

PART ONE

Greater Bay Area Mental Health Directors' Policy for Determining Responsibility for the Provision of Involuntary Treatment

(Revised September 28, 1994 San Francisco)

It is the responsibility of the Greater Bay Area Crisis Directors (GBACD) to provide timely and effective clinical treatment regardless of a patient's residency, and to act immediately to minimize pain and suffering. Patients should not be transferred from county to county solely or primarily to avoid the costs of involuntary treatment. On the other hand, the best care is based in the community where an individual resides.

Patients transferred under this agreement should have appropriate aftercare in the receiving county after acute care services are no longer needed.

For the purposes of providing involuntary treatment services, residency is defined as a combination of a person's declared intent to reside in a particular place and acts to establish a residence. Therefore, in order to determine residency, the GBACD and the Bay Area Psychiatric Emergency Services have agreed to the following procedures:

I. Residency Criteria

- A. Those who have recently moved to a county or taken acts to establish residence in a county, and have a clear and coherent intent to reside in the county are residents of that county.
- B. Those who are visiting a county when services are needed by them and who have an intent to reside in another county are treated as out-of-county residents.
- C. Those who, because of their mental status, cannot form or express a coherent or clear intent to reside anywhere, but for whom there is evidence of previous intent to reside elsewhere, are treated as out-of-county residents. If there is conflicting or mixed information, the following evidence can be used in assessing intent to reside (in order of importance): [1] Conservatorship (LPS or probate); [2] County that originated residential, medical or psychiatric placement; [3] Current housing; [4] Medi-Cal/SSI; [5] Well documented General Assistance; or [6] Ongoing community mental health clinical care during the last six months.
- D. Those who cannot express an intent and where there is no clear evidence of previous residency will be treated as the responsibility of the evaluating county until residency status is clear.

- E. Individuals who have adopted a transient, nomadic lifestyle should be offered emergency services at the facility where they appear and then be free to continue their way of life afterwards.
- F. Patients in legal custody should be evaluated within the county that originates legal proceedings. Individuals who are on probation or in a conditional release program and are restricted to a particular area should be seen by services within that area.
- G. LPS and probate conservatees are considered to be residents of the county in which they are conserved.

II. Emergency Services

Staff members of emergency services should refer to the above guidelines to resolve disagreements regarding a patient's residency, and therefore the treatment facility responsible for care. Patients should be transferred only when agreement between facilities is reached. If there is no satisfactory resolution of the problem, the following mediation procedures should be followed:

- A. Line staff refers the case to their supervisors who should attempt to resolve the differences.
- B. If disagreement persists, the respective unit directors (or designees) will seek resolution of the disagreement.
- C. If there is still no agreement on the determination of residency, the case should be referred to the mediator who will clarify residency based on the facts presented, as well as any other information he or she may feel necessary in order to make an informed decision.
- D. The mediator's resolution will be accepted by both parties.

III. Inpatient Services

Patients who require acute inpatient treatment in an involuntary setting should be treated in the county of residence. Patients for whom there is no evidence of residency are the responsibility of the evaluating county until residency status is clarified. Staff members of inpatient facilities, or the community mental health service designee, should refer back to the above guidelines to resolve disagreements regarding a patient's residency and therefore the treatment facility responsible for care. Patients should be transferred only when agreement between facilities is reached. The following conditions must be met before transfer can occur:

- A. Time Limitation

Except for patients on conservatorship (LPS or probate), facilities will have five (5) working days (excluding weekends and holidays) to identify residency. The five-day period will begin with time of admission to the emergency facility (or to the inpatient facility if no emergency facility exists). If residency is not established within five days, the responsibility for inpatient care up to the end of 5250 will be with the treating facility.

B. Transfers

1. Once residency has been established, the accepting facility, or the community mental health service designee, has one working day to find a bed for the patient so that transfer can occur within 24 hours.
2. If a patient has exceeded 48 hours of a 72-hour hold, the holding facility must retain the patient until the certification review hearing has been held. Transfer will not be impeded by the lack of a SB 665 hearing regarding involuntary medications.
3. The holding facility will pay the cost of transfer to the receiving facility.

C. Mediation Process for Inpatients

Step 1: Initial Discussion will take place between a representative from the inpatient service holding the patient, or the community mental health service designee, and the director of the emergency service or his/her designee.

Step 2: Director Discussion. Should Step 1 fail, discussion should continue between the directors of the crisis services of each facility as it does for emergency service patients.

