MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES MANUAL

Revised August, 2006
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>TITLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INTRODUCTION</td>
<td>1-1</td>
</tr>
<tr>
<td></td>
<td>Purpose</td>
<td>1-1</td>
</tr>
<tr>
<td></td>
<td>Authority</td>
<td>1-2</td>
</tr>
<tr>
<td></td>
<td>Scope</td>
<td>1-3</td>
</tr>
<tr>
<td></td>
<td>Legislative Intent</td>
<td>1-4</td>
</tr>
<tr>
<td></td>
<td>Mission and Philosophy</td>
<td>1-5</td>
</tr>
<tr>
<td></td>
<td>Target Population for Mental Health and Substance Abuse Services</td>
<td>1-5</td>
</tr>
<tr>
<td></td>
<td>Services for Youths with Developmental Disabilities</td>
<td>1-6</td>
</tr>
<tr>
<td></td>
<td>Guiding Principles</td>
<td>1-7</td>
</tr>
<tr>
<td></td>
<td>Youth Rights</td>
<td>1-8</td>
</tr>
<tr>
<td></td>
<td>Manual Overview</td>
<td>1-9</td>
</tr>
<tr>
<td></td>
<td>Manual Update</td>
<td>1-10</td>
</tr>
<tr>
<td>2</td>
<td>ADMINISTRATION AND MANAGEMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</td>
<td>2-1</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>2-1</td>
</tr>
<tr>
<td></td>
<td>Mental Health and Substance Abuse Services Components</td>
<td>2-1</td>
</tr>
<tr>
<td></td>
<td>Qualifications of Mental Health and Substance Abuse Professionals</td>
<td>2-4</td>
</tr>
<tr>
<td></td>
<td>Administration, Implementation and Coordination of Mental Health and Substance Abuse Services</td>
<td>2-11</td>
</tr>
<tr>
<td></td>
<td>Confidentiality of Mental Health and Substance Abuse Information</td>
<td>2-18</td>
</tr>
<tr>
<td>3</td>
<td>CONSENT REQUIREMENTS</td>
<td>3-1</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>3-1</td>
</tr>
<tr>
<td></td>
<td>General Consent Requirements Applicable to Mental Health and Substance Abuse Services</td>
<td>3-1</td>
</tr>
<tr>
<td></td>
<td>Consent Requirements Unique to Substance Abuse Services and Mental Health Crisis Intervention Services</td>
<td>3-10</td>
</tr>
<tr>
<td>4</td>
<td>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES DOCUMENTATION AND RECORDS MANAGEMENT</td>
<td>4-1</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>4-1</td>
</tr>
<tr>
<td></td>
<td>Individual Healthcare Record</td>
<td>4-1</td>
</tr>
<tr>
<td></td>
<td>Mental Health/Substance Abuse Section of the Individual Healthcare Record</td>
<td>4-3</td>
</tr>
<tr>
<td></td>
<td>Active Mental Health/Substance Abuse Treatment File</td>
<td>4-7</td>
</tr>
<tr>
<td></td>
<td>Confidentiality of Mental Health and Substance Abuse Treatment Records</td>
<td>4-8</td>
</tr>
<tr>
<td></td>
<td>On-Site Mental Health/Substance Abuse Tracking Logs</td>
<td>4-10</td>
</tr>
<tr>
<td></td>
<td>Health Services Statistical Reports</td>
<td>4-10</td>
</tr>
<tr>
<td>5</td>
<td>MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING AND EVALUATION</td>
<td>5-1</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>5-1</td>
</tr>
<tr>
<td></td>
<td>Mental Health and Substance Abuse Screening</td>
<td>5-2</td>
</tr>
<tr>
<td></td>
<td>Comprehensive Assessment Under Section 985.21(1)(a)4 and Pre-Disposition Comprehensive Evaluations Under Section 985.29 F.S.</td>
<td>5-15</td>
</tr>
<tr>
<td></td>
<td>Pre-Disposition Comprehensive Evaluations Under Section 985.29 F.S. and Updated Comprehensive Evaluations in Residential Commitment Programs</td>
<td>5-18</td>
</tr>
<tr>
<td></td>
<td>Alert Systems (&quot;Suicide Risk Alert&quot; and &quot;Mental Health Alert&quot;)</td>
<td>5-22</td>
</tr>
<tr>
<td></td>
<td>Drug Testing of Youths in Residential Commitment Programs Designated for RSAT and RSAT Overlay Services</td>
<td>5-25</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>TITLE</td>
<td>PAGE</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>6</td>
<td>MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT PLANNING AND IMPLEMENTATION OF TREATMENT SERVICES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>6-1</td>
</tr>
<tr>
<td></td>
<td>Mental Health and Substance Abuse Treatment Planning</td>
<td>6-2</td>
</tr>
<tr>
<td></td>
<td>Mental Health Treatment Techniques</td>
<td>6-7</td>
</tr>
<tr>
<td></td>
<td>Substance Abuse Treatment Techniques</td>
<td>6-9</td>
</tr>
<tr>
<td></td>
<td>Psychopharmacological Therapy</td>
<td>6-12</td>
</tr>
<tr>
<td></td>
<td>Psychiatric Services</td>
<td>6-13</td>
</tr>
<tr>
<td></td>
<td>Transition Planning: The Mental Health/Substance Abuse Treatment Discharge Summary</td>
<td>6-19</td>
</tr>
<tr>
<td></td>
<td>Specialized Treatment Services in Residential Commitment Programs</td>
<td>6-20</td>
</tr>
<tr>
<td>7</td>
<td>SUICIDE PREVENTION</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>7-1</td>
</tr>
<tr>
<td></td>
<td>Suicide Prevention Plan</td>
<td>7-1</td>
</tr>
<tr>
<td></td>
<td>Identification of “At Risk” Youths</td>
<td>7-4</td>
</tr>
<tr>
<td></td>
<td>Assessment of Suicide Risk</td>
<td>7-8</td>
</tr>
<tr>
<td></td>
<td>Suicide Precautions</td>
<td>7-14</td>
</tr>
<tr>
<td></td>
<td>Precautionary Observation</td>
<td>7-15</td>
</tr>
<tr>
<td></td>
<td>Secure Observation</td>
<td>7-19</td>
</tr>
<tr>
<td></td>
<td>Immediate Response to a Suicide Attempt or Incident of Serious Self-Inflicted Injury</td>
<td>7-27</td>
</tr>
<tr>
<td></td>
<td>Serious Suicide Attempt or Serious Self-Inflicted Injury Review and Mortality Review</td>
<td>7-29</td>
</tr>
<tr>
<td>8</td>
<td>MENTAL HEALTH CRISIS INTERVENTION</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>8-1</td>
</tr>
<tr>
<td></td>
<td>Mental Health Crisis Intervention Plan</td>
<td>8-1</td>
</tr>
<tr>
<td></td>
<td>Mental Health Evaluation: Crisis Assessment</td>
<td>8-3</td>
</tr>
<tr>
<td></td>
<td>Mental Health Crisis Intervention Techniques</td>
<td>8-5</td>
</tr>
<tr>
<td></td>
<td>Crisis Intervention Follow-Up and “Mental Health Alerts”</td>
<td>8-6</td>
</tr>
<tr>
<td>9</td>
<td>EMERGENCY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>9-1</td>
</tr>
<tr>
<td></td>
<td>Mental Health and Substance Abuse Emergency Care Plan</td>
<td>9-1</td>
</tr>
<tr>
<td></td>
<td>Emergency Mental Health Evaluations</td>
<td>9-3</td>
</tr>
<tr>
<td></td>
<td>Emergency Mental Health Placement</td>
<td>9-5</td>
</tr>
<tr>
<td></td>
<td>Emergency Substance Abuse Admissions</td>
<td>9-5</td>
</tr>
<tr>
<td>10</td>
<td>GLOSSARY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction to Glossary</td>
<td>10-1</td>
</tr>
<tr>
<td></td>
<td>The Glossary</td>
<td>10-1</td>
</tr>
<tr>
<td></td>
<td>Terms Specific to RSAT/RSAT Overlay Services in Designated DJJ Residential Commitment Programs</td>
<td>10-9</td>
</tr>
</tbody>
</table>

Updates Page
# Appendix

| A-1 | Authority for Evaluation and Treatment |
| A-2 | Guidelines for Obtaining Parental Signatures on the AET |
| B-1 | Clinical Psychotropic Progress Note |
| B-2 | Acknowledgement of Receipt of CPPN Form or Practitioner Form |
| C   | Parental Notification of Health-Related Care |
| D   | Youth Consent for Substance Abuse Treatment in RSAT or RSAT Overlay Services Programs |
| E   | Sample, Youth Consent for Substance Abuse Treatment |
| F   | Sample, Youth Consent for Release of Substance Abuse Treatment Records |
| G   | Sample, Mental Health/Substance Abuse Referral Summary |
| H   | Sample, Initial Mental Health/Substance Abuse Treatment Plan |
| I-1 | Sample, Individualized Mental Health/Substance Abuse Treatment Plan |
| I-2 | Sample, Individualized Mental Health/Substance Abuse Treatment Plan Review |
| J   | Sample, Counseling/Therapy Progress Note |
| K   | Sample, Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log |
| L-1 | MAYSI-2 Questionnaire |
| L-2 | PACT Pre-Screen |
| L-3 | PACT Full Assessment |
| L-4 | PACT Mental Health and Substance Abuse Screening Report and Referral |
| M-1 | SAMH-2 |
| M-2 | SAMH-3 |
| N   | DJJ Suicide Risk Screening Instrument (SRSI) |
| O   | Suicide Risk Screening Parent/Guardian Notification |
| P   | Assessment of Suicide Risk |
| Q   | Follow-Up Assessment of Suicide Risk |
| R   | Suicide Precautions – Observation Log |
| S-1 | Sample, Close Supervision – Visual Checks Log |
| S-2 | Sample, Mental Health Alert Observation Log |
| T-1 | Health Status Checklist |
| T-2 | Male Body Chart |
| T-3 | Female Body Chart |
| U   | Sample, Mental Health/Substance Abuse On-Site Tracking Log |
| V   | Mental Health/Substance Abuse Treatment Discharge Summary |
| W   | General Information Regarding Specialized Treatment Services in DJJ Residential Commitment Programs |
CHAPTER 1
INTRODUCTION

I. PURPOSE

This manual provides policy and interpretive guidelines for the delivery of mental health and substance abuse services in Department of Juvenile Justice (hereinafter referred to as the “Department” or “DJJ”) detention centers, residential commitment programs and day treatment programs. The purpose of this manual is embodied in the following three goals:

The first goal of this manual is to address the requirements of law for mental health and substance abuse services in departmental facilities and programs. Since DJJ looks to Florida law for its authority, applicable Florida Statutes have been the starting point for articulating guidelines for mental health and substance abuse services. This manual conforms to the requirements of law by addressing the components of mental health and substance abuse services required by law. They are: 1) Mental health and substance abuse screening; 2) Comprehensive mental health and substance abuse assessment and evaluation, when a need is indicated by screening; 3) Access to mental health and substance abuse treatment services; 4) Specialized mental health treatment such as sex offender therapy; 5) Suicide Prevention; 6) Crisis intervention and, 7) Emergency care.

The second goal of this manual is to facilitate the provision of necessary and appropriate mental health and substance abuse services to youths in DJJ facilities in need of such services within limited budget resources. DJJ facilities are not primarily mental health or substance abuse facilities, yet youths’ mental health and substance abuse treatment needs must be met within limited budget resources. This manual addresses these goals by focusing high priority on mental health and substance abuse screening and assessment and diagnostic evaluation using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revised (DSM-IV-TR) which is a mental health and substance abuse disorders classification system, to identify the youths in the general DJJ population who have, or are at high risk of, serious emotional disturbance, mental illness or substance abuse impairment. The manual also addresses the acute situations of suicide prevention, crisis intervention, and emergency care. The progressive stages of screening, evaluation and treatment maximize resources where they are needed most for the youths at each stage who indicate more evaluation or treatment is needed. One additional advantage of this staged process is that youths can be identified at the earliest point whose mental health or substance abuse impairment requires referral to a specialty facility.

The final goal of this manual is to provide a resource that assists in establishing mental health and substance abuse services within the DJJ continuum which promote public safety, are culturally sensitive, are provided in the least restrictive manner feasible and are accessible to youths in need of such services within budget limitations.
II. AUTHORITY

Florida Statutes 985.404; 985.224; 985.21; 985.229; 985.308; 985.31; 985.311; 393.11; 394.463; 394.467; 394.4784; 394.9082; 394.495; 397.675; 397.705; 397.706; 397.93; 397.951.

The primary sources of authority for the standards and policy set forth in this manual are:

Section 985.404(3), F.S. which provides in part: “The Department shall develop or contract for diversified and innovative programs to provide rehabilitative treatment, including…diagnostic and classification assessments, individual and family counseling…community-based substance abuse treatment services, community-based mental health treatment services, community-based residential and non-residential programs…”

Section 985.21(1)(a)4. F.S., which provides in part: “In addition to duties specified in other sections and through other departmental rules, the assigned juvenile probation officer shall be responsible for:

c. Performing the preliminary screening and making referrals for comprehensive assessment regarding the child’s need for substance abuse treatment services, mental health services, retardation services, literacy services or other educational or treatment services…

e. Making recommendations for services and facilitating the delivery of those services to the child, including any mental health services, educational services, family counseling services, family assistance services and substance abuse services…”

Section 985.308(2)&(4), F.S., “Juvenile sexual offender commitment programs; sexual abuse intervention networks” which provide: “Contingent upon a specific appropriation, the Department shall implement and operate programs to provide intensive educational and psychological services and other treatment to juvenile sexual offenders. The program shall include educational components, life management training, substance abuse treatment, and intensive psychological treatment provided by appropriate mental health professionals. Juvenile sex offenders shall be required to participate in all programs and treatment.”

Chapter 394, The Florida Mental Health Act

Chapter 397, The Hal S. Marchman Alcohol and Other Drug Services Act of 1993

Section 409.906 Optional Medicaid Services

Rule 65D-30.003(15) Florida Administrative Code
III. SCOPE

This manual applies to all DJJ detention centers, residential commitment programs at the low, moderate, high and maximum risk restrictiveness levels and day treatment programs. The manual also applies to Probation intake/detention screening processes and entities (Juvenile Probation Officer Units and Juvenile Assessment Centers in which preliminary mental health and substance abuse screening is conducted). Information provided in this manual which is applicable only to a detention center, residential commitment program or day treatment program will be so specified. This manual is intended to assist superintendents/program directors, clinicians, direct care staff and persons who are in any way involved in the intake, supervision and care of youths in applicable facilities and programs.

For purposes of this manual, a detention center is a facility used, pending adjudication or disposition, for the temporary care of a youth alleged or found to have committed a violation of law. A residential commitment program is defined as a treatment program operated or contracted by the Department for committed youths which provides 24-hour-a-day custody, care and supervision. A day treatment program is a probation program designed for youths who represent a minimum risk to themselves and public safety and do not require placement and services in a residential setting. These facilities, both state and privately operated, must adhere to the policies and provisions set forth in this manual.

This manual provides the Department's minimum requirements for delivery of mental health and substance abuse services. The provisions in the manual may be expanded upon to meet facility or program needs for mental health or substance abuse services which exceed the Department's minimum requirements, but the minimum requirements set forth in this manual cannot be reduced or weakened. Exemptions to any provision of this manual may only be authorized upon written approval from the Deputy Secretary. Requests for exemptions must be submitted in writing through the appropriate Juvenile Justice Assistant Secretary and must include, but not be limited to the following:

1. The provision(s) of the manual for which the exemption is being requested;
2. The justification for the exemption;
3. The proposed alternative provision; and
4. The time period for which the exemption is requested.

No exemption, unless otherwise specified in the written approval, shall extend more than one year from the date it was granted. Therefore, continuation of an exemption past one year shall require re-approval of the exemption request.
IV. LEGISLATIVE INTENT

In Section 985.02, F.S., the expression of the legislative intent for the juvenile justice system includes the following:

1. General Protections for Children:
   - Protection from abuse, neglect, and exploitation.
   - Effective treatment to address physical, social and emotional needs, regardless of geographic location.
   - Access to preventive services.
   - Gender-specific programming and gender-specific program models and services that comprehensively address the needs of a target gender group.

2. Substance Abuse Services: The delinquency system must have the ability to identify and provide appropriate intervention and treatment for children with personal or family-related substance abuse problems.

3. Juvenile Justice and Delinquency Prevention: Detention care, in addition to providing secure and safe custody, will promote the health and well-being of the children committed thereto and provide an environment which fosters their social, emotional, intellectual and physical development.

4. Serious or Habitual Juvenile Offenders: The Legislature finds that fighting crime effectively requires a multipronged effort focusing on particular classes of delinquent children, specifically, serious or habitual offenders and youths whose delinquent behavior is due to or connected with illicit substance abuse, and the development of particular programs. (Section 985.31, F.S. states that the serious or habitual juvenile offender program shall include diagnostic evaluation services; appropriate treatment modalities, including substance abuse intervention, mental health services, sexual behavior dysfunction interventions and gang related behavior interventions).

5. Gender-Specific Programming: The Legislature finds that the prevention, treatment, and rehabilitation needs of youth served by the juvenile justice system are gender-specific. Gender-specific programming refers to unique programs models and services that comprehensively address the needs of a targeted gender group. Gender-specific services require the adherence to the principle of equity to ensure that the different interests of young women and men are recognized and varying needs are met, with equality as the desired outcome.

Section 985.308(1)&(4), F.S., further states that "it is the intent of the Legislature to establish programs and strategies to effectively respond to juvenile sexual offenders." and "The program shall include educational components, life management training, substance abuse treatment, and intensive psychological treatment provided by appropriate mental health professionals."
V. MISSION AND PHILOSOPHY

The Department’s mission is: To protect the public by reducing juvenile crime and delinquency in Florida.

Because some juveniles’ capacity to change their delinquent behavior may be impaired due to mental health and substance related disorders the Department’s mission to reduce juvenile crime and delinquency must include the provision of necessary and appropriate mental health and substance abuse services to those youths through the establishment of mental health and substance abuse delivery systems which are efficient and effective.

VI. TARGET POPULATION FOR MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Within the general DJJ population there will be needs for mental health and substance abuse services for conditions ranging from acute emotional distress to chronic mental illness or substance abuse impairment. Through standardized screening procedures and utilization of the established evaluation criteria contained in the DSM-IV-TR, there are uniform methods of identifying youths with mental and substance related disorders and procedures for determining the severity of their condition. With limited resources, it is important to understand that there is a subset of youth in DJJ facilities with emotional disturbance, mental illness or substance abuse impairment and priority should be given to identifying, evaluating, and securing treatment for these youths.

The target population for mental health and substance abuse services is youth who have serious emotional disturbance, mental illness or substance abuse impairment and substantial functional limitations, or have emotional disturbance as follows:

- A youth enrolled in a special education program for the seriously emotionally disturbed or emotionally handicapped or
- A youth with a DSM-IV-TR diagnosis of schizophrenic disorder, major depression or bipolar disorder; or
- A youth with another DSM-IV-TR diagnosis and a score of 60 or below on the Axis V, Global Assessment of Functioning (GAF) Scale or Children’s Global Assessment Scale (CGAS); or
- A youth with co-occurring DSM-IV-TR mental health disorder and substance-related disorder and a score of 60 or below on the Axis V, Global Assessment of Functioning (GAF) Scale or Children’s Global Assessment Scale (CGAS); or
- A youth with a DSM-IV-TR mental health disorder and co-existing developmental disability and a score of 60 or below on the Axis V, Global Assessment of Functioning (GAF) Scale or Children’s Global Assessment Scale (CGAS); or
- A youth with a DSM-IV-TR diagnosis who does not have significant functional limitations, but without treatment is high risk for reduced functional ability; or
- A youth experiencing acute emotional distress or an emotional crisis.
The *DSM-IV-TR*, or subsequent revisions, will be the standard reference in evaluating the presence of mental disorder or substance related disorders.

## UPDATE

### VII. SERVICES FOR YOUTHS WITH DEVELOMENATIONAL DISABILITIES

There is a small subset of DJJ youths with mental retardation or developmental disability.

Under Florida law, a “developmental disability” means a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida or Prader Willi syndrome and that constitutes a substantial handicap that can be expected to continue indefinitely, and “retardation” means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the period from conception to age 18 (see Section 393.063(10) and Section 393.063(38) F.S.).

Within the context of this Manual, the term “developmental disability” is used interchangeably with the term “mental retardation”.

Because of their cognitive limitations, youths with developmental disabilities are likely to have difficulty understanding rules, following directions and adapting in the correctional setting. They are also vulnerable to exploitation and abuse by other youths. Early identification of youths who have developmental disability is critical to providing appropriate care and access to needed services.

Staff must be cognizant of information and behaviors which suggest developmental disability such as:

1. A psychological or mental health evaluation indicates an IQ below 70.
2. School records indicate exceptional education classes, particularly Educable Mentally Handicapped (EMH) classes, Trainable Mentally Handicapped (TMH) classes or Profoundly Mentally Handicapped (PMH) classes;
3. The youth has difficulty understanding and answering questions;
4. The youth has difficulty understanding and following directions; or
5. The youth’s abilities appear far below other youths his/her age.

**Note:** Youths classified by the school system or psychological testing as Profoundly Mentally Handicapped (PMH) or Trainable Mentally Handicapped (TMH) must be immediately brought to the attention of the facility superintendent/program director or designee and placed on constant supervision. (See “Severe Developmental Disability” paragraph below.)

Youths identified as possibly developmentally disabled must be brought to the attention of the facility superintendent/program director or designee and referred to mental health staff to determine the youth’s cognitive functioning, safety or security risks and treatment needs.

Severe Developmental Disability: Youths identified as possibly having severe developmental disability must be immediately brought to the attention of the facility superintendent/program director or designee and placed on constant supervision in the DJJ facility or program until mental health clinical staff determine the youth’s cognitive functioning, safety or security risks, supervision needs and treatment needs. Youths identified as possibly having a severe developmental disability
must also be brought to the attention of the DJJ regional counsel to determine whether the youth meets eligibility criteria for involuntary admission to developmental disability residential services under Section 393.11 F.S., or eligibility criteria for incompetent to proceed under Section 985.223 F.S.

Severe developmental disability is suggested when, because of mental retardation, the youth:
- Lacks basic survival and self-care skills;
- Is dependent on others to assist with personal care;
- Is at risk of harm to self or others.

Youths determined by mental health staff to be developmentally disabled who will continue in DJJ custody must be referred to the facility/program treatment team for an individualized mental health treatment plan with behavior oriented goals. Youths who are transitioning to the community should be referred to the Agency for Persons with Disabilities for appropriate developmental disability services.

### VIII. GUIDING PRINCIPLES

The guiding principles in providing mental health and substance abuse services in DJJ facilities are:

1. Youths experiencing acute or chronic mental disorder(s) or substance abuse impairment should be provided timely treatment performed by qualified persons, in an appropriate setting, according to prevailing professional standards. Timely treatment means there is no undue delay of treatment for relief of the youth’s distress or control of his/her symptoms consistent with prevailing professional practices.

2. In managing and treating youths with mental disorder or substance abuse impairment, the least restrictive alternative, taking into consideration both effective treatment of the youth’s mental health or substance related conditions and public safety, should be employed to address the presenting problem whenever possible. The least restrictive alternative means the treatment and conditions of treatment which, separately and in combination, are no more intrusive or restrictive of freedom than reasonably necessary to achieve a substantial therapeutic benefit or to protect the youth or others from physical injury.

3. Mental health and substance abuse records and information must be maintained in a confidential manner according to state and federal law and professional standards.

4. Maintaining timely, accurate, and thorough record-keeping or documentation of mental health and substance abuse services and treatment enhances the quality of care and ensures continuity of care in departmental facilities and programs.

5. Each youth who is receiving ongoing mental health and/or substance abuse treatment must have an individualized mental health and/or substance abuse treatment plan.

6. Cultural, ethnic, racial and gender influences or concerns should be considered in all aspects of mental health and substance abuse screening, assessment and treatment planning. In other words, the individual’s needs should be considered within the context of his or her gender,
sexual orientation, culture, race and ethnic background. Gender specific services (e.g., treatments, interventions, approaches) that address the unique needs, strengths and risk factors of girls and boys and foster positive gender identity development should be incorporated into mental health and substance abuse services provided to girls and boys in Departmental facilities and programs.

IX. YOUTH RIGHTS

Each youth’s individual rights and dignity shall be respected and protected as prescribed by law and as set forth in DJJ policy 1100 entitled “Rights of Youths in DJJ Care, Custody or Supervision”. The Department’s expectations for officers, staff and contracted providers are as follows:

In addition to respect for all human rights prescribed by law, the following should be considered to be the expectations of this Agency in regards to our professional interactions with the youth we serve.

We recognize that every officer, staff member, employee and contracted provider has an obligation to serve as a role model to youth by his or her deportment and conduct. Having an obligation to show the youth the way we would like them to behave, we must in turn model this behavior. This means that:

- We will, at all times, use appropriate language when speaking to or in the presence of youth.
- We will always strive to speak in a calm and respectful tone towards and around youth.
- We will never be deliberately confrontational with youth, unless warranted therapeutically or programmatically.
- We will always use appropriate counseling and intervention techniques before resorting to physical force. Physical force (as defined in PAR) shall always be used as a last resort when all other options have been exhausted and safety is compromised.
- We will not make threatening statements to youth. We will explain options, alternatives, and consequences in a calm and professional manner. We will always strive to encourage positive and compliant behavior.
- Staff should help youth learn to make proper decisions for themselves.
- We will always strive to be respectful and courteous to fellow employees and towards youth in our care, even when we are faced with disrespectful conduct.
- We will always provide for their basic needs, including food, clothing, shelter, medical care and security. We will not, through inaction or inattention, allow these needs to remain unmet.
Chapter One describes the purpose, authority, scope, and legislative intent and guiding principles applicable to this manual.

Chapter Two, entitled “Administration and Management of Mental Health and Substance Abuse Services” discusses practices and procedures to ensure appropriate mental health and substance abuse services in DJJ facilities. The areas described in this chapter are mental health and substance abuse services components, qualifications of mental health and substance abuse clinical staff, administrative oversight, implementation and coordination of mental health and substance abuse services, and confidentiality of mental health and substance abuse information.

Chapter Three, entitled “Consent Requirements” discusses the Department’s general consent requirements applicable to mental health and substance abuse services and requirements unique to substance abuse services and mental health crisis intervention services.

Chapter Four, entitled “Mental Health and Substance Abuse Services Documentation and Records Management”, discusses the individual healthcare record (i.e., medical record), documentation of mental health and substance abuse treatment, the active mental health/substance abuse treatment file and mental health tracking logs and the health services statistical report. State and federal laws pertaining to confidentiality of mental health and substance abuse clinical records are also discussed.

Chapter Five, entitled “Mental Health and Substance Abuse Screening and Evaluation” describes mental health and substance abuse screening procedures at initial intake into the juvenile justice system and upon entry to departmental facilities. Comprehensive, in-depth mental health and substance abuse evaluations are described.

Chapter Six, entitled “Mental Health and Substance Abuse Treatment Planning and Implementation of Treatment Services” describes the individualized mental health/substance abuse treatment plan and provides a brief overview of mental health and substance abuse treatment techniques. Mental health and substance abuse transition planning is also discussed.

Chapter Seven, entitled “Suicide Prevention” details elements of an effective suicide prevention plan, suicide-risk screening and suicide risk assessment, levels of supervision, and the Suicide Precautions methods: Precautionary Observation and Secure Observation.

Chapter Eight, entitled “Mental Health Crisis Intervention” describes the basic elements of a crisis intervention plan, crisis assessments and mental health crisis intervention techniques.

Chapter Nine, entitled “Emergency Care” discusses the elements of a mental health/substance abuse emergency care plan, and the requirements of law regarding emergency mental health evaluations (involuntary examination), emergency mental health admissions (involuntary placement), and emergency substance abuse evaluations and admissions.

Chapter Ten, entitled “Glossary” contains definitions of terms applicable throughout this manual. Terms which may be unfamiliar to readers have been italicized, and are defined in Chapter Ten.
Forms Appendix, This manual contains both standardized forms and forms designated as “Samples”. Standardized forms are designed to be uniformly used in all detention centers, residential commitment programs and day treatment programs. Sample forms delineate the minimum elements required by the Department, but may be expanded or reformatted to meet facility or program needs. Any alternative form, at a minimum, must contain all the elements of the Sample form unless the Manual provides an exception for a specific Sample form.

XI. MANUAL UPDATE

This manual will be reviewed annually by the Department and updated as necessary to ensure compliance with applicable existing laws, rules and policies.
CHAPTER 2
ADMINISTRATION AND MANAGEMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

I. INTRODUCTION

This chapter describes the fundamentals of a mental health and substance abuse services delivery system. A mental health and substance abuse services delivery system, incorporated into the DJJ service continuum, must include: 1) A systematic program for mental health and substance abuse screening, both at initial intake and subsequent entry points into facilities or programs; 2) Access to appropriate mental health and substance abuse assessments and evaluations performed by mental health or substance abuse clinical staff with appropriate qualifications; 3) An ongoing program for the identification, assessment and supervision of youths who are potential suicide risks or with acute mental health or substance abuse service needs; 4) Access to timely treatment when necessary and appropriate, performed by qualified mental health or substance abuse clinical staff in accordance with professional standards; 5) The provision of an individualized, written mental health/substance abuse treatment plan, based on a comprehensive mental health or substance abuse evaluation; and 6) Transition planning.

Each facility superintendent or program director must ensure that an effective mental health and substance abuse services delivery system is put into place within his/her facility or program, and includes reporting to ComStat. In order to accomplish this goal, the facility superintendent or program director must have an understanding of the individual elements which constitute an effective mental health and substance abuse services delivery system.

The information provided below sets forth the structure for providing mental health and substance abuse services to youths in DJJ facilities or programs, and explains the elements involved in the structure.

II. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICE COMPONENTS

This section briefly outlines the basic components of a mental health and substance abuse services system in a DJJ facility or program. These components provide a systematic framework for identifying youths in need of mental health and/or substance abuse services, determining the existence and severity of a mental disorder or substance related disorder, and providing treatment appropriate for the needs of the youth.

A. SCREENING: Section 985.21(1)(a)4.c., Florida Statues, provides for preliminary screening and referral for comprehensive assessment to determine a youth’s need for mental health and/or substance abuse services. Preliminary screening conducted during the youth’s initial intake into the juvenile justice system includes screening for mental health and substance abuse problems. The juvenile probation officer is responsible for performing preliminary screening and making referrals for youths identified through screening for comprehensive assessment regarding their need for mental health services, substance abuse treatment services, retardation services, literacy services or other education and treatment services. Youths entering a detention center will also receive suicide risk screening and may receive additional screening based upon staff
observation. Youths entering a residential commitment program shall receive mental health and substance abuse screening and suicide risk screening to identify those who may have emotional disturbance, mental illness or substance abuse impairment or may be at risk of suicide or self-harm. The facility superintendent or program director is responsible for establishing procedures for a thorough review, at admission, of preliminary screening performed before the youth’s admission to the facility/program, and is further responsible for establishing procedures for administration of mental health/substance abuse screening and/or suicide risk screening of youths upon entry to the facility or program (See Chapter Five, “Mental Health and Substance Abuse Screening and Evaluation”).

B. COMPREHENSIVE ASSESSMENT AND COMPREHENSIVE EVALUATION SERVICES: Sections 985.21(1)(a)4, 985.229, 985.31(2)(a)1., and 985.311(2)(a)1. Florida Statutes, provide for “comprehensive assessments” and pre-disposition “comprehensive evaluations” to determine mental health or substance abuse needs.

Section 985.21(1)(a)4 states: “In addition to duties specified in other sections and through departmental rules, the assigned juvenile probation officer shall be responsible for … Performing the preliminary screening and making referrals for comprehensive assessment regarding the child’s need for substance abuse treatment services, mental health services, retardation services, literacy services, or other educational or treatment services”. Youths identified during preliminary screening as possibly having a mental health or substance abuse problem must be referred for a “comprehensive assessment” as specified in Section 985.21(1)(a)4., F.S. A “comprehensive assessment” is accomplished through administration of the Substance Abuse and Mental Health Assessment-2 (SAMH-2) and completion of the SAMH-3, or a Department approved equivalent instrument. Comprehensive Assessments must be completed within 10 calendar days of referral for detained youths and 14 calendar days for all other youths.

Section 985.229(1), Florida Statutes provides that a comprehensive evaluation for physical health, mental health, substance abuse, academic, educational or vocational problems shall be ordered for any child for whom a residential commitment disposition is anticipated or recommended by an officer of the court or by the Department. Thus, youths for whom a residential commitment disposition is anticipated or recommended must receive a predisposition “comprehensive evaluation” as specified in Section 985.229(1), F.S. A “comprehensive evaluation” for mental health problems must be conducted by a licensed mental health provider and a “comprehensive evaluation” for substance abuse problems must be conducted by a licensed substance abuse provider. The pre-disposition Comprehensive Evaluations must be conducted within 10 calendar days of referral.

C. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT: Sections 985.21(1)(a)(4), 985.31(2)(a)2. and 985.311(2)(a)2. Florida Statutes, provide for access to mental health and/or substance abuse services or treatment as warranted. All youth must have access to necessary mental health and substance abuse services (mental health and substance abuse assessments, crisis intervention and treatment). The facility superintendent or program director must ensure that newly admitted youths are given orientation to mental health and substance abuse treatment services and receive instructions as to how to access such services. The facility superintendent or program director must further ensure that youths have access to short-term and/or on-going mental health treatment or substance abuse treatment (as determined necessary by a qualified mental health or substance abuse clinical staff person) for relief of symptoms or control of symptoms associated with serious mental disorder or substance abuse. See Chapter Six, “Mental Health and Substance Treatment Planning and Implementation of Treatment Services”.

2-2 UPDATED APRIL 2007
D. **SEX OFFENDER TREATMENT SERVICES:** Section 985.308(4), Florida Statutes, provides for substance abuse treatment and intensive psychological treatment in juvenile sexual offender commitment programs. Youths in sexual offender commitment programs must receive mental health treatment specifically designed for juvenile sexual offenders as determined by recognized professional standards. The superintendent or director of a program contracted by the Department specifically for treatment of juvenile sexual offenders must ensure that the program includes intensive psychological treatment provided by qualified mental health professionals and sex offender therapy provided by juvenile sexual offender therapists. Juvenile sexual offender therapy within all DJJ facilities and programs must be provided by a person qualified to provide juvenile sexual offender therapy as specified in Section 490.0145 F.S., and Rule 64B19-18.0025 F.A.C., or Section 491.0144, F.S., and Rule 64B4-7.007 F.A.C. A non-licensed mental health clinical staff person may be employed by a program operated by, or under contract with, the Department of Juvenile Justice if the program employs a professional who is licensed under Chapter 458, Chapter 459, Section 490.0145 or Section 491.0144 who manages and supervises the treatment services performed by the mental health clinical staff person. (See Section 490.012(8) F.S., and Section 491.012(1)(n) F.S.).

E. **CRISIS INTERVENTION:** Section 985.02(1)(e), Florida Statutes, provides for effective treatment to address the physical, social and emotional needs of youths, regardless of geographical location. The well-being of youths who demonstrate acute emotional distress (e.g., extreme anxiety, fear, panic, paranoia, agitation, impulsivity, rage) or behavioral problems must be protected by implementing procedures designed to prevent injury to self or others, to safely assess the youth’s mental status, and provide mental health intervention when needed. The facility superintendent or program director must develop a written plan and facility operating procedures regarding crisis intervention which include procedures for mental health assessments and treatment (as needed) in response to crisis situations. The plan must address notification and reporting procedures for relating concerns about a youth’s mental status, referral for crisis assessment by, or under the supervision of, a licensed mental health professional, and administrative and clinical review (See Chapter Eight of this manual).

F. **SUICIDE PREVENTION:** Section 985.02(1)(e),(g), Florida Statutes, provides for effective treatment to address the physical, social and emotional needs of youths, and access to preventive services. The well-being of all youths in departmental facilities or programs must be protected by implementing procedures designed to prevent suicide and harm resulting from intentional self-injurious behavior. The facility superintendent or program director must develop a suicide prevention plan and facility operating procedures which ensure:

- Staff training in suicide prevention;
- Identification of “at risk” youths through screening and staff observation;
- Assessment of suicide risk by, or under the supervision of, a licensed mental health professional;
- Facility Suicide Precaution methods: Precautionary Observation and Secure Observation;
- Communication, Notification, Referral and Documentation procedures for relating concerns about suicidal behavior;
- Immediate Response to Suicide Attempt or Incident of Serious Self-inflicted Injury;
- Administrative and clinical review of Suicide Precautions processes and procedures; and
- Serious Suicide Attempt or Serious Self-Inflicted Injury Review and Mortality Review (See Chapter Seven, of this manual).

G. **EMERGENCY CARE:** Section 985.224(5), F.S., provides that “a child may be provided mental health, substance abuse or retardation services, in emergency situations pursuant to Chapter
393, 394 or 397, F.S., whichever is applicable.” The well-being of youths must be protected by effecting procedures designed to ensure that a prompt and effective response is made to emergency physical and psychological needs of youth with emotional disturbance, mental illness, or substance abuse impairment. The superintendent or program director is responsible for developing procedures which ensure immediate access to emergency services on a 24-hour a day basis (see DJJ “Health Services Manual”, for details of emergency medical care). Procedures specifically addressing mental health and substance abuse emergencies are discussed in Chapter Nine of this manual.

### III. QUALIFICATIONS OF MENTAL HEALTH AND SUBSTANCE ABUSE PROFESSIONALS

Professionals from several mental health disciplines evaluate and/or treat youths who have emotional and/or behavioral problems. Those who provide mental health services primarily are trained in psychiatry, psychology, counseling, marriage and family therapy and social work. As described below, there is a broad range of mental health or mental health-related occupations covered by professional licensure. Chapter 397, Florida Statutes addresses the licensure requirements for provision of substance abuse services. The primary purpose of licensure or certification is to protect the public. Licensing requirements are imposed to ensure that those licensed possess knowledge and skills in sufficient degree to perform important professional activities safely and effectively.

The facility superintendent or program director is responsible for ensuring that mental health and substance abuse services are provided by individuals with appropriate qualifications. The qualifications of licensed and non-licensed mental health clinical staff and substance abuse clinical staff providing mental health and substance abuse services within departmental facilities are described below:

#### A. LICENSURE OF MENTAL HEALTH PROFESSIONALS:

Mental health treatment must be provided by a licensed mental health professional or a non-licensed mental health clinical staff person who is working under the direct supervision of a licensed mental health professional. A licensed mental health professional means a psychiatrist licensed pursuant to Chapter 458 or 459, F.S., who is board certified in Child and Adolescent Psychiatry or Psychiatry by the American Board of Psychiatry and Neurology or has completed a training program in Psychiatry approved by the American Board of Psychiatry and Neurology for entrance into its certifying examination, a psychologist licensed pursuant to Chapter 490, F.S., a mental health counselor, clinical social worker or marriage and family therapist licensed pursuant to Chapter 491, F.S., or a psychiatric nurse as defined in Section 394.455(23), Florida Statutes.

The qualifications of licensed mental health professionals are as follows:

1. **Psychiatrists:** A licensed psychiatrist is a physician licensed pursuant to Chapter 458 or 459, F.S. who is board certified in Child and Adolescent Psychiatry or Psychiatry by the American Board of Psychiatry and Neurology, or has completed a training program in Psychiatry approved by the American Board of Psychiatry and Neurology for entrance into its certifying examination. A psychiatrist who is board certified in Forensic Psychiatry by the American Board of Psychiatry and Neurology or the American Board of Forensic Psychiatry may provide services in DJJ facilities or programs, but must have prior experience and training in psychiatric treatment with children or adolescents. The practice of psychiatry generally encompasses diagnostic interview and examination which may include ordering and medical interpretation of laboratory or other medical diagnostic studies, medical diagnostic evaluation, supportive therapy, and pharmacological management which includes prescription, monitoring and review of psychotropic medication.
2. **Psychologists:** A licensed psychologist is a person licensed pursuant to section 490.005(1), F.S., or section 490.006 Florida Statutes. The practice of psychology as defined by statute is the observation, description, evaluation, interpretation and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health. The practice of psychology includes but is not limited to psychological testing and the evaluation or assessment of personal characteristics, all forms of psychotherapy, and use of psychological methods to diagnose and treat mental, nervous, psychological, or emotional disorders, alcoholism and substance abuse.

