SB 43 FAQ

DBH prepared these answers in response to questions received and should not be considered legal advice.

Questions from 5150 Designated Staff:

1. **Will we need to specify the diagnostic criteria for SUD on the 5150 forms? Can we just say the person served (PS) is suffering with severe substance use?**
    a. Please be as specific as possible with symptoms, behaviors, etc. for SUD and any relevant information of why they meet criteria for an involuntary hold.
2. **Have crisis stabilization centers (CSC)/psychiatric health facilities (PHFs) increased the number of staff in preparation of the potential increase in individuals fitting criteria of 5150's and would need the proper staff and units.**
    a. It is important to note that other counties who have already gone live for more than a year have not seen the drastic increase in involuntary holds they expected. The hypothesis is that those who were already being placed on holds likely have had already present co-occurring conditions. Nonetheless, DBH is working with CSC and EDs to ensure preparation for SB 43 and will continue monitoring staffing impact after SB 43 rolls out.
3. **Will inpatient facilities now have detox treatment available for these individuals who are placed on holds and start to experience withdrawal?**
    a. Inpatient facilities must meet certain requirements to serve severe SUD. Policies to treat SUD include the requirement to provide MAT services, which requires DHCS approval. DHCS has come out with a draft guidance of what this would entail but no final guidance at this time (see draft BHIN 25 XXX Requirements for PHFs and MHRCs to Admit Individuals with Severe SUDs).
4. **When authoring a 5150 related to a substance use–driven crisis, should we be advocating for the person served to be transported to a medical LPS–designated facility rather than one focused specifically on mental health stabilization?**
    a. Trained 5150 designated staff must work within their scope of practice. Responding ambulance/EMTs can make the proper assessment if the person needs medical attention. Also, when it makes sense to do so, the person served also has the opportunity to voice to be taken to the facility of their choice, but ultimately it depends on the presentation of the person and transportation provider (see draft BHIN 25 XXX Requirements for PHFs and MHRCs to Admit Individuals with Severe SUDs).

5. **Will hospitals be allowed to limit how many SUD only admissions they accept?**
    a. No
6. **Are there no places to send patients from the ER for SUD?**
    a. Unfortunately, no. Currently, Fresno County, like every County in the State, lacks a dedicated locked facility for involuntary SUD treatment. Infrastructure development is needed to fully support the expanded eligibility under SB 43. SB 1238 is helping in expanding this infrastructure development.
7. **So, if they were placed on this hold (for necessary medical care) could they receive medical care without their consent? Would they receive medical care involuntary?**
    a. Hospitals should continue to follow their policies and procedures when it comes to emergency medical treatment.
8. **For SUD Criteria, after 72 hours, do we Re-Assess? Sounds like everyday reality, we can take them in on the hold under the influence, they are sober, no beds.**
    a. Any person on an involuntary hold should be continually assessed to confirm they continue to meet criteria for an involuntary hold. They can be released before the 72 hours if they no longer meet criteria for DTS, DTO and/or GD. Involuntary holds should always be the last resort after the person refuses voluntary treatment. After the involuntary hold expires or is lifted early after they are deemed not being DTS, DTO and/or GD, a person has the right to refuse services. During discharge planning, the person should be connected to ongoing resources for MH and/or SUD treatment to give them an opportunity to accept treatment.
9. **Regarding grave disability, as a psychiatrist, if I am evaluating a patient for grave disability, keeping in mind the caveat "while operating within the scope of their practice," would that mean hypothetically that an MD/DO psychiatrist, who is evaluating for grave disability, would NOT be able to hold someone with extremely high blood pressure who is refusing their meds for Hypertension? in that case, assuming the pt is on a medical floor and not a psych floor, would a 1799 from the medical team apply in that case?**
    a. It is always important to consider how the person's symptoms or behaviors are related to a MH disorder, SUD or both. A person refusing to take their medication for blood pressure alone is not enough to warrant an involuntary hold. Now, if the person **due to a suspected MH and/or severe SUD** (has auditory hallucinations saying the medication is poison) is refusing to take medications for blood pressure and if left untreated is likely to result in serious bodily injury, after further assessment this could result in a possible

involuntary hold. Once the person served is admitted to the medical floor, the hospital can write a 1799. Hospitals will follow their internal policies. Health and Safety Code 1799.111 utilize the same definition we have listed under WIC 5008. So, the SB 43 updates for gravely disabled would apply. Psychiatrist will need ensure the person served meets criteria for the hold.

