assessment was highly recommended.
- The team approach (collaboration among providers) to assessment and intervention, treatment review, discharge, and aftercare should be employed. This includes the individual as a team member.
- Training and certification protocols must address the Core Competencies.
- The individual should be included throughout assessment process; the process should emphasize individual-centered, shared decision-making.
- Better understanding of HIPAA is required. Providers and first responders need to understand the requirements and exceptions of HIPAA as it relates to involuntary holds and care coordination.
- Separate and appropriate assessment tools for adults, older adults, children, and youth should be established.
- Physical assessment, mental health considerations, and SUD assessment should be combined.
- Providers should practice self-care, monitoring their own wellness and competencies for the services they are required to provide.
- All parties should consider individuals' personal effects and the safety and security of animals, car, family members, etc. at the time of 5150.

RECOMMENDATIONS FOR ADMINISTRATION

Although the expert panel and regional meetings were focused on Clinical Assessment Guidelines, many comments and recommendations reflected an awareness that a detained individual's experience is strongly influenced by administrative arrangements, and that key drivers of the problem require administrative action. A variety of such recommendations are listed here, and will be addressed more fully in the Clinical Assessment for Involuntary Detention Toolkit.

Administrative Policy

- Prohibit imposition of an involuntary hold on a person who accepts hospitalization voluntarily.

The stakeholder group acknowledged that while this policy makes sense there are forces that work against it such as:

- Fear that patients may elope
- Ambulance companies may force facility to initiate holds on voluntary placement for transport
- Staffing issues at receiving facilities cause them to want the patient on a hold so she/he has to stay until the next day when the physician can assess them.

Interdepartmental MOUs, Agreements, and Protocols

- Develop agreements and protocols for information sharing among components of a service system, fully implementing legal provisions for portability of information as well as confidentiality protections, as applicable.
- Develop agreements and protocols for information sharing across service systems and/or departments, fully implementing legal provisions for portability of information as well as confidentiality protections, as applicable.

Allocation of Resources

- Arrange for transportation by ambulance, instead of by police vehicles, whenever possible.
- Develop standards for when transportation should be provided by ambulance.
- If existing clinical staff cannot address individual concerns about personal effects (e.g., cars, bikes, pets, home) as an aspect of their job function, designate staff who specialize in that function.
- Develop facilities to provide a comfortable, safe, and familiar environment conducive to communication of assessment information.

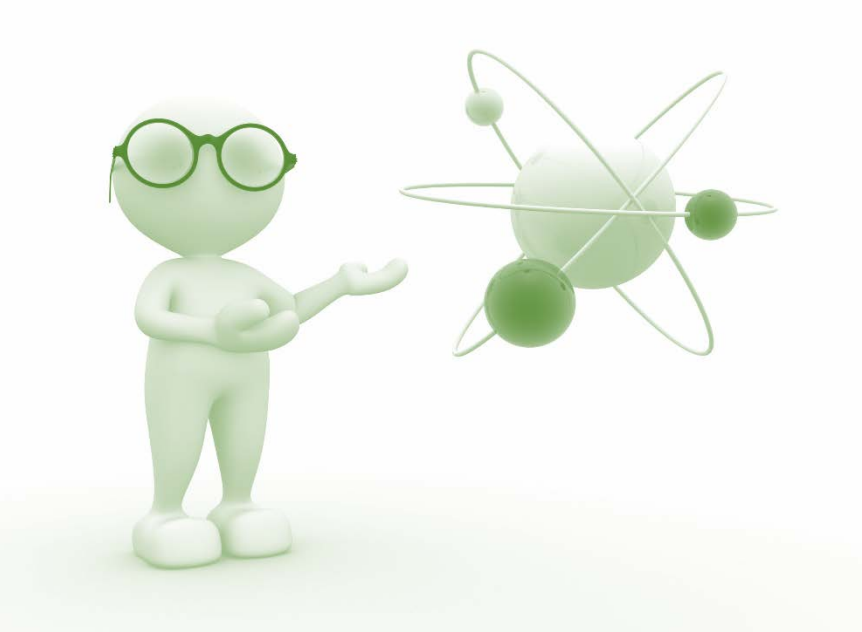
Management Reports

- Develop regular reporting procedures for service system management/administration regarding key aspects of involuntary holds.
- Develop relevant management reports to inform planning decisions and to provide a basis for evaluation of Clinical Assessment Guideline implementation.

The expert panel raised many questions regarding empirical data, calling for reports that were not on hand but that should either be created or made more accessible if they are already available. The panel recognized that data regarding variables such as the following are critical to making informed decisions regarding involuntary holds:

- Number and percentage of 5150 holds that lead to emergency room admissions
- Number and percentage of 5150 holds that lead to hospitalization

- Number and percentage of 5150 holds that are converted to voluntary admissions
- Differences between adults and children/youth about wait times between arrival and evaluation
- Number and percentage of 5150 holds initiated by law enforcement that are dropped by the initial clinical evaluation
- Number and percentage of 5150 holds due primarily to intoxication
- Number and percentage of 5150 holds in which the clinical evaluation is conducted only after receiving fast-acting medications
- Evaluate progress toward implementation of the Clinical Assessment Guidelines. Note that most of the Clinical Assessment Guidelines are subject to observable, measurable operational definitions for purposes of measurement and monitoring.
- Determine extent of compliance with existing Clinical Guidelines in addition to compliance with the new Clinical Assessment Guidelines.