3. **Mental Health Counselors:** A licensed mental health counselor is a person licensed pursuant to Chapter 491, F.S. to provide mental health counseling. The practice of mental health counseling as defined by statute is the use of scientific and applied behavioral science theories, methods and techniques for the purpose of describing, preventing and treating undesirable behavior and enhancing mental health and human development. Such practice includes the use of methods of a psychological nature to evaluate, assess, diagnose and treat emotional and mental dysfunctions or disorders whether cognitive, affective or behavioral; behavioral disorders, interpersonal relationships, sexual dysfunction, alcoholism and substance abuse.

4. **Clinical Social Workers:** A licensed clinical social worker is a person licensed pursuant to Chapter 491, F.S. to practice clinical social work. The practice of clinical social work as defined by statute is the use of scientific and applied knowledge, theories, and methods for the purpose of describing, preventing, evaluating and treating individual, couple, marital, family or group behavior, based on the person-in-situation perspective of psychosocial development, normal and abnormal behavior, psychopathology, unconscious motivation, interpersonal relationships, environmental stress, differential assessment, differential planning and data gathering. Such practices may include the use of methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorder and dysfunction, whether cognitive, affective or behavioral, sexual dysfunction, behavioral disorders, alcoholism or substance abuse.

5. **Marriage and Family Therapists:** A licensed marriage and family therapist is a person licensed pursuant to Chapter 491, F.S., to practice marriage and family therapy. The practice of marriage and family therapy as defined by statute is the use of scientific and applied marriage and family theories, methods and procedures for the purpose of describing, evaluating, and modifying marital, family and individual behavior. Such practice includes the use of methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders or dysfunction, whether cognitive, affective or behavioral; sexual dysfunction; behavioral disorders; alcoholism and substance abuse.

6. **Psychiatric Nurses:** A psychiatric nurse as defined by Section 394.455(23) is a licensed registered nurse who has a master's degree or a doctorate in psychiatric nursing and two years post-master's clinical experience under the supervision of a physician. A licensed and certified psychiatric advanced registered nurse practitioner (ARNP) under Chapter 464, F.S., with a master's degree or doctorate in psychiatric nursing or mental health nursing and two years post-master's clinical experience under the supervision of a physician would meet this definition.

- Verification of the **licensed mental health professional’s** Florida license is required prior to providing services to DJJ youths. The mental health professional’s license number and a copy of an up-to-date license document must be on file in the facility and in the DJJ contract manager’s office. Verification of healthcare professionals’
Florida licensure and certification can be accomplished by accessing Medical Quality Assurance (MQA) Services at the Florida Department of Health website: http://www.doh.state.fl.us/

B. LICENSURE OF SUBSTANCE ABUSE PROFESSIONALS: Chapter 397, Florida Statutes and Rule 65D-30.003(15), Florida Administrative Code provide the conditions for delivery of substance abuse services in DJJ detention and commitment facilities. Rule 65D-30.003(15) states the following:

“Licensing of Department of Juvenile Justice Commitment Programs and Detention Facilities. In those instances where substance abuse services are provided within Juvenile Justice Commitment programs and detention facilities, such services may be provided in accordance with any one of the four conditions described below.

c. The services must be provided in a facility that is licensed under Chapter 397, F.S., for the appropriate licensable service component as defined in subsection 65D-30.002(16), F.A.C.

d. The services must be provided by employees of a service provider licensed under Chapter 397.

e. The services must be provided by employees of the commitment program or detention facility who are qualified professionals licensed under Chapters 458, 459, 490 or 491, F.S.

f. The services must be provided by an individual who is an independent contractor who is licensed under Chapters 458, 459, 490, or 491, F.S.”

Thus, substance abuse services must be provided by employees of a service provider licensed under Chapter 397, F.S., or in a facility licensed under Chapter 397, F.S., [as specified in condition (a) or (b) of Rule 65D-30.003(15) F.A.C.] or by a qualified professional licensed under Chapter 458, 459, 490 or 491, F.S., (a physician licensed pursuant to Chapter 458 or 459; a psychologist licensed pursuant to Chapter 490; or a mental health counselor, clinical social worker or marriage and family therapist licensed pursuant to Chapter 491) [as specified in condition (c) or (d) of Rule 65D-30.003(15) F.A.C.]

• Verification of the facility’s license under Chapter 397, a qualified professional's license under Chapter 458, 459, 490 or 491, F.S., or service provider’s license under Chapter 397, Florida Statutes is required prior to providing services to DJJ youths. The license number, and a copy of the up-to-date licensure document must be on file in the facility or program and in the DJJ contract manager’s office. A copy of the certified addiction professional’s (CAP) Florida certification must also be on file in the facility or program and in the DJJ contract manager’s office.

C. REQUIREMENTS FOR MENTAL HEALTH CLINICAL STAFF AND SUBSTANCE ABUSE CLINICAL STAFF: The Department requires that mental health clinical staff and substance abuse clinical staff, if not otherwise licensed, must have, at a minimum, a Bachelor's degree from an accredited university or college with a major in psychology, social work, counseling or a related human services field. Related human services field is one in which major course work includes the study of human behavior and development, counseling and interviewing techniques, and individual, group or family therapy.
1. Mental Health Clinical Staff

a. A non-licensed mental health clinical staff person providing mental health services in a DJJ facility or program must meet one of the following qualifications:

(1) Hold a master’s degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field;

(2) Hold a bachelor’s degree from an accredited university or college in the field of counseling, social work, psychology or related human services field and have two years experience working with (e.g., assessing, counseling, treating) youths with serious emotional disturbance or substance abuse problems; or

(3) Hold a bachelor’s degree from an accredited university or college in the field of counseling, social work, psychology or related human services field and have 52 hours of pre-service training in the areas described below prior to working with youths. The 52 hours of pre-service training must include a minimum of 16 hours of documented training in their duties and responsibilities. When pre-service training has been successfully completed, the non-licensed person may begin working with youths, but must receive training for one year by a mental health staff person who holds a Master’s degree. (Note: See (b) below for training requirements for non-licensed mental health clinical staff providing mental health services under Medicaid).

(a) Pre-service training must cover, at a minimum, the following components: basic counseling skills, basic group skills, program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development and typical behavior problems.

(b) A non-licensed mental health clinical staff person holding a bachelor’s degree who provides mental health services in a DJJ facility or program designated for Medicaid behavioral health overlay services (BHOS) or Medicaid fee-for-service must meet the specific education and training requirements for bachelors level counselors or bachelors level practitioners set forth by the Agency for Health Care Administration (AHCA) in the Community Behavioral Health Services Coverage and Limitations Handbook and must meet applicable training requirements in DJJ policy, contract or subcontract.

b. A non-licensed mental health clinical staff person must work under the direct supervision of a licensed mental health professional.

c. A mental health clinical staff person (whether licensed or non-licensed) must provide services within the scope of their training and competence and within the purview of statutes applicable to their respective profession.

2. Substance Abuse Clinical Staff

a. A non-licensed substance abuse clinical staff person may provide substance abuse services in a DJJ facility or program only as an employee of a service provider licensed under Chapter 397 or in facility licensed under Chapter 397, Florida Statutes. The non-licensed substance abuse clinical staff person must have, at a minimum, a Bachelor’s degree from an accredited university or college with a major in psychology, social work, counseling or a related human services field and meet the training requirements provided in Chapter 65D-30, F.A.C.
b. A non-licensed substance abuse clinical staff person who is carrying out substance abuse treatment in a departmental facility licensed under Chapter 397 or as an employee of a service provider licensed under Chapter 397 must be working under the direct supervision of a qualified professional as defined in Section 397.311(25), Florida Statutes. A qualified professional under Section 397.311(25) means a physician licensed under chapter 458 or chapter 459, a professional licensed under chapter 490 or 491, or a person who is certified through a DCF recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor’s degree.

- Verification of the non-licensed mental health clinical staff person’s or non-licensed substance abuse clinical staff person’s educational background is required prior to providing services to DJJ youths. A copy of a college diploma and college transcript must be on file in the facility or program and in the DJJ contract manager’s office, unless the clinical staff person has an intern registration or provisional license under Chapter 490 or Chapter 491. A copy of the clinical staff person’s intern registration or provisional license must be on file in the facility or program and in the DJJ contract manager’s office.

D. CLINICAL SUPERVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE CLINICAL STAFF: Clinical supervisors must assure that clinical staff working under their supervision are performing services that they are qualified to provide based on education, training and experience.

1. A non-licensed mental health clinical staff person who is carrying out mental health treatment in a departmental facility or program must be working under the direct supervision of a licensed mental health professional (as permitted by law within his/her State of Florida licensure) employed by, or under contract with the departmental facility or program. (See Section 394.495(3)(c), Florida Statutes).

2. A non-licensed substance abuse clinical staff person who is carrying out substance abuse treatment in a departmental facility licensed under Chapter 397 or as an employee of a service provider licensed under Chapter 397 must be working under the direct supervision of a qualified professional as defined in Section 397.311(25), Florida Statutes. A qualified professional under Section 397.311(25) means a physician licensed under chapter 458 or chapter 459, a professional licensed under chapter 490 or 491, or a person who is certified through a DCF recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor’s degree.

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3. The licensed mental health professional providing direct supervision is responsible for reviewing and signing “as reviewer” assessments, evaluations (e.g., Comprehensive Assessments, Comprehensive Mental Health Evaluation, Assessment of Suicide Risk), mental health treatment plans, progress summaries and treatment discharge summaries prepared by the non-licensed mental health clinical staff person.

4. The “qualified professional” as defined in Section 397.311(25) providing direct supervision, in a departmental facility licensed under Chapter 397 or as an employee of a service provider licensed under Chapter 397, is responsible for reviewing and signing “as reviewer” assessments, evaluations (e.g., Comprehensive Assessments, Comprehensive Substance
Abuse Evaluation), substance abuse treatment plans, progress summaries and treatment discharge summaries prepared by the non-licensed substance abuse clinical staff person.

5. **Direct supervision** means that the licensed mental health professional or qualified professional as defined in Section 397.311(25), F.S., has at least one hour per week of on-site face-to-face interaction with the non-licensed or non-certified individual for the purpose of overseeing and directing (as permitted by law within his or her State of Florida licensure or certification) the mental health treatment or substance abuse treatment that the non-licensed individual is providing in the facility.

   a. **Direct supervision** must be documented in a format which provides a summary of the directions, instructions and recommendations made by the licensed professional regarding the services provided by the non-licensed clinical staff person. Direct supervision documentation must also indicate that the licensed person has reviewed a representative sample of the non-licensed clinical staff person’s treatment or summary notes. (see sample direct supervision log, Appendix K)

   b. Direct supervision sessions for each non-licensed mental health clinical staff person or non-licensed substance abuse clinical staff person may be provided individually or in a group format.

E. **QUALIFICATIONS TO PERFORM SPECIFIC MENTAL HEALTH OR SUBSTANCE ABUSE SERVICES IN DEPARTMENTAL FACILITIES/PROGRAMS:** The qualifications for performing the following services are:

1. **Mental Health or Substance Abuse Screening:** There are no specific professional qualifications for individuals administering initial, intake mental health or substance abuse screenings. However, each individual responsible for administering mental health and substance abuse screening in a DJJ facility or program must be trained on administration of the DJJ approved screening instruments utilized in the DJJ facility or program (i.e., Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), Positive Achievement Change Tool (PACT) and DJJ Suicide Risk Screening Instrument).

   a. Individuals who are to administer the MAYSI-2 or PACT in DJJ facilities or programs are required to successfully complete Departmental training prior to commencing administering the MAYSI-2 or PACT.

   b. Individuals who are to administer the DJJ Suicide Risk Screening Instrument in DJJ facilities or programs are required to successfully complete the Department’s training curriculum for suicide risk screening prior to commencing administering the DJJ Suicide Risk Screening Instrument.

2. **Clinical Mental Health Screening and Clinical Substance Abuse Screening in Residential Commitment Programs:**

   If Clinical Mental Health and Clinical Substance Abuse Screening are to be administered as an alternative to the MAYSI-2 in residential commitment programs, such clinical mental health screening must be conducted by a licensed mental health professional and such clinical substance abuse screening must be conducted by a “qualified professional” as defined in Section 397.311(25) F.S.

3. **Comprehensive Mental Health Evaluations:** Must be conducted by a licensed mental health professional or a non-licensed mental health clinical staff person who is working under
the *direct supervision* of a *licensed mental health professional* (as permitted by law within his or her state licensure).

4. **Comprehensive Substance Abuse Evaluations**: Must be provided by a qualified professional licensed under Chapter 458, 459, 490 or 491, F.S., or a *substance abuse clinical staff person* who is an employee of a service provider licensed under Chapter 397 or a *substance abuse clinical staff person* who is an employee in a facility licensed under Chapter 397, Florida Statutes (in accordance with Rule 65D-30.003(15) FAC). A non-licensed/non-certified *substance abuse clinical staff person* employed by a service provider or facility licensed under Chapter 397 must work under the *direct supervision* of a qualified professional as defined in Section 397.311(25), Florida Statutes.

5. **Mental Health and Substance Abuse Treatment Services (e.g., counseling, therapy, psychosocial and psychoeducational skills training)**: Mental health treatment services must be provided by a *licensed mental health professional*, or a *mental health clinical staff person* who is working under the direct supervision of a *licensed mental health professional*. Substance abuse treatment services must be provided by a qualified professional licensed under Chapter 458, 459, 490 or 491, F.S., or a *substance abuse clinical staff person* employed by a service provider licensed under Chapter 397 or employed in a facility licensed under Chapter 397, Florida Statutes. A non-licensed/non-certified *substance abuse clinical staff person* employed by a service provider or facility licensed under Chapter 397 must work under the direct supervision of a *qualified professional* as defined in Section 397.311(25), Florida Statutes.

6. **Juvenile Sexual Offender Therapy**: Must be conducted by a licensed psychologist meeting the requirements of Section 490.0145, F.S., and Rule 64B19-18.0025 F.A.C., or a licensed mental health counselor, clinical social worker or marriage and family therapist meeting the requirements of Section 491.0144, F.S., and Rule 64B4-7.007 F.A.C., for the practice of *juvenile sexual offender therapy*. A non-licensed *mental health clinical staff person* may be employed by a program operated by, or under contract with, the Department of Juvenile Justice if the program employs a professional who is licensed under Chapter 458, Chapter 459, Section 490.0145 or Section 491.0144 who manages and supervises the treatment services performed by the *mental health clinical staff person*. (See Section 490.012(8) F.S., and Section 491.012(1)(n) F.S.).

7. **Psychopharmacological Therapy**: Psychotropic medication must be prescribed by a licensed psychiatrist or a psychiatric advanced registered nurse practitioner (psychiatric ARNP) working under the clinical supervision of a licensed psychiatrist. Within the context of this Manual, a licensed psychiatrist is a physician licensed pursuant to Chapter 458 or 459, F.S., who is board certified in Child and Adolescent Psychiatry or Psychiatry by the American Board of Psychiatry and Neurology or has completed a training program in Psychiatry. A detailed account of psychotropic medication management in departmental facilities is provided in Chapter 12 of the Revised DJJ Health Services Manual.
F. BACKGROUND SCREENING OF MENTAL HEALTH AND SUBSTANCE ABUSE CLINICAL STAFF: The employment screening required under Section 985.01 shall be provided for all mental health and substance abuse clinical staff employed or contracted to provide services in DJJ facilities and programs.

IV. ADMINISTRATION, IMPLEMENTATION AND COORDINATION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Responsibility for the overall welfare of youths in departmental facilities rests with the facility superintendent or program director. He or she is responsible for ensuring that youths have access to and receive necessary and appropriate mental health and substance abuse services. The essential components of a mental health and substance abuse delivery system have been discussed as well as the credentials and qualifications of mental health and substance abuse clinical staff.

This section discusses the administrative processes involved in implementing mental health and substance abuse services into the operations of the facility or program.

A. ARRANGEMENTS FOR MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

1. The superintendent or program director is responsible and accountable for ensuring that qualified mental health and substance abuse clinical staff are accessible to youths in the facility or program. This may be accomplished by retaining licensed mental health/substance abuse staff who have the professional credentials to independently provide mental health or substance abuse services in the facility or program, or by developing partnerships or arrangements with mental health and substance abuse providers whereby mental health and/or substance abuse services may be provided on an “as needed” basis either on-site or off-site of the facility or program.

2. A mental health provider must be a public mental health agency licensed by the state, a private for-profit or not-for-profit mental health agency, a psychiatrist licensed under Chapter 458 or 459, a psychologist licensed under Chapter 490, or a mental health counselor, clinical social worker, or marriage and family therapist licensed under Chapter 491, F.S., or a service provider (agency or corporate entity) determined to be eligible to provide mental health services under Chapter 394 F.S., and Chapter 409 F.S.

3. A substance abuse service provider must be a public agency, a private for-profit or not-for-profit agency, a person who is a private practitioner, or a hospital, which agency, person, or hospital is licensed under Chapter 397, F.S., or exempt from licensure under Chapter 397, F.S. This includes a physician licensed under Chapter 458 or 459, F.S., a psychologist licensed under Chapter 490, F.S., or a clinical social worker, marriage and family therapist or mental health counselor licensed under Chapter 491, F.S.

B. RETAINING A DESIGNATED MENTAL HEALTH AUTHORITY OR CLINICAL COORDINATOR

The facility superintendent or program director is ultimately responsible for the administrative oversight and management of mental health and substance abuse services in the facility or program. Because mental health and substance abuse services in departmental facilities may include numerous mental health professionals, specialties and services, each departmental facility with an operating capacity of 100 or more youths, each facility providing DJJ specialized treatment services and every detention center is required to designate a single licensed mental health professional as a Designated Mental Health Authority.
Identifying a single individual as responsible and accountable for ensuring appropriate coordination and implementation of mental health and substance abuse services in the facility will promote consistent and effective services and allow the facility superintendent or program director and staff a specific source of expertise and referral.

1. **Designated Mental Health Authority:** The Designated Mental Health Authority must be a licensed mental health professional. He or she may be a psychiatrist licensed pursuant to Chapter 458 or 459, F.S., a psychologist licensed pursuant to Chapter 490, F.S., a mental health counselor, clinical social worker or marriage and family therapist licensed pursuant to Chapter 491, F.S., or a psychiatric nurse as defined by Section 394.455(23) F.S. (A licensed advanced registered nurse practitioner (ARNP) with a master's degree or doctorate in psychiatric nursing or mental health nursing and two years post-master's clinical experience under the supervision of a physician would meet this definition.)

   a. The Designated Mental Health Authority is accountable to the facility superintendent or program director for ensuring appropriate coordination and implementation of mental health and substance abuse services in the facility. Retention of a Designated Mental Health Authority may be through employment or contract. If the contract for mental health services is with an agency or corporate entity, rather than a single mental health professional, the agency or corporate entity must designate a single licensed mental health professional within the agency or corporate entity as the Designated Mental Health Authority for each facility or program.

   b. There must be clear organizational lines of authority and communication between the Designated Mental Health Authority and the clinical staff who are delivering on-site mental health and substance abuse services. The Designated Mental Health Authority must be on-site weekly, at a minimum.

   c. A Designated Mental Health Authority is required in the following departmental facilities/programs:
      
      (1) Detention centers;
      
      (2) Facilities with an operating capacity of 100 or more youths; and
      
      (3) Regardless of the size of the facility, each departmental facility providing DJJ specialized treatment services (e.g., mental health overlay services (MHOS), residential substance abuse treatment services (RSAT), residential substance abuse overlay services (RSAT Overlay Services), Medicaid behavioral health overlay services (BHOS), intensive mental health services, sex offender treatment services, developmental disability treatment services) must designate a single licensed mental health professional as a Designated Mental Health Authority.

2. **Clinical Coordinator:** Facilities/programs with an operating capacity of less than 100 youths that do not meet any of the criteria in 1.c. above are required, to designate either a Designated Mental Health Authority or a Clinical Coordinator. If the facility/program chooses the option of providing a Clinical Coordinator, the facility/program must designate a licensed mental health professional or non-licensed mental health clinical staff person as a Clinical Coordinator who is responsible for coordinating, and verifying implementation of necessary and appropriate mental health and substance abuse services in the facility/program. Designation of a non-licensed mental health clinical staff person as a Clinical Coordinator does not confer upon the non-licensed mental health clinical staff person the authority to function as a clinical supervisor.
C. COMPREHENSIVE PLAN FOR DELIVERY OF MENTAL HEALTH SERVICES

1. The facility superintendent or program director is responsible for the development of a comprehensive plan for delivery of mental health services to youths in need of such services.

2. The comprehensive plan for delivery of mental health services in detention centers must establish and describe a process which includes:
   - Review by intake staff and mental health clinical staff of Mental Health Screening (e.g., MAYSi-2, PACT), comprehensive assessments and/or comprehensive evaluations (when available) conducted prior to the youth’s admission to the detention center, and existing Alerts on JJIS.
   - Suicide Risk Screening,
   - Assessment of Suicide Risk,
   - Referral for Comprehensive Assessment conducted by the facility’s mental health provider when risk factors which have not previously been identified, are identified during the stay in detention,
   - Alert Systems to include Suicide Risk Alert and Mental Health Alert,
   - Mental Health Treatment Planning:
     - Development of an initial mental health treatment plan when the need is indicated by screening and assessment.
     - Periodic reviews/updating of the initial mental health treatment plan.
     - Note: Due to the short length of the detention stay and the nature of services in detention, an initial mental health/substance abuse treatment plan will be utilized for youths receiving short-term mental health and/or substance abuse services while in the detention center. An individualized mental health/substance abuse treatment plan will be developed for the youth whose stay in the detention center exceeds 30 days.
   - Transition planning for youth who have received services in detention to include:
     - Completion of a Mental Health/Substance Abuse Treatment Discharge Summary (see Chapter 6, Section VII)
     - Communication with and forwarding a copy of the Mental Health/Substance Abuse Treatment Discharge Summary to the youth’s assigned Juvenile Probation Officer and parent/legal guardian (as allowed).
     - For youths on Suicide Risk Alert/Suicide Precautions immediately prior to discharge to the community, ensuring the youth’s parent/legal guardian and Juvenile Probation Officer are verbally notified of the youth’s suicide risk status prior to discharge from the facility. The notification of suicide risk must be made and documented by the facility superintendent or his/her designee and permanently filed in the youth’s individual healthcare record.
     - Ensuring documentation of mental health/substance abuse screenings (MAYSi-2, SRSI), referrals, assessments (Assessment of Suicide, Crisis Assessment, Comprehensive Assessment), initial treatment plan, treatment notes, discharge summary, and for youth on suicide precautions (Suicide Precautions Observation Log), are permanently filed in the youth’s individual healthcare record prior to the youth’s release from the detention center.
     - For youths on Suicide Risk Alert/Suicide Precautions immediately prior to transfer to a detention center or residential commitment program, ensuring the facility superintendent or residential program director or his/her designee is verbally notified of the youth’s suicide risk status prior to discharge from the current detention center. The notification of suicide risk must be made and
documented by the facility superintendent or his/her designee and permanently filed in the youth’s individual healthcare record.

- For youths being transferred to a detention center or residential commitment program, ensuring that the youth’s individual healthcare record is forwarded to the detention center or residential commitment program.

- Delivery of mental health treatment services in accordance with the initial treatment plan:
  - Crisis intervention and emergency services
  - Suicide prevention services
  - Psychopharmacological management
  - Psycho-education/psychosocial skills training
  - Individual and group counseling and consultation as required by the initial treatment plan.
  - Coordination with existing community mental health provider therapist when youth is active in treatment when admitted to the detention center.

- Staff training on the signs/symptoms of emotional disturbance/mental illness, substance abuse/dependence and suicidal behaviors among children and adolescents, focusing on juvenile offenders.

3. The comprehensive plan for delivery of mental health services in residential commitment facilities/programs must establish and describe a process which includes:
   - Review by intake staff and mental health clinical staff of pre-commitment screenings, assessments/evaluations and existing Alerts on JJIS,
   - Mental Health Screening,
   - Suicide Risk Screening,
   - Assessment of Suicide Risk,
   - Comprehensive Mental Health Evaluation,
   - Alert Systems (Suicide Risk Alert; Mental Health Alert)
   - Mental Health Treatment Planning
     - Development of an individualized mental health treatment plan
     - Periodic reviews/updating of the mental health treatment plan
   - Transition Planning to include:
     - Completion of a Mental Health/Substance Abuse Treatment Discharge Summary (see Chapter 6, Section VII)
     - Communication with and forwarding a copy of the Mental Health/Substance Abuse Treatment Discharge Summary to the youth’s assigned Juvenile Probation Officer and parent/legal guardian (as allowed).
     - For youths on Suicide Risk Alert/Suicide Precautions immediately prior to discharge, verbal notification of the youth’s parent/legal guardian and Juvenile Probation Officer of the youth’s suicide risk prior to the youth’s discharge from the residential commitment program. The notification of suicide risk must be made and documented by the program director or his/her designee and permanently filed in the youth’s individual healthcare record.
     - Ensuring documentation of mental health/substance abuse screenings (MAYSI-2, Clinical Mental Health/Substance Abuse Screening), referrals, assessments (Assessment of Suicide Risk, Crisis Assessment), treatment plans, treatment notes, discharge summary, and for youths who were on suicide precautions (Suicide Precautions Observation Log) are permanently filed in the youth’s individual healthcare record prior to the youth’s release from the residential commitment program.
     - For youths on Suicide Risk Alert/Suicide Precautions immediately prior to transfer to a detention center or residential commitment program, ensuring the
facility superintendent or residential program director or his/her designee is verbally notified of the youth’s suicide risk status prior to discharge from the residential commitment program. The notification of suicide risk must be made and documented by the program director or his/her designee and permanently filed in the youth’s individual healthcare record.

- For youths being transferred to a detention center or a residential commitment program, ensuring that the youth’s individual healthcare record is forwarded to the detention center or residential commitment program.
- Delivery of Mental Health Treatment Services
  - Individual, group and family counseling/therapy
  - Behavioral therapy
  - Psycho-education/psychosocial skills training
  - Psychopharmacological therapy
  - Suicide Prevention Services
  - Crisis Intervention and Emergency Services
- Staff training on signs/symptoms of emotional disturbance/mental illness, substance abuse/dependence and suicidal behaviors among children and adolescents, focusing on juvenile offenders.

4. The comprehensive plan for delivery of mental health services in facility based day treatment programs must establish and describe a process which includes:

- Review by intake staff and mental health clinical staff of screenings, assessments/evaluations conducted prior to the youth’s admission to the day treatment program and existing Alerts on JJIS,
- Mental Health Screening,
- Suicide Risk Screening,
- Assessment of Suicide Risk,
- Comprehensive Mental Health Evaluation,
- Alert Systems (Suicide Risk Alert; Mental Health Alert)
- Mental Health Treatment Planning
- Development of an individualized mental health treatment plan
- Periodic reviews/updating of the mental health treatment plan
- Transition Planning to include:
  - Completion of a Mental Health/Substance Abuse Treatment Discharge Summary
  - Communication with and forwarding a copy of the Mental Health/ Substance Abuse Treatment Discharge Summary to the youth’s assigned Juvenile Probation Officer and parent/legal guardian (as allowed).
- For youths on Suicide Risk Alert/Suicide Precautions immediately prior to discharge, verbal notification of the youth’s parent/legal guardian and Juvenile Probation Officer of the youth’s suicide risk prior to the youth’s discharge from the day treatment program.
  The notification of suicide risk must be made and documented by the program director or his/her designee and permanently filed in the youth’s individual healthcare record.
- Ensuring documentation of mental health/substance abuse screenings (MAYSI-2, PACT), referrals, assessments (Assessment of Suicide Risk, Crisis Assessment), treatment plans, treatment notes, discharge summary, and for youths who were on suicide precautions (Suicide Precautions Observation Log) are permanently filed in the youth’s individual healthcare record prior to the youth’s release from the facility based day treatment program.
For youths on Suicide Risk Alert/Suicide Precautions immediately prior to transfer to a detention center or residential commitment program, ensuring the facility superintendent or residential program director or his/her designee is verbally notified of the youth’s suicide risk status prior to discharge from the facility. The notification of suicide risk must be made and documented by the program director or his/her designee and permanently filed in the youth’s individual healthcare record.

- Delivery of Mental Health Treatment Services
  - Individual, group and family counseling/therapy
  - Behavioral therapy
  - Psycho-education/psychosocial skills training
  - Psychopharmacological therapy
  - Suicide Prevention Services
  - Crisis Intervention and Emergency Services
- Staff training on signs/symptoms of emotional disturbance/mental illness, substance abuse/dependence and suicidal behaviors among children and adolescents, focusing on juvenile offenders.

D. COMPREHENSIVE PLAN FOR DELIVERY OF SUBSTANCE ABUSE SERVICES

1. The facility superintendent or program director is responsible for the development of a comprehensive plan for delivery of substance abuse services to youths in need of such services.

2. The **comprehensive plan for delivery of substance abuse services in detention centers** must establish and describe a process which includes:
   - Review of Substance Abuse screening
   - Referral for Comprehensive Assessment conducted by the facility’s substance abuse provider, when risk factors which have not previously been identified are identified during the stay in detention.
   - Mental Health Alert and Suicide risk Alert
   - Crisis Intervention and Emergency Services
   - Substance Abuse Education (See item 5 below)
   - Coordination with existing community substance abuse providers when youth is active in treatment when admitted to the detention center.
   - Substance Abuse Treatment Planning: Due to the short length of the detention stay and the nature of services in detention, an initial mental health/substance abuse treatment plan will be utilized for youths receiving short-term mental health and/or substance abuse services while in the detention center. An individualized mental health/substance abuse treatment plan will be developed for the youth whose stay in the detention center exceeds 30 days
   - Staff training on signs/symptoms of substance abuse and dependence, emotional disturbances/mental illness, and suicidal behaviors among children and adolescents, focusing on juvenile offenders.

3. The **comprehensive plan for delivery of substance abuse services in residential commitment programs** must establish and describe a process which includes:
   - Substance Abuse Screening,
   - Comprehensive Substance Abuse Evaluation
   - Substance Abuse Education (See item 5 below)
   - Substance Abuse Treatment Planning
     - Development of an individualized substance abuse treatment plan
• Periodic reviews/updating of the substance abuse treatment plan
• Transition Planning to include:
  • Completion of a Mental Health/Substance Abuse Treatment Discharge Summary (see Chapter 6, Section VII)
  • Communication with and forwarding a copy of the Mental Health/Substance Abuse Treatment Discharge Summary to the youth’s assigned Juvenile Probation Officer and parent/legal guardian (as allowed).
  • Ensuring documentation of mental health/substance abuse screenings (MAYSI-2 Clinical Mental Health/Substance Abuse Screening), referrals, assessments (Assessment of Suicide Risk, Crisis Assessment), treatment plans, treatment notes, discharge summary, and for youths who were on suicide precautions (Suicide Precautions Observation Log) are permanently filed in the youth’s individual healthcare record prior to the youth’s release from the residential commitment program.
• Delivery of Substance Abuse Treatment Services
  • Individual, group and family counseling/therapy
  • Substance abuse counseling
  • Life skills/substance refusal skills/psychosocial skills training
  • Relapse Prevention
  • Drug Testing (in RSAT and RSAT Overlay Services Programs)
  • Crisis Intervention and Emergency Services
• Staff training on signs/symptoms of substance abuse and dependence, emotional disturbances/mental illness, and suicidal behaviors among children and adolescents, focusing on juvenile offenders.

4. The comprehensive plan for delivery of substance abuse services in facility based day treatment programs must establish and describe a process which includes:
• Substance Abuse Screening,
• Comprehensive Substance Abuse Evaluation
• Substance Abuse Education (See item 5 below)
• Substance Abuse Treatment Planning
• Development of an individualized substance abuse treatment plan
• Periodic reviews/updating of the substance abuse treatment plan
• Transition Planning to include:
  • Completion of a Mental Health/Substance Abuse Treatment Discharge Summary
  • Communication with and forwarding a copy of the Mental Health/Substance Abuse Treatment Discharge Summary to the youth’s assigned Juvenile Probation Officer and parent/legal guardian (as allowed).
  • Ensuring documentation of mental health/substance abuse screenings (MAYSI-2, PACT), referrals, assessments (Assessment of Suicide Risk, Crisis Assessment), treatment plans, treatment notes, discharge summary, and for youths who were on suicide precautions (Suicide Precautions Observation Log) are permanently filed in the youth’s individual healthcare record prior to the youth’s release from the facility based day treatment non-residential commitment program.
• Delivery of Substance Abuse Treatment Services
  • Individual, group and family counseling/therapy
  • Substance abuse counseling
  • Life skills/substance refusal skills/psychosocial skills training
  • Relapse Prevention
  • Crisis Intervention and Emergency Services
• Staff training on signs/symptoms of substance abuse and dependence, emotional disturbances/mental illness, and suicidal behaviors among children and adolescents,
5. In limited circumstances, detention centers, residential commitment programs and day treatment programs may deliver substance abuse education without a license. The limited circumstances are only as provided in (a) and (b) below:

(a) The entity conducts a prevention program for a stated primary purpose other than substance abuse prevention (e.g., delinquency prevention). In this case the primary focus is delinquency prevention and, if the question was raised, the entity would have to be able to show specific evidence that the program has been shown to be effective in preventing delinquency. Any discussion of substance abuse would simply be an integral part of delinquency prevention in that it would be integrated with other delinquency prevention topics as part of a broad-based prevention strategy.

(b) The entity conducts an occasional showing of a drug prevention video or distributes printed materials on preventing substance abuse that are not part of an ongoing substance abuse prevention effort.

If substance abuse education is being delivered as a substance abuse service, then the entity providing the service must be licensed under Chapter 397, F.S.

E. INTEGRATED COMPREHENSIVE PLAN FOR DELIVERY OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES:

An integrated comprehensive plan for delivery of mental health and substance abuse services may be developed which incorporates all of the elements listed above in D. and E. applicable to the facility or program.

V. CONFIDENTIALITY OF MENTAL HEALTH AND SUBSTANCE ABUSE INFORMATION

Confidentiality of communication between mental health and substance abuse professionals and youths is embodied in ethical and professional standards and is protected under the law. The need for confidentiality of mental health and substance abuse treatment rests on the individual's expectations of privacy and non-disclosure of his or her communication during treatment, and the recognition by mental health and substance abuse professionals that confidentiality is essential to the satisfactory maintenance of the therapeutic relationship. Unless there is clear and imminent danger to an individual, society and/or others, mental health and substance abuse professionals are obligated to maintain confidentiality. They are also obligated to balance therapeutic needs of the youth with the need for security within the departmental facility or program.

The facility superintendent or program director is responsible for establishing and maintaining record keeping, reporting and classification systems that will balance the youth's right to confidentiality of mental health and substance abuse information with the general security and order of the facility. The facility superintendent or program director will ensure that all staff who have access to mental health and substance abuse information are trained regarding confidentiality of mental health and substance abuse records and information.

The facility superintendent or program director must ensure that mental health and substance abuse treatment staff are informed of notification procedures which are to take place when a youth discloses information which indicates a clear and imminent threat to the safety of the youth, others or the security of the facility. Staff shall be informed of reporting requirements set forth in policy 8000 for the Department's Central Communications Center. Staff shall also be informed of reporting requirements, under Florida law, for suspected abuse and neglect.
Section 490.0147 and Section 491.0147, Florida Statutes provide that the privilege of communication between a person licensed under Chapter 490 or Chapter 491 and a client may be waived when “there is a clear and immediate probability of physical harm to the client, other individuals or society and the person licensed under chapter 490 or 491 communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.”

The mental health or substance abuse clinical staff must immediately notify the facility superintendent/program director or designee when a youth presents the following:

1. Duty to Warn/Duty to Protect:
   a. The youth presents a clear risk of suicide or self-injury by virtue of behavior or statements; or
   b. The youth presents a clear risk of danger to others by virtue of behavior or statements; or
   c. The youth presents a clear risk of escape or creating internal disorder or riot.

2. Abuse of Children or Vulnerable Adults: (Vulnerable adult means an individual who meets the definition of a disabled adult or elderly person under Chapter 415, F.S.)
   a. The youth indicates, or there is reason to believe, that he or she has been or is being physically or sexually abused; or
   b. The youth indicates, or there is reason to believe, that he or she is at danger of being physically or sexually abused; or
   c. The youth presents a clear risk of physically or sexually abusing a child or vulnerable adult.

3. Any person who has reason to believe that a child has been abused or neglected is mandated by law to report such information to the Florida Abuse Registry (1-800-962-2873). See Section 39.201, Florida Statutes for information regarding mandatory reporting of child abuse, abandonment or neglect.

   See Chapter 4, page 4-9 for information regarding release of records in reporting of incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law.

For further information regarding confidentiality and/or release of mental health and substance abuse information and clinical records, see Chapter Four entitled “Mental Health and Substance Abuse Services Documentation and Records Management”.

For further information regarding confidentiality and/or release of mental health and substance abuse information and clinical records, see Chapter Four entitled “Mental Health and Substance Abuse Services Documentation and Records Management”.
CHAPTER 3
CONSENT REQUIREMENTS

I. INTRODUCTION

The requirement for consent in DJJ facilities and programs is expressed in Section 985.224(6), Florida Statutes, which provides that “nothing in this section shall be deemed to eliminate the rights of parents or the child to consent to examination or treatment for the child, except that consent of a parent shall not be required if the physician determines there is an injury or illness requiring immediate treatment and the child consents to such treatment or an ex parte court order is obtained authorizing treatment.”

Section II of this chapter contains the Department’s general consent requirements regarding authorization for the provision of necessary and appropriate physical and mental health care services to detained and residentially committed youth which are applicable to mental health and substance abuse services.

Section III of this chapter addresses consent requirements unique to mental health and substance abuse services.

A. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES WHICH DO NOT REQUIRE CONSENT:

The Department has been granted limited powers, under specific conditions, to provide, without consent, mental health and substance abuse services to youth who are detained or committed to its custody. Specifically, the Department may conduct, without consent, a preliminary screening of the youth to determine if the youth needs mental health or substance abuse services. The preliminary screening may assess the youth for psychiatric, psychological or substance abuse problems as provided in Section 985.21(1)(a)(2), Florida Statutes. However, preliminary screening can go no further than initial screening to determine the possible existence of mental health or substance abuse problems. For mental health or substance abuse services beyond preliminary screening, consent must be requested unless there is evidence of an emergency mental health or substance abuse condition which requires immediate attention.

II. GENERAL CONSENT REQUIREMENTS APPLICABLE TO MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

A. AUTHORITY FOR EVALUATION AND TREATMENT:

The Authority for Evaluation and Treatment (AET) is the document that, when signed by a parent or legal guardian, gives the Department the authority to assume responsibility for the provision of necessary and appropriate physical and mental health care to a youth in the Department’s physical custody, in most circumstances. The Authority for Evaluation and Treatment does not give DJJ authority to assume responsibility for the provision of substance abuse evaluation and treatment services to a youth within its custody (See page 3-10 of this manual).
1. Obtaining the Authority for Evaluation and Treatment:
   a. The DJJ juvenile probation officer (JPO) is accountable for ensuring that the Authority for Evaluation and Treatment (AET) is signed and dated by the parent or legal guardian and forwarded to the location where the youth is in custody (detention, facility-based day treatment or residential/correctional facility), in order that the original, signed, dated, and witnessed document can be filed in the youth’s individual healthcare record (IHCR). If the youth is home pending placement, the signed AET should be forwarded to the location of the IHCR (or the Commitment Packet, pending eventual inclusion in the IHCR). The standardized form will be signed and dated by the parent/legal guardian as soon as possible after the youth’s initial intake into the Department (See Appendix A-1).
   b. The AET and Medical History forms are to be completed during the initial intake conference, or when the youth who does not have an open case is presented for detention screening. If the parent/legal guardian is available, the youth’s juvenile probation officer (JPO) or staff at the detention center must explain the AET to the parent/legal guardian, and obtain the signature.
   c. If the parent or legal guardian is not available during detention screening, the assigned JPO needs to schedule an intake conference with the parent/legal guardian as soon as possible to complete the AET and Medical History forms.
   d. The DJJ representative who obtains the parent/legal guardian signature on the AET is responsible for reviewing the basic components of the document with the parent (See Appendix A-2, “Guidelines for Obtaining Parental Signature on AET”).
   e. In the event that a parent/legal guardian refuses to sign the AET or can’t be located, the Department’s regional counsel should be contacted in order to determine if another individual may sign or to obtain a court order.
   f. In the event that a foster child is detained, a court order should be obtained in lieu of the Authority for Evaluation and Treatment.

