Rick Scott,
Governor

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Secretary

# FLORIDA DEPARTMENT OF JUVENILE JUSTICE

# Mental Health and Substance Abuse Documentation

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# Standardized Forms

1. **Authority for Evaluation and Treatment (AET) and AET for Youth $\geq$ 18 years – HS 002 and HS 003**
2. **Youth Consent for Substance Abuse Treatment in RSAT or RSAT Overlay Program – MHSA 001**
3. **Suicide Risk Screening Instrument (SRSI) – MHSA 002**
4. **PACT, MAYSI-2**
5. **Suicide Risk Screening Parent/Guardian Notification – MHSA 003**

# Standardized Forms

6. **Assessment of Suicide Risk (ASR) and Follow-up Assessment of Suicide Risk – MHSA 004 and MHSA 005**
7. **Suicide Precautions Observation Log – MHSA 006**
8. **Health Status Checklist – MHSA 008**
9. **Detention Suicide Risk Parent/Guardian Notification – MHSA 009**
10. **Mental Health/Substance Abuse Treatment Discharge Summary -MHSA 011**

# Sample Forms

1. **Mental Health Alert – Observation Log – MHSA 007**
2. **Youth Consent for Substance Abuse Treatment – MHSA 012**
3. **Youth Consent for Release of Substance Abuse Treatment Records - MHSA 013**
4. **Mental Health/Substance Abuse Referral Summary - MHSA 014**
5. **Initial Mental Health/Substance Abuse Treatment Plan - MHSA 015**
6. **Individualized Mental/Substance Abuse Treatment Plan – MHSA 016**

# Sample Forms

7. **Individualized Mental/Substance Abuse Treatment Review – MHSA 017**
8. **Counseling/Therapy Progress Note – MHSA 018**
9. **Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log – MHSA 019**
10. **Close Supervision –Visual Checks Log - MHSA 020**
11. **Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk–MHSA 022**
12. **Crisis Assessment – MHSA 023**

# Authority for Evaluation and Treatment

- The department has been granted limited powers to:
  - complete preliminary screenings (to determine mental health or substance abuse problems)
  - or if there is evidence of a mental health emergency
- Beyond screening and emergency, the department must have consent to provide services

# Authority for Evaluation and Treatment

- In most circumstances, the AET gives DJJ the authority to assume responsibility for the provision of necessary and appropriate physical and mental health care to a youth in the DJJ's physical custody
- The AET does not give permission for substance abuse evaluation and treatment

# Admission to Detention and Residential Programs

**DETENTION** – JAC or JPO Unit Intake

- PACT Mental Health and Substance Abuse Referral Form
- MAYSI
- SRSI
  - JPO
  - JDO
  - Nurse and/or mental health staff
- Comprehensive Assessments (SAMH2-3)

**RESIDENTIAL**

- Standardized MH/SA Screening Process
  - Review of commitment information
  - MAYSI (or)
  - Clinical MH/SA Screening

# Suicide Risk Screening Instrument (SRSI)

- JPO interviews youth and contacts parent/guardian, and if applicable, assigned JPO and DCF (pages 1-4)
- Upon arriving at the detention facility, JDO conducting intake enters observations into SRSI (pages 3 & 4).
- Nursing and/or mental health staff interview youth and enter data into SRSI (pages 5-8).

# Suicide Risk Screening Instrument (SRSI)

- Any "YES" responses on the SRSI result in the youth's being placed on suicide precautions
- JJIS will automatically generate a SUICIDE ALERT in JJIS for any "YES" responses.

- JDO conducting intake must make a Mental Health Referral and place youth on Suicide Precautions for any youth whose SRSI is positive upon entry to the facility.

# Mental Health, Substance Abuse and Suicide Risk Screening

**Youth who are NOT screened at the JAC prior to entering the detention facility must undergo a screening based on available information at the detention facility.**

- The intake officer and/or Nursing and Mental Health staff at detention complete their sections of the SRSI, and if any positive responses, place the youth on suicide precautions and make a mental health referral for an assessment of suicide risk.