Step 3: Mediation

1. If there remains some disagreement regarding the application of guidelines, the case should be referred to the mediator who will clarify residency based on the facts presented.
2. The mediator's resolution will be accepted by both parties.

IV. Selection and Role of the Mediator

- A. The mediator is a crisis unit director who is selected, along with a back up, from the ranks of the Greater Bay Area Crisis Directors. If the mediator will not be available for a substantial part of the quarter, that individual

will notify the chair who will select a replacement and notify the GBACD of the change.

- B. Mediators will be rotated quarterly, and a schedule will be distributed once a year. The previous quarter's back-up mediator will succeed the current mediator every quarter. The chair of the GBACD will serve as a second backup. If none of these individuals are available, any available GBACD member can serve as a mediator for matters not involving his or her county.
- C. Mediators should not mediate issues involving their county, but should defer to backup mediators or to the chair of the GBACD.
- D. The mediator is available by phone Monday through Friday during normal business hours.
- E. After hours and weekends, continued efforts should be made by crisis unit supervisors, unit directors or designees to resolve residency.
- F. Cases should only be referred to mediation after exhausting other alternatives.

PART TWO

Greater Bay Area Mental Health Directors Policy for Determining Responsibility for the Provision of Services to for Out of County Placements (Revised September 22, 1994)

It is the responsibility of the Greater Bay Area Adult Services Directors (GBAASD) to ensure appropriate services are provided to clients placed in counties other than their home county of residence. Under this policy the referring county will remain responsible for their clients during and after placements. Emergency services will be provided according to the criteria outlined in the section of this document relating to the Provision of Involuntary Treatment. Other care and support services such as case management, medication therapy, day treatment services, etc., remain the responsibility of the referring county. Therefore, in order to clarify residence and determine responsibility for services provided to the client placed out of county, the GBAASD have agreed to the following:

- I. Individuals that are off conservatorship can choose to reside in a different county and are free to do so; the receiving county is obliged to provide services in the same priority as they would provide services to any other resident of their county.
- II. The ‘test’ for knowing the intended residence is that the individual has established residency independent of their treatment needs; not because of the inability of their home county to provide treatment services. The process for determining residency is described in more detail in Part One of Provision of Involuntary Treatment.
- III. Individuals who are off conservatorship but in treatment with the local mental health system will remain the responsibility of the originating county unless they have established residency in another county without the assistance of the local Mental Health program or Conservator’s office or other County agencies.
- IV. Individuals on conservatorship remain the responsibility of the originating county regardless of the individual’s expressed interest to reside in another county.
- V. Out-of-county residents who require acute inpatient treatment in an involuntary setting are the responsibility of the county of residence. Patients for whom there is no evidence of residency are the responsibility of the evaluating county until residency status is clarified. Staff members of inpatient facilities, or the community mental health designee, should refer back to the above guidelines to resolve disagreements regarding a patient’s residency and therefore the treatment facility responsible for care. Patients should be transferred only when agreement between facilities is reached. (See Provision of Involuntary Treatment, Section III, page 2.)
- VI. An individual discharged from the State Hospital who remains in the county of the State Hospital, remains the responsibility of the county of residence at the

time of admission to the State Hospital for 3 years. This applies to conserved and non-conserved individuals.

- VII. When placing an individual into another county facility (IMD, Board and Care, etc.), it is the originating county's responsibility to anticipate discharge contingencies and to communicate this with the host county if the plan will involve the host county providing any mental health services.
- VIII. Arrangements for after care for an individual discharged from host country facilities are best made before the individual is admitted into the facility. After care plans should be developed with the host country months before discharge from the facility.

IX. **Mediation Process for Continuing Care**

When there is disagreement between counties regarding responsibility for the provision of non-emergency care, the following process is to be followed.

Each month a different Bay Area Director (or designee) will be selected as a mediator with another Director or designee serving as a back up to avoid conflict of interest. The resolution reached by the mediator will be accepted by both parties.

Step 1: Initial Discussion will take place between a representative from the adult services of the host county and a representative from adult services for the referring county.

Step 2: Director Discussion. Should Step 1 fail, discussion should continue between the directors of the adult services of each county involved.

Step 3: Mediation

- 1. If there remains some disagreement regarding the application of guidelines, the case should be referred to the mediator who will clarify residency based on the facts presented.
- 2. The mediator's resolution will be accepted by both parties.