   NOTE: (Youth in the Care of the Department of Children and Families)
   For foster care youth, or those in the care of the Department of Children and Families (DCF) where there has been a termination of parental rights, the court must authorize provision of any psychotropic medication. The Authority for Evaluation and Treatment does not apply in this situation (see Section 39.407 Florida Statutes). (Language updated March 2007)

2. Duration of the Authority for Evaluation and Treatment:
   The Authority for Evaluation and Treatment (AET) is valid for the longer of the period: (1) The youth is under any type of supervision, custody or other form of legal control of the Department or, (2) For one year after it was signed by the parent/legal guardian whichever comes later. However, the Authority for Evaluation and Treatment Form, signed by the parent/legal guardian, is no longer valid upon the youth’s 18th birthday (at which time the youth can provide or withdraw consent and sign the AET form). This means that the AET remains valid during the time that a youth is on any form of departmental supervision, conditional release, probation and the like. (For example, an AET that has been signed while a youth is in the custody of detention continues to be valid during the full time of a residential commitment and aftercare, unless the parent or court modifies or revokes it). The parent/legal guardian may revoke or modify the AET at any time, in which case authorization...
for the revoked treatment or services is no longer valid. If the court revokes or modifies the AET, authorization for the revoked treatment or services is no longer valid.

a. If the AET has expired at the time the youth re-enters the physical custody of the Department (that is, has been under no form of supervision, control, custody, or other form of legal control by the Department and more than a year has elapsed since the signing of the first AET), the JPO must obtain parental/legal guardian signature on a new AET, following the steps in 1 above.

b. If the AET has not been revoked or modified by the parent/guardian or the court, and the youth has continuously remained under the supervision, custody, or other form of legal control of the Department, it is not necessary to obtain a new AET when the youth is transferred from one DJJ facility to another.

c. It is not necessary to obtain a new AET if the youth has absconded or escaped and returned to the custody of the Department, unless the parent/guardian or the court has modified or revoked it.

d. Parental signature on the Authority for Evaluation and Treatment is not required if the youth is 18 years or older. However, the signature of the youth, 18 years or older, is required on the AET form.

3. Revocation of the Authority for Evaluation and Treatment:

An Authority for Evaluation and Treatment (AET) can be revoked in its entirety, or the revocation can be only for certain treatment or services. For example, revocation of the AET could be in its entirety, revoking authorization for all mental health or physical health treatments, or could be only for a specific procedure or service. Revocation of the AET for only a specific service does not affect the validity of the AET for other services authorized by the AET.

The following procedures should be followed in documenting revocation or modification of an AET and obtaining a new AET.

a. If the Department is aware that the parent/legal guardian has orally revoked the AET, that revocation must be honored and the oral revocation should be documented thoroughly in the progress notes of the Individual Healthcare Record, with a witness to the oral revocation if possible.

1) Every reasonable effort should be made to obtain a written revocation. If a written revocation from the parent/guardian cannot be obtained, but the parent has orally revoked the AET, the Department’s regional counsel should be notified.

2) Once the Department is aware that there has been an oral or verbal revocation, it cannot rely on the AET as the authority to provide any health care service included in the revocation.

b. If the youth is in the custody of a residential commitment program and a parent/legal guardian revokes the original AET or the original AET is modified, staff at the residential program shall seek to obtain the parental signature on a new or modified AET (following the steps (outlined in 1 above).

c. The newly signed AET shall be filed immediately in front/on top of the prior (most recent) AET, in the Individual Healthcare Record (IHCR).
d. If the parent/guardian does revoke the AET in its entirety or revokes a portion of the AET, and is unwilling to sign a new AET authorizing the revoked service or treatment and the Department (through the medical, dental, or mental health provider) believes the procedure or treatment to be necessary for the benefit of the youth’s physical and/or mental well-being, or is otherwise in the youth’s best interests, the Facility Superintendent or designee will request the regional counsel to apply for a court order authorizing the Department to provide for the youth’s mental and physical health needs.

e. The Department’s regional general counsel shall immediately apply for a court order authorizing the Department to provide for the youth’s mental and physical health needs.

4. Filing of the Authority for Evaluation and Treatment:

a. The original signed and witnessed Authority for Evaluation and Treatment is to be filed in the youth’s Individual Healthcare Record (IHCR).

   NOTE: (Copies of the AET)
   If, for any reason, the original AET is not placed in the individual health care record, a legible copy will suffice, as long as the word “COPY” is legibly hand-written or stamped on the copy of the AET. It is particularly important that outside healthcare providers are aware of the parental consent and thus should be provided with a copy of the AET. The JPO should also maintain a copy of the AET in their files.

b. Should a subsequent Authority for Evaluation and Treatment be obtained (for example, the youth was no longer under any departmental jurisdiction, custody, or supervision, and re-entered the physical custody of the Department at a date which was greater than a year after the first AET was signed), the subsequent AET should be filed directly in front/on top of the prior AET. (If a court order was obtained because an AET could not be obtained, the court order shall be filed in the same fashion/order as the AET.)

5. Use of the Authority for Evaluation and Treatment (AET) With Regard to Medications the Youth is Prescribed at the Time of Entry Into the Physical Custody of the Department

a. The Authority for Evaluation and Treatment serves as the parent/legal guardian’s permission to continue administration of those medications (all classifications of medications, including psychotropic medications) for which the youth has a bona fide prescription at the time of his/her entry into the physical custody of the Department. This includes authorized refills and renewals of prescriptions that the youth was receiving at the time of admission, as long as there are no changes in the dosage or route upon renewal. Any administration of medication, including renewals, requires an automatic medical evaluation of the youth’s medical status if the youth’s behavior or physical health warrants, regardless of the status of the prescription.

b. If the youth is receiving a current prescription(s) when admitted to the physical custody of the Department (detention center and residential/correctional facility) the AET (when properly signed) provides the authority to: (1) continue the present medication(s) and administer the medication as ordered; (2) refill the prescription (pursuant to appropriate assessment requirements); (3) continue the medication until such time as the prescription expires; and, (4) renew the prescription (as long as the dosage and route does not change).
6. **Use of the Authority for Evaluation and Treatment (AET) with Regard to Medications Prescribed Subsequent to the Youth’s Entry Into the Physical Custody of the Department**

The Authority for Evaluation and Treatment (AET) cannot be used as the authorization to: Begin prescription medication(s) which are prescribed after the youth has entered the physical custody of the Department; or Change the dosage of prescription medication(s) of current medications the youth is prescribed at the time of entering the custody of the Department, after the youth has entered the physical custody of the Department; or Discontinue a prescription medication(s) (of current medications the youth is prescribed at the time of entering the custody of the Department), after the youth has entered the physical custody of the Department.

a. Copies of standardized notification forms sent to the parent/guardian notifying them whenever one of the following three actions are taken by a prescriber (physician, osteopathic physician, dentist, advanced registered nurse practitioner or physician assistant) will be kept in the youth’s individual healthcare record (IHCR):

   1. Prescribes or otherwise orders a prescription medication which the youth was not currently prescribed at the time of entering the physical custody of the Department, or
   2. Discontinues prescription medication(s) (which the youth was currently prescribed at the time of entering the physical custody of the Department) or discontinues medications which the youth has been prescribed since entering the physical custody of the Department; or
   3. A significant change in the dosage of prescription medication(s), (which the youth was currently prescribed at the time of entering the physical custody of the Department). A “significant change” in dosage of a medication is any increase or decrease in dosage beyond a small increment or beyond the normal dosage for youths of similar age.

   **Note:** The DJJ Authority for Evaluation and Treatment indicates that if there is a “significant change” in the dosage of a medication the youth was/is receiving, attempts will be made to contact the parent/legal guardian by telephone prior to making any of these changes, unless it is felt necessary to start the medication immediately, and notification of medication changes will be mailed to the parent/legal guardian. Thus, the parent/legal guardian must be contacted regarding a “significant change” in the dosage of medication and notified by mail of the change.

b. The standardized forms to be sent to the parent/guardian depend on the nature of the health-related event. In all instances in which a completed notification form is sent, a completed copy shall be maintained in the IHCR.

7. **Using the Authority for Evaluation for a Release of Information:**

When properly signed, the Authority for Evaluation and Treatment (AET) serves as a release of information. It serves as the Department’s authority to provide information to other healthcare providers that are or will be treating a youth and as a release to healthcare providers for the purpose of releasing medical records to the Department.
a. A copy of the original, current signed AET on file in the youth’s IHCR shall be provided to a treating healthcare provider whenever healthcare information is requested from that provider by the Department.

b. Whenever a youth is taken off-site to a healthcare provider, the healthcare provider shall be provided a copy of the original, current signed AET on file in the youth’s Individual Healthcare Record (IHCR), in order that the healthcare provider may provide to the Department information on the Summary of Off-Site Care, and provide any other instructions/orders necessary for the healthcare of the youth (e.g., discharge instructions, consultative reports, and the like).

c. In the event that the youth is taken to a healthcare provider for treatment that has been specifically court-ordered, a copy of that court order shall be provided to the healthcare provider (the original shall be taken to the appointment).

d. In the event that a youth is taken to a healthcare provider for services which are covered by a general court order (in lieu of the AET because the parent/guardian refused to sign the AET or the parent/guardian could not be located, etc.), a copy of that court order shall be provided to the healthcare provider.

e. Information related to a youth’s HIV status shall not be released without the youth’s consent.

f. All information contained in a youth’s individual healthcare record is confidential. All releases of healthcare information are subject to the laws and regulations of the State of Florida governing such releases, and all federal regulations. (See HIPAA requirements and exceptions for DJJ youths at page 3-9) Any disclosures of information contained in a youth’s individual healthcare record shall only be made for the purposes of providing or obtaining healthcare for that youth or for evaluating health care delivery. (The restrictions on disclosure do not apply to the reporting of incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law. See Chapter 4, section IV for more details regarding disclosure of information regarding suspected child abuse or neglect).

B. CONSENT FOR PRESCRIBING OF PSYCHOTROPIC PRESCRIPTION MEDICATION(S):

1. For the prescribing of all psychotropic prescription medication(s) (which the youth was not currently prescribed at the time of entry into the physical custody of the Department), a copy of the 3rd page of the standard form, “Clinical Psychotropic Progress Note” (CPPN) shall be sent via certified mail to the parent/guardian at the address on record, after completion by the prescriber (See Appendix B-1, “Clinical Psychotropic Progress Note”).

2. This form (a copy of the 3rd page of the standard form, “Clinical Psychotropic Progress Note” (CPPN) shall be accompanied by a cover letter (See Appendix B-2, “Acknowledgment of Receipt of CPPN Form or Practitioner Form [AOR]”) to the parent/guardian).

3. Telephone consent must be attempted and must include a discussion of the information contained on page 3 of the CPPN (Contents of pages 1 & 2 of the CPPN are not to be disclosed to the parent/guardian for purposes of notification/consent for psychotropic medications).

4. If a youth has remained continuously in the physical custody of a detention center and is transferred directly from a detention center to a residential/correctional facility, the
residential/correctional facility is not required to send CPPNs for medications that the youth is currently prescribed at the time of entering its physical custody.

5. If a youth has remained continuously in the physical custody of a residential/correctional facility and is transferred directly to a detention center, the detention center is not required to send CPPNs for medications that the youth is currently prescribed at the time of entering its physical custody.

C. OTHER INSTANCES IN WHICH THE PARENTAL NOTIFICATION OF HEALTH-RELATED CARE FORM MUST BE SENT TO THE PARENTS:

1. A Parental Notification of Health-Related Care (see Appendix C) must be sent to the parent/guardian whenever a youth has a chronic mental or physical health condition and a licensed healthcare practitioner has determined that a significant change has occurred in the chronic health condition of that youth. This shall not include those limited conditions to which, by statute, a youth can legally consent to screening, evaluation and/or treatment without the parent/guardian’s knowledge or consent (and which are to be protected from disclosure to the parent/guardian). See section D, below, for a discussion of these conditions/treatments.

2. A Parental Notification of Health-Related Care must be sent to the parent/guardian whenever a youth complains of the same complaint three (3) or more times during a two-week period. Mailing of a Parental Notification of Health-Related Care for multiple sick call visits is not required in the following situations:

   a. Youth who return for on-site follow-up of a sick call complaint at the instruction/direction by a physician, osteopathic physician, advanced registered nurse practitioner or physicians’ assistant; and

   b. Youth who report to sick call for complaints which are of such a nature that they are statutorily protected from disclosure to parents/guardians (e.g., evaluation/treatment of sexually transmitted illnesses/diseases).

3. A Parental Notification of Health-Related Care must be sent to the parent/guardian on any occasion in which the oral temperature equals or exceeds 103 orally. An attempt should also be made to notify the parent by telephone.

4. A Parental Notification of Health-Related Care must be sent to the parent/guardian whenever a youth is taken off-site for healthcare, except when the type of care for which the youth is taken off is statutorily protected from disclosure to the parent. This includes assessment and treatment for sexually transmitted diseases, assessment and treatment for HIV positivity or AIDS, pregnancy and/or family planning care, including gynaecological services that, in the opinion of the health care provider, are necessary for the health and well-being of the youth. (For the types of mental health treatment which a youth may consent to without parental consent, please see section III of this chapter.

5. A Parental Notification of Health-Related Care must be sent via certified mail to the parent/guardian if the parent/guardian has specifically prohibited certain types of care, or requested that they be notified prior to certain types of care to be administered.

   a. Written permission from the parent/guardian must be obtained prior to the initiation of a treatment which the parent has previously specifically prohibited. This may be in the form of a letter obtained from the parent/guardian, or facility staff may check the box on the bottom of the Parental Notification form, indicating that the parent is to sign the form
and return it to the facility if the parent/guardian agrees to the care. Telephone consent should be attempted and documented as well and the Department’s regional general counsel should be notified.

b. A copy of the Parental Notification of Health-Related Care that was sent to the parent/guardian and the returned form with the parent’s signature must be filed in the Individual Healthcare Record, in the section reserved for parental notices, directly behind the Authority for Evaluation and Treatment, in reverse chronological order (most recent Parental Notification on top in that section).

6. A Parental Notification of Health-Related Care must be sent to the parent/guardian whenever the youth is taken off-site for medical treatment (for example, to an emergency room or hospital, doctor’s office, dentist’s office). Exceptions include situations in which the reason for the transfer and treatment are related to the conditions which, by statute, a youth may consent to without parental knowledge or consent (assessment and treatment for sexually transmitted diseases, assessment/treatment for HIV/AIDS, pregnancy and/or family planning services and those gynecological services that, in the opinion of the health care provider, are necessary for the health and well-being of the youth. In these situations, the youth must provide consent for the Department to notify the parent.

   a. Telephone notification is required as soon as feasible. If possible, telephone notification and mailing of the Parental Notification should be done ahead of time (for example, if there is a pending dental appointment).

   b. The written notice shall be sent regardless of the telephone notification.

7. Written parental notification is required for the administration of over-the-counter medications (OTCs) administered per approved protocols or an order (unless the parent has prohibited the administration of OTCs on the Authority for Evaluation and Treatment in which case over-the-counter medications will not be administered). See Chapter 4 of the Revised Health Services Manual for further information regarding parental notification requirements for over-the-counter medications.

8. Written parental notification is not required for treatment or services which are court-ordered.

NOTE: (When Parental Notification of Health-Related Care Cannot Be Accomplished By Telephone or Mail)

When parental notification cannot be accomplished through telephone contact or by mail, the DJJ facility superintendent, program director or his/her designee must contact the youth’s juvenile probation officer (JPO) and request that the JPO visit the parent or legal guardian for the purpose of providing the necessary parental notification. The JPO must document all efforts to provide parental notification to the parent or legal guardian.

NOTE: (Parent Notification When the Youth’s Illness or Injury Requires Emergency Medical Services or is Life Threatening)

When the youth’s illness or injury requires emergency medical services or is life threatening (after necessary medical treatment is obtained for the youth) the facility superintendent or program director must make every effort to immediately notify the parent/legal guardian. If the parent or legal guardian cannot be contacted, the following steps must be taken:

1) Use alternative contact methods as documented in the youth’s record. Such alternative methods may include, but are not limited to, contact via the parent’s or legal guardian’s work address, pager/cell phone or electronic notification or contact via a relative or neighbor.
2) Contact the youth’s juvenile probation officer to request assistance with notification. In the case where the youth’s family lives in close proximity to the JPO’s work location or area, request that the JPO drive by the parent’s or legal guardian’s home, place of work, school or other known location outside of the home.

3) Contact law enforcement to request assistance in locating the parent or legal guardian.

The facility superintendent or program director must document all efforts to contact the parent or legal guardian.

D. INSTANCES WHEN ADDITIONAL WRITTEN CONSENT OF THE PARENT OR LEGAL GUARDIAN IS REQUIRED:

Additional, written parental consent is required in certain circumstances. The form to be used shall be the form used by the healthcare provider that is providing the services. Examples of the types of care requiring additional, procedure-specific, written, informed parental consent include the following:

1. Any time it is recommended that the youth be hospitalized;
2. Any surgical procedure (except those to which a minor may consent without parental knowledge or consent as allowed under Chapter 743, Chapter 390 and Chapter 384, Florida Statutes);
3. Dental services other than evaluation and routine prophylaxis (for example, dental extractions, endodontic services and periodontal services require additional, written consent);
4. Any procedure or service of an invasive nature for which one would reasonably assume that a parent would want to be informed and personally involved in the decision to provide such treatment (with the exception of those types of services to which a youth may consent without parental knowledge);
5. Any procedure where there is uncertainty as to the benefits to the child (apart from the normal uncertainty that accompanies any medical or mental health practice or procedure); and,
6. Any procedure or service which the parent/guardian has specifically prohibited.

E. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):

With regard to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, in most cases under the HIPAA Rule, the parent or legal guardian is the “personal representative” of the minor child and can exercise the minor’s rights with respect to protected health information, because the parent usually has the authority to make health care decisions about his or her minor child. Regardless of whether a parent is the personal representative, the Privacy Rule permits a covered entity to disclose to a parent, or provide the parent with access to, a minor child’s protected health information when and to the extent it is expressly permitted or required by State or other laws (including relevant case law). Likewise, the Privacy Rule prohibits a covered entity from disclosing a minor child’s protected health information to a parent, or providing to a parent, or providing a parent access to, such information when and to the extent it is expressly prohibited under State or other laws (including relevant case law). Thus, State or other applicable law governs when such law explicitly requires, permits, or
prohibits the disclosure of, or access to, the health information about the child. (Office for Civil Rights HIPAA Compliance Assistance, Summary of the HIPAA Privacy Rule April 3, 2003)

1. The Privacy Rule allows covered entities (such as doctors or psychiatrists and hospitals) to disclose protected health information (PHI) to the Department or its contracted providers without an authorization from the individual in the Department’s custody (that is, the custodial parent or guardian as personal representative) if the Department represents that the PHI is necessary for the:
   a. Individual’s (youth’s) treatment,
   b. Health and safety of the youth or others in custody,
   c. Health and safety of officers, employees, law enforcement and others at the facility, as well as those responsible for transporting the youth, or
   d. Administration and maintenance of the safety, security and good order of the facility and/or institution. See 45 C.F.R. § 164.512(k)(5).

   Thus, the protected health information (PHI) of a youth in the Department’s care and custody may be used and exchanged between all of its facilities, public and private.

   Note: Under the HIPAA Rule, “protected health information” is all individually identifiable health information that is created, received or maintained by a covered entity, regardless of its form, that relates to the past, present or future physical or mental health or condition of an individual or the provision of, or payment for, health care to an individual, living or dead.

2. With regard to access to records, the individual who is the subject of the PHI, or that individual’s personal representative (for youth under age 18, this is their custodial parent or guardian), has the right to access their health care record. Access should be limited to only health care information and must exclude:
   a. Psychotherapy notes (which are therapists’ impressions and not their reports), and
   b. Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.
   c. Substance abuse treatment records (unless a written consent for disclosures has been provided by the youth.)

3. Within the Florida Department of Juvenile Justice, the right to a copy of the youth’s health care record may be denied, in whole or in part, if it “would jeopardize the health, safety, security, custody or rehabilitation of the individual or other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting of the inmate.” See 45 C.F.R. §164.524(a)(2)(ii). Under HIPAA, these denials are not reviewable.

III. CONSENT REQUIREMENTS UNIQUE TO SUBSTANCE ABUSE SERVICES AND MENTAL HEALTH CRISIS INTERVENTION SERVICES

With regard to mental health services, there are exceptions to general consent requirements, which permit a youth to legally consent to his or her treatment. For substance abuse services, in most instances a youth must consent to his or her treatment. Consent provisions unique to mental health and substance abuse services are discussed below:
A. SUBSTANCE ABUSE EVALUATION AND TREATMENT SERVICES:

Section 397.601 F.S., provides that the disability of minority for persons under 18 years of age is removed solely for the purpose of obtaining voluntary substance abuse impairment services from a licensed service provider, and consent to such services by a minor has the same force and effect as if executed by a client who has reached the age of majority.

1. The effect of this law is that a youth must provide consent for substance abuse evaluation and treatment, unless substance abuse evaluation and treatment has been ordered by the court.

   a. The DJJ form entitled “Youth Consent for Residential Substance Abuse Treatment Services in a DJJ RSAT or RSAT Overlay Services Program”, provided at Appendix D, shall be used in residential commitment programs designated to provide RSAT or RSAT Overlay Services.

   b. Youth consent for substance abuse services may be provided on a form developed by the facility or program or the sample form entitled “Youth Consent for Substance Abuse Treatment” provided in Appendix E. The consent form must contain, at a minimum, all the elements provided in the sample form in Appendix E.

2. If a youth in need of substance abuse services refuses to provide consent for substance abuse evaluation and treatment, the Department shall apply for a court order for the provision of substance abuse evaluation and treatment services.

B. RELEASE OF SUBSTANCE ABUSE RECORDS:

1. Section 397.501(7)(a), Florida Statutes provides that “the records of service providers which pertain to the identity, diagnosis, and prognosis of and service provision to any individual client are confidential” in accordance with chapter 397 and with applicable federal confidentiality regulations and are exempt from the public records provision of Chapter 119, Florida Statutes and s.24(a), Article 1 of the Florida Constitution. Such records may not be disclosed without the written consent of the youth to whom they pertain, except that appropriate disclosure may be made without such consent as follows:

   a. To medical personnel in a medical emergency.

   b. To service provider personnel if such personnel need to know the information in order to carry out duties relating to the provision of services to the client.

   c. To the Secretary of the Department of Children and Families or the Secretary’s designee, for purposes of scientific research, in accordance with federal confidentiality regulations, but only upon agreement in writing that the youth’s name and other identifying information will not be disclosed.

   d. In the course of review of records on service provider premises by persons who are performing an audit or evaluation on behalf of any federal, state, or local government agency, or third-party payer providing financial assistance or reimbursement to the service provider. However, reports produced as a result of such audit or evaluation may not disclose youths names or other identifying information and must be in accord with federal confidentiality regulations.

   e. Upon court order based on application showing good cause for disclosure.

2. A minor acting alone has the legal capacity to voluntarily apply for and obtain substance abuse treatment. Any written consent for disclosure may be given only by the minor
client. This restriction includes, but is not limited to, any disclosure of youth identifying information to the parent, legal guardian, or custodian of a minor youth for the purpose of obtaining financial reimbursement.

a. Youth consent for release of substance abuse records may be provided on a form developed by the facility or program or the sample form entitled “Youth Consent for Release of Substance Abuse Treatment Records” provided in Appendix F. The consent for release of substance abuse records must contain, at a minimum, all the elements provided in the sample form in Appendix F.

3. When the consent of a parent, legal guardian, or custodian is also required under Chapter 397 in order for a minor to obtain substance abuse treatment, any written consent for disclosure must be given by both the minor and the parent, legal guardian, or custodian. Requirements for parental consent are in addition to consent by the youth.

4. The restrictions on disclosure of section 397.501(7) do not apply to communications from provider personnel to law enforcement officers which:

a. Are directly related to a youth’s commission of a crime on the premises of the provider or against provider personnel or to a threat to commit such a crime; and

b. Are limited to the circumstances of the incident, including the client status of the youth committing or threatening to commit the crime, that youth’s name and address, and that youth’s last known whereabouts.

5. The restrictions on disclosure and use in section 397.501(7) do not apply to the reporting of incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law. However, such restrictions on disclosure continue to apply to the original substance abuse records maintained by the provider, including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

6. Any answer denying a request for a disclosure of client records must be made in a way that will not affirmatively reveal that a youth has been, or is being diagnosed or treated for substance abuse.

C. MENTAL HEALTH CRISIS INTERVENTION SERVICES AND TREATMENT:

Section 394.4784, F.S., provides that the "disability of nonage" is removed for any minor age 13 or older to access services under specified circumstances. This statutory provision allows a minor 13 or older to consent to crisis intervention services under the following circumstances:

1. Outpatient diagnostic and evaluation services:

a. The minor (age 13 or older) must be experiencing an emotional crisis to such a degree that he/she perceives the need for professional assistance;

b. Diagnostic and evaluation services must be provided by a licensed mental health professional or in a licensed mental health facility;

c. The purpose of such services shall be to determine the severity of the problem and the potential for harm to the person or others if further professional services are not provided;

d. The diagnostic and evaluation service cannot involve medication or other somatic methods, aversive stimuli or substantial deprivation; and

e. Such services cannot occur more than two times weekly in response to a crisis situation before parental consent is required for further services. Such services may include
2. Outpatient crisis intervention therapy and counseling services
   a. The minor (age 13 years or older) must be experiencing an emotional crisis to such a
      degree that he/she perceives the need for professional assistance;
   b. The therapy must be provided by a licensed mental health professional, or in a licensed
      mental health facility;
   c. The intervention cannot involve medication or other somatic methods, aversive stimuli or
      substantial deprivation;
   d. The counseling cannot occur more than two times weekly before parental consent is
      required for further services. Such services may include parental participation when
      determined to be appropriate by the mental health professional or facility; and
   e. The intervention services permitted in this circumstance are individual psychotherapy,
      group therapy, counseling or other forms of verbal therapy.

D. RELEASE OF MENTAL HEALTH TREATMENT RECORDS: (For providers contracted or
   licensed by the Department of Children and Families to provide mental health services
   pursuant to Chapter 394, F.S.)

Section 394.4615, Florida Statutes provides that a mental health clinical record is confidential
and exempt from the public records provisions of s. 119.07(1). Unless waived by express and
informed consent by the youth of legal age or the minor youth’s guardian, the confidential status
of the clinical record is not lost by either authorized or unauthorized disclosure to any person,
organization or agency.

1. The clinical record shall be released when:
   a. The youth of legal age or the minor youth’s parent/legal guardian authorizes the release;
   b. The youth is represented by counsel and the records are needed by the youth’s counsel
      for adequate representation; or
   c. The court orders such release.

2. Information from the clinical record may be released when:
   a. A youth declares an intention to harm other persons; or
   b. The administrator of the facility or Secretary of the Department of Children and Families
      deems release to a qualified researcher as defined in administrative rule, an aftercare
      treatment provider, or an employee or agent of the Department of Children and Families
      is necessary for treatment of the youth, maintenance of adequate records, compilation of
      treatment data, aftercare planning, or evaluation of programs.

3. Any person, agency or entity receiving information pursuant to s. 394.4615 shall maintain
   such information as confidential and exempt from the provision of s. 119.07(1).
I. INTRODUCTION

Comprehensive, detailed documentation is essential to an effective mental health and substance abuse delivery system. Daily documentation and record-keeping provides a mechanism by which administrative, clinical and direct care staff share information and remain informed of mental health and substance abuse services delivered, requested or needed by youths in the facility or program. Accurate documentation and record-keeping in a systematic format reduces the likelihood of miscommunication, confusion or duplication of mental health and substance abuse services.

Accurate and detailed documentation is also essential to establish accountability for program monitoring and audit purposes. Program records must be maintained in a manner whereby they are readily available for examination for monitoring and auditing purposes.

The facility superintendent/program director and Designated Mental Health Authority or mental health/substance abuse staff are responsible for implementing a record-keeping system which ensures the confidentiality, security and integrity of mental health and substance abuse clinical records and information. He or she is also responsible for establishing procedures whereby mental health and substance abuse assessment and treatment procedures, and referral decisions are documented.

The following information is provided to assist in developing a standardized mental health and substance abuse documentation and record-keeping system in DJJ facilities and programs.

II. INDIVIDUAL HEALTHCARE RECORD

The Individual Healthcare Record (i.e., “medical record”) refers to the unified cumulative hard-copy collection of records, histories, assessments, treatments, diagnostic tests, and the like, which relate to a youth’s medical, mental/behavioral and dental health which have been obtained to facilitate care or document care provided while in the youth is in a detention center or residential commitment program. Section A below addresses mental health and substance abuse issues pertinent to the general requirements of maintaining the individual healthcare record.

A. INDIVIDUAL HEALTHCARE RECORD GENERAL REQUIREMENTS:

1. It is the responsibility of each DJJ facility superintendent or program director to ensure appropriate documentation of mental health and substance abuse information obtained regarding the youth, services and care in the individual healthcare record in accordance with this manual, the DJJ Revised Health Services Manual and applicable Departmental policies.
2. The DJJ facility/program provider or subcontracted provider may, at its option, retain the original documentation of an instance of care.
   a. If the facility/program provider or subcontracted provider chooses to retain the original documentation of an instance of care, then it shall make a copy of the original and insert it in the *individual healthcare record* in place of the original documentation.
   b. It is the facility superintendent/program director's responsibility to ensure that a complete, intact, cumulative, permanent *individual healthcare record* is maintained and transmitted with the youth, and that the *individual healthcare record* contains either the original documentation of instances of care or copies of any original documentation of instances of care which are retained by the DJJ facility/program provider or subcontracted provider.

*Note:* When health services (physical, mental health or substance abuse services) are provided on-site in a DJJ facility or program by a health services provider that is not under a DJJ contract or DJJ provider subcontract, it is the facility superintendent/program director's responsibility to ensure that a written agreement exists which provides that documentation of instances of care or copies of any original documentation of instances of care which are retained by the health services provider are maintained in the youth's DJJ *individual healthcare record* and transmitted with the youth.

3. Terminal disposition and storage (when the committed youth is discharged from the custody of the Department) of the *individual healthcare record* shall be in accordance with the dictates and procedures provided in the "Residential Commitment Services Manual" and applicable Departmental policies.

4. If a youth is discharged to the community from a detention center, the youth's *individual healthcare record* may be terminally stored at the detention center or a location decided upon by the Office of Detention in accordance with applicable Departmental policy.

5. The outside of the file, folder, or chart jacket containing the *individual healthcare record* shall contain the youth's name (last name, first name, middle initial), the youth's DJJ number, denotation of allergies on an allergy label, and the notation, "CONFIDENTIAL".

6. All information contained in the *individual healthcare record* and all information verbally or electronically relayed concerning a youth's health status is considered confidential. Only staff who, by virtue of job description and duties, require information on a youth's health status for the purpose of providing health care to that youth, or protecting the safety of that youth, may have access to a youth's health-related records and/or information. Access shall only be to that portion of the record which is required for the above purposes.

7. The agency and/or its authorized representatives shall have access to a youth's health related records, when such access is needed in the performance of its official responsibilities.

8. Information related to a youth's Human Immunodeficiency Virus (HIV) status requires special precautions to ensure that confidentiality is maintained.

9. Mental health and substance abuse treatment records are to be made available to the Agency for Health Care Administration and the Department of Children and Families as provided for in service contracts with these agencies.
10. DJJ programs providing mental health and/or substance abuse treatment services funded in whole or in part by Medicaid and the Agency for Health Care Administration (AHCA), the Florida Department of Law Enforcement (FDLE) RSAT subgrant or other federal grants must retain mental health and/or substance abuse treatment records in accordance with the requirements set forth by the applicable funding agency or agencies and DJJ contract.

III. MENTAL HEALTH/SUBSTANCE ABUSE SECTION OF THE INDIVIDUAL HEALTH CARE RECORD

The mental health/substance abuse section of the individual healthcare record will contain mental health and substance abuse records collected during the youth’s involvement in the juvenile justice system, and will be permanently filed in the individual healthcare record. The mental health/substance abuse section of the individual healthcare record should contain the following:

A. **Data Base:** Mental health or substance abuse histories, mental status examinations, clinical interviews and assessments, typically in the form of a bio-psychosocial, psychological or psychiatric evaluation, or diagnostic interview, or other records which document the youth’s emotional, mental or behavioral functioning and DSM-IV-TR diagnoses.

B. **Mental Health/Substance Abuse Referral Summary:** The document which summarizes communication between program staff and the mental health or substance abuse clinical staff regarding the youth’s mental health or substance abuse problem, condition or symptoms that indicate the need for mental health or substance abuse services. The Mental Health/Substance Abuse Referral Summary may be recorded on a form developed by the facility/program, or on the sample form provided in Appendix G. The Mental Health/Substance Abuse Referral Summary form must contain, at a minimum, all of the elements in the sample form in Appendix G.

Note: DJJ residential commitment programs designated for specialized treatment services (e.g., BHOS, MHOS, RSAT, RSAT Overlay Services), wherein youths are routinely referred for a specific mental health or substance abuse services (e.g., initial interview, updated comprehensive evaluation) as part of established procedure, do not have to use the form in Appendix G and may utilize existing referral processes (e.g., referral log, notes) for documentation purposes. However, referral of youths for non-routine mental health/substance abuse services (e.g., Assessments of Suicide Risk, Crisis Assessments, Sex Offender Evaluations) must be documented on the form provided at Appendix G, or an alternative form equivalent in content to the form provided in Appendix G.

C. **INITIAL MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT PLAN:** When mental health or substance abuse treatment (including treatment with psychotropic medication) is initiated in a DJJ facility or program, an Initial Mental Health/Substance Abuse Treatment Plan must be completed and filed in the mental health/substance abuse section of the individual healthcare record, unless an individualized mental health/substance abuse treatment plan has already been completed. The initial mental health/substance abuse treatment plan documents that mental health or substance abuse treatment is to begin and the initial course of treatment. The initial mental health/substance abuse treatment plan may be recorded on a form developed by the facility or program or on the sample form provided

**UPDATE**

in (Appendix H). The initial mental health/substance abuse treatment plan form must contain, at a minimum, all the elements in the sample form in Appendix H and must address the following points:
1. Reason for mental health and/or substance abuse treatment;
2. Initial DSM-IV-TR diagnoses or presenting symptoms;
3. Initial treatment methods (including psychiatric services);
4. Initial treatment goals and objectives.

Note: DJJ residential commitment programs designated for specialized treatment services (e.g., BHOS, MHOS, RSAT, RSAT Overlay Services), wherein youths routinely receive an individualized mental health/substance abuse treatment plan within 30 days of admission as part of established procedure, may utilize an initial treatment note or an initial treatment plan signed by the mental health/substance abuse clinical staff person and youth. The initial treatment note may be recorded on an existing form or progress note. Then initial treatment plan may be provided on the form provided at Appendix H, or an alternative form developed in accordance with Rule 65D-30.

(See Chapter Five for further information regarding the Initial Mental Health/Substance Abuse Treatment Plan)

D. INDIVIDUALIZED MENTAL HEALTH TREATMENT PLAN AND INDIVIDUALIZED SUBSTANCE ABUSE TREATMENT PLAN: The document which describes the goals and objectives of on-going mental health or substance abuse treatment (including treatment with psychotropic medication), the methods to be used in the treatment process and schedule for assessing progress and updating the plan. An integrated mental health and substance abuse treatment plan may be developed for youth that receive simultaneous mental health and substance abuse treatment. The individualized mental health treatment plan or individualized substance abuse treatment plan may be recorded on a form developed by the facility or program, or on the sample form provided in Appendix I. The individualized mental health treatment plan or individualized substance abuse treatment plan must contain, at a minimum, all the elements in the sample form in Appendix I. (See Chapter Five for further information regarding the Individualized Mental Health Treatment Plan and Individualized Substance Abuse Treatment Plan)

E. PROGRESS NOTES/TREATMENT NOTES: Narrative notes of mental health or substance abuse clinical staff that follow the individualized mental health/substance abuse treatment plan, and document the course of counseling/therapy, psychosocial skills training, relapse prevention, or other mental health/substance abuse services provided in the facility or program. Progress notes/treatment notes provide a description of the treatment session/activity and the youth’s participation in the treatment session/activity. Progress/treatment notes document the course of treatment and the youth’s progress in meeting his or her clinical goals and objectives as specified in the treatment plan. Progress/treatment notes may be recorded on the day the treatment service/activity is provided, or may be recorded weekly.

To conform with AHCA requirements, the weekly progress note/summary must include the following information:

- Summary of the treatment interventions delivered, the youth’s response to the interventions and progress toward reaching individualized goals, significant events occurring during the week and contact with family and other agencies.
- Information that the interventions authorized in the treatment plan were delivered in accordance with the plan.
- Observations of the staff’s implementation of the plan.
Summary of the treatment team meetings related to the youth and information to reflect that the youth’s individualized goals, progress and identified treatment needs were discussed.

Substantiation that mental health or substance abuse services were delivered each day that these services were billed by documenting the therapeutic interventions and interactions that the primary counselor or the staff provided to the youth based on the youth’s mental health/substance abuse treatment plan.

The note must be dated and signed by the mental health or substance abuse clinical staff person that provided the treatment session or activity. (See sample form entitled “Counseling/Therapy Progress Note” provided in Appendix J).

F. DOCUMENTATION OF ON-SITE SPECIALIZED MENTAL HEALTH AND SUBSTANCE ABUSE ASSESSMENTS, CONSULTATIONS OR INTERVENTIONS: Documentation of specialized mental health and substance abuse assessments, consultations or interventions (e.g., sex offender assessment, family assessment, trauma assessment, neuropsychological assessment) conducted on-site must provide details of the assessment, consultation or intervention in a format which enables those persons entitled to access this confidential information to review the document and clearly determine the mental health or substance abuse service provided, the mental health or substance abuse professional’s findings, clinical impression and recommendations (See Section V of this chapter for confidentiality provisions). The format for documenting on-site interventions will be determined by the mental health or substance abuse professional using the following criteria: DAP (Data, Assessment and Plan), SOAP (Subjective, Objective, Assessment and Plan) formats or alternative formats such as the example below are acceptable.

1. Title: The written consultation should be given a title which contains the appropriate descriptive term (e.g., sex offender assessment, neuropsychological assessment, family assessment, trauma assessment).

2. Date, Time and Sources: The date and time that the consultation or intervention note was written and a list of the sources of information used by the mental health or substance abuse professional.

3. Identifying Statement: The youth’s presenting problem or condition as well as events or behaviors that precipitated the referral.

4. History: The youth’s past or current mental health or substance abuse problems, life events, social and interpersonal problems which appear related to the current condition or symptoms.

5. Interview and Observations: The youth’s appearance, behavior, affect, emotional state, insight, cooperation and judgment.

6. Formulations: The mental health or substance abuse professional’s findings, clinical impression, or formulation of a primary or provisional DSM-IV-TR diagnosis, if indicated.