# PACT Mental Health and Substance Abuse Screening Report & Referral

- Immediate referral for assessment of suicide risk is indicated by the SRSI

- Immediate referral for assessment of suicide risk is indicated by the PACT
  - Suicide scale
  - Depression (History of impairment in every day tasks due to depression/anxiety" Domain 3 Mental Health, item 3

# PACT Mental Health and Substance Abuse Screening Report & Referral

- A referral for further testing or services (e.g. comprehensive assessment) is indicated by PACT or screener override.

*** Suicide Scale**
*** Aggression Scale**
*** Mental Health Problems**
*** Depression**
***Substance Abuse**
*** Other**

# Standardized MH/SA Screening Process-Residential

- Review of commitment information:
  - Mental health staff reviews commitment information including commitment packet, reports, or existing mental health documentation
  - Mental health professionals note any risk factors found in the review

# Standardized MH/SA Screening Process-Residential

- Risk factors can include, but are not limited to:
  - Inpatient/outpatient mental health or substance abuse treatment
  - Emergency room evaluations for mental health/substance abuse related issues
  - Suicide attempt, suicide behaviors or suicide risk
  - Self-injurious behaviors (e.g., head
  - banging, self-mutilation, intentional self-injury)

# Standardized MH/SA Screening Process-Residential

- Risk factors cont.
  - Treatment with psychotropic medications
  - Drug/alcohol use or drug/alcohol possession
  - Emotional instability (e.g., depression, anxiety, mood swings, violent rage)
  - History of significant trauma
  - History of mental illness in family

# Standardized MH/SA Screening Process-Residential

- MAYSI-2
  - Should be conducted the day of admission in a private/confidential manner
  - Can only be administered by staff who have successfully completed CORE "Using the MAYSI-2 to Screen for Mental Health and Substance Abuse Problems".
  - Should be conducted and recorded in JJIS

# Standardized MH/SA Screening Process-Residential

- The person conducting the MAYSI-2 should:
  - Use the provided script to explain the process
  - Give examples and explain the questions if needed
  - Provide enough time for the youth to answer
  - Determine if a referral for further assessment or immediate attention is to be made due to special circumstances (i.e. misreported by answering “no” to all items, refuses to answer, etc.)

# Standardized MH/SA Screening Process-Residential

- The person conducting the MAYSI-2 should:
  - **Regardless of the MAYSI-2 findings**, when the staff person obtains information that the youth has a mental health or substance abuse problem or is a possible suicide risk, a referral for further evaluation or immediate attention must be made.

# Standardized MH/SA Screening Process-Residential

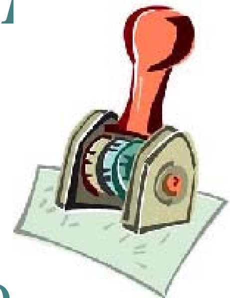
- Clinical Mental Health and Substance Abuse Screening
  - Conducted by a licensed mental health professional
  - Must use valid and reliable instruments (i.e. SASSI-3, POSIT, etc.)
  - **MUST** include valid and reliable suicide risk screening instrument (i.e. Suicide Ideation Questionnaire or Suicide Probability Scale)

# Standardized MH/SA Screening Process-Residential

- Clinical Mental Health and Substance Abuse Screening (cont.)
  - **Must reflect consideration of the following:**
    - **Recent Mental Health/Substance Abuse History**
    - **Recent History of Trauma and/or Victimization**
    - **Current Mental Status**
    - **Behavioral Observations**
    - **Suicide Risk Screening**
    - **Findings and recommendations for further evaluation or treatment**
    - **Disposition**

# Standardized MH/SA Screening Process-Residential

- Clinical Mental Health and Substance Abuse Screening (cont.)
  - Must use a form that clearly states "*Clinical Mental Health and Substance Abuse Screening*" on provider/program stationery
  - Must provide details of findings
  - Must be signed and dated by licensed clinician who completed the form
  - The clinician will make a decision regarding further evaluation/assessment , ASR, emergency evaluation, and confer with the program director and DMHA
  - The program director documents the consultation on the mental health substance abuse referral summary



# Standardized MH/SA Screening Process-Residential

- An ASR is required if:

  - The MAYSI-2 category "suicide ideations," R-PACT Suicide Ideation Scale or Domain 3, Item 3 indicates the need for assessment
  - When other information is gathered that indicates need for an ASR (i.e. observations, information found in commitment packet, recent suicide ideations/attempts, etc.)