Statewide Data Reports

Consistent state level reporting practices are also necessary and may include:

- County by county comparisons
    - Differences in regulations
    - Documented differences in interpretation among hearing officers within and between counties

Empirical Reports of Environmental Conditions

- Participants on the stakeholders' panel as well as the expert panel expressed concern about the effects of inaccurate and stigmatizing public perceptions of mentally ill individuals. Unfortunately, in the absence of available data, these concerns had to be expressed in generalities. For example, "The framing buys in to the public perception of people with mental illness as being violent. Federal government data shows that three to five percent of violence is from people with mental health conditions, whereas ninety-five percent of violent crimes are from non-mentally ill people." This statement includes data to demonstrate that "the public perception" is inaccurate, but there is no data to help us understand that nature and extent of "the public perception." Certain types of information would make it possible for anti-stigma public education campaigns to focus on targeted segments of the general population in a manner that is culturally accessible to the targeted audience.'

- Develop empirical data regarding public perceptions, such as:

    - Proportion of general population perceiving mentally ill individuals as exceptionally dangerous
    - Demographic and other factors correlated with perceptions of mentally ill individuals as exceptionally dangerous
    - Proportion of general population preferring restrictive environments over community-based treatment
    - Demographic and other factors correlated with preferring restrictive environments over community-based treatment
    - Proportion of general population perceiving mentally ill individuals as victims of violence and another trauma
    - Demographic and other factors correlated with perceptions of mentally ill individuals as victims of violence and another trauma

PARADOXICAL RECOMMENDATIONS

A substantial degree of consensus emerged throughout the expert panel and regional meetings, including consensus in support of several mutually exclusive themes. There is consensus support for having clinical assessments of detained individuals be based on both:

- uniformity/consistency AND flexibility/adaptation to individual needs and specific environments
- use of standardized, validated instruments AND clinicians insightful enough to "read between the lines"
- a uniform, standardized approach AND including multiple participants with multiple perspectives in the assessment and planning processes
- a uniform set of core competencies AND varied lived experience
- recovery orientation AND the perspectives of family and friends on the "assessment team" regardless of their familiarity with or acceptance of recovery principles

Two additional themes, although not mutually exclusive, simultaneously called for different emphases:

- focus on training for new knowledge, skills, and attitudes AND on administrative oversight/accountability for what has already been trained
- focus on solutions emphasizing clinical competencies AND on solutions emphasizing service system design

It is not hard to see the value in both sides of these ambivalent themes. Fortunately, such inherent conflicts are only insurmountable when taken as absolutes. When implementing Guidelines, both clinical staff and administration will inevitably need to find realistic and implementable balances between both sides of these important polarities.

SUMMARY AND NEXT STEPS

One of the primary challenges in developing statewide Clinical Assessment Guidelines lies within the diverse practices, resources, and policies among California counties. This diversity has resulted in inconsistent interpretation and application of the LPS Act.

Resources, including access to acute care facilities, beds, duration of stay, and alternative options for hospitalization, vary by county as well. For example, some counties use hospital emergency rooms as the "front door" for 5150 assessments and consideration for admission on involuntary hold. Other counties, however, have crisis stabilization units or Psychiatric Health Facilities (PUFs) with a limited number of beds.

What is consistent among counties, yet still poses a challenge, is that law enforcement is typically the first responder and often the first to assess individuals in possible need of an involuntary hold. Behavioral health crisis intervention training for law enforcement exists but is not standardized or regulated throughout the state. However, in January 2016, California endorsed behavioral health crisis intervention training for law enforcement with Senate Bills 11 and 29. Law enforcement training is essential to the project's success, not least because it includes law enforcement as a key collaborative partner in the assessment, intervention, and aftercare team process. Reportedly, there are thirty (30) California counties implementing Behavioral Health Crisis Intervention Training (BH CIT) for law enforcement and other first responders. The trainings are certified per the Police Officer Standards and Training (POST) guidelines and range from 8–40 hours.

Next Steps

CIBHS, in partnership with the MHSOAC, will:

- Develop a LPS Consensus Assessment Toolkit to be utilized for training and professional development
- Conduct five (5) regional training sessions on how to utilize the LPS Consensus Assessment Toolkit

The process of implementing these guidelines, tools, and training programs will not be without its challenges, but stands to benefit all citizens of the State of California by ensuring the safety and health of its people and creating respectful, supportive processes for caring for individuals with mental illness.