7. Recommendations: The interventions, treatment or services recommended by the mental health or substance abuse professional to resolve the problem.
G. DOCUMENTATION OF OFF-SITE MENTAL HEALTH OR SUBSTANCE ABUSE EVALUATIONS OR TREATMENT: Off-site mental health and substance abuse service providers' documentation of assessment and treatment is considered privileged and confidential information. Federal and state laws prevent the exchange of mental health and substance abuse clinical records and information without written consent for disclosure of such information. Through collaborative efforts, however, departmental facilities and programs and mental health or substance abuse service providers can arrange for sharing of information while maintaining the privileged and confidential status of clinical information. The Authority for Evaluation and Treatment Form, when properly executed by the parent or guardian, serves as a consent for release of mental health clinical records information to the Department, but does not serve as consent for disclosure of substance abuse clinical records or information. Section 397.501(7)(e)1. states: “Since a minor acting alone has the legal capacity to voluntarily apply for and obtain substance abuse treatment, any written consent for disclosure may be given only by the minor client.” Thus, release of substance abuse clinical records or information from a service provider must be authorized by written consent of the youth.

The following guidelines are offered with regard to obtaining documentation of off-site mental health and substance abuse treatment:

1. Documentation of Off-Site Mental Health Treatment: The mental health professional or service provider must be provided a copy of the Authority for Evaluation and Treatment Form signed by the parent or guardian on the youth’s behalf. The mental health provider should be informed as to the specific clinical information being requested by the departmental facility or program and how the information will be used. For example, a youth’s off-site mental health diagnostic and assessment information and treatment plans may be requested to assist in needs assessment, performance planning and facilitating the delivery of appropriate services.

2. Documentation of Off-Site Substance Abuse Treatment: The substance abuse service provider must obtain the minor’s consent for release of clinical information. The service provider’s consent form or a consent form for release of substance abuse records and information provided by the departmental facility or program may be used. See Appendix F for a sample youth consent form for release of substance abuse treatment records.

3. Documentation of Off-Site Mental Health or Substance Abuse Treatment must be permanently filed in the youth’s individual healthcare record.

H. MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT DISCHARGE SUMMARY: This document summarizes the youth’s mental health and/or substance abuse treatment in the DJJ facility/program and the youth’s mental health and/or substance abuse service needs upon leaving the program or facility (transition). The Mental Health/Substance Abuse Treatment Discharge Summary must be recorded on the form provided in Appendix V. A copy of the Mental Health/Substance Abuse Treatment Discharge Summary should be provided to the youth, the youth’s parent or legal guardian and the youth’s Juvenile Probation Officer prior to the youth’s discharge from the facility/program.
IV. ACTIVE MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT FILE

It is essential that mental health and substance abuse clinical staff have immediate access to mental health and substance abuse records pertaining to ongoing mental health or substance abuse treatment in departmental facilities or programs. Because structural design may limit mental health or substance abuse clinical staff’s access to individual healthcare records in some facilities, an option is presented wherein a temporary mental health/substance abuse file (“Active Mental Health/Substance Abuse Treatment File”) may be maintained during a youth’s ongoing mental health or substance abuse treatment.

The “Active Mental Health/Substance Abuse Treatment File” refers to a temporary file containing a youth’s non-medical mental health and/or substance abuse information which is needed for ongoing mental health or substance abuse treatment. When utilized, a youth’s “Active Mental Health/Substance Abuse Treatment File” must be maintained in an specified area of the facility or program designated as the, “Active Mental Health/Substance Abuse Treatment Files Area”.

The Active Mental Health/Substance Abuse Treatment Files Area may consist of a secure room or other similarly protected area. The room must be accessible only to appropriate mental health and/or substance abuse staff, and designated administrative, supervisory and medical staff who have a need for the information in connection with their duty to monitor the youth’s progress or to participate in the assessment and treatment of the youth.

A. The Active Mental Health/Substance Abuse Treatment File is not required, but is an option in facilities where individual healthcare records are not readily accessible to mental health or substance abuse staff.

B. The “Active Mental Health/Substance Abuse Treatment File” must be maintained until the mental health or substance abuse clinical staff person determines that the youth’s on-going mental health or substance abuse treatment is completed, at which time the Active Mental Health/Substance Abuse Treatment File must be placed in the youth’s individual healthcare record.

C. Departmental facilities which provide specialized, on-going mental health or substance abuse assessment or treatment services may maintain an Active Mental Health/Substance Abuse Treatment File throughout the course of a youth’s commitment in the facility/program. The Active Mental Health/Substance Abuse Treatment File or a copy of the file must be placed in the youth’s individual healthcare record prior to his/her transition from the program.

D. The Active Mental Health/Substance Abuse Treatment File must be restricted to documentation of mental health and substance abuse treatment of a non-medical nature (e.g., does not involve medication or other somatic methods).

Note: The documentation of administration and management of medication and somatic methods (e.g., medical services) must be filed in the youth’s individual healthcare record.
V. CONFIDENTIALITY OF MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT RECORDS

Mental health and substance abuse treatment information and records are protected by state and federal laws. Furthermore, mental health and substance abuse professionals have legal and ethical obligations related to their state licensure and professional standards which prohibit their release of client information, except under certain conditions, without consent (For example: s.90.503, s.455.667 and s.455.671, F.S., 45 CFR ss164.512(k)(5)). The confidentiality of substance abuse treatment set forth in Section 397.501(7) F.S., (discussed in detail on pages 4-9 and 4-10), and parallel Federal provisions in 42 CFR Part 2, are very stringent. However, the disclosure of information obtained under Chapter 985 in the discharge of official duty by licensed professionals or licensed community agency representatives participating in the assessment and treatment of juvenile offenders to the Department and its designees is authorized as provided below.

Section 985.04(3) provides that all information obtained under Chapter 985 in the discharge of official duty by any licensed professional or licensed community agency representative participating in the assessment and treatment of a juvenile is confidential and may be disclosed only to authorized personnel of the court, the Department of Juvenile Justice and its designees, law enforcement agents, school superintendents and their designees, any licensed professional or licensed community agency representative participating in the assessment or treatment of a juvenile, and others entitled under Chapter 985 to receive that information, or upon order of the court. Section 985.31(4)(f) provides that the privileged and confidential status of the clinical and assessment treatment record shall not be lost by either authorized or unauthorized disclosure to any person, organization or agency. Thus, the confidentiality of treatment information and records obtained by the Department must be maintained.

A. MENTAL HEALTH TREATMENT RECORDS: (For providers contracted or licensed by the Department of Children and Families to provide mental health services pursuant to Chapter 394, F.S.)

Section 394.4615, Florida Statutes provides that a mental health clinical record is confidential and exempt from the public records provisions of s. 119.07(1). Unless waived by express and informed consent by the youth of legal age or the minor youth’s guardian, the confidential status of the clinical record is not lost by either authorized or unauthorized disclosure to any person, organization or agency.

1. The clinical record shall be released when:
   a. The youth of legal age or the minor youth’s parent/legal guardian authorizes the release.
   b. The youth is represented by counsel and the records are needed by the youth’s counsel for adequate representation.
   c. The court orders such release.

2. Information from the clinical record may be released when:
   a. A youth declares an intention to harm other persons.
   b. The administrator of the facility or Secretary of the Department of Children and Families deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the Department of Children and Families is necessary for treatment of the youth, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs.
c. For reporting of incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law.

Any person, agency or entity receiving information pursuant to s. 394.4615 shall maintain such information as confidential and exempt from the provision of s. 119.07(1).

**B. SUBSTANCE ABUSE TREATMENT RECORDS**

1. Section 397.501(7)(a), Florida Statutes provides that "the records of service providers which pertain to the identity, diagnosis, and prognosis of and service provision to any individual client are confidential" in accordance with chapter 397 and with applicable federal confidentiality regulations and are exempt from the public records provision of Chapter 119, Florida Statutes and s.24(a), Article 1 of the Florida Constitution. Such records may not be disclosed without the written consent of the youth to whom they pertain, except that appropriate disclosure may be made without such consent as follows:

   a. To medical personnel in a medical emergency.

   b. To service provider personnel if such personnel need to know the information in order to carry out duties relating to the provision of services to the client.

   c. To the Secretary of the Department of Children and Families or the Secretary’s designee, for purposes of scientific research, in accordance with federal confidentiality regulations, but only upon agreement in writing that the youth’s name and other identifying information will not be disclosed.

   d. In the course of review of records on service provider premises by persons who are performing an audit or evaluation on behalf of any federal, state, or local government agency, or third-party payer providing financial assistance or reimbursement to the service provider. However, reports produced as a result of such audit or evaluation may not disclose youths names or other identifying information and must be in accord with federal confidentiality regulations.

   e. Upon court order based on application showing good cause for disclosure.

   f. For reporting of incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law. (See 5. below).

2. A minor acting alone has the legal capacity to voluntarily apply for and obtain substance abuse treatment. **Any written consent for disclosure may be given only by the minor client.** This restriction includes, but is not limited to, any disclosure of youth identifying information to the parent, legal guardian, or custodian of a minor youth for the purpose of obtaining financial reimbursement.

3. When the consent of a parent, legal guardian, or custodian is required under Chapter 397 in order for a minor to obtain substance abuse treatment, any written consent for disclosure must be given by **both the minor and the parent, legal guardian, or custodian.** Requirements for parental consent **are in addition to consent by the youth.**

4. The restrictions on disclosure of section 397.501(7) do not apply to communications from provider personnel to law enforcement officers which:

   a. Are directly related to a youth’s commission of a crime on the premises of the provider or against provider personnel or to a threat to commit such a crime; and
b. Are limited to the circumstances of the incident, including the client status of the youth committing or threatening to commit the crime, that youth’s name and address, and that youth’s last known whereabouts.

5. **Section 397.50(7) F.S., provides the following:**

“The restrictions on disclosure and use in section 397.501(7) do not apply to the reporting of incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law. However, such restrictions on disclosure continue to apply to the original substance abuse records maintained by the provider, including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.”

6. Any answer denying a request for a disclosure of client records must be made in a way that will not affirmatively reveal that a youth has been, or is being diagnosed or treated for substance abuse.

### VI. ON-SITE MENTAL HEALTH/SUBSTANCE ABUSE TRACKING LOGS

An on-site tracking log is a form of documentation which may be utilized to record and monitor mental health or substance abuse care or findings. The on-site tracking log may be used to monitor requests for mental health or substance abuse services and to facilitate follow-up care or services.

Mental health on-site tracking logs are not required, but may be utilized to monitor mental health services such as assessments of suicide risk, comprehensive mental health evaluations, sex offender therapy, and crisis intervention.

However, DJJ residential commitment programs providing DJJ *specialized treatment services* (e.g., MHOS, RSAT, RSAT Overlay, BHOS) must maintain a log/reports of youths served and dates of service in accordance with subgrant and/or DJJ contract requirements, utilizing the specific report forms/format specified in the subgrant and/or contract.

All DJJ facilities/programs must maintain records documenting the delivery of contracted or subcontracted mental health and/or substance abuse services in accordance with applicable DJJ contract requirements or conditions and/or Departmental policy.

The on-site tracking log, when utilized, should not disclose information protected by confidentiality standards and regulations. An example of a mental health on-site tracking log is provided in Appendix U.

### VII. HEALTH SERVICES STATISTICAL REPORTS

Because the need, demand for, and utilization of health services in departmental facilities/programs may vary depending upon the characteristics of youths entering the juvenile justice system, it is important to have procedures in place whereby provision of health services may be reviewed.

The facility superintendent/program director and Designated Mental Health Authority or mental health/substance abuse clinical staff must implement procedures for the collection of data pertaining to the characteristics of youth needing and utilizing mental health and/or substance
abuse services in the DJJ facility/program. The Health Services Statistical Report provided on JJIS must be completed on a monthly basis.
CHAPTER 5
MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING AND EVALUATION

I. INTRODUCTION

The Department’s continuum of services must have the capacity to identify youths who are in need of mental health or substance abuse treatment. This objective is accomplished through timely administered and effective screening and evaluation procedures.

“Screening” refers to procedures used to substantiate that there is reason for concern that a mental health or substance abuse problem exists, and to identify the need for further assessment or evaluation. Initial mental health or substance abuse screening conducted during a youth’s intake into a facility or program generally involves information gathering and does not involve clinical judgment. Accordingly, intake screenings are generally conducted by non-clinical staff. When initial screening indicates that a youth may have a mental health or substance abuse problem, further mental health or substance abuse assessment or evaluation must be conducted.

It is important to emphasize that mental health and substance abuse screening should be available at key points in the Department’s continuum of services, not solely at the entry point (e.g., initial intake). Since movement from one facility to another can have a significant impact on the youth, all facilities and programs must have an efficient screening process in place which identifies, refers and provides services to youths in need of immediate mental health or substance abuse treatment.

Within the Department’s continuum of services, youths identified through preliminary screening as in need of further mental health and/or substance abuse assessment must be referred for comprehensive assessment by a licensed mental health or substance abuse service provider. The comprehensive assessment provides the juvenile probation officer information regarding the youth’s needs for further evaluation and/or treatment services. Youths for whom residential commitment is anticipated or recommended, must be referred for pre-disposition comprehensive evaluation to include comprehensive mental health evaluation and/or comprehensive substance abuse evaluation.

A comprehensive mental health or substance abuse evaluation involves the collection of detailed information using procedures such as clinical interviews, questionnaires, rating scales and/or psychological/psychometric tests to determine the presence or absence of a mental disorder or substance abuse impairment. Comprehensive mental health or substance abuse evaluation determines the nature and complexity of the youth’s mental disorder or substance related disorder and initial diagnostic impression, and assists in developing treatment recommendations.

This chapter discusses guidelines for mental health and substance abuse screening as well as guidelines and procedures for comprehensive assessments, pre-disposition comprehensive evaluations, comprehensive mental health and substance abuse evaluations and updated comprehensive mental health and substance abuse evaluations. This chapter also discusses “Alert Systems” for coding and tracking youths identified as a potential suicide risk or having mental disorder or acute emotional distress which poses a potential safety or security risk.
II. MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING

All youth who are delivered to the Department are screened for substance abuse and mental health needs in a private/confidential manner, using the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2) or the DJJ Positive Achievement Change Tool (PACT) and the DJJ Suicide Risk Screening Instrument (SRSI), during the initial intake process in a Juvenile Assessment Center (JAC) or juvenile probation officer unit. Further mental health screening is conducted upon the youth’s admission to a detention center, residential commitment program or facility-based day treatment program. The mental health and substance abuse screenings provided during the initial intake process and upon entry to a facility or program are described below:

A. JAC AND JUVENILE PROBATION OFFICER UNIT INTAKE/DETENTION SCREENING AND DETENTION CENTER MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING:

Detention screening is a part of the intake process, and is the main entry point into the juvenile justice system for juveniles who have been arrested. The detention screening process begins when a law enforcement officer delivers a juvenile who has been taken into custody to the Department. Detention screening may occur at a detention center, law enforcement agency, Juvenile Assessment Center, or case management unit. Detention screening includes preliminary mental health and substance abuse screening as follows:

1. Massachusetts Youth Screening Instrument, Second Version (MAYSI-2) or Positive Achievement Change Tool (PACT) at the JAC or Juvenile Probation Officer (JPO) Unit:

The preliminary mental health and substance abuse screening conducted during the youth’s initial intake into the juvenile justice system currently includes administration of the Massachusetts Youth Screening Instrument, Second Edition (MAYSI-2, see Appendix L1) or administration of the Positive Achievement Change Tool (PACT, see Appendix L2 and L3). Administration of the PACT is required in JAC and JPO Units where the Office of Probation and Community Corrections’ PACT training for JAC and JPO screeners has been completed.

Note: The PACT will be utilized instead of the MAYSI-2 in JAC and JPO Units where the Office of Probation and Community Corrections’ PACT training for JAC and JPO screeners has been completed and implemented in the circuit.

a. The MAYSI-2 or PACT must be administered only by a juvenile probation officer or contracted intake person that has successfully completed the DJJ training developed specifically for the MAYSI-2 or PACT.

b. The MAYSI-2 or PACT must be administered and scored as provided on the DJJ Juvenile Justice Information System (JJIS) and in accordance with the specifications of the Office of Probation and Community Corrections.

c. The juvenile probation officer or contracted intake worker at the JAC administering the MAYSI-2 or PACT must determine whether a referral for further assessment or immediate attention must be made due to special circumstances which impact the MAYSI-2 or PACT results for the youth being screened, such as:

• The youth is known to have misreported his/her behavior when answering “no” to all items;

• Refuses to answer questions or does not appear to understand questions due to his or her age; or suspected learning/cognitive deficits or language barriers.
Furthermore, when the juvenile probation officer or intake person at the JAC obtains information from parents, staff members or other informed persons or behavioral observations which indicates the youth has a mental health or substance abuse problem or is a possible suicide risk, a referral for further assessment or immediate attention must be made regardless of the MAYSI-2 or PACT findings.

c. When a juvenile probation officer or contracted intake worker administering the MAYSI-2 or PACT determines special circumstances or collateral information indicate that a referral for further assessment or immediate attention is needed, the specific information that led to the determination that a referral for further evaluation or immediate attention is needed must be documented in the appropriate section of the MAYSI-2 or PACT Mental Health and Substance Abuse Screening Report and Referral form.

d. When the MAYSI-2 or PACT state-approved cut-off score or other intake/admission information indicates the need for referral for an assessment (i.e., comprehensive assessment or assessment of suicide risk) or crisis/emergency services, a referral must be made for further assessment or immediate attention.

e. When the MAYSI-2 “Suicide Ideation” scale or PACT Suicide Subscale or PACT Depression Subscale (“History of impairment in everyday tasks due to depression/anxiety” Domain 3 Mental Health, item 3) indicates further assessment is needed, or other information obtained at intake/admission suggests potential suicide risk, the youth must be referred for an assessment of suicide risk to be conducted within 24 hours or immediately if the youth is in crisis. Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the assessment of suicide risk is to be conducted immediately rather than within 24 hours.

Examples of information obtained at intake that suggest potential suicide risk are:
Current suicide ideation, suicide threats, self-inflicted injury or self-mutilation; History of suicide attempt, suicide ideation/suicide thoughts, suicide threat, self-inflicted injuries or self-mutilation; Serious psychiatric disturbance/serious mental health problem that has been/is causing significant distress or impairment (particularly depression, anxiety, bipolar disorder [dramatic mood swings], or psychosis) within the past six months; Substance dependence; Recent major loss (death of parent, sibling, best friend), within the past six months. Note: Indicators of recent significant psychiatric disturbance or serious mental health problem include, but are not limited to: Treatment with psychotropic medication (particularly medication for depression, bipolar disorder, anxiety disorder, and psychotic disorder), crisis stabilization, psychiatric hospitalization, or Baker Act evaluation within the past six months.

Given the high incidence of suicidal behavior in youths in juvenile correctional facilities, any youth with risk factors for suicide must be referred for an assessment of suicide risk to be conducted within 24 hours, or immediately if the youth is in crisis. Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the assessment of suicide risk is to be conducted immediately rather than within 24 hours. Any youth who makes a suicide attempt or attempts serious self-inflicted injury must receive an immediate assessment of suicide risk or emergency services.

g. If the MAYSI-2, PACT Mental Health and Substance Abuse Screening Report and Referral form or other information regarding the youth’s behavior or history indicates the
need for further mental health or substance abuse assessment, the youth must be referred by the juvenile probation officer for comprehensive assessment. The Comprehensive Assessment process must include either the administration of the Substance Abuse and Mental Health Assessment (SAMH-2) (see Appendix M-1) which is an in-depth assessment conducted by a licensed mental health or substance abuse service provider, and completion of the SAMH-3 (see Appendix M-2) which is a summary of findings and recommendations. The results of the SAMH-2 assessment (summarized on the SAMH-3 form) or an equivalent assessment instrument must be forwarded to the DJJ juvenile probation officer. The juvenile probation officer is responsible for noting the assessment findings and related recommendations on the pre-disposition report. (For additional information on the SAMH-2 process see the Probation and Community Corrections procedural handbook.)

h. The juvenile probation officer must ensure that the MAYSI-2 or PACT is entered and scored on JJIS and that the MAYSI-2 or PACT Mental Health and Substance Abuse Screening Report and Referral form is provided for the admitting detention officer prior to placing a youth in a detention center.

i. The juvenile probation officer must ensure that youths who are to be detained who are identified by the MAYSI-2 or PACT Mental Health and Substance Abuse Screening Report and Referral form, and/or special circumstances or collateral information, as in need of crisis intervention/treatment or referral for assessment of suicide risk are referred for the specified treatment or assessment of suicide risk within 24 hours (or immediately when the youth is in need of emergency services, crisis intervention or immediate Assessment of Suicide Risk) prior to placing the youth in the detention center. The Juvenile Probation Officer should request notification from the contracted assessor that the assessment has been completed.

j. The juvenile probation officer is responsible for ensuring that a referral for comprehensive assessment (e.g., SAMH-2, SAMH-3) for detained youths is completed based upon the findings of the MAYSI-2 or PACT screening. When the Comprehensive Assessment is received, the information will be forwarded to the detention center. If an assessment is not received by the juvenile probation officer by the 14th day after referral, the juvenile probation officer shall contact the detention center and inform detention center staff of the status of the assessment.

2. Review of Preliminary Screening (MAYSI-2 or PACT) and Comprehensive Assessments in Detention Centers: The detention center superintendent or designee is responsible for establishing procedures for a thorough review of preliminary screening conducted by the Office of Probation and Community Corrections (e.g., MAYSI-2 or PACT Mental Health and Substance Abuse Screening Report and Referral form findings). The facility superintendent or designee is also responsible for establishing procedures to track the receipt of comprehensive assessments at the detention center. If the comprehensive assessment is not received within 14 days of the youth’s admission, the juvenile probation officer shall contact the detention center and inform detention center staff of the status of the assessment.

a. The results of preliminary screening and comprehensive assessment (e.g., MAYSI-2, PACT, SAMH-2, SAMH-3) and other available assessment findings should be used to assist in identifying youths who may pose security or safety risk related to emotional or behavior disturbance. See section VI. “Mental Health Alert” of this chapter.
b. If, while the youth is in detention, the youth exhibits behavior, or information is obtained, which indicates the youth is in need of further mental health or substance abuse assessment, the juvenile detention center is responsible for referring the youth for comprehensive assessment by the facility’s mental health provider or substance abuse provider. **Note:** Detained youths who do not disclose or exhibit symptoms of mental disorder or substance abuse at the time of preliminary screening in the JAC and were not referred for further comprehensive assessment may later disclose or exhibit needs for mental health or substance abuse services while in the detention center. Therefore, the detention facility superintendent or designee must develop procedures whereby youths identified with mental health or substance abuse needs after admission to a detention center are referred for comprehensive assessment by the detention center’s mental health provider or substance abuse provider (See section III.B. for further information regarding comprehensive assessments in detention centers).

2. **DJJ Suicide Risk Screening Instrument:** When a youth is delivered to DJJ for intake screening, the juvenile probation officer screens the youth for suicide risk factors using the DJJ Suicide Risk Screening Instrument (Appendix N). The DJJ Suicide Risk Screening Instrument is also administered upon the youth’s admission to a detention center with portions administered by the detention officer and portions administered by the detention center nurse or mental health clinical staff person. The following briefly describes the Suicide Risk Screening process:

   a. **Probation and Community Corrections:** The juvenile probation officer administers the DJJ Suicide Risk Screening Instrument during the youth’s initial intake screening. The DJJ Suicide Risk Screening Instrument must be administered on the DJJ Juvenile Justice Information System (JJIS). If JJIS is not accessible, the SRSI written version may be used, but must be recorded on JJIS as soon as possible. The juvenile probation officer is responsible for completing the sections of the DJJ Suicide Risk Screening Instrument designated: “Identifying Data”, “Interview of Arresting/Transporting Officer”, “Juvenile Probation Officer Interview of Child”, “Juvenile Probation Officer Interview of Parent/Guardian or Relative and/or Assigned DCF Case Manager/Counselor”, “Juvenile Probation Officer & Detention Officer Observations”, and “Juvenile Probation Officer Screening Results”.

   (1) If further assessment is indicated by the DJJ Suicide Risk Screening Instrument administered by the juvenile probation officer (i.e., there is a “yes” for any of the DJJ Suicide Risk Screening Instrument questions, Appendix N), or by the MAYSI-2 Suicide Ideation Scale, PACT Suicide Subscale or PACT Depression Subscale (“History of impairment in everyday tasks due to depression/anxiety” Domain 3 Mental Health, item 3) or information obtained at initial intake suggests the youth is a potential suicide risk, the following must take place:

      (a) If the youth is to be released into the custody of the parent or guardian, the parent or guardian must be informed verbally and in writing that suicide risk findings were disclosed during screening and that an assessment of suicide risk should be conducted by a qualified mental health professional.

         • The parent or guardian must be provided the form entitled “Suicide Risk Screening Parent/Guardian Notification” at Appendix O.

         • A copy of the “Suicide Risk Screening Parent/Guardian Notification” form, signed by the parent or guardian, is to be permanently filed in the youth’s case management record.
(b) If the youth is to remain in the custody of DJJ, a Suicide Risk Alert is to be immediately entered into JJIS and the youth is to be placed on constant supervision until an Assessment of Suicide Risk is conducted by or under the supervision of a licensed mental health professional.

(c) The youth is to be referred for an Assessment of Suicide Risk to be conducted within 24 hours, or immediately if the youth is in crisis. Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the assessment of suicide risk is to be conducted immediately rather than within 24 hours. Any youth who makes a suicide attempt or attempts serious self-inflicted injury must receive an immediate assessment of suicide risk or emergency services.

Note: Youths with positive findings on the DJJ Suicide Risk Screening Instrument must also be referred for comprehensive assessment (SAMH-2 and SAMH-3).

(2) The youth’s DJJ Suicide Risk Screening Instrument must follow him/her from the juvenile probation officer to the detention officer to the detention nurse or mental health clinical staff person. The juvenile probation officer, detention officer and detention nurse or mental health clinical staff person must each document his/her observations and all other required information in the designated sections of the instrument on the DJJ Juvenile Justice Information System (JJIS). If JJIS is not accessible, the SRSI written version may be used, but must be recorded on JJIS as soon as possible, and no later than the next calendar day. The youth’s DJJ Suicide Risk Screening Instrument must be provided to the mental health clinical staff person who will perform the assessment of suicide risk when the need for an assessment of suicide risk is indicated by the instrument.

(3) A copy of the DJJ Suicide Risk Screening Instrument on JJIS or paper version of the SRSI must be placed in the youth’s record.

b. Suicide Risk Screening in Detention Centers: Upon the youth’s admission to a detention center, the DJJ Suicide Risk Screening Instrument must be administered by the detention officer and detention nurse or mental health clinical staff person on the DJJ Juvenile Justice Information System (JJIS).

(1) The detention officer must complete the sections of the instrument designated: “Juvenile Probation Officer and Detention Officer Observations” and “Detention Officer Screening Results” of the instrument.

(2) Following the detention officer’s completion of designated sections of the Suicide Risk Screening Instrument, the detention nurse or mental health clinical staff person administers his or her designated portions of the instrument. The detention nurse or mental health clinical staff person must complete the sections designated “Nursing Screening or Mental Health Clinical Staff Screening” and “Nursing Screening or Mental Health Clinical Staff Screening Results” of the instrument.

(3) If further assessment is indicated by the DJJ Suicide Risk Screening Instrument administered by the detention officer or detention nurse or mental health clinical staff person (i.e., there is a “yes” for any of the DJJ Suicide Risk Screening Instrument questions), a Suicide Risk Alert is to be immediately entered into JJIS and the youth must be placed on Suicide Precautions and maintained on at least constant supervision until an assessment of suicide risk is conducted by, or under the direct
supervision of, a licensed mental health professional within 24 hours, or immediately if the youth is in crisis. **Note:** Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the *assessment of suicide risk* is to be conducted immediately rather than within 24 hours. Any youth who makes a *suicide attempt* or attempts *serious self-inflicted injury* must receive an immediate *assessment of suicide risk* or emergency services.

(4) When the need for an *assessment of suicide risk* is indicated, the superintendent or his/her designee must be immediately notified of the youth’s suicide risk factors. The superintendent or designee is responsible for contacting the Designated Mental Health Authority or licensed mental health professional who conducts or supervises *assessment of suicide risk* to discuss the case and request that an *assessment of suicide risk* be conducted. (See Chapter Seven, entitled “Suicide Prevention” for details pertaining to Suicide Precautions and *assessment of suicide risk*).

(5) The superintendent or his/her designee must document on the *mental health/substance abuse referral summary* consultation with the Designated Mental Health Authority or licensed mental health professional (see sample, Appendix G).

**B. RESIDENTIAL COMMITMENT PROGRAM MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING:**

Screening conducted upon a youth’s admission to a residential commitment program or when a youth that had been on *inactive status* re-enters a program must address risk factors for mental health and substance abuse problems which, if identified, would require further evaluation and assessment or immediate attention.

**Residential Mental Health and Substance Abuse Screening Procedures:** The residential program director is responsible for developing written facility operating procedures for the implementation of a standardized admission/intake mental health and substance abuse screening process. The written facility operating procedures must address the following elements:

- A standardized mental health and substance abuse screening process which includes: Review of each juvenile offender’s commitment packet information, reports and records; Administration of the MAYSI-2 on the Department’s Juvenile Justice Information System (JJIS) or Clinical Mental Health and Substance Abuse Screening by a licensed mental health professional and referral of juvenile offenders identified by screening as in need of further evaluation or immediate attention.

- Staff training in mental health and substance abuse issues and the administration of the MAYSI-2 in accordance with the Department’s standards and requirements.

- A standardized process for referral of juvenile offenders identified as in need of further mental health and/or substance abuse evaluation to an appropriate service provider/professional or, when immediate attention is needed, to a hospital or receiving facility.

**1. Standardized Mental Health and Substance Abuse Screening Process:** The mental health and substance abuse screening process developed in the written facility operating procedures must include, at a minimum, the following provisions in (a) through (c):
a. Review of Commitment Information: Residential program staff designated to provide mental health and substance abuse screening will review each youth's commitment packet information, reports and records for existing documentation of mental health or substance abuse problems, needs or risk factors including, but not limited to, a history of:

- Inpatient or outpatient mental health/substance abuse treatment;
- Emergency room evaluations for mental health/substance-related issues;
- Suicide attempt, suicide behaviors or suicide risk;
- Self-injurious behaviors (e.g., head banging, self-mutilation, intentional self-injury);
- 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.

The residential program staff will note any existing documentation of mental health or substance abuse problems, needs or risk factors and report the documentation to appropriate clinical and administrative staff. Procedures must be in place for mental health clinical staff to review existing documentation of mental health and/or substance abuse problems, risk factors or needs.

b. Administration of the MAYSI-2 or Clinical Mental Health/Substance Abuse Screening: Either the MAYSI-2 or Clinical Mental Health and Clinical Substance Abuse Screening must be administered upon each youth's admission to a residential commitment program.

1. MAYSI-2 Screening: If the MAYSI-2 is utilized the following procedures must be followed:

   (a) The MAYSI-2 shall be administered, in a private/confidential manner, to the youth upon admission to a residential commitment program on the day of the admission.

   (b) The MAYSI-2 shall be administered only by residential program staff who have successfully completed the Department's training module entitled “Using the MAYSI-2 to Screen for Mental Health and Substance Abuse Problems”.

   (c) The MAYSI-2 shall be administered and scored using the Department's Juvenile Justice Information System (JJIS).

   (d) The program staff administering the MAYSI-2 shall:

      (1) Begin the screening by explaining the MAYSI-2 using the script provided in the Department’s MAYSI-2 training module which states:

         "These are some questions about things that sometimes happen to people. For each question, please answer "yes" or "no" as to whether the question has been true for you in the past few months. Please answer these questions as well as you can".

      (2) Ask the youth the questions cited in the MAYSI-2 on JJIS at the pages identified as: [Step 1 of 5, Step 2 of 5, Step 3 of 5 and Step 4 of 5]. The MAYSI-2 questions shall be read aloud to the youth individually and in a confidential manner (out of hearing range of others). The staff person may explain MAYSI-2 questions/items by giving examples or restating the question. The staff person may also answer questions about the meaning of words in the MAYSI-2 items.
(3) Provide sufficient time for the youth to answer the MAYS1-2 questions. If the youth has difficulty deciding whether an item is true or not true, the staff person may explain that he or she should answer "yes" if the question has "probably been true" or if it is "a little true". If the youth refuses or cannot answer a question, the staff person should proceed to the next MAYS1-2 question/item and continue until the MAYS1-2 has been completed.

(4) Determine whether a referral for further evaluation or immediate attention is to be made due to special circumstances which impact the MAYS1-2 results for the youth being screened. The MAYS1-2 results may be impacted by special circumstances such as: the youth is known to have misreported his/her behaviors when answering "no" to all items, refuses to answer questions or does not appear to understand questions due to his or her age, suspected learning/cognitive deficits or language barriers.

- When the staff person obtains information from the commitment packet, parents, staff members or other informed persons which indicates 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 regardless of the MAYS1-2 findings.

- If special circumstances or collateral information indicates that a referral for further evaluation is needed regardless of the MAYS1-2 results, the staff person will place a "check" in the box provided on JJIS at [Step 5 of 7] and will document, in the narrative section, the specific information that led to the determination that a referral for further evaluation or immediate attention is to be made.

(5) Score the MAYS1-2 on JJIS at [Step 6 of 7]. The JJIS screen/form will list the "yes" responses made by the youth for each category of the MAYS1-2 and will indicate whether an assessment is required, based on the MAYS1-2 findings.

(6) Analyze the information provided by the MAYS1-2, the commitment packet, parents, staff members and other informed persons, or observed during the screening process to determine if a referral for further evaluation or immediate attention is needed.

- If the MAYS1-2 indicates assessment is required (there is a “YES” under the “Assessment Required” column) at JJIS [Step 6 of 7], a referral must be made for further evaluation or immediate attention. However, the decision to make a referral for further evaluation can be made even if the MAYS1-2 indicates a referral is not necessary.

- If the staff person has information, observations or concerns that suggest the youth has a mental health or substance abuse problem or is a suicide risk, the staff person should make a referral for further evaluation or immediate attention, regardless of the MAYS1-2 findings.

- If the staff person determines that referral for further evaluation or immediate attention is needed but the MAYS1-2 does not indicate a referral is necessary, the staff person will return to JJIS [Step 5 of 7] and document the information, observations, events or concerns that led to
the determination that a referral for further evaluation or immediate attention is to be made.

(7) Document recommendations with regard to referral for further mental health and/or substance abuse evaluation on the JJIS at [Step 7 of 7]. The staff person shall click one of the boxes provided on the form as follows:

Service response:
- a) Assessment referral based on MAYS screen
- b) Override of MAYS results and referral made due to observation or collateral information
- c) No referral necessary based upon available information

(8) When the MAYS-2 or other intake/admission information indicates the need for referral for an assessment (i.e., comprehensive mental health or substance evaluation and/or assessment of suicide risk), crisis intervention or emergency services, the residential program director or designee must be notified and referral made.

(e) The residential program director shall ensure that an Assessment of Suicide Risk is conducted within 24 hours when the MAYS category “Suicide Ideation” indicates further assessment is needed, or other information obtained at intake/admission suggests potential suicide risk. Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the assessment of suicide risk is to be conducted immediately rather than within 24 hours.

Examples of information obtained at intake that suggest potential suicide risk are: Current suicide ideation, suicide threats, self-inflicted injury or self-mutilation; History of suicide attempt suicide ideation/suicide thoughts, suicide threat, self-inflicted injuries or self-mutilation; Serious psychiatric disturbance/serious mental health problem, within the past six months, that has been/is causing significant distress or impairment (particularly depression, anxiety, bipolar disorder [dramatic mood swings], or psychosis); Substance dependence; Recent major loss, within the past six months, (death of parent, sibling, best friend). Note: Indicators of recent significant psychiatric disturbance or serious mental health problem include, but are not limited to: Treatment with psychotropic medication (particularly medication for depression, bipolar disorder, anxiety disorder, psychotic disorder), crisis stabilization or psychiatric hospitalization, Baker Act evaluation within the past six months.

Given the high incidence of suicidal behavior in youths in juvenile correctional facilities, any youth with risk factors for suicide must be referred for an assessment of suicide risk to be conducted within 24 hours or immediately if the youth is in crisis. Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the assessment of suicide risk is to be conducted immediately rather than within 24 hours. Any youth who makes a suicide attempt or attempts serious self-inflicted injury must receive immediate assessment of suicide risk or emergency services.

(f) The residential program director shall ensure that comprehensive mental health and substance abuse evaluations or updated evaluations are provided by
qualified providers/professionals within 30 days of screening. If the comprehensive evaluation is not completed within 30 days, reasons are documented in the case file. (See section IV for further information regarding comprehensive evaluations).

2. Clinical Mental Health Screening and Clinical Substance Abuse Screening:

Clinical Mental Health Screening and Clinical Substance Abuse Screening are screening processes at intake/admission to a residential commitment program providing in-depth mental health and substance abuse screening as an alternative to administration of the MAYSI-2. If Clinical Mental Health and Clinical Substance Abuse Screening are to be administered as an alternative to the MAYSI-2, the following provisions must be followed:

(a) Clinical Mental Health Screening must be conducted by a licensed mental health professional. The Clinical Mental Health Screening must utilize valid and reliable screening instruments (e.g., Diagnostic Interview Schedule for Children (DISC), Diagnostic Interview for Children and Adolescents (DICA), Symptom Checklist-90).

(b) Clinical Substance Abuse Screening must be conducted by a “qualified professional” as defined in Section 397.311(25), Florida Statutes [in accordance with Rule 65D-30.003(15) F.A.C]. The Clinical Substance Abuse Screening must utilize valid and reliable substance abuse screening instruments (e.g., Substance Abuse Subtle Screening Inventory-3 (SASSI-3), Problem Oriented Screening Instrument for Teenagers (POSIT)).

(c) Clinical Mental Health Screening and Clinical Substance Abuse Screening must include suicide risk screening utilizing a validated and reliable suicide risk screening instrument such as the Suicide Ideation Questionnaire or Suicide Probability Scale.

(d) Clinical Mental Health/Substance Abuse Screening must reflect consideration of the following elements:
   - 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

(e) Documentation of Clinical Mental Health/Substance Abuse Screening must be provided by the licensed mental health professional on a form clearly identified as “Clinical Mental Health/Substance Abuse Screening” on provider/program stationary.

(f) The Clinical Mental Health/Substance Abuse Screening must provide details of the information obtained by the screening (youth statements, behavioral observations, collateral information). The specific information supporting the Clinical Mental Health/Substance Abuse Screening findings and recommendations must be documented on the form.
(g) The Clinical Mental Health or Clinical Substance Abuse Screening form must be signed and dated by the licensed mental health professional or “qualified professional” under 397.311(25) F.S., conducting the screening.

(h) Based upon the outcome of the clinical mental health screening or clinical substance abuse screening, the licensed mental health or “qualified professional” as defined in Section 397.311(25) will make a decision regarding the need for further evaluation or treatment.

(i) When Clinical Mental Health/Substance Abuse Screening indicates the need for an assessment of suicide risk or emergency mental health evaluation, the residential program director or designee must be immediately notified. The residential program director or designee is responsible for contacting the Designated Mental Health Authority or licensed mental health professional who conducts or supervises assessments of suicide risk to discuss the case and request that an assessment of suicide risk be conducted.

(j) The residential program director or his/her designee and the Designated Mental Health Authority or other licensed mental health professional responsible for mental health evaluations in the facility shall confer regarding cases viewed as urgent and, if it is determined that an emergency exists, act according to the facility operating procedures for emergency care.

(k) The residential program director or his/her designee must document on the mental health/substance abuse referral summary consultation with the Designated Mental Health Authority or licensed mental health professional (see sample, Appendix G).

c. Procedures when Suicide Risk Factors are Identified by MAYSi-2 or Clinical Mental Health or Clinical Substance Abuse Screening:

When suicide risk factors are identified by the MAYSi-2 “Suicide Ideation” category, other information obtained at intake or Clinical Mental Health/Substance Abuse Screening, a Suicide Risk Alert is to be immediately entered into JJIS and the youth must be placed on Suicide Precautions and maintained on constant supervision until an assessment of suicide risk is conducted. The youth must be referred for an assessment of suicide risk to be conducted within 24 hours or immediately if the youth is in crisis.