# Standardized MH/SA Screening Process-Residential

- An ASR is required if:
  - When the Clinical Mental Health and Substance Abuse Screening indicates need for an ASR or emergency mental health evaluation
    - ***A JJIS alert should be entered immediately and the youth be placed on suicide precautions (constant supervision) for any of the aforementioned scenarios
    - ***Youth with current suicide ideations must be assessed immediately

# Mental Health and Substance Abuse Referral Summary

- A MH/SA Referral Summary is generated in the following instances:
  - Positive SRSI
  - Elevated PACT Scales
  - Elevated MAYSI-2 Scales
  - Collateral information from parent/guardian, records, and/or observations of youth's behavior
  - Information gathered in the Clinical Mental Health and Substance Abuse Screening.
  - Reason for referral should be included in form e.g., elevated PACT Suicide Scale, youth prescribed Depakote.

# Mental Health and Substance Abuse Referral Summary

Referral for the following services:

- Assessment of Suicide Risk
- Crisis Assessment/Intervention
- Comprehensive Mental Health/Substance Abuse Evaluation or Updated Evaluation
- Mental Health Consultation or Mental Health Support Services

# Mental Health, Substance Abuse and Suicide Risk Screening

## DETENTION

- If PACT or MAYSI-2 Subscales are elevated, SRSI is positive, or intake/admission information indicates need: youth is referred by the JAC for a comprehensive assessment under Rule 63D, to be completed by a provider contracted with Probation.

## RESIDENTIAL

- The program director is responsible for ensuring that comprehensive MH/SA evaluations or updated evaluations are received

  within 30 days of initial screening

# Assessment of Suicide Risk

The following will result in a placement of a youth on suicide precautions and referral for an Assessment of Suicide Risk (ASR):

- Positive SRSI
- Elevated PACT Suicide Scale on the PACT, or PACT Depression Subscale ("History of impairment in everyday tasks due to depression/anxiety" Domain 3-Mental Health, Item 3)
- Elevated MAYSI-2 Suicide Ideation Scale
- Other information gathered (i.e. observations, collateral information, etc.)

# Assessment of Suicide Risk

- Must be documented on form MHSA 004
- Reason for Assessment of suicide risk
- Method of Assessment
  - Interview
  - Suicide Scale/Questionnaire
  - Testing

- Current Mental Status Exam (to include direct questioning of the youth and collateral information)

# Assessment of Suicide Risk

- Suicide risk factors such as:
  - Current thoughts of suicide/harming self
  - Suicide plan and method
  - Youth's confidence in his/her ability to carry out the plan
  - Availability/access to means to harm self
  - Precipitating stressful events
  - Previous attempts
  - Lethality of previous attempts
  - Psychiatric/mental health history
  - Drug abuse/dependence
  - Hopelessness

# Assessment of Suicide Risk

- Determining Dangerousness to Self:
  - Imminence of behavior
  - Intent of behavior
  - Clarity of danger
  - Lethality of behavior

- Determination of Suicide Risk
- Supervision recommendations
- Summary of findings
- Recommendations for treatment of follow up
- Consultation with licensed MH Professional
- Conferred with Facility Superintendant/Director
- Notifications

# Suicide Precautions

## Administrative and Clinical Reviews:

- Following the removal of a youth from suicide precautions, administrative and clinical reviews by the facility superintendent/designee and licensed mental health professional (for ASRs completed by non-licensed clinical staff) are completed
- *Detention*: documented in the ASR/FASR Disposition in DFMS.
- *Residential*: documented on the paper ASR/FASR

# Assessment of Suicide Risk

- Follow-Up Assessment of Suicide Risk
- Request for Discontinuation of Suicide Precautions
- Disposition

# Assessment of Suicide Risk Common Errors

- Minimal information regarding reason for assessment.
- Consultation with LMHP and/or Superintendent/Director does not include date and/or time of conferral.
- Notification to parent/guardian is not made for youth who remain on suicide precautions following an initial (intake) ASR or for youth placed on suicide precautions during length of stay.
- Recommendations not consistent with assessment data.
- ASR not completed (including consult) w/in 24 hrs.