10. **Are there any anticipated changes regarding holds placed on inmates at the Fresno County Jail?**
    a. For jail operations and processes, you will need to follow up with Fresno County Sherriff's Office. When writing a hold, it is recommended to add "Any LPS facility" on the 5150 form "To (name of 5150 designated facility)" section to provide flexibility of which facility the individual is transferred to as this depends on need of the person and any sudden changes can occur while in route to a facility by EMT transport. This can mean needing medical attention prior to transferring to a LPS designated facility or for other providers, if CSC is on diversion, the flexibility of pivoting to an ED.
11. **Are inpatient facilities going to accept patients with medical needs such as open wounds?**
    a. Medical clearance is required before being admitted to an inpatient facility or CSC. Medical care would need to be provided by the EDs
12. **Where can we find the newest 1801 form?**
    a. The latest version should be dated 6/2024 and can be found here: **https://www.dhcs.ca.gov/formsandpubs/forms/Documents/DHCS-1801.pdf**

Additional Questions from Providers:

13. **Will SB 43 lead to forced treatment or government overreach?**
    A: No. LPS conservatorship is a legal process with due process protections and is not automatic or permanent.
    - Conservatorship is a 1-year term, reviewed annually.
    - Conservatorship can be terminated early if no longer gravely disabled.
    - Conservatees may contest conservatorship every 6 months.
    - Courts must consider less restrictive options first.
    - Legal representation is provided to proposed conservatees and court hearings are required throughout the LPS proceedings.
14. **Is SB 43 a faster way to conserve people?**
    a. No. It remains a structured legal process, typically involving multiple evaluations, feedback from treatment providers and support system, history of involuntary holds (5150, 5250, 5270, etc.), and a formal referral to the

Public Guardian by a LPS facility. SB 43 does not bypass existing legal standards or procedures.

15. **What is the role of peace officers or clinicians initiating 5150s?**
    a. As under current law, peace officers and designated professionals are not required to diagnose. Their role is to make a reasonable determination based on observation and probable cause.

    - They may consider relevant history (WIC 5150.05)
    - A qualified clinician will make the formal diagnosis later at an LPS facility for formal evaluation and treatment.
    - No liability arises from initiating a 5150 if done in good faith.

16. **What about assessing for "necessary medical care"?**
    a. Field professionals must use their best judgment based on observations. If someone appears unable to seek or manage medical care due to their MH or severe SUD condition, this may meet the threshold for grave disability.
17. **How does SB 43 impact privacy under 42 CFR Part 2 (SUD records)?**
    a. It does not. SUD treatment records provided by Part 2 programs continue to be protected by federal law (42 CFR Part 2). Part 2 program records may only be shared with patient consent or court order.
18. **Does Fresno County have a locked facility for severe SUD?**
    a. Currently, Fresno County, like every County in the State, lacks a dedicated locked facility for involuntary SUD treatment. Infrastructure development is needed to fully support the expanded eligibility under SB 43.
    b. Although SB43 itself lacks dedicated funding, it is connected to the Governor's other behavioral health initiatives which do have funding, such as Proposition 1. In March 2024, a $6.4 billion bond measure was passed that expanded behavioral health treatment facilities and supportive housing, intended to increase the state's capacity to provide MH and severe SUD care.

SB 43 Re-Convening Questions:

19. **Regarding the Proposition 1 funds received by DBH with plans to build a Crisis Residential Facility for those under 21, are one of the requirements that they be Child Welfare involved or in foster care?**
    a. DBH is still unsure on the specifics at present time as the BCHIP award is still under final approval.
20. **How does SB 43 impact the transitions from CSU to the PHFs?**
    a. Any clinical care decisions for any transitions will remain the same as they are at present time by the current vendor. The remodeled CSC's and PHF's will have a secluded corridor that can be used as a safe physical transition between the CSC to the PHF.

21. **What happens to those that are placed on a severe SUD only hold that need to stay longer than 23 hours at the CSC?**
    a. CSC has a max of 23 hour stay but there are times where overstays do occur depending on their clinical needs. The main goal is to have those safely discharged to their placement and connected to services. DBH is also exploring what type of settings would be the most appropriate for the future SB 43 PHF such as medical detox, etc. DBH will be looking specifically at the medical component to make sure people who are admitted can safely detox from substances.
22. **Regarding mobile crisis services what are the percent of calls from collateral persons or individuals calling that are under the influence?**
    a. Very low for SUD only, but more so for co-occurring. Mobile Crisis clinicians are trained to assess for crisis intervention and the domains impacting the individual (social support, housing, substance use, etc.). Dispatch screenings have shown extremely low callers being intoxicated due to substances where it has been a concern to respond.
23. **What do I do if I am a member of the community and I see someone running into the street, who do I call?**
    a. This should be a call to 911 due to the emergent situation. Mobile crisis does not do welfare checks and the person who is having the crisis must know that the mobile crisis team will be arriving.