Note: Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the assessment of suicide risk is to be conducted immediately rather than within 24 hours. Any youth who makes a suicide attempt or attempts serious self-inflicted injury must receive immediate assessment of suicide risk or emergency services.

1. When the need for an assessment of suicide risk is indicated, the following procedures must be followed:

   (a) The residential program director or his/her designee must be immediately notified. The residential program director or designee is responsible for contacting the Designated Mental Health Authority or licensed mental health professional who conducts or supervises assessments of suicide risk to discuss the case and request that an assessment of suicide risk be conducted.

   (b) The residential program director or his/her designee and the Designated Mental Health Authority or other licensed mental health professional responsible for assessment of suicide risk in the facility shall confer regarding cases viewed as
urgent and, if it is determined that an emergency exists, act according to the facility operating procedures for emergency care.

(c) The residential program director or his/her designee must document on the mental health/substance abuse referral summary consultation with the Designated Mental Health Authority or licensed mental health professional. (See sample, Appendix G).

(d) The residential program director or his/her designee shall ensure that the Assessment of Suicide Risk is conducted by, or under the supervision of, a licensed mental health professional within 24 hours of referral. (See Chapter Seven, “Suicide Precautions” for details pertaining to Suicide Precautions and assessment of suicide risk).

C. FACILITY BASED DAY TREATMENT PROGRAM MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING:

Screening conducted upon a youth’s admission to a facility based day treatment program must address risk factors for mental health and substance abuse problems which, if identified, would require further evaluation and assessment or immediate attention.

1. Facility Based Day Treatment Mental Health and Substance Abuse Screening Procedures: The program director is responsible for developing written facility operating procedures for the implementation of a standardized admission/intake mental health and substance abuse screening process. The written facility operating procedures must address the following elements:

- A standardized mental health and substance abuse screening process which includes: Review of each juvenile offender's referral packet information, reports and records (including the MAYSI-2 or PACT, if available) and referral of juvenile offenders identified by screening as in need of further evaluation or immediate attention.

- A standardized process for referral of juvenile offenders identified as in need of further mental health and/or substance abuse evaluation to an appropriate service provider/professional or, when immediate attention is needed, to a hospital or receiving facility.

2. Standardized Mental Health and Substance Abuse Screening Process: The mental health and substance abuse screening process developed in the written facility operating procedures must include, at a minimum, the following provisions:

a. Review of Referral Information: Facility based day treatment program staff designated to provide mental health and substance abuse screening will review each youth’s referral packet information, reports and records for existing documentation of mental health or substance abuse problems, needs or risk factors including, but not limited to, a history of:

- Inpatient or outpatient mental health/substance abuse treatment;
- Emergency room evaluations for mental health/substance-related issues;
- Suicide attempt, suicide behaviors or suicide risk;
- Self-injurious behaviors (e.g., head banging, self-mutilation, intentional self-injury);
- Treatment with psychotropic medications;
- Drug/alcohol use or drug/alcohol possession;
FLORIDA DEPARTMENT OF JUVENILE JUSTICE  
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES MANUAL

- Emotional instability (e.g., depression, anxiety, mood swings, violent rage);
- History of significant trauma;
- History of mental illness in family.

The facility based day treatment program staff will note any existing documentation of mental health or substance abuse problems, needs or risk factors and report the documentation to appropriate clinical and/or administrative staff.

b. Administration of the MAYSI-2: The MAYSI-2 must be administered upon each youth’s admission to a facility based day treatment program, unless a PACT Assessment has been completed on JJIS in the past 45 days in which case the MAYSI-2 will not be administered. Administration of the MAYSI-2 requires the following:

1. The MAYSI-2 shall be administered, in a private/confidential manner, to the youth upon admission to a day treatment program on the day of the admission.

2. The MAYSI-2 shall be administered only by program staff who have successfully completed the Department’s training module entitled “Using the MAYSI-2 to Screen for Mental Health and Substance Abuse Problems”.

3. The MAYSI-2 shall be administered and scored using the Department’s Juvenile Justice Information System (JJIS).

4. When the MAYSI-2 or other intake/admission information indicates the need for referral for an assessment (i.e., comprehensive mental health or substance evaluation and/or assessment of suicide risk), crisis intervention or emergency services), the program director or designee must be notified and referral made.

5. The program director shall ensure that comprehensive mental health and substance abuse evaluations or updated evaluations are provided by qualified providers/professionals within 30 days of screening. If the comprehensive evaluation is not completed within 30 days, reasons are documented in the case file.

3. Procedures When Suicide Risk Factors are Identified by MAYSI-2 or PACT: The program director shall ensure that an Assessment of Suicide Risk is conducted immediately or within 24 hours when the MAYSI-2 category “Suicide Ideation” or PACT Suicide Subscale or PACT Depression Subscale (“History of impairment in everyday tasks due to depression/anxiety” Domain 3 Mental Health, item 3) indicates further assessment is needed, or other information obtained at intake/admission suggests potential suicide risk. Note: Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the assessment of suicide risk is to be conducted immediately rather than within 24 hours. Any youth who makes a suicide attempt or attempts serious self-inflicted injury must receive immediate assessment of suicide risk or emergency services.

Examples of information obtained at intake that suggest potential suicide risk are: Current suicide ideation, suicide threats, self-inflicted injury or self-mutilation; History of suicide attempt, suicide ideation/suicide thoughts, suicide threat, self-inflicted injuries or self-mutilation; Serious psychiatric disturbance/serious mental health problem, within the past six months, that has been/is causing significant distress or impairment (particularly depression, anxiety, bipolar disorder [dramatic mood swings], or psychosis); Substance dependence; Recent major loss, within the past six months, (death of parent, sibling, best
friend). **Note:** Indicators of recent significant psychiatric disturbance or serious mental health problem include, but are not limited to: Treatment with psychotropic medication (particularly medication for depression, bipolar disorder, anxiety disorder, psychotic disorder), crisis stabilization or psychiatric hospitalization, Baker Act evaluation within the past six months.

a. When the need for an **assessment of suicide risk** is indicated, the following procedures must be followed:

(1) The program director or his/her designee must be immediately notified. The program director or designee is responsible for contacting the **Designated Mental Health Authority** or **licensed mental health professional** who conducts or supervises **assessments of suicide risk** to discuss the case and request that an **assessment of suicide risk** be conducted.

(2) The program director or his/her designee and the **Designated Mental Health Authority** or other **licensed mental health professional** responsible for **assessment of suicide risk** in the facility shall confer regarding cases viewed as urgent and, if it is determined that an emergency exists, act according to the facility operating procedures for emergency care.

(3) The program director or his/her designee must document on the **mental health substance abuse referral summary consultation with the Designated Mental Health Authority or licensed mental health professional.** (See sample, Appendix G).

(4) The program director or his/her designee shall ensure that the **Assessment of Suicide Risk** is conducted by or under the supervision of a **licensed mental health professional** within 24 hours of referral. (See Chapter Seven, “Suicide Precautions” for details pertaining to **Suicide Precautions and assessment of suicide risk**.

### III. COMPREHENSIVE ASSESSMENTS UNDER SECTION 985.21(1)(a)4 AND PRE-DISPOSITION COMPREHENSIVE EVALUATIONS UNDER SECTION 985.229 F.S. (WHEN RESIDENTIAL COMMITMENT IS ANTICIPATED OR RECOMMENDED)

#### A. COMPREHENSIVE ASSESSMENTS UNDER SECTION 985.21(1)(a)4:

Section 985.21(1)(a)4 states: “In addition to duties specified in other sections and through departmental rules, the assigned juvenile probation officer shall be responsible for ... Performing the preliminary screening and making referrals for comprehensive assessment regarding the child’s need for substance abuse treatment services, mental health services, retardation services, literacy services, or other educational or treatment services”. The **comprehensive assessment** is accomplished through administration of the Substance Abuse and Mental Health Assessment-2 (SAMH-2) and completion of the SAMH-3 which is a summary of SAMH-2 findings and recommendations. The **comprehensive assessment** is typically a psychosocial assessment which provides the juvenile probation officer information regarding the youth’s needs for further evaluation and/or treatment services.

1. The juvenile probation officer is responsible for ensuring that youths identified through preliminary screening as in need of further mental health and/or substance abuse assessment are referred for **comprehensive assessment** by the Office of Probation contracted provider or Juvenile Assessment Center (JAC).
2. The juvenile probation officer is responsible for ensuring that when the comprehensive assessment of a detained youth is received, the information will be forwarded to the detention center. If an assessment is not received by the juvenile probation officer by the 14th day after referral, the juvenile probation officer shall contact the detention center and inform detention center staff of the status of the assessment.

3. The juvenile probation officer is responsible for ensuring that youths for whom a residential commitment disposition is anticipated or recommended and who are identified through preliminary screening and comprehensive assessment as having a mental health and/or substance abuse problem, are referred for a pre-disposition comprehensive evaluation which includes an in-depth mental health and/or substance abuse evaluation.

4. The juvenile probation officer is responsible for ensuring that comprehensive assessments are forwarded to the provider(s) contracted to provide comprehensive evaluations. Thus, ensuring that data and information provided through the comprehensive assessment is not needlessly duplicated, but is included in the comprehensive evaluation.

5. The detention center superintendent or designee is responsible for establishing procedures for a thorough review of comprehensive assessments or comprehensive evaluations conducted by the Office of Probation and Community Corrections.

B. COMPREHENSIVE ASSESSMENTS FOR YOUTHS IN DETENTION CENTERS OR DAY TREATMENT PROGRAMS

The Probation and JAC intake/detention screening process (described in Section II, A(1) of this chapter) ensures that youths identified through preliminary screening as having mental health and substance abuse issues or problems receive in-depth mental health and/or substance abuse assessment shortly after intake to the juvenile justice system.

However, detained youths or youths in day treatment programs who do not disclose or exhibit symptoms of mental disorder or substance abuse at the time of preliminary screening and were not referred for further mental health or substance abuse assessment may later disclose or exhibit needs for mental health or substance abuse services. Therefore, the detention facility superintendent, day treatment program director or designee must develop procedures whereby youths identified with mental health or substance abuse needs after admission to a detention center or day treatment program are referred for comprehensive assessment by the detention center/day treatment program’s mental health provider or substance abuse provider as provided below.

1. If, while the youth is in a detention center or day treatment program, the youth exhibits behavior, or information is obtained, which indicates the youth is in need of in-depth mental health or substance abuse assessment, the facility superintendent/program director or designee is responsible for ensuring the youth is referred for comprehensive assessment by the detention center’s or day treatment program’s mental health provider or substance abuse provider.

   a. The comprehensive assessment may consist of administration of the SAMH-2 and SAMH-3 or a comparable instrument that contains all the elements of the SAMH-2 and is approved by DJJ.

   b. The comprehensive assessment must be completed within 30 days of the referral.

2. The facility superintendent/program director or designee is responsible for ensuring that information obtained after the youth’s admission to a detention center or day treatment program is included in the comprehensive assessment and is forwarded to the provider(s) contracted to provide comprehensive evaluations.
program regarding the youth’s mental health or substance abuse problems or needs are provided to the detention center’s or day treatment program’s mental health or substance abuse provider.

3. The detained youth for whom a residential commitment disposition is anticipated or recommended, who exhibits mental health or substance abuse problems or needs after admission to the detention center must also be brought to the attention of the youth’s juvenile probation officer. The facility superintendent or designee is responsible for ensuring that the juvenile probation officer is informed of the youth’s mental health/substance abuse issues. The juvenile probation officer is responsible for ensuring that information obtained after the youth’s admission to the detention center regarding the youth’s mental health or substance abuse problems or needs are provided to the provider(s) contracted to provide pre-disposition comprehensive evaluations.

C. PREDISPOSITION COMPREHENSIVE EVALUATIONS UNDER SECTION 985.229(1):

Section 985.229(1), Florida Statutes provides that a comprehensive evaluation for physical health, mental health, substance abuse, academic, educational or vocational problems shall be ordered for any child for whom a residential commitment disposition is anticipated or recommended by an officer of the court or by the Department.

1. The juvenile probation officer is responsible for ensuring that youths screened through the Supervision Risk Classification Instrument who are recommended for commitment or for whom commitment is anticipated, are referred for comprehensive evaluation. Youths identified through preliminary screening and comprehensive assessment as having a mental health and/or substance abuse problem who are recommended for commitment or for whom commitment is anticipated must receive a comprehensive evaluation which includes an in-depth mental health and/or substance abuse evaluation.

2. A comprehensive evaluation for mental health problems must be conducted by a licensed mental health provider and a comprehensive evaluation for substance abuse problems must be conducted by a licensed substance abuse service provider as provided in the Office of Probation and Community Corrections Handbook and Departmental policies.

3. If a comprehensive evaluation is ordered, the predisposition report shall include a summary of the comprehensive evaluation.

4. The juvenile probation officer is responsible for ensuring that comprehensive evaluations are updated or re-administered in accordance with the timeframes required by the Office of Probation and Community Corrections.

5. The juvenile probation officer is responsible for ensuring that pre-disposition comprehensive evaluations for detained youths are forwarded to the detention center.

6. The juvenile probation officer is responsible for ensuring that comprehensive evaluations are included as part of the youth’s commitment packet and shall accompany the youth to the residential commitment program in which the youth is placed.
IV. PRE-DISPOSITION COMPREHENSIVE EVALUATIONS UNDER SECTION 985.229 F.S. AND UPDATED COMPREHENSIVE EVALUATIONS IN RESIDENTIAL COMMITMENT PROGRAMS

The pre-disposition comprehensive evaluation process (described in Section V) ensures that youths for whom a residential commitment is anticipated or recommended who are identified through preliminary screening as having mental health and/or substance abuse issues or problems receive a pre-disposition comprehensive evaluation which includes comprehensive mental health evaluation and/or comprehensive substance abuse evaluation prior to disposition and placement in a residential commitment program.

However, youths who do not disclose or exhibit symptoms of mental disorder or substance abuse at the time of preliminary screening or comprehensive evaluation may later disclose or exhibit needs for mental health or substance abuse services. Therefore, DJJ facilities and programs must develop procedures whereby youths identified with mental health or substance abuse needs after admission to a residential commitment program are referred for in-depth mental health or substance abuse assessment or evaluation.

A. COMPREHENSIVE MENTAL HEALTH EVALUATIONS AND COMPREHENSIVE SUBSTANCE ABUSE EVALUATIONS:

In most instances, youths in need of in-depth mental health and/or substance abuse evaluation will receive a pre-disposition comprehensive evaluation which includes comprehensive mental health evaluation and/or comprehensive substance abuse evaluation prior to admission to the residential commitment program. However, youths who demonstrate behaviors/symptoms indicative of acute psychological distress, serious emotional disturbance, mental illness or substance abuse impairment during the screening process or after admission to a facility/program must be referred to a qualified mental health or substance abuse professional to determine the need for comprehensive mental health or substance abuse evaluation or updated comprehensive mental health or substance abuse evaluation.

A comprehensive mental health evaluation is an in-depth evaluation conducted by, or under the direction of, a licensed mental health professional to determine the presence of, or nature and complexity of a mental health disorder. A comprehensive substance abuse evaluation is an in-depth evaluation conducted by a qualified professional as defined in Section 397.311(25), F.S., in accordance with Rule 65D-30.003(15) FAC to determine the presence of, or nature and complexity of a substance related disorder. The comprehensive mental health or substance abuse evaluation guides decisions regarding referral for treatment and level of services needed to address the youth’s problems.

1. Comprehensive Mental Health Evaluations: Within the context of this manual, “comprehensive mental health evaluation” refers to an in-depth mental health evaluation conducted by, or under the supervision of, a licensed mental health professional to establish the presence of, or nature and complexity of mental disorder. A variety of assessment methods may be used during comprehensive mental health evaluations. These methods include clinical interviews and standardized assessment instruments (e.g., structured interview, rating scales, or tests).

   a. A comprehensive mental health evaluation must be conducted by a licensed mental health professional or a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional. Direct supervision
means that a licensed mental health professional has at least one hour per week of on-site face-to-face interaction with the non-licensed individual for the purpose of overseeing and directing the mental health evaluation and treatment which he or she is providing in the facility.

b. **Comprehensive mental health evaluations** must reflect consideration of the following:

1. Identifying Information;
2. Reason for Evaluation;
3. Relevant Background Information: (Including home environment/family functioning; history of physical abuse, sexual abuse, neglect, witnessing violence and other forms of trauma; behavioral functioning; health [physical health, mental health and substance abuse] and educational functioning)
4. Behavioral Observations/Mental Status Examination;
5. Interview or Procedures Administered;
6. Discussion of Findings;
7. Diagnostic Impression/Formulation;
8. Recommendations.

The comprehensive mental health evaluation must be responsive to the specific problems or issues raised by screening or staff observations.

d. **Comprehensive mental health evaluations** must be completed within 30 days of referral. However, if screening, staff observations or other information indicates the youth has a mental health problem which poses a safety risk to himself/herself or others, completion of the comprehensive mental health evaluation must be expedited based upon the urgency of the youth’s symptoms.

e. **Comprehensive mental health evaluations** must be signed and dated by the mental health professional conducting the evaluation. If the comprehensive mental health evaluation is conducted by a non-licensed mental health clinical staff person, the evaluation must be reviewed, signed as reviewed and dated by a licensed mental health professional within 10 calendar days after the evaluation is conducted.

2. **Comprehensive Substance Abuse Evaluations:**

A comprehensive substance abuse evaluation is an in-depth evaluation conducted by a qualified substance abuse professional in accordance with Rule 65D-30.003(15) FAC to determine the presence of, or nature and complexity of a substance related disorder. Youths who have been identified during the screening process as presenting a substance abuse problem (e.g., youth who use substances on a daily, weekly or monthly basis or youth with substance dependence or addiction) require a comprehensive substance abuse evaluation.

The comprehensive substance abuse evaluation involves the collection of detailed information concerning the youth’s substance use, emotional and behavioral functioning, social roles and other areas that may reflect the severity of the youth’s abuse of alcohol or other drugs.

a. **Comprehensive substance abuse evaluations** must be conducted in accordance with the licensure requirements in Rule 65D-30.003(15), Florida Administrative Code. (see Manual page 2-6)

Under Rule 65D-30.003(15), FAC, condition (a) and condition (b), a comprehensive substance abuse evaluation must be conducted by a substance abuse clinical staff
person who is employee of a facility licensed under Chapter 397 or an employee of a service provider licensed under Chapter 397, F.S., and under condition (c) and (d), the substance abuse clinical staff person must be a qualified professional licensed under chapter 458, 459, 490 or 491, Florida Statutes.

b. Comprehensive Substance Abuse Evaluation must reflect consideration of the following:
   (1) Reason for Assessment
   (2) Pertinent Background Information (Including home environment/family functioning; history of physical abuse, sexual abuse, neglect, witnessing violence and other forms of trauma; behavioral functioning; health [physical health, mental health and substance abuse] and educational functioning)
   (3) Behavioral Observations
   (4) Methods of Assessment
   (5) Patterns of Alcohol and Other Drug Abuse
   (6) Impact of Alcohol and Other Drug Abuse on Major Life Areas
   (7) Risk Factors for Continued Alcohol and Other Drug Abuse
   (8) Clinical Impression and Recommendations

c. The comprehensive substance abuse evaluation must be responsive to the specific problems or issues raised by screening or staff observations.

d. Comprehensive substance abuse evaluations must be completed within 30 days of referral. However, if screening, staff observations or other information indicates the youth has a substance abuse problem which poses a safety risk to himself/herself or others, completion of the comprehensive substance abuse evaluation must be expedited based upon the urgency of the youth’s symptoms.

e. Comprehensive substance abuse evaluation must be signed and dated by the professional conducting the evaluation. If the comprehensive substance abuse evaluation is conducted by a non-licensed/non-certified substance abuse clinical staff person employed by a service provider licensed under Chapter 397 or in a facility licensed under Chapter 397, F.S., the evaluation must be reviewed, signed "as reviewer" and dated by a qualified professional under Section 397.311(25), Florida Statutes within 10 calendar days after the evaluation is conducted.

Updated Comprehensive Mental Health and Substance Abuse Evaluations:

When the youth’s file contains a comprehensive mental health evaluation or comprehensive substance abuse evaluation which was completed within twelve months of the youth’s admission to the DJJ facility or program, and the previous comprehensive evaluation was conducted in accordance with DJJ requirements as specified in this chapter, in lieu of conducting a comprehensive mental health or comprehensive substance abuse evaluation, the previous corresponding comprehensive evaluation may be utilized to conduct an updated comprehensive mental health or comprehensive substance abuse evaluation as follows:

1. The updated comprehensive evaluation must be identified as an “Updated Comprehensive Mental Health Evaluation” or “Updated Comprehensive Substance Abuse Evaluation” or “Updated Mental Health and Substance Abuse Evaluation”, and must be attached to the previous comprehensive evaluation(s) which are being updated.

2. The updated comprehensive mental health or substance abuse evaluation must be responsive to the specific problems and/or issues identified by screening or staff observations which necessitated referral for comprehensive evaluation.
3. The updated comprehensive evaluation must provide any updated and/or additional information applicable to each area specified in section IV, A, paragraphs 1.b. and 2.b. of this chapter, based upon current information provided by the youth, his or her family/legal guardians and the youth’s records.

4. The updated comprehensive evaluation must provide findings and recommendations which are current and address the problems or issues identified by screening or staff observations and disclosed during the updated comprehensive evaluation process.

5. Updated comprehensive mental health or comprehensive substance abuse evaluations must be completed within 30 days of referral. However, if screening, staff observations or other information the youth has a mental health problem or substance abuse problem which poses a safety risk to himself/herself or others, completion of the updated comprehensive mental health evaluation or updated comprehensive substance abuse evaluation must be expedited based upon the urgency of the youth’s symptoms.

6. Updated comprehensive mental health evaluations must be signed and dated by the mental health clinical staff person conducting the evaluation. If the updated comprehensive mental health evaluation is conducted by a non-licensed mental health clinical staff person, the evaluation must be reviewed, signed “as reviewer” and dated by a licensed mental health professional within 10 calendar days after the updated comprehensive mental health evaluation is conducted.

7. Updated Comprehensive substance abuse evaluations must be signed and dated by the substance abuse clinical staff person conducting the evaluation. If the updated comprehensive substance abuse evaluation is conducted by a non-licensed substance abuse clinical staff person employed by a service provider licensed under Chapter 397 or in a facility licensed under Chapter 397, F.S., the evaluation must be reviewed, signed “as reviewer” and dated by a qualified professional under Section 397.311(25), Florida Statutes within 10 calendar days after the updated comprehensive substance abuse evaluation is conducted.

C. MENTAL HEALTH AND SUBSTANCE ABUSE ASSESSMENT INSTRUMENTS:

Assessment instruments are widely used by mental health and substance abuse treatment professionals to assist in making clinical decisions and treatment recommendations. Assessment instruments are standardized tools designed to assess individuals in multiple areas (e.g., intellectual functioning, personality, behavior, alcohol or other drug use). Assessment instruments may be viewed as resources available to mental health professionals and other clinicians to assist them in better understanding the individual youth.

The assessment instruments used in comprehensive mental health or substance abuse evaluations should reflect high standards of research and standardization, and be used for the purpose intended in the development of the instrument. It is important that individuals who administer and interpret assessments and tests are trained to understand and adhere to administration and scoring procedures, interpret test results, and conform to accepted practices and professional standards. Basic rules for test administration and scoring must be followed carefully to assure that the examination of youths’ behavior or characteristics are comparable across different occasions and with diverse people.

It is essential that assessment findings and recommendations regarding intellectual handicap and/or exceptionality be based upon administration or review of psychological testing which includes the Wechsler Intelligence Scale for Children Fourth Edition (WISC-IV), Wechsler Adult
E. RECORDING OF DSM-IV-TR DIAGNOSES IN COMPREHENSIVE MENTAL HEALTH AND SUBSTANCE ABUSE EVALUATIONS:

Any specific mental disorders or substance related disorders identified during mental health or substance abuse evaluation should be reported in the written report according to criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (DSM-IV-TR), or subsequent revisions, and the severity of functional impairment should be reported in the written report according to Global Assessment of Functioning (GAF) Scale, as outlined in the DSM-IV-TR or Children’s Global Assessment Scale (CGAS). Clinical information should be provided for DSM-IV-TR multi-axial format (Axis I, Axis II, Axis III, Axis IV and Axis V).

V. ALERT SYSTEMS (“SUICIDE RISK ALERT” AND “MENTAL HEALTH ALERT”)

Youths identified during screening or staff observations as a potential suicide risk or as having a mental disorder or acute emotional distress which may pose a safety/security risk must be brought to the attention of the superintendent or program director and other staff via the facility’s “alert system” process. A “Suicide Risk Alert” or “Mental Health Alert” must result in a referral to a mental health professional. The purpose of the “alert system” is to promote communication and increased staff vigilance for the protection of the youth and others.

A. SUICIDE RISK ALERT DESIGNATION CRITERIA:

1. A “suicide risk alert” designation must be made by direct care or clinical staff when a youth is identified during screening or evaluation as a potential suicide risk. Examples of potential suicide risk indicators include the following:
   - History of suicide attempt or suicide gesture.
   - History of suicide ideas, statements, threats.
   - Intentional self-injurious behavior (self-mutilation, carving/cutting self within 6 months).
   - Statements or behaviors which suggest thoughts, intent or plans to harm self.
   - Statements suggesting lack of hope or preoccupation with death or dying.
   - Extreme withdrawal or lack of interest in surroundings.
   - Significant loss of appetite or unexplained loss of weight.
   - Serious psychiatric disturbance (particularly depression, bipolar disorder, psychosis).
   - Substance dependence (particularly cocaine, alcohol, multiple drugs).
   - Recent major loss (death of parent, sibling, best friend)

2. The youth coded as a “Suicide Risk Alert” must be placed on Suicide Precautions and maintained on constant supervision until an assessment of suicide risk is conducted.

3. The Suicide Risk Alert must be entered on JJIS and the program’s alert plan (see Section C below) implemented.

B. MENTAL HEALTH ALERT DESIGNATION CRITERIA: A “mental health alert” designation must be made by direct care or clinical staff when a youth is identified as having a mental disorder or acute emotional distress which may pose a safety/security risk.

1. Generally, the Designated Mental Health Authority or mental health staff will identify the youth as a Mental Health Alert. However, supervisory or direct care staff may denote a
mental health alert when the youth’s mental health issues appear to pose a safety/security risk. Examples of mental health alert indicators are as follows:

a. Recent history of self-injurious behavior (e.g. self-mutilation, carving/cutting self, ingestion of objects, head banging within 6 months);

b. Recent history of psychosis [hallucinations, delusions] (within 6 months);

c. Recent mental health crises (grief reaction, panic attacks, hyperventilation, explosive rage, severe aggression and diagnosed mental disorder (within 4 weeks);

d. Recent history of Baker Act evaluation (within 6 months);

e. Recent history of drug/alcohol intoxication/overdose or withdrawal symptoms (within 6 months);

f. Recent history of Marchman Act evaluation (within 6 months);

g. Current diagnosis or evidence of serious symptoms of a major mental disorder such as Schizophrenia, Major Depressive Disorder, Bipolar Disorder, Generalized Anxiety Disorder, Intermittent Explosive Disorder, Obsessive Compulsive Disorder;

h. Mental retardation and co-occurring mental illness or serious emotional disturbance; or.

i. Severe mental retardation.

2. It is possible for a youth to exhibit behaviors which require both a “Suicide Risk Alert” and “Mental Health Alert” (e.g. self-injurious behavior, depression). In such instances, the procedures for a “Suicide Risk Alert” must be followed.

3. The Mental Health Alert must be entered on JJIS and the program’s alert plan implemented (see Section C below)

C. CODING AND TRACKING OF SUICIDE RISK ALERT AND MENTAL HEALTH ALERT: The “suicide risk alert” and/or “mental health alert” must be entered on JJIS. The Department’s Data Integrity Officers (DIOs) are responsible for creating JJIS user accounts and assisting with training in the use of JJIS. A listing of DJJ Data Integrity Officers is located at the following website: [http://www.djj.state.fl.us/Research/index.html](http://www.djj.state.fl.us/Research/index.html)

The facility/program must also have a process in place for staff recognition and tracking of youths on alert status.

D. SUICIDE RISK ALERT AND MENTAL HEALTH ALERT FACILITY PLAN: Each facility/program must develop a “suicide risk alert” and “mental health alert” plan which provides a process for:

1. Identification of youths who may pose safety or security risks related to suicide risk or mental illness/emotional disturbance or developmental disability.

2. Coding and Tracking of youths meeting designation criteria for “Suicide Risk Alert” or “Mental Health Alert” on JJIS. The facility/program must also have a process in place for staff recognition and tracking of youths on alert status. A current listing of youths on alert status must be maintained and provided to direct care and clinical staff on a daily basis. Youths on suicide precautions (Precautionary Observation or Secure Observation) shall be coded as a “Suicide Risk Alert” until suicide precautions are removed. Each youth’s supervision level while on Mental Health Alert shall be denoted on JJIS.
3. **Increased Supervision** and staff vigilance of youths placed on “Suicide Risk Alert” or “Mental Health Alert”
   
a. A “**Suicide Risk Alert**” indicates that the youth must be maintained on *Suicide Precautions* (i.e., *Precautionary Observation* or *Secure Observation*) and, at least, *constant supervision at all times* (see Chapter 7).

b. A “**Mental Health Alert**” must reflect levels of supervision consistent with the following definitions:

   **One-to-One Supervision** refers to the supervision of one youth by one staff member who must remain within five feet of the youth at all times (including when the youth uses the shower or toilet). The staff member must maintain constant visual and sound monitoring of the youth at all times. A sample form for documentation of One-to-One Supervision for youths placed on Mental Health Alert is provided at Appendix S-2.

   **Constant Supervision** refers to the continuous and uninterrupted observation of a youth by a staff member who has a clear and unobstructed view of the youth and unobstructed sound monitoring of the youth at all times. A sample form for documentation of Constant Supervision for youths placed on Mental Health Alert is provided at Appendix S-2.

   **Close Supervision** requires supervision of youths at five-minute intervals throughout their stay in their rooms. Visual checks must be made of the youth’s condition while in his/her room at intervals not to exceed five minutes. Visual checks must be documented, in writing, at intervals not to exceed five minutes. A sample form entitled “Close Supervision - Visual Checks Log” is provided at Appendix S-1.

   **Standard Supervision** for youths who have been assessed by a mental health professional and have been transitioned to standard supervision.

4. **Referral** for *assessment of suicide risk*, *crisis assessment*, crisis intervention or emergency services, as needed.

5. **Mental Health Support** and follow-up assessment for youths coded as a “Mental Health Alert”. Supportive services for youths on Mental Health Alert shall be based upon the individualized needs of the youth as determined by the mental health clinical staff. Youths on Suicide Risk Alert shall receive supportive services as described in Chapter 7.

6. **Placement and Removal** of youth from “Alert” status. Direct care staff, supervisory staff or clinical staff may place a youth on Suicide Alert or Mental Health Alert. However, only a *licensed mental health professional* or *mental health clinical staff person* may recommend a downgrade or discontinuation of a youth’s alert status.

   The downgrade or discontinuation of alert status must be based upon the assessment findings and recommendations of a *licensed mental health professional* or a *mental health clinical staff person* working under the direct supervision of a *licensed mental health professional*. The *licensed mental health professional’s* concurrence with the *mental health clinical staff person’s* recommendation to downgrade or discontinue alert status must be documented prior to the downgrade or discontinuation of the youth’s alert status.

7. **Documentation** of the identification/screening, referral, mental health assessment, observation and any supportive services provided for youths designated as a “Suicide Risk
Alert” or “Mental Health Alert” must be detailed and permanently filed in the mental health/substance abuse section of the youth’s individual healthcare record.

“Suicide Risk Alerts” and “Mental Health Alerts” must be documented on JJIS. Each youth’s supervision level while on “Suicide Risk Alert” or “Mental Health Alert” must be documented on JJIS.

Note: Documentation of initial mental health screening and referrals completed by intake staff (e.g., MAYSI-2, SRSI), staff observation and reports for youths on suicide precautions (i.e., Suicide Precautions Observation Log,) must be permanently filed in the youth’s individual healthcare record prior to his/her discharge from the facility or program.

Documentation of mental health/substance abuse services: assessments, evaluations, treatment, supportive services are to be permanently filed in the youth’s individual health care record.

VI. DRUG TESTING OF YOUTHS IN RESIDENTIAL COMMITMENT PROGRAMS DESIGNATED FOR RSAT AND RSAT OVERLAY SERVICES

A. RESIDENTIAL COMMITMENT PROGRAM DRUG TESTING OF YOUTHS PARTICIPATING IN RSAT AND RSAT OVERLAY SERVICES

The Department has established uniform drug testing procedures specifically applicable to youths participating in residential commitment programs designated as Residential Substance Abuse Treatment (RSAT) Programs and Residential Substance Abuse Treatment Overlay Services (RSAT Overlay Services) Programs. The purpose of drug testing youths in the DJJ RSAT/RSAT Overlay Services program is to maintain the integrity of the program, ensure that all youths in treatment remain alcohol and drug free and to meet applicable federal grant and funding requirements.

The drug testing procedures described in this section focus on urinalysis, as it is currently the most widely used and cost-effective drug testing method available in RSAT and RSAT Overlay Services Programs. However, other non-invasive, cost-effective drug testing procedures such as breath analysis, sweat analysis or saliva testing may also be utilized.

The DJJ RSAT/RSAT Overlay Services residential program director is accountable for compliance with the provisions of this section as follows:

1. Youth Consent for Drug Testing and Notification of Drug Testing Requirements:

   a. Youth Consent for Drug Testing

      (1) Any youth who participates in the DJJ designated RSAT/RSAT Overlay Services program shall have a written consent or a court order for residential substance abuse assessment and treatment, including urinalysis drug testing, as a condition precedent to entry into the treatment program. The DJJ form entitled “Youth Consent for Residential Substance Abuse Treatment in a DJJ RSAT or RSAT Overlay Services Program” provided at Appendix D shall be used.

      (2) Programs utilizing several drug testing procedures (urinalysis, breath analysis, sweat analysis or saliva testing) must obtain youth consent for each drug testing procedure utilized.
(3) Youth consent for drug testing is not required when a court order for residential substance abuse assessment, including urinalysis drug testing, and substance abuse treatment has been obtained.

(4) If there is no court order, designated program staff will obtain from the youth a written consent for residential substance abuse treatment, including urinalysis drug testing as a condition precedent to entry into residential substance abuse treatment. The designated program staff will explain the consent form to the youth prior to execution of the form. The consent shall be valid for as long as the youth is in the program. If the youth revokes his or her consent while in the program, such revocation shall be grounds for termination from residential substance abuse treatment, DJJ review of the youth’s placement or return to court.

(5) If the youth refuses to provide written consent, the program will notify the Juvenile Probation Officer (JPO) and make a request for the JPO to obtain a court order for residential substance abuse assessment and treatment, including urinalysis drug testing.

b. Youth Notification of Drug Testing Requirements

(1) The residential program director shall ensure that youths are advised in writing (e.g., bulletin, posted notice, orientation manual) that they are subject to drug testing and are subject to loss or restriction of privileges for:
   - Failure to submit to testing or to provide a urine sample;
   - Tampering or attempting to tamper with the specimen or test results;
   - Receiving a positive test result for which there is no satisfactory explanation (i.e., unauthorized use of medication/drug).

2. Drug Testing Methods:

a. Intake and Routine Drug Testing:

(1) Upon intake to the DJJ designated RSAT/RSAT Overlay Services program each youth will, at a minimum, be tested for five of the following substances: alcohol, amphetamine, barbiturates, benzodiazepines, cannabinoid (marijuana), cocaine, methamphetamine, opiates, and phencyclidine. Each facility’s drug testing should include drugs most frequently available and used in that geographical area.

(2) The DJJ designated RSAT/RSAT Overlay Services program shall, on a monthly basis, collect urine specimens for routine drug testing of all youths participating in the program. Routine drug testing shall, at a minimum, test for three of the following substances: alcohol, amphetamine, barbiturates, benzodiazepines, cannabinoid (marijuana), cocaine, methamphetamine, opiates, and phencyclidine.

   a) The DJJ designated RSAT/RSAT Overlay Services program shall as a part of monthly screening, on a routine basis, collect urine specimens from youths who are allowed to participate in off-campus activities and home visits. The monthly routine drug testing should be conducted when feasible, to coincide with the youth’s return to the designated program and shall, at a minimum, test for three of the substances listed in number two above.

(3) The residential program director shall ensure reasonable security, privacy and sanitary conditions exist during drug testing of youths in the DJJ designated RSAT/RSAT Overlay Services program.
b. Random Drug Testing:

(1) The DJJ designated RSAT/RSAT Overlay Services program shall develop a list of the JJID numbers of youths, generated by random selection, for random drug testing. At least 5% to 10% of the youth population will be randomly tested each month. Random drug testing shall be in addition to routine in-treatment drug testing.

(2) Each youth on the random drug testing list will be tested for a minimum of three drugs, from the following substances: alcohol, amphetamine, barbiturates, benzodiazepines, cannabinoid (marijuana), cocaine, methamphetamine, opiates, and phencyclidine.

(3) If a youth's JJID number appears on successive random lists for testing, he or she will be tested regardless of whether or not they were previously tested.

(4) The residential program director will be responsible for the development of facility operating procedures to protect the security of the random list.

c. Reasonable Suspicion Drug Testing:

(1) Youths participating in the DJJ designated RSAT/RSAT Overlay Services program for whom there is a reasonable suspicion, as set out in the definition herein, of involvement with drugs shall be subject to reasonable suspicion urinalysis drug testing.

(2) The supervisor on duty shall be notified when a staff member has a reasonable suspicion that a youth is using or has used drugs in violation of the Department's policy. An incident report must be prepared which must include at a minimum:

- Dates and times of reported drug-related events;
- Observations and/or supporting evidence leading to the belief the youth is abusing drugs.
- Staff notation of the specific drug(s) suspected to have been used by the youth, if possible; however, failure of the staff to identify a specific drug, or subsequent determination that staff has noted the incorrect drug shall not be grounds for either requiring re-testing or for invalidating the test results.

(3) Reasonable suspicion drug testing incident reports and requests must be forwarded to the residential program director or his/her Designee for immediate action. The residential program director will be responsible for the development of facility operating procedures to ensure appropriate incident reporting and coordination of reasonable suspicion drug testing in the facility/program.

(4) The Drug Testing Coordinator is responsible for determining the number and type of drugs to be screened.

3. Drug Testing Procedures:

a. Drug Testing Coordinator Responsibilities:

(1) Each facility providing a DJJ RSAT Program or RSAT Overlay Services Program shall designate a licensed healthcare professional (licensed physician or physician assistant under Chapter 458 or 459, F.S., or licensed nurse under Chapter 464, F.S.) as "Drug Testing Coordinator".

(2) The Drug Testing Coordinator will be responsible for coordinating the collection, control and processing of urine specimens, and developing facility operating procedures for the safe, uniform collection and processing of urine specimens consistent with this policy.
b. Drug Test Chain of Custody Procedures

A drug test chain of custody form/record must be filled out and accompany the urine sample throughout the drug testing process. Drug test chain of custody forms may be developed or obtained from a licensed/certified laboratory. The drug test chain of custody form must, at a minimum, contain the following:

- Collection date and time
- Youth's ID number
- Youth's sex
- Drug Test Coordinator's name and DJJ Facility/Program Name
- Type of Test (Routine, Random, Reasonable Suspicion)
- Lines for entry of staff signature when specimens are transferred from the custody of one staff person to another. (e.g., from nursing staff to transporting staff)

c. Drug Testing Safety/Security Procedures:

(1) Direct care staff safety/security responsibilities may include:

- Verifying the identity of the youth to be tested.
- Searching the youth for foreign substances.
- Requiring the youth to wash and rinse his/her hands prior to specimen collection.
- Visually observing the giving of the urine sample (observation must be by a staff member of the same gender as the youth).
- Verifying that the urine specimen container lid is securely closed by the youth.