# Suicide Risk Screening Parent/Guardian Notification

- Detention Suicide Risk Parent/Guardian Notification (MHSA 009).
  - Youth released from detention prior to undergoing an ASR.
  - Youth released from detention after being assessed by mental health staff and placed/maintained on suicide precautions.

# Suicide Risk Screening Parent/Guardian Notification

- Suicide Risk Screening Parent/Guardian Notification (MHSA 003)
  - Youth whose screening indicated suicidal risk and are released from the JAC prior to undergoing an assessment.

# Transfer to DJJ Facility While on Suicide Precautions

- To a commitment facility:
  - Open JJIS alert
  - Observation log
  - Youth's individual healthcare record should accompany the youth with appropriate mental health documentation present
  - Staff must notify new facility prior to or upon arrival/admission

- To a detention center
  - Open JJIS alert
  - Observation log
  - Staff must notify new facility prior to or upon arrival/admission

# Suicide Precautions Observation Log

Maintained for youth on Precautionary or Secure Observation by direct care staff in order to monitor behavior, signs, and symptoms of youth on precautions

# Suicide Precautions Observation Log

- Behavior is documented at 30 minute intervals for youth on One to One or Constant Supervision.
- Codes on form should be used
- Log must be reviewed/signed by supervisors a minimum of every shift
- Log must be reviewed/signed by mental health staff daily

# Suicide Precautions Observation Log – Warning Signs

Warning Signs (coded as 13 – 20) include the following:

- Threats to harm self or others
- Superficial attempts to hurt self
- Possible hallucinations
- Talking incoherently
- Taking off clothes/stripping
- Crying, very sad
- Shaking/Trembling
- Very sad and agitated or impulsive

# Suicide Precautions
# Observation Log – Warning Signs

- Warning signs must result in notification to Superintendent/Program Director and Mental Health Staff.
- Documentation of notification is made on the logsheet, along with any instructions provided by mental health staff.

# Suicide Precautions Observation Log

Common Errors:

- Missing  entries
- Warning signs without proper notifications
- Entries not made in “real time”
- Missing shift supervisor signatures
- Missing mental health staff signatures

# Secure Observation

- Youth whose suicidal risk behavior requires level of observation and control beyond that provided by Precautionary Observation.
- Youth who is in behavioral confinement and presents with suicidal behavior.
- Youth on suicide precautions whose misbehavior results in placement on disciplinary confinement.

# Secure Observation

- Health Status Checklist (Form MHSA008)
- Room Search
- Youth Search
- Assessment of Suicide Risk
  - Follow-up ASR
  - Disposition

# Secure Observation

- Time Frames:
  - DMHA or licensed MH professional *MUST* be contacted when initiated
  - ASR must be conducted within 8 hours of initiation, unless placement occurs during the evening or night shift. Then, the ASR must be completed the following morning shift
  - DMHA or licensed MH professional must give authorization for continuation of secure every 8 hours

# Mental Health Alert Observation Log (MHSA 007)

- Completed in the same manner as Suicide Precautions Observation Log for youth on One to One or Constant Supervision who are **NOT** on suicide precautions (Precautionary or Secure Observation).

# Close Supervision Visual Checks Log

- Youth undergoes visual checks a minimum of every 5 minutes while in his/her room
- Log is not intended for youth on Suicide Precautions.
- **Used when youth is stepped down from suicide precautions (constant supervision) to close observation and transitioned to normal routine**.
- Can also be used for youth with a mental health alert.

# Crisis Assessment (Form MHSA 023)

- Crisis: a youth's acute emotional or behavioral problem or psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) is extreme and does not respond to ordinary crisis intervention and mental health expertise is needed

# Crisis Assessment (Form MHSA 023)

- Detailed evaluation of a youth demonstrating acute psychological distress (e.g., extreme anxiety, fear, panic, paranoia, agitation, impulsivity, rage) to determine the severity of his/her symptoms, and level of risk to self or others
- Conducted by, or under the supervision of, a LMHP.
- Reviewed within 24 hours if conducted by a non-licensed clinician

# Crisis Assessment (Form MHSA 023)

Must include the following:

- Reason for assessment
- MSE and interview
- Determination of dangerousness
  - Imminence of behavior/Intent/Clarity of danger/Lethality
- Initial clinical impressions
- Supervision and treatment recommendations
- Recommendations for follow-up/further evaluation
- Notification to parent/guardian of follow-up recommendations

# Substance Abuse Consent/Release

- For substance abuse services, in most instances a youth must consent to his or her treatment unless substance abuse evaluation and treatment have been ordered by the court.