(2) Any direct care staff involved in the handling and/or transport of urine samples shall receive training in drug test chain of custody procedures and infection control procedures.

d. Urine Specimen Collection Procedures

(1) Collection of urine samples shall be conducted by a healthcare professional certified or licensed under Chapter 458, 459 or 464, F.S., or by staff who have received training in urine specimen collection, infection control and chain of custody procedures.

(2) Infection control/universal precaution procedures shall be followed during the urine specimen collection process. Infection control procedures shall be reviewed by a licensed or certified healthcare professional under Chapter 458, 459 or 464, F.S.

(3) The healthcare professional or staff person shall ensure the urine specimen container is securely closed, labeled, sealed, and prepared for storage or transport.

e. Youth Inability or Refusal to Produce Urine Specimens

(1) Youth who are unable to produce a urine specimen on demand are to be detained by the Drug Testing Coordinator and remain under staff observation for one hour. The youth should be allowed to drink one cup (8 ounces) of water during this time period. If after this period a youth still fails to submit a urine specimen, the Drug Testing Coordinator will determine whether the youth needs more time or is refusing to produce a specimen.

(2) If a youth who is taking medication is unable to produce urine specimen, the procedure in number one above shall be followed. At the end of the one hour period, the youth shall be instructed to produce whatever urine he/she can. If the youth is unable to
produce any urine, the incident shall be documented and discussed with the residential program director and healthcare professional prescribing the medication.

(3) After four hours, a youth’s failure to submit urine specimen will be documented as a refusal to submit a urine specimen (unless the Drug Testing Coordinator determines that there is a satisfactory explanation for the youth’s inability to provide a specimen). Sanctions as described in section four may be imposed when a youth refuses to submit a urine specimen.

4. Urine Specimen Storage and Transfer

a. On-Site Testing Devices and Laboratory Drug Testing

(1) Urine specimens may be tested at the DJJ facility/program utilizing a U.S. Food and Drug Administration (FDA) approved on-site testing device or transported to a laboratory certified under Drug-Free Workplace Program Requirements, Section 440.102(9), Florida Statutes or certified by the National Institute on Drug Abuse. A copy of the laboratory’s certification must be on file in the office of the Drug Testing Coordinator.

(2) The Drug Testing Coordinator will ensure that urine specimens are tested at the DJJ facility/program, or transported to the laboratory, on the day of collection. If circumstances prevent same day testing or transfer of urine specimens, the Drug Test Coordinator will ensure the appropriate refrigeration and secure storage of the specimens pending testing or transfer.

(3) The Drug Testing Coordinator shall ensure an appropriate carrying case is used for transporting urine specimens. The case must be locked and sealed when provided to the transporting staff person.

(4) The Drug Testing Coordinator shall ensure that the drug test chain of custody form(s) is appropriately completed and transported with all collected urine specimens.

b. On-Site Drug Testing and Reporting of Test Results

(1) On-site drug testing must be conducted by a healthcare professional certified or licensed under Chapter 458, 459 or 464, F.S., who has successfully completed the manufacturer’s training program on the on-site testing device.

a) Documentation of the healthcare professional’s successful completion of the manufacturer’s training program for utilizing the on-site testing device and the Department’s drug testing guidelines as specified in this chapter must be documented and filed in the healthcare professional’s training or personnel record.

b) The healthcare professional will record each youth’s test results on a drug-testing report form developed by the manufacturer of the on-site testing device or the program.

c) If a positive result is received on the on-site testing device, a confirmatory test of the original sample must be conducted by a laboratory as specified in section (c) below.

d) Each facility must maintain records pertaining to on-site testing in a secure file. This includes, but is not limited to, drug testing lists and results and laboratory confirmation results.
e) All on-site drug testing, regardless of purpose, will be documented in the youth's chart.

c. Laboratory Drug Testing and Reporting of Test Results

(1) Laboratory testing of urine specimens must be conducted at a laboratory certified under Drug- Free Workplace Program Requirements, Section 440.102(9), Florida Statutes or certified by the National Institute on Drug Abuse.

(2) After the specimen has been analyzed, the Laboratory must send the test results to the designated program’s Drug Testing Coordinator. Formal arrangements with the Laboratory must specify that positive results are to be followed by a confirmatory test of the original sample. Positive results must be reported to the designated program’s Drug Testing Coordinator as soon as possible. Written test results should be printed on Laboratory letterhead.

(3) Each designated program is responsible for providing a secure fax number to the Laboratory for which drug test results are to be transmitted. All written drug test results are to be maintained in a confidential and secure file.

(4) It must be the responsibility of the Laboratory to report positive drug test results by telephone and transmit such results by secure fax to the Drug Testing Coordinator as soon as possible.

(5) Negative drug test results shall be transmitted by secure fax or mailed from the Laboratory within three to five days from receipt of the specimen. All negative results are to be reviewed and documented by the Drug Testing Coordinator.

d. Review of Positive Drug Tests

(1) When a positive result is obtained, the youth’s individual healthcare record will be reviewed by a licensed physician or pharmacist for any authorized use of drugs/medications.

(2) The use of medically approved prescribed or over-the-counter medication that would cause a positive result must be verified and made a part of the youth’s individual healthcare record.

(3) If medical staff (a licensed physician or pharmacist) determine that none of the medications a youth is taking would produce a positive result, a confirmation laboratory test [as specified in (b) or (c) above] must be conducted to support the finding of the initial test.

(4) If the Drug Testing Coordinator or other designated healthcare professional determines that no satisfactory explanation exists for a positive result, the youth shall be subject to loss or restriction of privileges.

(5) Positive test results indicating unauthorized use of drugs will be immediately documented by the Drug Testing Coordinator and brought to the attention of the facility superintendent/program director.

(6) Facility safety/security procedures shall be initiated when drug use on DJJ RSAT/RSAT Overlay Services program premises is suspected. Safety/security measures shall include, but are not limited to: Search and questioning of youth, room search, general facility search, and close monitoring/supervision of youth.
5. Sanctions for Positive Drug Tests

a. DJJ RSAT/RSAT Overlay Services Programs Sanctions

(1) In all cases where a youth is identified as having a positive test for unauthorized drug use, refuses to provide a urine sample, or attempts to tamper with a urine specimen or test results, a sanction from a graduated scale of sanctions shall be imposed.

(2) Sanctions may include, but are not limited:
   - Extra work assignments
   - Extra written assignments
   - Loss of privileges
   - Loss of points/levels (when applicable).
   - Increased frequency of drug testing
   - Denial of off-campus activities (as appropriate).
   - Extended stay, or denial or revocation of release in appropriate circumstances.

(3) In all cases where a youth is found to have possession of drugs, DJJ policy regarding juvenile offender possession of drugs/contrabands shall be followed.

6. Drug Treatment/Intervention

a. RSAT and RSAT Overlay Services

(1) DJJ RSAT/RSAT Overlay Services programs provide comprehensive residential substance abuse treatment services designed specifically for juvenile offenders who are substance abusers. Youth admitted to these programs must have been diagnosed with DSM-IV-TR Substance-Related Disorder and demonstrate impaired functioning related to their substance abuse problems. Many of the youth admitted to the DJJ RSAT/RSAT Overlay Services programs have histories of drug-related offenses and drug-seeking behavior. Substance abuse treatment within the DJJ RSAT/RSAT Overlay Services programs will focus on all aspects of substance abuse rehabilitation, and included cognitive behavioral therapy, interpersonal or psychodynamic therapy, family therapy, and psycho-educational skills training.

(2) DJJ RSAT/RSAT Overlay Services programs shall conduct monthly routine drug testing, as well as random and reasonable suspicion drug testing. Youth who test positive for drugs will receive intensive monitoring and treatment in the designated program. The youth’s substance abuse treatment plan shall be designed to address the youth’s drug using behavior, specific treatment needs, and sanctions related to the youth’s drug use.

(3) DJJ RSAT/RSAT Overlay Services programs shall provide quarterly statistics, in accordance with subgrant and/or contract requirements, which include the number of youth testing positive for drugs on routine, random and reasonable suspicion urinalysis drug testing.

(4) DJJ RSAT/RSAT Overlay Services programs shall focus on ensuring youth receive the skills necessary to maintain a drug-free and law-abiding lifestyle. The programs shall require intensive relapse prevention and transition planning.
CHAPTER 6
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT PLANNING AND
IMPLEMENTATION OF TREATMENT SERVICES

I. INTRODUCTION

Mental health and substance abuse treatment within the context of this manual must be distinguished from the various habilitative or rehabilitative interventions provided within juvenile justice settings which are not provided specifically as treatment of emotional disturbance/mental illness or substance abuse impairment. For example, psychoeducational training such as social skills training and problem-solving training may be provided in juvenile justice settings to youths who do not have mental illness or substance abuse impairment, by individuals who are not mental health or substance abuse professionals. Such habilitative or rehabilitative intervention focuses on improving youths’ social and personal competence and thereby reducing their delinquency.

By contrast, mental health and substance abuse treatment refers to specific psychotherapeutic intervention or medical/somatic intervention provided by qualified mental health or substance abuse clinical staff in response to a serious emotional disturbance, mental illness or substance abuse impairment. Mental health treatment primarily focuses on reducing or eliminating symptoms of mental disorder associated with significant impairment in emotional or behavioral functioning. Substance abuse treatment primarily focuses on eliminating drug or alcohol abuse or dependence and impairment in daily functioning.

Mental health and substance abuse treatment is conducted within the framework of psychotherapeutic intervention (primarily individual, group and family counseling/therapy and psychosocial or psychoeducational skills training) or medical/somatic intervention (primarily administration and management of psychotropic medication). Both must involve individualized treatment planning for the subset of youth in the Department’s continuum of services who require ongoing mental health or substance abuse treatment.

Effective mental health and substance abuse treatment planning must involve a reliable and valid description of problem areas on which to focus mental health and substance abuse interventions. The primary means to describe problem areas is by an established diagnostic system. The diagnostic system most commonly utilized is the DSM-IV-TR as developed by the American Psychiatric Association. However, mental health and substance abuse treatment is not organized solely around a descriptive diagnosis. Decisions made about mental health and substance abuse treatment are also based upon variables such as the personal characteristics of the youth, setting in which the treatment is to take place, treatment formats available, frequency and duration of treatment, and the goals of mental health or substance abuse treatment for the individual youth.

It is important that mental health and substance abuse treatment follow an individualized treatment plan in order to: 1) identify the issues being addressed in mental health or substance abuse treatment; 2) provide feedback to the youth regarding his or her progress in mental health or substance abuse treatment; 3) provide feedback to the mental health or substance abuse clinical staff regarding the progress of the youth on each goal as treatment progresses; and 4) to guide the youth and mental health or substance abuse clinical staff toward a series of treatment objectives.
Mental health and substance abuse treatment planning should consider each youth’s unique developmental, gender, cultural and family issues, particularly issues concerning trauma or victimization. A crucial issue related to the provision of mental health and substance abuse services to delinquent youths is victimization and trauma. Many youths who become involved in delinquency have histories of trauma, particularly physical abuse, sexual abuse and witnessing violence. Youth with trauma histories may react differently to being confined, handcuffed, transported in secure vehicles and exposed to large groups of noisy and aggressive peers. When diagnosing and working with delinquent youth, trauma should be suspected as an underlying issue related to a variety of behavioral, mental health and substance abuse problems. Mental health and substance abuse clinical staff must be attuned to youths’ traumatic experiences, particularly physical and sexual abuse and exposure to violence. Trauma histories should be considered in all aspects of treatment planning, interventions and daily living activities.

II. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT PLANNING

All youths who are determined to have serious mental disorder or substance abuse impairment, and are receiving mental health or substance abuse treatment in a DJJ facility or program must have an initial mental health treatment plan or initial substance abuse treatment plan or individualized mental health treatment plan or individualized substance abuse treatment plan.

The initial mental health treatment plan or initial substance abuse treatment plan is a written guide which structures the focus of a youth’s short-term or initial mental health or substance abuse treatment. The plan specifies the short-term or preliminary goals and objectives of mental health or substance abuse treatment and the initial course of treatment.

The individualized mental health treatment plan or individualized substance abuse treatment plan is a written, individualized guide which structures the focus of a youth’s ongoing mental health or substance abuse treatment, the methods to be used in the treatment process and a schedule for assessing progress and updating the plan.

With regard to substance abuse, Section 397.311(17), Florida Statutes defines “individualized treatment or service plan” as “an immediate and a long range plan for substance abuse or ancillary services developed on the basis of a child’s assessment needs”. Section 397.501(2)(b), Florida Statutes provides with regard to youths receiving substance abuse services: “Each client in treatment must be afforded the opportunity to participate in the formulation and periodic review of his or her individualized treatment or service plan to the extent of his or her ability to so participate.”

Mental health and substance abuse treatment planning in departmental facilities or programs focuses on providing mental health or substance abuse interventions which will reduce or alleviate the youth’s symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately in the juvenile justice setting. It requires the identification of: 1) Specific symptoms which will be the focus of treatment; 2) Specific goals and objectives of mental health or substance abuse treatment; 3) Mental health or substance abuse treatment methods to be implemented, and the time-frame for implementation; and 4) Measures to be used to chart progress during treatment and to evaluate mental health or substance abuse treatment effectiveness.
The superintendent or program director (in conjunction with the Designated Mental Health Authority or mental health and substance abuse clinical staff) is responsible for ensuring the development and review of an initial mental health treatment plan or initial substance abuse treatment plan or individualized mental health treatment plan or individualized substance abuse treatment plan for each youth receiving mental health and/or substance abuse treatment in the facility or program.

A. DEVELOPMENT OF THE INITIAL MENTAL HEALTH OR INITIAL SUBSTANCE ABUSE TREATMENT PLAN:

When mental health or substance abuse treatment is initiated in a DJJ facility or program, an initial mental health/substance abuse treatment plan must have been completed unless an individualized mental health/substance abuse treatment plan has already been completed. (See page 6-4 for alternatives to initial mental health/substance abuse treatment plans for residential commitment programs designated for specialized treatment services).

1. “Mini-treatment Teams” and Initial Treatment Plans in Detention Centers: Each youth who is determined by clinical staff to need mental health treatment, including treatment with psychotropic medication, or substance abuse treatment while in a detention center must be assigned to a “mini-treatment team”. The mini-treatment team allows the development and implementation of an initial plan for mental health or substance abuse services developed on an expedited basis. The mini-treatment team is responsible for developing an initial mental health treatment plan or initial substance abuse treatment plan for youths receiving short-term mental health or substance abuse treatment while in the detention center. An individualized mental health/substance abuse treatment plan must be developed for the youth whose stay in the detention center exceeds 30 days. (See section II. B.).

a. The mini-treatment team must be composed of at least a mental health clinical staff person and one other staff person from a different service area (e.g., administrative, supervisory and/or medical staff) and the youth, and should include the youth’s parent or legal guardian (when possible). The initial mental health/substance abuse treatment plan must be developed by the mini-treatment team within 7 days of initiation of treatment, or for youths receiving psychotropic medication within 7 days of the initial psychiatric diagnostic interview (see Section VI. 7., of this chapter). The review/updating of the initial mental health/substance abuse treatment plan should be determined by the superintendent or program director and mental health or substance abuse treatment clinical staff. The initial mental health treatment plan or initial substance abuse treatment plan must be recorded on a form developed by the detention center or on the sample form (Appendix H). The initial treatment plan form must, at a minimum, contain all of the elements of the sample form provided in Appendix H.

b. The initial mental health treatment plan or initial substance abuse treatment plan developed by the mini-treatment team must contain, at a minimum, the following elements:

- Reason for mental health and/or substance abuse treatment;
- Initial DSM-IV-TR diagnosis or presenting symptoms;
- Initial treatment methods (including psychiatric services for youths receiving psychotropic medication or other psychiatric services)
- Initial treatment goals and objectives.
c. The *initial mental health treatment plan* or *initial substance abuse treatment plan* must be signed and dated by the *mental health clinical staff person* (for the initial mental health treatment plan) or the *substance abuse clinical staff person* (for the initial substance abuse treatment plan) and the youth. The plan must be reviewed and signed “as reviewer” by a *licensed mental health professional* (for the initial mental health treatment plan) or *qualified professional* under Chapter 397.311(25) F.S., and in accordance with Rule 65D-30.003(15) FAC (for an initial substance abuse treatment plan) within 10 days of completion.

2. **Multidisciplinary Treatment Teams and Treatment Planning in Facility Based Day Treatment Programs and Residential Commitment Programs:** Each youth must be assigned to a treatment team upon his/her arrival to a facility based day treatment program or residential commitment program. The multidisciplinary treatment team must be composed of representatives from the program’s administration, educational, vocational, residential, medical, mental health, substance abuse and counseling components and the youth, and should include the youth’s parent or legal guardian (when possible).

The treatment team is responsible for assessing the youth’s rehabilitative treatment needs, assisting in the development and implementation of the youth’s DJJ supervision plan in facility based day treatment programs or performance plan in residential commitment programs, and for youths receiving mental health or substance abuse services, assisting in developing, reviewing and updating the youth’s *individualized mental health/substance abuse treatment plan* or an *initial mental health treatment plan or initial substance abuse treatment plan* when mental health or substance abuse treatment is to be provided on an expedited basis, prior to the development of an *individualized mental health/substance abuse treatment plan*.

**Note:** Residential commitment programs designated for *specialized treatment services* (e.g., BHOS, MHOS, RSAT, RSAT Overlay), wherein youths routinely receive an individualized mental health/substance abuse treatment plan within 30 days of admission as part of established procedure, *may utilize an initial treatment note or an initial treatment plan* signed by the mental health/substance abuse clinical staff person and youth. The initial treatment note may be recorded on an existing form or progress note. The initial treatment plan may be provided on the form provided at Appendix H, or an alternative form developed in accordance with Rule 65D-30.

a. **Initial Treatment Plans in Residential Commitment Programs and Facility Based Day Treatment Programs:** An *initial mental health treatment plan or initial substance abuse treatment plan* is utilized when mental health or substance abuse treatment is to be provided on an expedited basis. An option is provided for residential commitment programs designated for specialized treatment services to provide an initial treatment plan or initial treatment note as described above.

(1) The *initial mental health treatment plan or initial substance abuse treatment plan* must be developed within 7 days of initiation of treatment, or for youths receiving psychotropic medication within 7 days of the initial psychiatric diagnostic interview (see Section VI. 7., of this chapter). The *initial mental health treatment plan or initial substance abuse treatment plan* must be recorded on a form developed by the program or on the sample form (Appendix H). The initial treatment plan form must, at a minimum, contain all of the elements of the sample form provided in Appendix H.
(2) The *initial mental health treatment plan* or *initial substance abuse treatment plan* must contain, at a minimum, the following elements:

- Reason for referral for mental health and/or substance abuse treatment;
- Initial DSM-IV-TR diagnosis or presenting symptoms;
- Initial treatment methods; (including psychiatric services for youths receiving psychotropic medication or other psychiatric services)
- Initial treatment goals and objectives.

(3) The *initial mental health treatment plan* or *initial substance abuse treatment plan* must be signed and dated by the mental health clinical staff person (for the initial mental health treatment plan) or the substance abuse clinical staff person (for the initial substance abuse treatment plan), the youth and treatment team. The plan must be reviewed and signed “as reviewer” by a licensed mental health professional (for the initial mental health treatment plan) or qualified professional under Chapter 397.311(25) F.S., and in accordance with Rule 65D-30.003(15) FAC (for an initial substance abuse treatment plan) within 10 days of completion.

B. Development of the Individualized Mental Health Treatment Plan or Individualized Substance Abuse Treatment Plan in Detention Centers, Residential Commitment Programs and Facility Based Day Treatment Programs:

An *individualized mental health treatment plan* is required when a youth enters on-going mental health treatment (including treatment with psychotropic medication) and an *individualized substance abuse treatment plan* is required when a youth enters on-going substance abuse treatment. A comprehensive mental health and/or substance abuse evaluation must be completed by or reviewed by a licensed mental health professional prior to the development of the *individualized mental health* or *individualized substance abuse treatment plan*.

The *individualized mental health treatment plan* or *individualized substance abuse treatment plan* must be recorded on a form developed by the DJJ program, or the sample form provided in Appendix I-1 may be used. The treatment plan form must, at a minimum, contain all of the elements of the sample form provided in Appendix I-1.

1. The *individualized mental health treatment plan* or *individualized substance abuse treatment plan* must be developed:

   - For detention centers, by the mini-treatment team for a youth whose stay in detention center exceeds 30 days, and must be completed by the 31st day the youth is in the detention center;
   
   - For facility-based day treatment programs and residential commitment programs, by the multidisciplinary treatment team within 30 days of the youth’s admission or for youths who begin treatment subsequent to admission, within 30 days of initiation of treatment (including treatment with psychotropic medication).

2. The *individualized mental health treatment plan* or *individualized substance abuse treatment plan* must contain the following elements:

b. The specific symptoms that will be the focus of treatment

c. Mental health treatment goals or substance abuse treatment goals and objectives, written in achievable and measurable terms, which are:
   • Related to the diagnosis(es);
   • Based on comprehensive mental health evaluation or comprehensive substance abuse evaluation;
   • Responsive to the youth’s symptoms of mental disorder or substance abuse impairment and enhance (or maintain) current psychological functioning
   • Address specific behaviors, symptoms, skill deficits, strengths and needs of the youth.

d. The mental health interventions/strategies or substance abuse interventions/strategies to be provided and target dates for completion. The intervention/strategies provided should be based upon best practices and effective treatment models that are appropriate to the individual characteristics and needs of the youth.

e. The youth’s functional strengths/abilities and preferences/needs which may affect his/her success in mental health or substance abuse treatment.

f. The youth’s psychiatric service needs (for youths receiving psychotropic medication or other psychiatric services).

g. The signature of the youth, the mental health clinical staff person that prepared the plan (for the individualized mental health treatment plan) or the substance abuse clinical staff person that prepared the plan (for the individualized substance abuse treatment plan) and the treatment team members who participated in the development of the plan.

   • The plan must be reviewed and signed “as reviewer” by a licensed mental health professional (for the individualized mental health treatment plan) or qualified professional as defined in Chapter 397.311(25) F.S. and in accordance with Rule 65D-30.003(15) FAC (for an individualized substance abuse treatment plan) within 10 days of completion.

h. The signature of the parent or legal guardian. (If the parent or guardian’s signature cannot be provided on the mental health or substance abuse treatment plan, there must be clear documentation of at least one of the following: There is a reason for non-involvement consistent with the youth’s needs; Efforts to secure the parent or guardian involvement have been unsuccessful; or There is a reason for non-involvement consistent with statutory requirements)

3. A review of the individualized mental health treatment plan or individualized substance abuse treatment plan must be conducted by the treatment team every 30 days. The treatment plan review will assess the youth’s progress in meeting his/her treatment goals and objectives, and will ascertain whether modifications to the treatment plan are needed.
a. The treatment plan review findings and recommendations must be documented on a form developed by the DJJ program, or the sample form provided in Appendix I-2 may be used.

b. Any modifications made to the individualized mental health treatment plan or individualized substance abuse treatment plan must be documented on the review form and must be clearly and specifically identified as a modification to the individualized mental health treatment plan or individualized substance abuse treatment plan. The treatment plan review form must, at a minimum, contain all of the elements of the form provided in Appendix I-2.

c. The treatment plan review form must be signed and dated by a mental health clinical staff person (for mental health treatment) or substance abuse clinical staff person in accordance with Rule 65D-30.003(15) FAC (for substance abuse treatment) and the youth, and must be reviewed and signed “as reviewer” by a licensed mental health professional (for the individualized mental health treatment plan) or qualified professional under Section 397.311(25), F.S., and in accordance with Rule 65D-30.003(15) FAC, (for substance abuse treatment) within 10 days of the treatment plan review.

4. The individualized mental health treatment plan or individualized substance abuse treatment plan must be permanently filed in the youth’s individual healthcare record.

C. INTEGRATED MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT PLANS:

It is essential that youths diagnosed with both mental disorder and substance-related disorder (dual diagnosis/co-occurring disorders) receive integrated treatment services based upon an integrated mental health/substance abuse treatment plan which is appropriate to the severity of the mental disorder and substance-related disorder and the youth’s treatment needs.

1. The integrated mental health and substance abuse treatment plan should be developed with the input of both mental health and substance abuse clinical staff who understand the dynamics and challenges of dual diagnosis/co-occurring disorders.

2. The integrated mental health and substance abuse treatment plan should provide interventions and strategies demonstrated effective in treatment of dual diagnosis/co-occurring disorder.

3. The integrated mental health/substance abuse treatment plan must contain and meet all of the elements listed in item B(2) above and the review procedures in B(3) above and the filing requirements in B(4) above must be followed.

III. MENTAL HEALTH TREATMENT TECHNIQUES

The mental health treatment of juvenile offenders is generally provided as an "overlay service" in addition to delinquency programming in a juvenile justice rehabilitation program. Both mental health treatment and rehabilitative intervention provided in juvenile justice facilities or programs seek to promote positive changes in juvenile offenders which will reduce the likelihood of their re-offending. Mental health treatment primarily focuses on alleviating symptoms of mental disorder which interfere with the youth’s emotional and behavioral functioning, and may have contributed to his/her...
delinquency. Delinquency rehabilitative interventions, on the other hand, primarily focus on improving youths’ educational, vocational, social and life skills utilizing restorative justice principles and strategies. When mental health treatment reduces or eliminates symptoms of mental disorder, it is reasonable to expect that the youth will be more amenable to rehabilitative interventions provided within the juvenile justice setting.

A. TREATMENT TECHNIQUES. The following mental health treatment techniques are utilized for treatment of youths with mental disorder:

1. Individual, Group, Family and Behavior Therapies: Counseling or psychotherapy is a planned and structured face-to-face treatment of a youth’s emotional disturbance or mental illness. The treatment is based on the youth’s symptoms and DSM-IV-TR diagnosis identified by an in-depth mental health evaluation, and seeks to accomplish the measurable goals and objectives specified in the youth’s initial or individualized mental health treatment plan.

a. Individual Psychotherapy or Counseling: Individual psychotherapy or counseling refers to one-to-one counseling between a youth with a diagnosed mental disorder and a licensed mental health professional or a mental health clinical staff person working under the direct supervision of a licensed mental health professional. The focus of individual psychotherapy or counseling is to relieve symptoms of serious emotional disturbance or mental illness and to resolve problems which interfere with the youth’s daily living. Individual psychotherapy or counseling within juvenile justice facilities/programs may vary according to the setting and resources available within the setting. For example, individual psychotherapy or counseling is most likely to address the acute emotional and behavioral needs and crises of youths within detention centers. The focus of individual psychotherapy or counseling in residential commitment programs is more likely to be on improving the emotional and behavioral functioning of the youth with a serious mental disorder. Individual counseling or psychotherapy must be based on effective treatment models such as cognitive behavioral therapy, reality therapy and family systems therapy.

b. Group Psychotherapy or Counseling: Group psychotherapy or counseling refers to an assembly of youths (typically five to ten youths who have a diagnosed mental disorder), and a licensed mental health professional or a mental health clinical staff person working under the direct supervision of a licensed mental health professional, for the purpose of using the emotional interactions of members of the group to help them get relief from distressing symptoms and to modify their behavior. The essence of group psychotherapy/counseling is that the individual is encouraged to acquire certain knowledge (self-understanding and understanding of others) and adaptation skills within a framework that seeks to foster generalization from the small group to society. Group counseling must be based on best practices and effective treatment models such as cognitive behavioral therapy. Research-based treatment and curriculums should be used, whenever possible.

For consistency with AHCA/Medicaid requirements, group therapy/counseling provided in DJJ residential commitment programs designated for specialized treatment services (e.g., MHOS, BHOS, Intensive Mental Health Services, Specialized Mental Health Services) must not exceed 10 participants with mental health diagnoses and not exceed 15 youths with substance abuse diagnoses.

c. Family Counseling or Therapy: Family counseling or therapy refers to an assembly of a youth with acute or chronic mental disorder, his/her family members (parents or legal guardians and siblings) and a licensed mental health professional or a mental health clinical...
staff person working under the direct supervision of a licensed mental health professional for the purpose of improving the youth’s and family’s functioning in areas which appear to impact his/her mental disorder and delinquent behavior. Family counseling or therapy must be based on effective treatment approaches such as Family Systems Therapy, Functional Family Therapy and Multi-Systemic Therapy.

d. Behavior Therapy: Behavior therapy refers to a mode of treatment provided by a licensed mental health professional, a mental health clinical staff person working under the direct supervision of a licensed mental health professional, or a certified behavior analyst which focuses on modifying the behavior of a youth with a diagnosed mental disorder by assisting him/her in learning new, more acceptable and adaptable forms of behavior.

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Behavioral therapy requires that the youth’s problem behavior be clearly specified, that behavioral and environmental factors associated with the youth’s difficulties be identified, and that a detailed schedule of exercises (e.g., positive reinforcement system) be developed to encourage desirable behavior.

2. Psychosocial Skills Training: Psychosocial Skills Training are therapeutic activities designed to address specific skill deficits or maladaptive behaviors and promote skill development and improved functioning of youths with mental disorder. Psychosocial Skills Training may be provided in individual, group or family sessions. Psychosocial Skills Training may be provided by a licensed mental health professional or a mental health clinical staff person working under the direct supervision of a licensed mental health professional. Psychosocial Skills Training must address the specific deficits or maladaptive behaviors identified in the youth’s treatment plan.

The superintendent or program director is responsible for ensuring that youths who are diagnosed as suffering from an acute or chronic mental disorder, and determined in need of mental health treatment by a qualified mental health staff person, receive necessary and appropriate mental health treatment.

Mental health treatment must be provided by, or under the supervision of, a licensed mental health professional. Mental health treatment may be provided on-site by a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional or by a licensed mental health professional who is employed by or under contract with the Department, or may be provided off-site by licensed mental health professionals or providers. A licensed mental health professional must review and sign the non-licensed mental health clinical staff person’s progress/treatment notes or weekly progress/summary notes and provide weekly direct supervision.

IV. SUBSTANCE ABUSE TREATMENT TECHNIQUES

Florida law requires that youths who are identified as having a substance abuse problem receive appropriate intervention and treatment. Substance abuse treatment will vary depending on the individual needs of the youth. The most common substance abuse treatment provided in juvenile justice settings are: individual, group, and family substance abuse counseling provided in conjunction with cognitive behavioral interventions, psychoeducational and psychosocial skills training and relapse prevention combined with therapeutic community,12-step or AA/NA concepts and strategies.
These techniques as utilized within the context of substance abuse treatment are discussed briefly below:

A. TREATMENT TECHNIQUES. The following substance abuse treatment techniques are utilized for treatment of youths with substance-related disorder:

1. Individual, Group, Family and Behavior Therapies: Substance abuse counseling or therapy is a planned and structured face-to-face treatment of a youth’s substance-related disorder. The treatment is based on the youth’s substance use, symptoms and DSM-IV-TR diagnosis identified by an in-depth substance abuse evaluation, and seeks to accomplish the measurable goals and objectives specified in the youth’s initial or individualized mental health treatment plan.

a. Individual Substance Abuse Counseling or Therapy: Individual substance abuse counseling or therapy refers to one-to-one counseling between a youth with substance abuse impairment and a qualified professional licensed under Chapter 458, 459, 490 F.S, or a substance abuse clinical staff person who is an employee in a facility licensed under Chapter 397 or an employee of a service provider licensed under Chapter 397, F.S., working under the direct supervision of a qualified professional (in accordance with Rule 65D-30.003(15) FAC). Individual substance abuse counseling or therapy in substance abuse treatment focuses on: helping the youth resolve to stop using psychoactive substances; teaching coping skills to help the youth avoid relapse after achieving an initial period of abstinence; fostering management of distressing feelings; and improving interpersonal functioning. Individual therapy is particularly effective for helping a youth to discuss issues which he/she may not be ready to discuss in a group context. Individual substance abuse counseling must be based on effective treatment models such as cognitive behavioral therapy and multi-systemic and stages of change approaches.

b. Group Substance Abuse Counseling or Therapy: Group substance abuse counseling or therapy refers to an assembly of youths (typically five to ten youths with substance abuse impairment), and a qualified professional licensed under Chapter 458, 459, 490 or 491, F.S, or a substance abuse clinical staff person who is an employee in a facility licensed under Chapter 397 or an employee of a service provider licensed under Chapter 397, F.S., working under the direct supervision of a qualified professional (in accordance with Rule 65D-30.003(15) FAC) who meet regularly (at least once a week) for the purpose of promoting abstinence from all mood-altering drugs and recovery from addiction. Group substance abuse counseling or therapy involves peers in a group process that encourages them to address personal problems and the consequences of their alcohol and drug use. Through sharing, discussion, and problem-solving, youths can begin to take responsibility for their alcohol and/or drug use and begin to recognize denial and other signs of minimizing their drug problems. Group substance abuse counseling must be based on best practices and effective treatment models. Research-based treatment and curriculums provided by the National Institute of Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) should be used, whenever possible.

For consistency with AHCA/Medicaid requirements, group counseling/therapy provided in DJJ residential commitment programs designated for specialized treatment services (e.g., RSAT, RSAT Overlay, Dual Diagnosis) must not exceed 10 participants with mental health diagnoses and not exceed 15 youths with substance abuse diagnoses.
c. **Family Counseling or Therapy**: Family counseling or therapy refers to an assembly of a youth with substance abuse impairment, members of his/her family and a *qualified professional* licensed under Chapter 458, 459, 490 or 491, F.S, or a *substance abuse clinical staff person* who is an employee in a facility licensed under Chapter 397 or an employee of a service provider licensed under Chapter 397, F.S., working under the *direct supervision* of a *qualified professional* (in accordance with Rule 65D-30.003(15) FAC) for the purpose of involving the family in the youth’s alcohol/drug treatment. Family counseling or therapy in substance abuse treatment focuses on helping the family to actively support the youth’s abstinence from alcohol and/or drugs, and teaching the family methods of reinforcing the youth’s positive behaviors. Family counseling or therapy must be based on effective treatment approaches. Research-based treatment and curriculums provided by the National Institute of Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) should be used, whenever possible.

d. **Psychosocial Skills Training**: Psychosocial Skills Training are therapeutic activities designed to improve the social, emotional and behavioral functioning and life skills of the youth with substance-related disorder. Psycho-education or Psychosocial Skills Training may be provided in individual, group or family sessions. Psycho-education or Psychosocial Skills Training may be provided by a *qualified professional* licensed under Chapter 458, 459, 490 or 491, F.S, or a *substance abuse clinical staff person* who is employee in a facility licensed under Chapter 397 or an employee of a service provider licensed under Chapter 397, F.S., working under the *direct supervision* of a *qualified professional* (in accordance with Rule 65D-30.003(15) FAC). Psychosocial Skills Training must address the specific deficits or maladaptive behaviors identified in the youth’s treatment plan.

The superintendent or program director is responsible for ensuring that youths who are diagnosed as suffering from an acute or chronic substance related disorder, and determined in need of substance abuse treatment by a qualified substance abuse professional, receive *necessary and appropriate substance abuse treatment*. The substance abuse treatment provided in the facility or program should be based on strategies and practices demonstrated to be effective in correctional/juvenile justice settings.

Substance abuse treatment must be provided in accordance with Chapter 65D-30.003(15) F.A.C., which states the following:

“Licensing of Department of Juvenile Justice Commitment Programs and Detention Facilities. In those instances where substance abuse services are provided within Juvenile Justice Commitment programs and detention facilities, such services may be provided in accordance with any one of the four conditions described below.

e. The services must be provided in a facility that is licensed under Chapter 397, F.S., for the appropriate licensable service component as defined in subsection 65D-30.002(16), F.A.C.

f. The services must be provided by employees of a service provider licensed under Chapter 397.

g. The services must be provided by employees of the commitment program or detention facility who are qualified professionals licensed under Chapters 458, 459, 490 or 491, F.S.
h. The services must be provided by an individual who is an independent contractor who is licensed under Chapters 458, 459, 490, or 491, F.S.”

Under Rule 65D-30.003(15), F.A.C., condition (a) and condition (b), substance abuse treatment must be conducted by a substance abuse professional who is an employee in a facility licensed under Chapter 397 or an employee of a service provider licensed under Chapter 397, F.S., and under condition (c) and (d), the substance abuse professional must be a qualified professional licensed under chapter 458, 459, 490 or 491, Florida Statutes.

V. PSYCHOPHARMACOLOGICAL THERAPY

Note: For more comprehensive guidelines for use of psychotropic medication, see the Revised Health Services Manual, Chapter 12 “Psychotropic Medication Management”.

When symptoms of serious mental disorder or substance abuse impairment significantly interfere with the youth’s functioning, psychotropic medication may provide symptom relief and allow the youth to more successfully participate in mental health activities and activities of daily living. Psychotropic medication refers to medications capable of affecting the individual’s thinking, mood and behavior which are used to treat symptoms of mental illness. A variety of psychotropic medications may be helpful in the treatment of youths with mental disorders or substance related disorders.

Following an initial diagnostic psychiatric interview with the psychiatrist or psychiatric ARNP, youths who are to continue receiving psychotropic medication or who are prescribed psychotropic medication must be referred to the mini treatment team in detention centers or multidisciplinary treatment team in residential commitment programs for development of an initial treatment plan or individualized mental health/substance abuse treatment plan.

Psychotropic medication should be only one component of an initial treatment plan (see Appendix H) or individualized mental health/substance abuse treatment plan (see Appendix I-1) which includes psychotherapeutic interventions (e.g., clinical counseling or psychotherapy, supportive counseling, psychosocial skills training, psycho-education).

Psychotropic medication shall be prescribed and administered consistent with nationally recognized professional standards, such as those set forth by the American Academy of Child and Adolescent Psychiatry or American Academy of Pediatrics, and in accordance with Florida law, Departmental policies and standards and the commonly accepted practices of the psychiatric community.

Psychotropic medications shall not, under any circumstance, be used for discipline or punishment, as a substitute for behavioral or other programming, convenience of staff, or for experimental purposes.

There will be no Emergency Treatment Orders for psychotropic medication.

The Department’s policy and operating guidelines for administration and management of psychotropic medication are detailed in the Revised DJJ Health Services Manual, chapter entitled “Psychotropic Medication Management”.

6-12

UPDATED APRIL 2007
VI. PSYCHIATRIC SERVICES:

Within the context of this Manual, psychiatric services are psychiatric evaluation, psychiatric consultation, medication management and medical supportive counseling provided to youths with a diagnosed DSM-IV-TR mental disorder and substantial functional limitations. Psychiatric services within DJJ facilities and programs must be provided by a licensed psychiatrist or a licensed and certified psychiatric advanced registered nurse practitioner (ARNP) working under the clinical supervision of a licensed psychiatrist as specified in this section.

1. A licensed psychiatrist shall have ultimate responsibility for psychiatric services provided in a DJJ facility or program. A licensed psychiatrist is a physician licensed under Chapter 458 or 459, Florida Statutes, who is board certified in Child and Adolescent Psychiatry or Psychiatry by the American Board of Psychiatry and Neurology or has completed a training program in Psychiatry approved by the American Board of Psychiatry and Neurology for entrance into its certifying examination. A licensed psychiatrist who is board certified in Forensic Psychiatry by the American Board of Psychiatry and Neurology or American Board of Forensic Psychiatry may provide services in DJJ facilities or programs, but must have prior experience and training in psychiatric treatment with children or adolescents.

The psychiatrist must actively participate in, manage and supervise psychiatric services in the DJJ facility/program as follows:

   a. The psychiatrist or psychiatric ARNP must conduct an initial diagnostic interview of the youth who is to continue or begin treatment with psychotropic medication as follows:

   • When a youth is currently prescribed psychotropic medication at the time of entering a DJJ facility or program, the psychotropic medication shall be administered as currently prescribed until the psychiatrist or psychiatric ARNP conducts an initial diagnostic interview of the youth. The initial diagnostic psychiatric interview must be conducted within 14 days of the youth’s admission.

   • When a youth who is not currently prescribed psychotropic medication at the time of entry into a DJJ facility or program later exhibits serious emotional disturbance or mental illness and is referred for psychiatric examination, the psychiatrist or psychiatric ARNP must conduct an initial diagnostic interview of the youth prior to prescribing psychotropic medication. The initial diagnostic psychiatric interview must be conducted within 14 days of the youth’s referral to the psychiatrist or psychiatric ARNP.

The initial diagnostic interview must include: History (medical, mental health and substance abuse history); Mental Status Examination; DSM-IV-TR Diagnostic Formulation (Axis I–V); Treatment Recommendations; Prescribed Medication (if applicable); Explanation of the need for psychotropic medication; and Frequency of Medication Monitoring/Management. The initial diagnostic interview shall be used to establish a diagnosis and target symptoms to be treated with the medication and to develop the youth’s mental health treatment plan.

   b. The psychiatrist must personally render psychiatric services or provide clinical supervision of the licensed and certified psychiatric ARNP also rendering psychiatric services in the DJJ facility or program.
c. The psychiatric ARNP must be licensed as a registered nurse and certified as an advanced registered nurse practitioner with a specialty in psychiatric mental health pursuant to Chapter 464, Florida Statutes. The psychiatric ARNP may provide psychiatric services only as specified in the current written collaborative practice protocol with the supervising psychiatrist filed with the Florida Department of Health. Verification of required licensure and certification may be accomplished by accessing Medical Quality Assurance (MQA) Services at the Florida Department of Health website: http://www.doh.state.fl.us/.

1) A current and updated copy of the official collaborative practice protocol between the supervising psychiatrist and psychiatric ARNP and a copy of the notice required by section 458.348(1) F.S., must be kept on-site at each DJJ facility or program where the psychiatric ARNP provides psychiatric services.

a) A copy of the official collaborative practice protocol must be provided to the Department prior to execution of a DJJ contract for psychiatric services which includes a psychiatric ARNP.

2) Any alterations to the official collaborative practice protocol or amendments filed with the Department of Health must be copied and kept on-site at each DJJ facility or program where the psychiatric ARNP provides psychiatric services.

d. The supervising psychiatrist must be available to the psychiatric ARNP by telephone or by other communication device when not physically available on the premises.

e. The supervising psychiatrist must provide and document clinical supervision of the psychiatric ARNP on-site at the DJJ facility or program on a bi-weekly basis (every two weeks), at a minimum.

f. Consultation with the supervising psychiatrist must be provided as specified in the collaborative practice protocol and under the following circumstances:

1) Conditions for which the diagnosis and/or treatment are beyond the scope of the psychiatric ARNP’s knowledge and/or skills;

2) Changes in youth’s symptoms or impairment not managed by standard interventions (medication adverse effects, non-response or poor response);

3) Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started;

4) As requested by the DJJ mental health clinical staff, DJJ administrative staff or youth.

2. Coordination of Psychiatric Services: If the youth was receiving psychotropic medication or psychiatric services prior to admission to the DJJ facility, it is the responsibility of the psychiatrist or psychiatric ARNP or other healthcare staff to contact the psychiatrist or other provider treating the youth prior to admission, to coordinate services and obtain treatment records. The psychiatrist or psychiatric ARNP is responsible for contacting the prior psychiatrist or provider with any questions or concerns regarding the effectiveness of prescribed drugs and psychotherapeutic interventions utilized prior to admission.
a. Contact with the previous psychiatrist or provider treating the youth prior to admission must be documented in the youth's individual healthcare record.

b. The psychiatrist or psychiatric ARNP must assume responsibility for delivery and management of the youth's psychiatric services while in the DJJ facility, including psychiatric assessment and provision of psychopharmacological treatment.

c. The continuation or renewal of psychotropic medications from community providers shall be based on the psychiatrist's or psychiatric ARNP's timely evaluation of the youth.

3. Psychiatric Evaluation: A psychiatric evaluation is performed by a licensed psychiatrist or psychiatric ARNP to determine the presence of, or nature and complexity of a mental health or substance abuse disorder. If disorder(s) exists a psychiatric evaluation establishes differential diagnoses and tentative diagnostic formulation, and develops treatment recommendations and a treatment plan.

All youths currently receiving psychotropic medications at the time of admission or prescribed psychotropic medication subsequent to admission must receive an in-depth psychiatric evaluation or an updated psychiatric evaluation by a licensed psychiatrist or psychiatrist ARNP working under the clinical supervision of the psychiatrist within 30 days of admission to the DJJ facility or program (for youths currently receiving psychotropic medications at the time of admission) or within 30 days of the initial prescription of psychotropic medication (for youths prescribed psychotropic medication subsequent to admission).

Psychiatric Evaluation Components are as follows:

a. The psychiatrist or psychiatric ARNP must review available medical, mental health and substance abuse reports, arrest reports and pertinent DJJ records prior to evaluation.

b. The psychiatrist or psychiatric ARNP must complete and document the psychiatric evaluation on the day it was conducted. If a transcription service is used, the psychiatrist may place a summary note in the youth's individual healthcare record on the day the evaluation is conducted and file the dictated report in the individual healthcare record within 7 calendar days.

c. The psychiatric evaluation must reflect consideration of the following:

1) The stated reasons and factors leading to the referral;

2) History (developmental history, medical history [including medical disorders, head trauma and prenatal exposure to alcohol or drugs], substance abuse history, school history, social history, emotional development, peer relations, family relationships, interests/talents and traumatic experiences [physical abuse, sexual abuse, neglect, witnessing violence and other forms of trauma]);

Note: When a detailed history has already been documented in a comprehensive mental health evaluation conducted immediately prior or subsequent to the youth’s admission to the DJJ facility or program (i.e., within the past 3 months), the psychiatrist or psychiatric ARNP may utilize the detailed history provided in the previous comprehensive evaluation rather than repeating the history. However, pertinent interval history that has been obtained since the last report must be added in this section. A notation must be made in the psychiatric evaluation history section that the history is documented in the previous...
comprehensive evaluation and the comprehensive evaluation must be attached to the psychiatric evaluation.

3) History of psychiatric illness, psychotropic medication management, mental health treatment and/or substance abuse treatment;

4) Assessment of symptoms (the nature and complexity of the youth’s behavioral difficulties, functional impairments, and subjective distress);

5) Mental Status Examination;

6) Identification of individual, family and/or environmental factors that may potentially account for, influence or ameliorate the youth’s difficulties;

7) Diagnostic formulation (Multi-axial DSM-IV-TR diagnoses);

8) Treatment recommendations and intervention(s) for a youth in order to assist in stabilizing the psychiatric disorder;

9) Prescribed medication (if applicable) and frequency of medication monitoring/management;

10) Explanation of the need for psychotropic medication related to the youth’s diagnosis, target symptoms, potential side effects and risks and benefits of taking the medication;

11) Most recent applicable therapeutic serum drug levels (laboratory tests); and

12) Signature of the practitioner conducting the psychiatric evaluation.

d. The psychiatric evaluation may be documented on the DJJ form entitled “Clinical Psychotropic Progress (CPPN) (all 3 pages) or in a form developed by the facility or program. The form utilized (CPPN) or facility/program form must be clearly identified as a “Psychiatric Evaluation”. However, if the psychiatric evaluation results in the prescription of psychotropic medications or changes to a youth’s existing psychotropic medication regimen, page 3 of the CPPN must be completed, regardless of the format used to document the psychiatric evaluation.

e. Youths with a documented psychiatric evaluation within the past 6 months may receive an updated psychiatric evaluation as follows:

If a recent psychiatric evaluation (within the past 6 months) is on file in the Individual Healthcare Record and/or is obtainable from the youth’s past prescribers, an updated psychiatric evaluation may be conducted. The up-dated psychiatric evaluation shall be documented using either the standardized form, Clinical Psychotropic Progress Note (CPPN) (all 3 pages), or on a form developed by the facility/program as long as all the form is clearly identified as an “Updated Psychiatric Evaluation” and all the components listed in paragraph C. above are present.

4. Psychiatric Follow-up Assessment/Consultation

a. Following the Psychiatric Evaluation, additional psychiatric follow-up assessments may be provided, as clinically indicated, to evaluate response to/maintenance on a prescribed medication, progress toward treatment goals, or assessment following discharge from a psychiatric inpatient facility.
b. Follow-up Assessments are less in-depth than a psychiatric evaluation, but shall contain at least the following information:
   1) Identifying Data: name and date of service
   2) Interval History: pertinent information/changes/progress since last seen
   3) Review of Recent Testing/Lab Results
   4) Mental Status Exam
   5) Assessment of Symptoms
   6) Medications and Orders (if applicable)
   7) Signature of the Practitioner.

5. Psychotropic Medication Management Services
   (See the Revised Health Services Manual, Chapter 12 entitled “Psychotropic Medication Management” for more comprehensive guidelines for use of psychotropic medication)

   a. Psychotropic Medication Management services are those services related to the prescription, monitoring and review of psychopharmacological medications. Psychotropic medication management services must be provided by a licensed psychiatrist or a psychiatric ARNP working under the clinical supervision of a licensed psychiatrist (as specified in a collaborative practice protocol between the psychiatrist and psychiatric ARNP).

      1) Clinical supervision means that the psychiatrist provides bi-weekly (every two weeks) on-site supervision of the advanced registered nurse practitioner’s medication management services. Psychotropic medication management services must be reviewed and approved by the psychiatrist.

      2) The psychiatrist must be on-site every two weeks and available to evaluate and monitor youths, as needed. However, all youths must receive psychotropic medication monitoring/review every 30 days (see paragraph (b) below).

      3) The psychiatrist must be available for emergency consultation 24 hours a day, 7 days a week.

   b. Medication monitoring/review includes evaluating and monitoring medication effects and the need for continuing or changing the medication regimen. At a minimum, follow-up medication monitoring/review shall be provided every 30 days.

      1) Psychotropic medication monitoring/review shall include, but is not limited to:
         a) Monitoring the effects of prescribed psychotropic medication and clinical outcomes as described in the youth’s treatment plan
         b) Evaluation of potential side effects
         c) Assessment of medication adherence/compliance
         d) Evaluation of the need for medication adjustments or discontinuation
         e) Informing the youth and parent/legal guardian of the potential side effects of each psychotropic medication prescribed, dose schedule and anticipated therapeutic effects.
         f) Providing information regarding continuation and maintenance of psychotropic medication.
         g) Monitoring of indices such as height, weight and blood pressure or other laboratory findings (e.g., ordering and monitoring serum therapeutic drug levels, EKG, EEG).
         h) Ensuring any expected or common side effects of psychotropic medication are effectively communicated to the facility staff who supervise the youth.
c. If psychotropic medication is prescribed or continued by the psychiatrist or psychiatric ARNP, the following information will be documented for each psychotropic medication monitoring/review visit.

1) Documentation of medication monitoring/review shall include:
   a) Identifying data
   b) Diagnosis
   c) Target symptoms of each medication
   d) Evaluation and description of effect of prescribed medication on target symptom(s)
   e) Prescribed psychotropic medication, if any (name, dosage and quantity of the medication)
      - Normal dose range
      - Ordered Dosage
      - Frequency and route of administration
      - Reasons for changes in medication and/or dosage shall be clearly documented by the psychiatrist or psychiatric ARNP
   f) Side Effects (description of response to medication(s) both positive and adverse drug experiences or documentation if none present)
   g) Youth’s adherence to the medication regime
   h) Height, weight, blood pressure, most recent serum drug levels or laboratory findings (as appropriate)
   i) Whether there was telephone contact with the parent/legal guardian to discuss medication when one of the following actions is taken by the psychiatrist or psychiatric ARNP:
      - Prescribes or otherwise orders a prescription medication which the youth was not currently prescribed at the time of entering the physical custody of the Department, or
      - Discontinues prescription medication(s) (which the youth was currently prescribed at the time of entering the physical custody of the Department) or discontinues medications which the youth has been prescribed since entering the physical custody of the Department; or
      - A significant change in the dosage of prescription medication(s), (which the youth was currently prescribed at the time of entering the physical custody of the Department). A “significant change” in dosage of a medication is any increase or decrease in dosage beyond a small increment or beyond the normal dosage for youths of similar age.
   j) Signature of prescribing practitioner
   k) Date of signature

2) Psychotropic medication that is prescribed or significantly changed shall be documented on the CPPN. Psychotropic medication that is continued without significant change shall be documented either on the CPPN or in a format developed by the facility or program.

d. The psychiatrist or psychiatric ARNP shall prescribe psychotropic medications, as appropriate, which address the youth’s specific diagnosis and target symptoms. If psychotropic medications are prescribed, the psychiatrist or psychiatric ARNP will:
   1) Monitor target symptoms;
   2) Order labs required by prescribed medication, including serum drug levels to ensure a safe and therapeutic range;
3) Review lab results within 72 hours of notification of results; (The psychiatrist may accomplish the review of lab results off-site through review of an electronically transmitted or faxed copy of the lab results.);
4) Assist with parental notification;
5) Document medication management services in accordance with b. and c. above.

6. **Medical Supportive Counseling/Therapy** is face-to-face interaction between the psychiatrist or psychiatric ARNP and the individual, family or group designed to provide information and improved understanding of the youth’s symptoms, prognosis, potential treatments and outcomes and encourage and reinforce the youth’s strengths, successful coping techniques and progress towards identified goals.

**UPDATE**

7. **Treatment Planning**

   a. The psychiatrist or psychiatric ARNP providing psychiatric services must either be a member of the mini-treatment team or multidisciplinary treatment team, or must on a weekly basis, brief a representative of the treatment team on the psychiatric status of each youth receiving psychiatric services who is scheduled for treatment team review. The briefing may be accomplished through face-to-face interaction or telephonic communication with the representative or treatment team.

   b. The psychiatrist or psychiatric ARNP’s evaluation and recommendations for the youth shall be incorporated into mental health clinical staff’s evaluations of the youth and the youth’s individualized mental health or substance abuse treatment plan.

**VII. TRANSITION PLANNING: THE MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT DISCHARGE SUMMARY**

During the final phase of mental health or substance abuse treatment, referred to as the transition phase, the mental health or substance abuse clinical staff person, treatment team and youth must establish a plan whereby improvements made during mental health or substance abuse treatment will be maintained upon the youth’s movement from one facility to another, or return to his/her community. This plan is documented through the *Mental Health/Substance Abuse Treatment Discharge Summary* (see Appendix V).

The *mental health/substance abuse treatment discharge summary* documents the focus and course of the youth’s mental health or substance abuse treatment, and recommendations for mental health or substance abuse services upon the youth’s movement out of the facility.

**A. MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT DISCHARGE SUMMARY:**

1. The *mental health/ substance abuse treatment discharge summary* must contain the following elements:
   - The dates mental health/substance abuse treatment started and ended;
   - The relevant mental health/substance abuse history;
   - The reason mental health or substance abuse treatment ended;
   - The problems which were the focus of mental health or substance abuse treatment;
   - The course of the youth’s mental health/substance abuse treatment, and the youth’s progress in treatment;
   - The youth’s pre-treatment and post-treatment DSM-IV-TR diagnoses;
The youth’s current Alert Status;
- The youth’s continued mental health or substance abuse service needs and treatment recommendations;
- Psychotropic medications the youth has been receiving and to be continued upon discharge from the facility; and
- Follow-up appointments scheduled for the youth which include the contact names and telephone numbers of the providers that will be treating the youth.

2. For youths on Suicide Risk Alert/Suicide Precautions immediately prior to discharge to the community, the youth’s parent/legal guardian and Juvenile Probation Officer must be verbally notified of the youth’s suicide risk status prior to discharge from the facility. If verbal notification cannot be accomplished, written notification of the youth’s suicide risk status must be provided to the parent/legal guardian prior to the youth’s discharge from the facility. The notification of suicide risk must be made and documented by the facility superintendent or his/her designee and permanently filed in the youth’s individual healthcare record.

3. For youths on Suicide Risk Alert/Suicide Precautions immediately prior to transfer to a DJJ facility/program, the facility superintendent/program director where the youth is to be transferred must be verbally notified of the youth’s suicide risk status prior to discharge. The notification of suicide risk must be made and documented by the facility superintendent/program director or designee and permanently filed in the youth’s individual healthcare record.

4. The Mental Health/Substance Abuse Treatment Discharge Summary must consider the services needed for daily maintenance of the positive improvement in behavioral, emotional and social skills made by the youth during treatment.

5. The Mental Health/Substance Abuse Treatment Discharge Summary should be discussed with the youth, parent/legal guardian (when available) and Juvenile Probation Officer prior to the youth’s release from the detention center or during the exit conference conducted prior to a youth’s release from a residential commitment program. A copy of the Mental Health/Substance Abuse Treatment Discharge Summary will be provided to the youth, the youth’s assigned Juvenile Probation Officer and to the parent/legal guardian (as allowed). [See the Residential Commitment Services Manual 2006, chapter entitled “Release, Transfer and Discharge” for further information regarding transition planning in residential commitment programs.]

6. The Mental Health/Substance Abuse Treatment Discharge Summary documentation of pre and post symptomatology and functional status may be used as mental health and substance abuse outcome measures.

VIII. SPECIALIZED TREATMENT SERVICES IN RESIDENTIAL COMMITMENT PROGRAMS

Specialized treatment services are primarily provided in residential commitment programs designated as DJJ “Specialized Treatment Services Programs” or designated to provide “Specialized Treatment Overlay Services”. However, all DJJ residential commitment programs, even if they do not provide any “specialized treatment services”, must ensure that youths have access to and receive necessary and appropriate mental health and/or substance abuse services. DJJ Specialized Treatment Services in residential commitment programs include the following:
A. DJJ SPECIALIZED TREATMENT SERVICES PROGRAMS

1. COMPREHENSIVE SERVICES FOR MAJOR DISORDERS provide the most intensive level of mental health treatment within the DJJ continuum of specialized treatment programs.

   a. Dual Diagnosis – Major Disorders Programs are designed specifically for youths diagnosed with both a major mental disorder and a substance-related disorder. This program is capable of treating youths with very serious to severe mental health disorders and substance abuse problems.

   b. Intensive – Major Disorders Programs provide the most intensive level of mental health treatment within the DJJ continuum of commitment programs/services, and is intended to serve youths in need of a very intensive level of clinical support and services. Youths admitted to this program are likely to have a recent history of very serious to severe mental health symptoms, use of psychotropic medication and on-going mental health treatment. Youths who are demonstrating challenging behaviors in juvenile justice settings such as self-mutilation, self-injury, emotional instability, paranoia or bizarre behavior may be considered appropriate for this program.

2. INTENSIVE SERVICES PROGRAMS are designed specifically for youths with intensive mental health needs, youths with an adjudicated sex offense or youths with development disability. Intensive Services Program must also be capable of providing services for youths with co-occurring disorders. Within DJJ residential and correctional programs, the Intensive Services Programs provided are:

   a. Intensive Mental Health Treatment Services Programs are provided to youths with serious to severe mental disturbance whose level of impairment and maladaptive behavior impedes their ability to function in a general residential commitment program.

   b. Sex Offender Treatment Services–Secure Programs are provided for youths with an adjudicated sex offense who are classified as high risk to public safety. Sex offender treatment services include comprehensive sex offender assessments and evaluations, sex offender therapy services and individualized sex offender treatment planning.

   c. Developmental Disability Treatment Services Programs are provided for youths with an IQ less than seventy whose level of cognitive impairment and related functional limitations impede their ability to function in a general offender program. Programs providing Developmental Disability Treatment Services must have the capacity to provide mental health services and/or substance abuse services for youths with co-occurring mental health disorder.

3. SPECIALIZED SERVICES PROGRAMS are designed specifically for youths with moderate to serious mental disorder, youths with serious substance-related disorder, or youths with an adjudicated sex offense who are moderate risks to public safety. Within DJJ residential and correctional programs, the Specialized Services Programs provided are:

   a. Specialized Mental Health Services Programs are provided to youths with moderate to serious mental disturbance whose level of impairment and maladaptive behavior impedes their functioning, but are not at the level of intensive services. Specialized Mental Health Services Programs are designed specifically for youths with serious mental disturbance, but must also be capable of providing substance abuse treatment services for youths with
co-occurring substance-related disorder. Specialized Mental Health Services Programs provide a higher intensity service than MHOS, but are not at the level of Intensive Mental Health Treatment Services.

b. **Residential Substance Abuse Treatment (RSAT) Programs** provide a full array of substance abuse treatment services including substance abuse assessment, treatment and relapse prevention. DJJ RSAT programs provide substance abuse treatment over a six to twelve month period within residential and correctional facilities that offer a therapeutic community model and are set apart from the general offender population. DJJ RSAT Programs focus primarily on the substance abuse problems of juvenile offenders and are designed to develop the youth’s cognitive, behavioral, social and other skills to solve their substance abuse, delinquency and related problems. Funding for the DJJ RSAT Program is provided by FDLE through a U.S. Department of Justice Residential Substance Abuse Treatment for State Prisoners grant. DJJ RSAT Programs are licensed under Chapter 397, Florida Statutes, to provide residential substance abuse treatment.

c. **Sex Offender Treatment Services – Non-Secure Programs** are provided for youths with an adjudicated sex offense. Sex offender treatment services include comprehensive sex offender assessments and evaluations, sex offender therapy services and individualized sex offender treatment planning.

B. **DJJ SPECIALIZED TREATMENT OVERLAY SERVICES** are specialized treatment services provided to youths placed in a general residential commitment program who have mental health and/or substance use disorders. DJJ residential commitment programs that provide Specialized Treatment Overlay Services receive an enhanced per diem rate designated specifically for specialized treatment services provided to eligible youths within a general residential commitment program setting. However, if all of the beds/slots in a general residential commitment program have been designated for specialized treatment overlay services, the program should be expected to function as a DJJ specialized treatment services program.

Within DJJ residential commitment programs, the Specialized Treatment Overlay Services provided are:

1. **Mental Health Overlay Services (MHOS)** are provided to youths placed in a general residential commitment program who have moderate to serious mental or emotional disturbance and impairment which impedes their ability to function.

2. **Behavioral Health Overlay Services (BHOS)** are behavioral health (mental health and substance abuse) services provided to youths who are placed in the care of Medicaid enrolled, certified residential commitment programs under contract with the Department of Juvenile Justice. BHOS providers provide a comprehensive array of mental health and substance abuse services as an overlay to the residential care and delinquency programming provided. BHOS providers must provide services in accordance with requirements set forth by DJJ and the Agency for Health Care Administration, Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

3. **Residential Substance Abuse Treatment Overlay Services (RSAT Overlay Services)** are substance abuse treatment services, including substance abuse assessment, treatment and relapse prevention provided to juvenile offenders placed in a general residential commitment program who are substance abusers. These youth receive daily substance abuse treatment within a general residential commitment program setting. However, if all of the beds/slots in a
DJJ general residential commitment program have been designated for residential substance abuse treatment overlay services (RSAT Overlay Services), the program should be expected to function as a *specialized treatment services* program. DJJ RSAT Overlay services require a therapeutic structure for the subset of juvenile offenders who are substance abusers and clinical activities that promote long-term abstinence from drug use, and which address the full complexity of each youth’s substance abuse.

See Appendix W for general information regarding youth eligibility, clinical services and clinical staffing in specialized treatment services programs.
CHAPTER 7
SUICIDE PREVENTION

UPDATE

I. INTRODUCTION

This chapter describes the essential components of a suicide prevention plan, and provides guidelines for the identification, management and assessment of a potential suicide risk or “at risk” youth. Within the context of this chapter, the "potential suicide risk" or “at risk” youth refers to youths who have a history of, or demonstrate behaviors which indicate that he/she is thinking about or contemplating suicide, but is not acutely suicidal. In contrast, the acutely suicidal youth who attempts suicide or presents an imminent threat of suicide must be treated as an emergency (see Chapter 9 of this manual).

II. SUICIDE PREVENTION PLAN

Each detention center, residential commitment program and facility based day treatment program must have a written plan that details suicide prevention procedures. The facility/program’s plan for suicide prevention must include the following elements:

A. IDENTIFICATION. The superintendent or program director must ensure that any youth identified through screening or alert processes as having suicide risk factors is classified as a Suicide Risk Alert on JJIS and is referred for an assessment of suicide risk. A youth may be identified as having suicide risk factor through any of the following: the Suicide Risk Screening Instrument; MAYSI-2 Suicide Ideation Scale; PACT Suicide Subscale or Depression Subscale (“History of impairment in everyday tasks due to depression/anxiety” Domain 3 Mental Health, item 3); Clinical Mental Health or Clinical Substance Abuse Screening; by information obtained at intake; or is identified as a suicide risk through staff observations after admission to a DJJ detention facility, residential commitment program, or facility based day treatment program.

B. ASSESSMENT. When suicide risk factors or suicide tendencies are indicated by screening or staff observations, an assessment of suicide risk must be conducted to determine the level of suicide risk. An assessment of suicide risk must be conducted by a licensed mental health professional or a non-licensed mental health clinical staff person, working under the direct supervision of a licensed mental health professional. A licensed mental health professional means a mental health professional licensed pursuant to Chapter 458, 459 F.S., (psychiatrists), Chapter 490, F.S., (psychologists), Chapter 491, F.S., (mental health counselors, clinical social workers, marriage and family therapists), or as defined in Section 394.455(23), F.S., (psychiatric nurses). A non-licensed mental health clinical staff person conducting an assessment of suicide risk must have received at least 20 hours training and supervised experience in assessing suicide risk, mental health crisis intervention and emergency mental health services. The non-licensed mental health clinical staff person’s training hours must have included administration of, at a minimum, five assessments of suicide risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional. The non-licensed mental health clinical staff
person’s training and supervised experience must be provided by a licensed mental health professional and must be documented and on-file in the facility or program.

C. TRAINING. All staff who work with youths must be trained to recognize verbal and behavioral cues that indicate suicide risk. Each facility or program must provide at least 6 hours of training annually on suicide prevention and implementation of Suicide Precautions. The training provided in the facility or program must be documented.

D. SUICIDE PRECAUTIONS. The suicide prevention plan must specify the facility’s Suicide Precautions (the method: Precautionary Observation or Secure Observation) utilized for supervising, observing, monitoring, and housing a youth who has been identified through screening as having suicide risk factors or identified through assessment as a potential suicide risk. The plan must specify the areas of the facility designated for Precautionary Observation and Secure Observation.

E. LEVELS OF SUPERVISION. A level of supervision, of at least constant supervision must be maintained while a youth is on Precautionary Observation or Secure Observation. The suicide risk youth must not be placed in a locked room unless at least constant supervision is maintained and the room is as suicide proof as possible.

The suicide prevention plan must reflect levels of supervision of youths consistent with the following definitions:

One-to-One Supervision during suicide precautions refers to the supervision of one youth by one staff member who must remain within five feet of the youth at all times (including when the youth uses the shower or toilet). The staff member must maintain constant visual and sound monitoring of the youth at all times. If the youth is in a secure observation room, the staff member assigned to one-to-one supervision of the youth must be stationed at the entrance to the room, no further than five feet from the door. One-to-One Supervision must be documented on the Appendix form R entitled “Suicide Precautions Observation Log”.

Constant Supervision during suicide precautions refers to the continuous and uninterrupted observation of a youth by a staff member who has a clear and unobstructed view of the youth and unobstructed sound monitoring of the youth at all times. Constant supervision shall not be accomplished through video/audio surveillance. If video/audio surveillance is utilized in the facility, it shall be used only to supplement physical observation by staff. Constant Supervision must be documented on the Appendix form R entitled “Suicide Precautions Observation Log”.

Close Supervision upon removal from suicide precautions requires supervision of youths at five-minute intervals throughout their stay in their rooms. Visual checks must be made of the youth’s condition (i.e., outward appearance, behavior, position in the room) while in his/her room at intervals not to exceed five minutes. Visual checks must be documented in writing at intervals not to exceed five minutes. A sample form entitled “Close Supervision - Visual Checks Log” is provided at Appendix S-1. Close Supervision is to be used only as a step-down method of supervision of an “at risk” youth who has received an Assessment of Suicide Risk, has been removed from Suicide Precautions, and is being transitioned back into a normal routine. Close Supervision is not an option for Precautionary Observation or Secure Observation.

F. REFERRAL. The suicide prevention plan must specify the procedures for referring “at risk” youths to mental health care providers or emergency facilities.
G. **COMMUNICATION.** Procedures for immediate and timely communication between mental health care professionals and facility staff regarding the status of the youth must exist to provide clear and current information and instructions. Procedures must also be in place for communication with the youth’s parent or legal guardian to obtain information regarding suicide risk factors and to inform the parent/legal guardian of the youth’s potential suicide risk as indicated by an *Assessment of Suicide Risk*.

H. **NOTIFICATION.** Procedures must be in place for notifying the parent/legal guardian that DJJ suicide risk screening indicated possible suicide risk and need for further assessment if the youth is being released to the parent/legal guardian prior to administration of an *Assessment of Suicide Risk* (See Appendix O for notification form). Procedures for verbally notifying the superintendent or program director, supervisors, outside authorities, the juvenile probation officer and the parent or legal guardian of the youth’s potential suicide risk, as indicated by an *Assessment of Suicide Risk*, or an attempted suicide must also be in place.

For youths on Suicide Risk Alert/Suicide Precautions in a DJJ facility/program immediately prior to discharge to the community, the youth’s parent/legal guardian and Juvenile Probation Officer must be verbally notified of the youth’s suicide risk status prior to discharge from the facility. If verbal notification cannot be accomplished, written notification of the youth’s suicide risk status must be provided to the parent/legal guardian prior to the youth’s discharge from the facility. The notification of suicide risk must be made and documented by the facility superintendent or program director or his/her designee and permanently filed in the youth’s individual healthcare record.

For youths on Suicide Risk Alert/Suicide Precautions immediately prior to transfer to a DJJ facility/program, the facility superintendent/program director where the youth is to be transferred must be verbally notified of the youth’s suicide risk status prior to discharge. The notification of suicide risk must be made and documented by the facility superintendent/program director or designee and permanently filed in the youth’s individual healthcare record.

**NOTE: (Parent Notification When a Suicide Attempt or Self-Inflicted Injury Requires Emergency Medical Services or is Life Threatening)**

When the youth’s suicide attempt or self-inflicted injury requires emergency medical services or is life threatening (after necessary medical treatment is obtained for the youth) the facility superintendent or program director must make every effort to immediately notify the parent/legal guardian. If the parent or legal guardian cannot be contacted, the following steps must be taken:

1) Use alternative contact methods as documented in the youth’s record. Such alternative methods may include, but are not limited to, contact via the parent’s or legal guardian’s work address, pager/cell phone or electronic notification or contact via a relative or neighbor.

2) Contact the youth’s juvenile probation officer to request assistance with notification. In the case where the youth’s family lives in close proximity to the JPO’s work location or area, request that the JPO drive by the parent’s or legal guardian’s home, place of work, school or other known location outside of the home.

3) Contact law enforcement to request assistance in locating the parent or legal guardian.

The facility superintendent or program director must document all efforts to contact the parent or legal guardian.
I. **DOCUMENTATION.** Procedures for documenting the identification, referral, monitoring, assessment and follow-up of a youth identified as a potential risk of suicide or who has attempted suicide must be detailed. The forms/formats provided in this chapter and the facility log must be utilized for documentation of suicide prevention processes and procedures.

J. **IMMEDIATE RESPONSE TO SUICIDE ATTEMPT OR INCIDENT OF SERIOUS SELF-INFlicted INJURY.** The suicide prevention plan must specify the procedures for immediate staff response to a suicide attempt or incident of serious self-inflicted injury, in accordance with Section VII of this chapter.

K. **REVIEW PROCESS.** The suicide prevention plan must specify the procedures for mental health and administrative review of suicide prevention procedures. The plan must also specify the facility’s review process for every serious suicide attempt or serious self-inflicted injury (i.e., requiring hospitalization or medical attention) and mortality review process for a completed suicide. (See section IX of this chapter for further information regarding serious suicide attempt reviews and mortality reviews). The facility’s suicide prevention plan must be reviewed annually.

### III. IDENTIFICATION OF “AT RISK” YOUTHS

A. **SCREENING FOR SUICIDE RISK**

Screenings conducted during initial intake to the juvenile justice system and at entry to departmental facilities or programs assist in identifying suicide risk as follows:

1. **Suicide Risk Screening by Juvenile Probation Officers:** If further assessment is indicated by the DJJ Suicide Risk Screening Instrument administered by the juvenile probation officer (i.e., there is a “yes” for any of the DJJ Suicide Risk Screening Instrument questions, Appendix N), or the Massachusetts Youth Screening instrument (MAYS-I-2) Suicide Ideation Scale, Positive Achievement Change Tool (PACT) Suicide Subscale or Depression Subscale (“History of impairment in everyday tasks due to depression/anxiety” Domain 3 Mental Health, item 3), or information obtained at initial intake suggests the youth is a potential suicide risk, the following must take place:

   a. If the youth is to be released to the custody of the parent or guardian, the parent or guardian must be informed that suicide risk findings were disclosed during screening and that an assessment of suicide risk should be conducted by a qualified mental health professional.

      (1) The parent or guardian must be provided the form entitled “Suicide Risk Screening Parent/Guardian Notification” at Appendix O.

      (2) A copy of the “Suicide Risk Screening Parent/Guardian Notification” form, signed by the parent or guardian, is to be permanently filed in the youth’s case management record.

   b. If the youth is to remain in the custody of DJJ, a Suicide Risk Alert must be entered into JJIS and the youth placed on constant supervision until an Assessment of Suicide Risk is conducted.
2. **Suicide Risk Screening in Detention Centers:** If further assessment is indicated by the DJJ Suicide Risk Screening Instrument administered by the detention officer, detention nurse or mental health clinical staff person (i.e., there is a “yes” for any of the DJJ Suicide Risk Screening Instrument questions, Appendix N), or the MAYSI-2 Suicide Ideation Scale, PACT Suicide Subscale or Depression Subscale (“History of impairment in everyday tasks due to depression/anxiety” Domain 3 Mental Health, item 3), or information obtained at intake or staff observations suggests the youth may be a potential suicide risk (examples provided below), the following must take place:

a. **A Suicide Risk Alert** must be entered into JJIS and the youth must be placed on Suicide Precautions and at least constant supervision until an assessment of suicide risk is conducted by, or under the direct supervision of, a licensed mental health professional.

b. The facility superintendent or designee must be immediately notified of the youth’s suicide risk factors. The superintendent or his/her designee is responsible for contacting the Designated Mental Health Authority or the licensed mental health professional who is to conduct or supervise the assessment of suicide risk to discuss the case and to request that an assessment of suicide risk be conducted.

c. The superintendent or his/her designee and the Designated Mental Health Authority or other licensed mental health professional who is responsible for mental health care in the facility/program, shall confer regarding cases where the circumstances are viewed as urgent and, if it is determined that an emergency exists, act according to the facility operating procedures for emergency care.

d. The superintendent or his/her designee must document the referral for assessment of suicide risk and recommendations made by the mental health professional on the mental health/substance abuse referral summary (see sample, Appendix G).

e. The superintendent or designee must ensure that procedures for maintaining Suicide Precautions are put into place within the facility or program.

f. If the case is not an emergency, the assessment of suicide risk must be conducted by, or under the direct supervision of, a licensed mental health professional within 24 hours of the referral.

**Examples of information obtained at intake that suggest potential suicide risk:** Current suicide ideation, suicide threats, self-inflicted injury or self-mutilation; History of suicide attempt, suicide ideation/suicide thoughts, suicide threat, self-inflicted injuries or self-mutilation; Serious psychiatric disturbance/serious mental health problem that has been or is causing significant distress or impairment (particularly depression, anxiety, bipolar disorder [dramatic mood swings], or psychosis) within the past six months; Substance dependence; Recent major loss (death of parent, sibling, best friend) within the past six months. **Note:** Indicators of recent significant psychiatric disturbance or serious mental health problem include, but are not limited to: Treatment with psychotropic medication (particularly medication for depression, bipolar disorder, anxiety disorder, psychotic disorder), crisis stabilization, psychiatric hospitalization or Baker Act evaluation(s) within the past six months.

Given the high incidence of suicidal behavior in youths in juvenile correctional facilities, any youth with risk factors for suicide must be referred for an assessment of suicide risk to be conducted within 24 hours, or immediately if the youth is in crisis. **Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the**
assessment of suicide risk is to be conducted immediately rather than within 24 hours. Any youth who makes a suicide attempt or attempts serious self-inflicted injury must receive immediate assessment of suicide risk or emergency services.

3. Suicide Risk Screening in Residential Commitment Programs: When suicide risk factors are identified by the MAYSI-2 Suicide Ideation Scale, Clinical Mental Health/Substance Abuse Screening or other information obtained at intake or after admission to the program (examples provided below), the following must take place:

a. A Suicide Risk Alert must be entered into JJIS and the youth must be placed on Suicide Precautions and at least constant supervision until an assessment of suicide risk is conducted by, or under the direct supervision of, a licensed mental health professional.

b. The superintendent/program director or his/her designee must be notified, and a referral for an assessment of suicide risk must be made. The superintendent/program director or his/her designee is responsible for contacting the Designated Mental Health Authority or other licensed mental health professional who conducts or supervises assessments of suicide risk for the facility/program to discuss the case and to request that an assessment of suicide risk be conducted.

c. The superintendent/program director or his/her designee must document the referral for assessment of suicide risk, and any recommendations made by the Designated Mental Health Authority or licensed mental health professional who is to conduct or supervise the assessment of suicide risk on the mental health/substance abuse referral summary (see Appendix G).

d. The facility superintendent/program director or his/her designee and the Designated Mental Health Authority, or other licensed mental health professional responsible for mental health care in the facility/program shall confer regarding cases viewed as urgent and, if it is determined that an emergency exists, act according to the facility operating procedures for emergency care.

e. The superintendent or designee must ensure that procedures for maintaining Suicide Precautions are put into place within the facility or program.

f. If the case is not an emergency, the assessment of suicide risk must be conducted by, or under the direct supervision of, a licensed mental health professional within 24 hours of the referral.

Examples of information obtained at intake that suggest potential suicide risk: Current suicide ideation, suicide threats, self-inflicted injury or self-mutilation; History of suicide attempt, suicide ideation/suicide thoughts, suicide threat, self-inflicted injuries or self-mutilation; Serious psychiatric disturbance/serious mental health problem that has been or is causing significant distress or impairment (particularly depression, anxiety, bipolar disorder [dramatic mood swings], or psychosis) within the past six months; Substance dependence; Recent major loss (death of parent, sibling, best friend) within the past six months. Note: Indicators of recent significant psychiatric disturbance or serious mental health problem include, but are not limited to: Treatment with psychotropic medication (particularly medication for depression, bipolar disorder, anxiety disorder, psychotic disorder), crisis stabilization or psychiatric hospitalization, Baker Act evaluation(s) within the past six months.
Given the high incidence of suicidal behavior in youths in juvenile correctional facilities, any youth with risk factors for suicide must be referred for an assessment of suicide risk to be conducted within 24 hours, or immediately if the youth is in crisis. **Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the assessment of suicide risk is to be conducted immediately rather than within 24 hours. Any youth who makes a suicide attempt or attempts serious self-inflicted injury must receive immediate assessment of suicide risk or emergency services.**

4. **Suicide Risk Screening in Facility Based Day Treatment Programs:** When suicide risk factors are identified by the MAYSI-2 Suicide Ideation Scale, PACT Suicide Subscale or Depression Subscale (“History of impairment in everyday tasks due to depression/anxiety” Domain 3 Mental Health, item 3), or other information obtained at intake or after admission to the program (examples provided below), the following must take place:

a. **A Suicide Risk Alert** must be entered into JJIS and the youth must be placed on Suicide Precautions and at least constant supervision until an assessment of suicide risk is conducted by, or under the direct supervision of, a licensed mental health professional.

b. The program director or his/her designee must be notified, along with the parent/legal guardian and a referral for an assessment of suicide risk must be made. The program director or his/her designee is responsible for contacting the Designated Mental Health Authority or other licensed mental health professional who conducts or supervises assessments of suicide risk for the facility/program to discuss the case and to request that an assessment of suicide risk be conducted.

c. The program director or his/her designee must document the referral for assessment of suicide risk, and any recommendations made by the Designated Mental Health Authority or licensed mental health professional who is to conduct or supervise the assessment of suicide risk on the mental health/substance abuse referral summary (see Appendix G).

d. The program director or his/her designee and the Designated Mental Health Authority, or other licensed mental health professional responsible for mental health care in the facility/program shall confer regarding cases viewed as urgent and, if it is determined that an emergency exists, act according to the facility operating procedures for emergency care.

e. The program director or designee must ensure that procedures for maintaining Suicide Precautions are put into place within the facility or program.

f. If the case is not an emergency, the assessment of suicide risk must be conducted by, or under the direct supervision of, a licensed mental health professional within 24 hours of the referral either through the facility or coordinated by the parent/legal guardian.