*Section 397 F.S. Substance Abuse Services*

# Substance Abuse Consent/Release

- Youth Consent for Substance Abuse Treatment in a DJJ RSAT or RSAT Overlay Services Pgm (MHSA 001)
- Youth Consent for Substance Abuse Treatment (MHSA 012)
- Youth Consent for Release of Substance Abuse Treatment Records (MHSA 013)

# Mental Health/Substance Abuse Treatment Plans

- All youth with a serious mental health disorder or substance abuse disorder, and getting mental health treatment while in a DJJ, facility should have an initial treatment or individualized treatment plan

- The plan should focus on alleviating symptoms and allow the youth to function in the DJJ setting

# Initial Mental Health/Substance Abuse Treatment Plans (MHSA 015)

- Reason for treatment
- Initial DSM-IV-TR diagnosis or presenting symptoms
- Initial treatment methods
  - Duration/Amount/Frequency
  - Psychotropic medication and frequency of psychiatric monitoring

# Initial Mental Health/Substance Abuse Treatment Plans (MHSA 015)

- Initial goals and objectives
- Detention: must be signed/dated by clinical staff and the youth.
- Residential: must be signed/dated by clinical staff, youth and treatment team.

# Initial Mental Health/Substance Abuse Treatment Plans Time Frames

- Must be developed:
  - Within 7 days of initiation of treatment
  - OR for those youth on psychotropic medications, within 7 days of the initial psychiatric diagnostic interview
- If developed by an non-licensed professional it must be reviewed and signed by a licensed MH professional (for the MH tx plan), or by a “qualified professional” (for SA tx plan) within 10 days of completion

# Mini Treatment Team

## Detention

- Responsible for developing initial/individualized treatment plan
- At least mental health staff and a person from different service area (i.e. medical)
- Should involve parent/guardian (when possible)

# Multi-Disciplinary Treatment Teams in Residential Programs

- Composed of administration, educational, vocational, residential, medical, mental health, substance abuse and counseling components
- *Specialized treatment services programs* (e.g., BHOS, MHOS, RSAT, RSAT Overlay), **may utilize an initial treatment note or an initial treatment plan** signed by the mental health/substance abuse clinical staff person and youth.
- Follow-up appointments and contact names/numbers

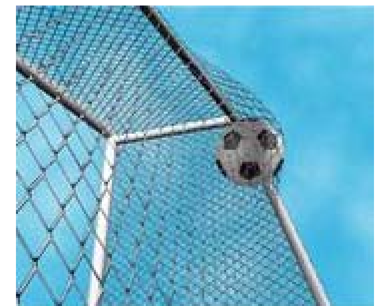
# Individualized Mental Health/Substance Abuse Treatment Plans (MHSA 016)

- Detention
  - Individualized Treatment Plans should be completed by the 31st day when a youth stays beyond 30 days

- Residential and Day Treatment:
  - Within 30 days of admission or for youths who begin treatment subsequent to admission, within 30 days of initiation of treatment (including treatment with psychotropic medication).

# Individualized Mental Health/Substance Abuse Treatment Plans

- DSM-IV-TR Diagnoses and Symptoms
- MH/SA  Treatment Goals
- MH/SA Treatment Objectives and Methods/Interventions
  - Symptoms
  - Objectives (Measurable/Achievable)
  - Methods/Interventions (Durations/Amt/Frequency)
  - Target Dates



# Individualized Mental Health/Substance Abuse Treatment Plans

- Psychiatric Services
  - Psychotropic medications
  - Frequency of psychiatric monitoring
- Youth and family strengths and needs

# Treatment Plans
# Parent/Guardian Signatures

- For both Initial and Individualized Treatment Plans) documented efforts should be made to have a parent/guardian signature, unless
- There is clear documentation as to why signature is not present.
  - Non-involvement consistent with youth's needs and/or statutory requirements;
    - Substance abuse treatment
    - Youth is emancipated (documented) or $\geq$18
  - Efforts to secure involvement have been unsuccessful.

# Individualized Mental Health/Substance Abuse Treatment Plan Review (MHSA 017)

- The Individualized Treatment Plan must be reviewed every 30 days.
- Any revisions to diagnoses, goals/objectives, methods/interventions or target dates are documented in Individualized MH/SA Treatment Plan Review (MHSA017)

REVISED

- The review should have signatures of youth, clinician, and treatment team members

# Counseling/Therapy Progress Note (MHSA 018)

- Provide a description of the treatment session/activity and the youth's participation in the treatment session/activity. Document the course of treatment and the youth's progress in meeting his/her clinical goals/objectives per treatment plan.
- May be provided on the day treatment is provided or recorded weekly.

# Weekly Progress Note/Summary

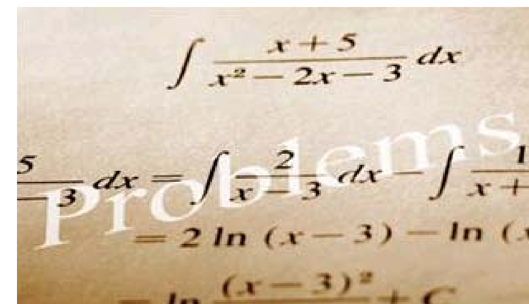
Must include the following:

- Summary of the treatment interventions delivered, youth's response, progress, significant events, contact with family/other agencies.
- Information that interventions authorized in treatment plan were delivered as per plan
- Observations of staff's implementation of plan
- Summary of treatment team meetings related to youth
- Substantiation that services were delivered each day that such were billed (including interventions and interactions of counselor and staff with youth)

# Mental Health/Substance Abuse Discharge Summary (MHSA 011)

- Final phase of treatment – transition phase.
- Plan ideally developed by clinical staff, youth, and treatment team whereby improvements made during treatment will be maintained upon youths' movement between facilities or return to community.
- Copies provided to youth, JPO and parent/guardian (as allowed).

# Mental Health/Substance Abuse Discharge Summary (MHSA 011)




- Dates treatment started/ended
- Relevant MH/SA history
- Reason MH/SA treatment initiated
- Problems which were the focus of treatment
- Course of treatment and youth's progress
- Pre/post treatment DSM-IV-TR diagnoses
- Current alert status
- Continued MH/SA service needs and treatment recommendations
- Psychotropic medications

# Assessment of Suicide Risk Non-Licensed Mental Health Clinical Staff Training

- All non-licensed clinical staff conducting ASR's must receive a minimum of 20 hours training and supervised experience in assessing suicide risk, mental health crisis intervention and emergency mental health services.

NOTE: The non-licensed persons training and supervised experience must be provided by a licensed mental health professional

# Assessment of Suicide Risk Non-Licensed Mental Health Clinical Staff Training

- All non-licensed clinical staff conducting ASR's must receive a minimum of 20 hours training and supervised experience in assessing suicide risk, mental health crisis intervention and emergency mental health services.
- This includes administration of at least 5 ASRs or Crisis Assessments conducted on site in the presence of a licensed mental health professional.

(See Sample Form MHSA 022)

# Assessment of Suicide Risk Non-Licensed Mental Health Clinical Staff

- Documentation must include the DJJ ID#s of the 5 supervised assessments.
- Please refer to Sample Form MHSA 022

# Licensed Mental Health Professional's and Licensed/Certified Substance Abuse Professional's Direct Supervision Log (MHSA 019)

- All non-licensed mental health professional must receive a minimum of 1 hour documented face to face supervision by a LMHP (psychiatrist, psychologist, LCSW, LMHC, LMFT, psychiatric nurse) per week

# Licensed Mental Health Professional's and Licensed/Certified Substance Abuse Professional's Direct Supervision Log (MHSA 019)

- All non-licensed substance abuse professionals must be provided a minimum of 1 hour documented face to face supervision per week by a "qualified professional" under Ch 397 (physician or physician assistant [licensed under 458 or 459] , licensed psychologist, LCSW, LMFT, LMHC, an advanced registered nurse practitioner having a specialty in psychiatry licensed under part 1 of Chapter 464, or a person who is certified through a DCF recognized certification process for substance abuse treatment)

# Questions

# Contact Information

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