**Examples of information obtained at intake that suggest potential suicide risk:** Current suicide ideation, suicide threats, self-inflicted injury or self-mutilation; History of suicide attempt, suicide ideation/suicide thoughts, suicide threat, self-inflicted injuries or self-mutilation; Serious psychiatric disturbance/serious mental health problem that has been or is causing significant distress or impairment (particularly depression, anxiety, bipolar disorder [dramatic mood swings], or psychosis) within the past six months; Substance dependence; Recent major loss (death of parent, sibling, best friend) within the past six months. Note: Indicators of recent significant
psychiatric disturbance or serious mental health problem include, but are not limited to: Treatment with psychotropic medication (particularly medication for depression, bipolar disorder, anxiety disorder, psychotic disorder), crisis stabilization or psychiatric hospitalization, Baker Act evaluation(s) within the past six months.

Given the high incidence of suicidal behavior in youths in juvenile correctional facilities, any youth with risk factors for suicide must be referred for an assessment of suicide risk to be conducted with 24 hours, or immediately if the youth is in crisis. Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the assessment of suicide risk is to be conducted immediately rather than within 24 hours. Any youth who makes a suicide attempt or attempts serious self-inflicted injury must receive immediate assessment of suicide risk or emergency services.

B. STAFF OBSERVATIONS: Each departmental facility or program must develop operating procedures to ensure that all direct care and clinical staff are aware of the necessity of immediately documenting and reporting any of the following observations to the facility superintendent/program director or his/her designee, and are referred for an assessment of suicide risk by, or under the direct supervision of, a licensed mental health professional:

1. Intentional self-injurious behavior.
2. Statements or threats which suggest thoughts, intent or plans to harm self.
3. Behaviors that suggest intent or plans to harm self, such as tying of clothing or sheet in a noose.
4. Note which suggests thoughts, intent or plans to harm self.
5. Statements suggesting lack of hope or preoccupation with death or dying.
6. Extreme withdrawal or lack of interest in surroundings.
7. Significant loss of appetite or unexplained loss of weight.

IV. ASSESSMENT OF SUICIDE RISK

All youths identified as having suicide risk factors by screening, information obtained regarding the youth or staff observations must receive an assessment of suicide risk. The superintendent or program director is responsible for ensuring that all assessments of suicide risk are conducted by, or under the direct supervision of, a licensed mental health professional, and that assessments of suicide risk are appropriately administered, documented and reviewed within the facility as follows:

A. COMPONENTS OF AN ASSESSMENT OF SUICIDE RISK: An assessment of suicide risk must reflect consideration of the following elements:
1. Reason for Assessment of Suicide Risk;
2. Methods of Assessment (e.g., Interview, Suicide Scale/Questionnaire, Testing);
3. Mental Status Examination to include direct questioning of the youth and collateral informants regarding the youth's appearance, behavior, mood and affect, emotional state, insight, cooperation, judgment, and suicide risk factors such as:
a. Current thoughts of suicide/harming self,
b. Suicide plan and method,
c. Youth’s confidence in his/her ability to carry out the plan,
d. Availability/access to means to harm self,
e. Precipitating stressful event(s),
f. Previous attempt(s),
g. Lethality of previous attempt(s),
h. Psychiatric/mental health history,
i. Drug abuse/dependence,
j. Hopelessness.

4. Determining Dangerousness to Self:
   a. Imminence of behavior,
   b. Intent of behavior,
   c. Clarity of danger (i.e., Definiteness of danger posed to the youth)
   d. Lethality of behavior.

5. Determining Level of Suicide Risk;
6. Supervision Recommendations (e.g., Suicide Precautions);
7. Summary of Findings; and
8. Recommendations for Treatment or Follow-up

B. DOCUMENTATION OF ASSESSMENT OF SUICIDE RISK:

1. Documentation of an assessment of suicide risk must be provided by the mental health clinical staff person on the form provided in Appendix P.

2. The assessment of suicide risk must provide details of the information obtained by the assessment (youth statements, behavioral observations, collateral information). The specific information supporting the assessment of suicide risk findings and recommendations must be documented on the form.

3. The Assessment of Suicide Risk Form must be signed and dated by the mental health clinical staff person conducting the assessment. If the assessment of suicide risk is conducted by a non-licensed mental health clinical staff person a licensed mental health professional must review, sign as a reviewer and date the assessment. The licensed mental health professional must sign the Assessment of Suicide Risk Form the next scheduled time he/she is on-site.

4. Youths determined to be a potential suicide risk through assessment of suicide risk must be placed or maintained on Suicide Precautions (i.e., Precautionary Observation or Secure Observation) until follow-up assessment of suicide risk, by or under the direct supervision of a licensed mental health professional, determines the youth is no longer a potential suicide risk.

C. PROFESSIONAL QUALIFICATIONS: An assessment of suicide risk must be conducted by a licensed mental health professional or a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional.

A licensed mental health professional means a mental health professional licensed pursuant to Chapter 458, 459 F.S. (psychiatrists), Chapter 490, F.S. (psychologists), Chapter 491, F.S., (mental health counselors, clinical social workers, marriage and family therapists), or as defined in Section 394.455(23), F.S. (psychiatric nurses).
A non-licensed mental health clinical staff person conducting an assessment of suicide risk must meet the education/training requirements provided at pages 2-7 and 2-8 of the Manual and must have received at least 20 hours training and supervised experience in assessing suicide risk, mental health crisis intervention and emergency mental health services. The non-licensed mental health clinical staff person’s training hours must have included administration of five assessments of suicide risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional. The non-licensed mental health clinical staff person’s training and supervised experience must be provided by a licensed mental health professional and must be documented and on-file in the facility or program.

D. TIMEFRAME FOR ASSESSMENTS OF SUICIDE RISK: The assessment of suicide risk must be conducted by, or under the direct supervision of, a licensed mental health professional within 24 hours of the referral, or immediately if the youth is in crisis.

Note: Any youth with current suicide ideation must be immediately referred to a mental health clinical staff person who will confer with a licensed mental health professional to determine whether the assessment of suicide risk is to be conducted immediately rather than within 24 hours. Any youth who makes a suicide attempt or attempts serious self-inflicted injury must receive immediate assessment of suicide risk or emergency services.

An assessment of suicide risk conducted by a non-licensed mental health clinical staff person must be reviewed by a licensed mental health professional within 24 hours of the referral.

In the circumstance where the Assessment of Suicide Risk is conducted by a non-licensed mental health clinical staff person within 24 hours of the referral but cannot be reviewed by a licensed mental health professional within 24 hours of the referral through face-to-face interaction, the licensed mental health professional may accomplish a review of the Assessment of Suicide Risk within 24 hours of the referral through the following methods each of which requires verbal consultation:

1. Verbal consultation through telephonic communication (telephone, cell phone, blackberry) with the non-licensed mental health clinical staff person detailing the Assessment of Suicide Risk findings. The verbal consultation and telephonic communication must be documented and summarized in the Assessment of Suicide Risk form by the non-licensed mental health clinical staff person, including any instructions or recommendations made by the licensed mental health professional. The Assessment of Suicide Risk form must be placed in the youth’s mental health file and Verbal consultation AND consultation through electronically transmitted communications (e-mail) between the non-licensed mental health clinical staff person and licensed mental health professional detailing the Assessment of Suicide Risk findings. The verbal consultation and e-mail communications must be documented and summarized in the Assessment of Suicide Risk form by the non-licensed mental health clinical staff person, including any instructions or recommendations made by the licensed mental health professional. The Assessment of Suicide Risk form and e-mail must be placed in the youth’s mental health file and each document must be reviewed and the Assessment of Suicide Risk signed “as reviewer” by the licensed mental health professional the next scheduled time he/she is on-site.

2. Verbal consultation AND off-site review of an electronically transmitted or faxed copy of the completed Assessment of Suicide Risk form. The licensed mental health professional would fax or electronically transmit confirmation the Assessment of Suicide Risk was reviewed and whether he or she concurs with the findings. The faxed or electronic transmission and the Assessment of Suicide Risk must be placed in the youth’s mental health file. The original
Assessment of Suicide Risk and must be signed “as reviewer” by the licensed mental health professional the next scheduled time he/she is on-site.

E. ASSESSMENTS OF SUICIDE RISK PERFORMED IN THE FACILITY OR PROGRAM:

1. Documentation. When an assessment of suicide risk is conducted in the facility, the mental health clinical staff person conducting the assessment must document his/her findings and recommendations on the form provided in Appendix P. The Assessment of Suicide Risk must provide details of the information obtained by the assessment (youth statements, behavioral observations, collateral information). The specific information supporting the Assessment of Suicide Risk findings and recommendations must be documented on the form. The Assessment of Suicide Risk form must be signed and dated by the mental health clinical staff person conducting the assessment. If the Assessment of Suicide Risk is conducted by a non-licensed mental health clinical staff person, a licensed mental health professional must review, sign as a “reviewer” and date the original assessment form the next scheduled time he/she is on-site. The facility superintendent or program director or his/her designee must be notified of the assessment of suicide risk findings and recommendations in accordance with facility operating procedures.

2. Review of Findings/Recommendations. The superintendent or program director or his/her designee is responsible for reviewing assessment of suicide risk findings and recommendations and ensuring that procedures are in place to follow findings and recommendations pertaining to monitoring and supervision. Administrative and/or supervisory staff instructions with regard to the assessment of suicide risk findings and recommendations and Suicide Precaution decisions must be documented in the facility log in accordance with facility operating procedures and on the Assessment of Suicide Risk form (Appendix P).

NOTE: Youths determined to be a potential suicide risk through Assessment of Suicide Risk must be placed or maintained on Suicide Precautions (i.e., Precautionary Observation or Secure Observation) until follow-up assessment of suicide risk, by or under the supervision of a licensed mental health professional, determines that the youth is not a potential suicide risk.

3. The assessment of suicide risk must be permanently filed in the youth’s individual healthcare record.

F. ASSESSMENTS OF SUICIDE RISK PERFORMED OUTSIDE OF THE FACILITY/PROGRAM:

1. Documentation. When an assessment of suicide risk is conducted outside of the facility, documentation of the assessment should be requested by the juvenile justice representative responsible for the youth during the off-site assessment. For example, if a youth is seen in an emergency room by a psychiatrist, is not found suicidal and is discharged back to the facility, the emergency room discharge summary or other form of documentation of the assessment should be requested by the juvenile justice representative for review upon the youth’s return to the facility.

Upon the youth’s return from an off-site assessment due to suicide risk behaviors, the youth must be placed on constant supervision until a mental health clinical staff person reviews the off-site assessment documents and provides a follow-up assessment of suicide risk.

2. Review of Findings/Recommendations. The superintendent or program director is responsible for ensuring that assessment of suicide risk documents are reviewed by designated administrative or supervisory staff and designated mental health clinical staff upon the youth’s return to the facility, and that recommendations contained in the assessment
of suicide risk regarding Suicide Precautions are followed. Administrative or supervisory staff’s instructions regarding supervision and monitoring of the youth must be documented in the facility log in accordance with facility operating procedures.

**NOTE:** Youths determined to be a potential suicide risk through Assessment of Suicide Risk must be placed or maintained on Suicide Precautions (i.e., Precautionary Observation or Secure Observation) until follow-up assessment of suicide risk, by or under the supervision of a licensed mental health professional, determines that the youth is not a potential suicide risk.

3. The assessment of suicide risk must be permanently filed in the youth’s individual healthcare record.

**G. FOLLOW-UP ASSESSMENT OF SUICIDE RISK**

1. When a youth has received an assessment of suicide risk and has been determined by a licensed mental health professional or non-licensed mental health clinical staff person after consultation with a licensed mental health professional to be a potential suicide risk and is being maintained on suicide precautions, follow-up assessment of suicide risk must be provided to determine the youth’s mental status and dangerousness to self. A follow-up assessment of suicide risk must be documented and reviewed by a licensed mental health professional prior to the youth’s removal from suicide precautions.

A follow-up assessment of suicide risk must reflect consideration of the following elements:

a. Mental Status Examination to include direct questioning of the youth and collateral informants regarding the youth’s appearance, behavior, mood and affect, emotional state, insight, cooperation, judgment, and suicide risk factors.
   - Current thoughts of suicide/harming self,
   - Suicide plan and method,
   - Precipitating and current stressors,
   - Hopelessness

**UPDATE**

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

c. Determining Level of Suicide Risk;

d. Supervision Recommendations (e.g., Suicide Precautions); and

e. Recommendations for Treatment or Follow-up

2. Documentation of Follow-up Assessment of Suicide Risk:

   a. Documentation of a follow-up assessment of suicide risk must be provided by the mental health clinical staff person on the form provided in Appendix Q.

   b. The follow-up assessment of suicide risk must provide details of the information obtained by the assessment (youth statements, behavioral observations, collateral information). The specific information supporting the follow-up assessment of suicide risk findings and recommendations must be documented on the form.

   c. The follow-up assessment of suicide risk form must be signed and dated by the mental health clinical staff person conducting the assessment. If the Assessment of Suicide Risk
is conducted by a non-licensed mental health clinical staff person, a licensed mental health professional must review, sign as a reviewer and date the original assessment form the next scheduled time he/she is on-site.

d. Youths must be maintained on Suicide Precautions (i.e., Precautionary Observation or Secure Observation) until a follow-up assessment of suicide risk, by or under the supervision of a licensed mental health professional, determines that the youth is not a potential suicide risk.

3. Professional Qualifications: A follow-up assessment of suicide risk must be conducted by a licensed mental health professional or a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional.

A licensed mental health professional means a mental health professional licensed pursuant to Chapter 458, 459 F.S. (psychiatrists), Chapter 490, F.S. (psychologists), Chapter 491, F.S., (mental health counselors, clinical social workers, marriage and family therapists), or as defined in Section 394.455(23), F.S. (psychiatric nurses).

A non-licensed mental health clinical staff person conducting a follow-up assessment of suicide risk must meet the education/training requirements provided at page 2-7 of the Manual and must have received at least 20 hours training and supervised experience in assessing suicide risk, mental health crisis intervention and emergency mental health services. The non-licensed mental health clinical staff person’s training hours must have included administration of five assessments of suicide risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional. The non-licensed mental health clinical staff person’s training and supervised experience must be provided by a licensed mental health professional and must be documented and on-file in the facility or program.

4. Review of Findings: In the circumstance where the follow-up assessment of suicide risk is conducted by a non-licensed mental health clinical staff person but cannot be reviewed by a licensed mental health professional within 24 hours of assessment through face-to-face interaction, the licensed mental health professional may accomplish a review of the follow-up assessment of suicide risk within 24 hours through the following methods each of which requires verbal consultation:

1. Verbal consultation through telephonic communication (telephone, cell phone, blackberry) with the non-licensed mental health clinical staff person detailing the follow-up assessment of suicide risk findings. The verbal consultation and telephonic communication must be documented and summarized in the follow-up assessment of suicide risk form by the non-licensed mental health clinical staff person, including any instructions or recommendations made by the licensed mental health professional. The follow-up assessment of suicide risk form must be placed in the youth’s mental health file and must be reviewed and signed “as reviewer” by the licensed mental health professional the next scheduled time he/she is on-site.

2. Verbal consultation AND consultation through electronically transmitted communications (e-mail) between the non-licensed mental health clinical staff person and licensed mental health professional detailing the follow-up assessment of suicide risk findings. The verbal consultation and e-mail communications must be documented and summarized in the follow-up assessment of suicide risk form by the non-licensed mental health professional, including any instructions or recommendations made by the licensed mental health professional.


**V. SUICIDE PRECAUTIONS**

Within the context of this manual, “Suicide Precautions” refers to methods utilized for supervising, observing, monitoring and housing the youth who has been identified through screening as having suicide risk factors or identified through assessment as a potential suicide risk. Suicide Precautions require that specific action be taken within the facility or program to protect the “at risk” youth from potential self-injury or suicide. In DJJ facilities and programs, either Precautionary Observation or Secure Observation must be used as a Suicide Precaution method when the youth has been identified as a suicide risk. Any youth exhibiting suicide risk behaviors must be placed on Suicide Precautions (Precautionary Observation or Secure Observation) until an assessment of suicide risk is conducted. The decision as to which method is used for a particular youth must be made by the superintendent or program director and Designated Mental Health Authority or other licensed mental health professional.

Precautionary Observation and Secure Observation include the following elements:

1. Authorization for the Suicide Precautions method;

2. Criteria for youth placement on Precautionary Observation or Secure Observation;

3. Procedures for placement on Precautionary Observation or Secure Observation;

4. Staff supervision (i.e., observations, documentation of observations, supervisory and clinical review of observations) requirements;

5. Assessment of suicide risk by or under the direct supervision of a licensed mental health professional;

6. Requirements and procedures for youth removal from Precautionary Observation or Secure Observation;

7. Monitoring upon youth's removal from the Precautionary Observation or Secure Observation;

8. Administrative and clinical review of Suicide Precautions.

Each facility/program must have in place a tracking system to review the frequency and proper implementation of Precautionary Observation and Secure Observation, and to identify any staff training needs in suicide prevention services.
The suicide precaution methods, Precautionary Observation and Secure Observation, are discussed at length in Sections VI., and VII., below.

VI. PRECAUTIONARY OBSERVATION

Precautionary Observation provides for the constant supervision of an “at risk” or “potential suicide risk” youth in designated observation areas of the facility or program which are safe and secure. Precautionary Observation is intended to permit the “at risk” youth to participate in selected activities with other youths in the DJJ facility/program while being maintained on constant supervision. The observation areas used in Precautionary Observation shall not limit a youth’s activity to an individual cell (whether locked or unlocked) or any confinement room, nor shall it restrict a youth to his/her sleeping room. Precautionary observation should not be used for youth who present an imminent threat of suicide. Such youth must be referred for emergency care.

A. PURPOSE: This section discusses a framework for Department of Juvenile Justice facilities to implement procedures for PRECAUTIONARY OBSERVATION whereby areas of a facility/program are designated as “safe housing or observation areas” within which a youth considered “at risk” of suicide may participate in selected program activities while being maintained on constant supervision by staff. This section serves to:

1. Specify the criteria used to determine whether an “at risk” youth should be placed on “precautionary observation”;
2. Specify procedures for placing a youth on “precautionary observation”;
3. Define staff supervision requirements for “at risk” youths who are placed on precautionary observation;
4. Specify requirements and procedures for removal of an “at risk youth” from “precautionary observation”.

B. AUTHORIZATION: Precautionary Observation must be utilized as a suicide precaution method in all DJJ facilities and programs. Facility operating procedures must be developed specifically for this level of monitoring of youths at risk of suicide. Facility operating procedures must be reviewed and approved by the superintendent or program director in conjunction with the Designated Mental Health Authority (in applicable facilities) or licensed mental health professional.

C. CRITERIA FOR PLACEMENT ON PRECAUTIONARY OBSERVATION: A youth may be placed on “precautionary observation” if the youth is identified by intake screening or staff observations as having suicide risk factors, or is determined to be a potential suicide risk by an Assessment of Suicide Risk conducted by, or under the supervision of, a licensed mental health professional and the youth’s level of suicide risk behaviors indicates that his/her condition requires observation and monitoring beyond that which is normally provided. Precautionary Observation may be appropriate based upon the following factors:

1. The youth’s statements and/or behavior suggests current suicide thoughts, suicide threats or suicide plans, or
2. The youth’s statements and/or behavior suggests serious depression, withdrawal, and/or hopelessness, or
3. The youth’s statements and/or behavior suggests thoughts of death and/or thoughts of harming self; or

4. The youth has a recent history of attempted suicide, self-mutilation or self-injury

D. PROCEDURES: The superintendent/program director or his/her designee must confer with the Designated Mental Health Authority, or licensed mental health professional, as to whether precautionary observation is appropriate for a specific youth.

1. When the decision has been made to place a youth on precautionary observation, the superintendent/program director or his/her designee shall designate in writing the specific “safe housing/observation areas” of the facility and activities which the youth will be allowed to utilize, based upon the individualized needs of the youth. The “safe housing/observation areas” of the facility and activities will be documented on the form “Suicide Precautions Observation Log” (see Appendix R). Instructions regarding precautionary observation of a youth must be recorded in the facility daily log and on the “Suicide Precautions Observation Log” form (see Appendix R).

2. The designated “safe housing/observation areas” of the facility must be regularly inspected to ensure that the area is safe and secure. The documented daily safety/security checks of the facility will suffice provided that the daily safety/security checks include the areas of the facility designated for Precautionary Observation.
   a. The area should be in close proximity to a staff duty station or control center to maximize staff interaction with youths participating in activities in this area of the facility.
   b. The area must be immediately accessible to the direct care staff maintaining constant supervision of the youth.
   c. The area must be structurally designed to eliminate devices or materials which might aid in self-harm such as devices or materials which would enable a youth to hang him/herself, sharp objects which could be used to inflict physical damage to self or others or materials/substances which would enable the youth to burn or poison him/herself.
   d. The area shall not limit the youth’s activity to an individual cell (whether locked or unlocked) or a confinement room of any kind, nor shall it restrict a youth to his/her sleeping room as a suicide precaution. (Secure Observation is required when an individual cell is to be utilized as a suicide precaution method see Section VII).

3. Mental health supportive services shall be provided to the youth being maintained on Precautionary Observation, based upon the individualized needs of the youth as determined by the mental health clinical staff. Mental health supportive services shall be provided by, or under the direct supervision of, a licensed mental health professional, and shall include, but not be limited to:
   a. Supportive counseling or therapy;
   b. Crisis intervention counseling or therapy;
   c. On-going assessment/evaluation of suicide potential and mental status;
   d. An Assessment of Suicide Risk or follow-up assessment of suicide risk must be conducted prior to the youth’s removal from Suicide Precautions. The assessment must consider the youth’s appearance, behavior, mood and affect, emotional state, insight, cooperation, judgment and statements relevant to suicide risk and dangerousness to self.
4. Mental health supportive services shall be documented in the youth’s mental health record and reviewed and signed “as reviewer” by a licensed mental health professional.

E. SUPERVISION REQUIREMENTS:

1. Youths placed on precautionary observation must be maintained on, one-to-one supervision or constant supervision at all times. Constant Supervision refers to the continuous and uninterrupted observation of a youth by a staff member who has a clear and unobstructed view of the youth and unobstructed sound monitoring of the youth at all times (including when the youth is in the shower or toilet).

2. The staff person(s) assigned to monitor the youth in a precautionary observation area must maintain, one-to-one supervision or constant supervision of the youth and document his/her observations of the youth’s behavior on the form “Suicide Precautions Observation Log” (see Appendix R) at 30 minute intervals.

3. If “warning signs of mental disorder” listed on this form are observed, the superintendent, program director or designee and mental health professional must be immediately notified.
   a. The “Suicide Precautions Observation Log” must be reviewed by supervisory staff each shift and daily by a mental health clinical staff person while the youth is being maintained on precautionary observation.
   b. The supervisory staff’s review shall be noted on the “Suicide Precautions Observation Log”
   c. When “warning signs” are observed, the superintendent, program director or designee’s and mental health clinical staff person’s instructions regarding the “warning signs” shall be documented on the “Suicide Precautions Observation Log” and instructions followed.
   d. The shift supervisor is responsible for ensuring that a listing of youths currently placed on precautionary observation is passed on to the next shift, and that any concerns or observations regarding youths on precautionary observation have been documented and communicated to the next shift.
   e. When the “Suicide Precautions Observation Log” is completed, the form must be placed in the youth’s individual healthcare record (mental health section).

F. DISCONTINUATION/TERMINATION OF PRECAUTIONARY OBSERVATION:

1. The youth must be maintained on Precautionary Observation until he/she has received an assessment of suicide risk or follow-up assessment of suicide risk by, or under the direct supervision of, a licensed mental health professional.

2. The assessment of suicide risk or follow-up assessment of suicide risk findings and recommendations must be reviewed by the superintendent/program director or designee. Based upon the assessment of suicide risk findings, the licensed mental health professional and facility superintendent/program director or designee will determine and document the appropriate course of action to be taken with regard to continued Suicide Precautions.

3. If the assessment of suicide risk findings/recommendations indicate the need for continued Suicide Precautions, the youth must be maintained on Precautionary Observation until subsequent follow-up assessment of suicide risk conducted by, or under the direct
supervision of, a licensed mental health professional indicates Suicide Precautions may be discontinued.

4. When deemed appropriate by the licensed mental health professional and superintendent or program director or designee, the youth may be removed from Precautionary Observation.

a. Documentation of the assessment of suicide risk, or follow-up assessment of suicide risk findings which indicate Suicide Precautions may be discontinued, must be reviewed by a licensed mental health professional prior to the youth’s removal from Precautionary Observation.

In the circumstance where the assessment of suicide risk or follow-up assessment of suicide risk is conducted by a non-licensed mental health clinical staff person but cannot be reviewed by a licensed mental health professional within 24 hours of the referral through face-to-face interaction, the licensed mental health professional may accomplish a review of the assessment of suicide risk or follow-up assessment of suicide risk through the following methods each of which requires verbal consultation:

(1) Verbal consultation through telephonic communication (telephone, cell phone, blackberry) with the non-licensed mental health clinical staff person detailing the assessment of suicide risk or follow-up assessment of suicide risk findings. The verbal consultation and telephonic communication must be documented and summarized in the assessment of suicide risk or follow-up assessment of suicide risk form by the non-licensed mental health clinical staff person, including any instructions or recommendations made by the licensed mental health professional. The assessment of suicide risk or follow-up assessment of suicide risk form must be placed in the youth’s mental health file and must be reviewed and signed “as reviewer” by the licensed mental health professional the next scheduled time he/she is on-site.

(2) Verbal consultation AND consultation through electronically transmitted communications (e-mail) between the non-licensed mental health clinical staff person and licensed mental health professional detailing the assessment of suicide risk or follow-up assessment of suicide risk findings. The verbal consultation and e-mail communications must be documented and summarized in the assessment of suicide risk or follow-up assessment of suicide risk form by the non-licensed mental health clinical staff person, including any instructions or recommendations made by the licensed mental health professional. The assessment of suicide risk or follow-up assessment of suicide risk form must be placed in the youth’s mental health file and must be reviewed and signed “as reviewer” by the licensed mental health professional the next scheduled time he/she is on-site.

(3) Verbal consultation AND off-site review of an electronically transmitted or faxed copy of the completed assessment of suicide risk or follow-up assessment of suicide risk form. The licensed mental health professional would fax or electronically transmit confirmation the assessment of suicide risk or follow-up assessment of suicide risk was reviewed and whether he or she concurs with the findings. The faxed or electronic transmission and the assessment of suicide risk or follow-up assessment of suicide risk form must be placed in the youth’s mental health file. The original assessment of suicide risk or follow-up assessment of suicide risk and must be signed “as reviewer” by the licensed mental health professional the next scheduled time he/she is on-site.
b. Documentation that the licensed mental health professional concurs with the youth’s removal from Precautionary Observation and the facility superintendent/program director or designee’s written authorization is required for removal of a youth from Precautionary Observation.

c. Discontinuation of Precautionary Observation and step-down to Close Supervision must be documented by the mental health clinical staff and superintendent/program director, or designee, on the “Assessment of Suicide Risk” or “Follow-Up Assessment of Suicide Risk” form.

G. MONITORING UPON REMOVAL OF PRECAUTIONARY OBSERVATION: Youths removed from Precautionary Observation should continue to be monitored during the transition back into the facility/program’s normal routine, until deemed stable by the Designated Mental Health Authority or licensed mental health professional.

1. Close Supervision must be initiated and maintained for any youth who had been placed or maintained on Precautionary Observation following an assessment of suicide risk conducted by, or under the direct supervision of, a licensed mental health professional, which identified the youth as a potential suicide risk. (Note: The youth placed on Precautionary Observation prior to an assessment of suicide risk who receives an assessment of suicide risk and is not found to be a potential suicide risk may be transitioned directly to standard supervision).

2. Close Supervision must be maintained until determined no longer necessary by the Designated Mental Health Authority or licensed mental health professional.

3. The Designated Mental Health Authority or mental health clinical staff should maintain regular contact with the youth for support and to determine changes in his or her status during close supervision.

4. Discontinuation of close supervision must be documented by the superintendent or program director or designee as specified in the facility’s suicide prevention plan, and must be documented in the youth’s mental health file by the mental health clinical staff person and reviewed/signed by the licensed mental health professional.

H. ADMINISTRATIVE AND CLINICAL REVIEW OF PRECAUTIONARY OBSERVATION: The superintendent/program director or assistant superintendent/program director and designated licensed mental health professional must review and track the frequency and proper implementation of Precautionary Observation.

VII. SECURE OBSERVATION

At times, a youth’s “at risk” or suicide risk behavior may require a level of observation and control beyond that which can be provided by Precautionary Observation. A secure observation room may be provided for a youth whose level of “at risk” or suicide risk behavior constitutes a strong potential threat to the youth’s safety or to the safety of others. For example, the “at risk” youth appears extremely restless, fearful, agitated, depressed or his/her behavior appears unpredictable, volatile or highly impulsive. A secure observation room is a designated safe room within the facility which is used for the purpose of preventing a youth from injuring himself or herself, or others, and to provide continuous staff supervision and monitoring. A secure observation room shall be used for observation of “at risk” youths only when other less restrictive means of control are not effective or appropriate.
The secure observation room shall not be used for youth who present an imminent threat of suicide. Such youth shall be referred for emergency care.

Although authorized for use, secure observation rooms are not required in that Precautionary Observation may preclude the need for a secure observation room in some facilities. However, if an "at risk" youth requires placement in an individual cell (whether locked or unlocked) due to potentially self-injurious or suicide risk behaviors, Secure Observation must be implemented. When a youth on Suicide Precautions (Precautionary Observation or Secure Observation) is placed in disciplinary confinement due to misbehavior, Secure Observation must be implemented or maintained. This means that a youth currently on Precautionary Observation who requires placement in disciplinary confinement must be placed in a secure observation room, and a youth already on Secure Observation who requires placement in disciplinary confinement must remain in the secure observation room until the disciplinary confinement is discontinued. However, a licensed mental health professional must provide written concurrence for a youth to remain in a secure observation room beyond 24 hours for any reason.

The youth in Secure Observation must receive an assessment of suicide risk or follow-up assessment of suicide risk by a licensed mental health professional or a mental health clinical staff person working under the direct supervision of a licensed mental health professional within 8 hours of the youth’s placement in the secure observation room for any reason, or if the youth is placed in the secure observation room during the evening or night shift, the follow-up assessment of suicide risk must be conducted the following morning shift.

A. PURPOSE: This section discusses a framework for Department of Juvenile Justice facilities to implement procedures governing the use of secure observation for potentially self-injurious or potential suicide risk youths. This section serves to:

1. Specify the criteria used to determine whether a potential suicide risk youth should be placed in a secure observation room;

2. Specify procedures for placing a potential suicide risk youth in a secure observation room;

3. Define staff supervision requirements for potential suicide risk youths who are placed in a secure observation room;

4. Specify the structural requirements for a room designated for use as a secure observation room;

5. Specify requirements for removal of a youth from secure observation.

B. ACCOUNTABILITY: The superintendent or program director is charged with the responsibility of daily on-site facility/program management and operation and is accountable for assuring that a secure observation room is appropriately utilized. The guidelines set forth in this manual are intended to guide the superintendent or program director and staff in the use of secure observation. However, these guidelines are not intended to prescribe every action to be taken or decision to be made in using secure observation rooms. Therefore, it is essential that the superintendent or program director develop and implement a self-monitoring plan addressing the following:

1. Self-Monitoring. Each facility/program must have in place a self-monitoring plan to track, manage and facilitate oversight of secure observation practices. The self-monitoring plan must include at a minimum: a) a tracking system to document frequency of secure
observation use; b) supervisory reviews; c) medical and mental health interventions; d) staff training needs; and e) other practices related to use of secure observation rooms.

2. **Proper Use.** The facility/program self-monitoring plan must ensure that secure observation is used in a humane and non-abusive manner.

3. **Staff Training.** The superintendent or program director is accountable for ensuring that facility/program staff are appropriately trained in the use of secure observation procedures.

C. **STRUCTURAL SPECIFICATIONS OF A SECURE OBSERVATION ROOM:**

   To the extent possible, the structure of a Secure Observation Room should meet the following specifications:

1. **Size:** A minimum of 35 square feet of unencumbered space. Unencumbered space is usable space that is not encumbered by any furnishing or fixture. At least one dimension of the unencumbered space is no less than 7 feet.

2. **Doors:** Solid core hardwood or metal that has a shatter-resistant observation window or metal frame with wire mesh (holes no larger than 3/16 inch). The door observation window must permit constant visual and sound monitoring of the youth. A door with bars or expanded metal door is acceptable if small wire mesh or lexan shields the bars from the inside. Outward opening doors are preferable but not required.

3. **Floors/Walls:** Solid, smooth and high impact resistant without protrusions.

4. **Ceilings:** Solid, single piece ceiling which is out of the youth’s reach and has no appendages that can be grasped or tied onto with cloth or other materials.

5. **Vents:** Must be covered with small mesh or a metal plate (holes no larger than 3/16 inch). Vents must be unreachable to the youth. Edges of wire mesh or metal covering must not be exposed. Vents should not be immediately accessible from the toilet, sink or bed.

6. **Lighting:** Light fixtures should be recessed and covered with shatter-resistant material such as lexan.

7. **Windows:** Must be made of shatter-resistant material. Glass windows that are not shatter resistant must be covered with security-rated screens or other materials that prevent access to the glass.

8. **Toilet/Sink:** Fixtures must be smooth and devoid of handles or parts that cloth or other material could be tied to or hung from. Must be mounted against the wall with water shut off valve outside of room.

9. **Electrical Switches/Outlets:** Electrical outlets are not permitted and switches must be located outside the room.

10. **Beds:** Must provide a security-rated plastic mattress suitable for floor use or suicide resistant bed. The bed must be anchored to the floor or secured to the wall, be of one piece construction (no springs) must be no higher than 18 inches from the floor and have a plastic fire retardant mattress.

D. **AUTHORIZATION AND CRITERIA FOR PLACEMENT IN A SECURE OBSERVATION ROOM:**

An “at risk” youth may be placed in a secure observation room if:
1. Authorized by the superintendent, program director or his/her designee in conjunction with the Designated Mental Health Authority (in applicable facilities) or licensed mental health staff; and

The youth is demonstrating behaviors that potentially threaten his or her safety (For example, the “at risk” youth appears extremely restless, fearful, agitated, depressed or his/her behavior appears unpredictable, volatile or highly impulsive).

2. The youth is currently on Precautionary Observation and requires placement in disciplinary confinement due to misbehavior. A youth who is already on Secure Observation who requires placement in disciplinary confinement will remain in the secure observation room.

E. PROCEDURES FOR PLACEMENT IN A SECURE OBSERVATION ROOM: The superintendent, program director or designee must confer with the Designated Mental Health Authority, or other licensed mental health professional as to whether secure observation is appropriate for a specific youth. The consultation with the licensed mental health professional and reason for secure observation must be documented on the form, “Suicide Precautions Observation Log”, Appendix R.

When the decision has been made to place an “at risk’ youth in a secure observation room, the following should occur:

1. Sufficient staff should be available to assure the physical means to enforce the placement.

2. The secure observation room must be inspected immediately prior to the youth’s placement to ensure that it is safe and secure.

3. A staff member of the same sex will conduct a visual check of the youth to determine if there are any observable injuries that would make placement in the secure observation room inappropriate. The “Health Status Checklist” (Appendix T) must be completed to document the youth’s physical condition. If a physical injury is observed, the youth complains of injury or illness, or the youth has been observed to have experienced a fall, impact or blow to such an extent that injury would be expected, medical personnel must be immediately notified for an immediate assessment and treatment.

4. The youth must be searched by a staff member of the same sex. At the time of the search, all jewelry, pocket items, hair ties, and hair pins must be removed. All clothing items which could be used for self-injury must be removed (e.g., shoes, shoelaces, socks, and belt). The youth is not to be stripped. The youth is not to be required to dress in any garment or put on any covering that sexually exposes the youth.

5. The youth must be told that his/her behavior requires observation beyond that normally provided, and a period in the secure observation room is needed until he or she is seen by a mental health clinical staff person.

F. MENTAL HEALTH CONSULTATION, ASSESSMENT OF SUICIDE RISK AND SUPPORTIVE SERVICES:

1. Each youth placed in a secure observation room due to “at risk” or suicide risk behavior must be immediately referred for an assessment of suicide risk.

- The assessment of suicide risk must be conducted by the close of the workday unless the youth is placed in the secure observation room during the evening or night shift. The youth
placed in secure observation during the evening or night shift must receive an assessment of suicide risk during the following day shift.

- **A youth may not remain in a secure observation room for more than eight hours unless a licensed mental health professional has been consulted and agrees to a limited time extension.**

- **The youth on Suicide Precautions placed on disciplinary confinement must receive a follow-up assessment of suicide risk by a licensed mental health professional or a mental health clinical staff person working under the direct supervision of a licensed mental health professional within 8 hours of the youth’s placement in disciplinary confinement, or if the youth is placed on disciplinary confinement during the evening or night shift, the follow-up assessment of suicide risk must be conducted the following morning shift.**

- **When Secure Observation is implemented for the youth on Suicide Precautions who is placed on disciplinary confinement due to misbehavior, the youth may remain in the secure observation room until the disciplinary confinement is discontinued.**

- **However, a licensed mental health professional must provide written concurrence for a youth to remain in Secure Observation beyond 24 hours for any reason.**

2. The superintendent, program director or his/her designee is responsible for consulting the Designated Mental Health Authority or other licensed mental health professional to discuss the case and refer the youth for an assessment of suicide risk. The superintendent, program director or designee’s consultation with the mental health professional must be documented in the mental health section of youth’s individual healthcare record. The licensed mental health professional’s recommendations with regard to supervision, monitoring and time frame for assessment of suicide risk must be documented.

3. The superintendent or program director and Designated Mental Health Authority (when applicable) or other licensed mental health professional shall confer on cases viewed as urgent and act accordingly. The superintendent or program director’s consultation with the Designated Mental Health Authority and referral for assessment of suicide risk must be documented in the mental health section of the youth’s individual healthcare record.

4. Mental health supportive services shall be provided to the youth being maintained on Suicide Precautions, based upon the individualized needs of the youth. Mental health supportive services shall be provided by, or under the direct supervision of, a licensed mental health professional, and shall include, but not be limited to:
   a. Supportive counseling or therapy;
   b. Crisis intervention counseling or therapy;
   c. On-going assessment/evaluation of suicide potential and mental status;
   d. The follow-up assessment of suicide risk conducted prior to the youth’s removal from Suicide Precautions must consider the youth’s appearance, behavior, affect, emotional state, insight, cooperation, judgment and statements relevant to suicide risk and dangerousness to self.

5. Mental health supportive services shall be documented and reviewed and signed “as reviewer” by a licensed mental health professional.
G. **SUPERVISION REQUIREMENTS:**

1. Youths placed in a *secure observation room* due to “at risk” or “suicide risk” behavior must be maintained on either one-to-one or constant supervision. *One-to-One supervision* should be maintained until the superintendent/program director or designee receives specific recommendations from the Designated Mental Health Authority or mental health clinical staff person who is to conduct the *assessment of suicide risk*. One-to-one supervision and constant supervision are defined as follows:

   a. **One-to-One Supervision** refers to the supervision of one youth by one staff member who must remain within five feet of the youth at all times (including when the youth uses the shower or toilet). If the youth is in a *secure observation room*, the staff member assigned to *one-to-one supervision* of the youth must be stationed at the entrance to the room, no further than five feet from the door. The staff member must maintain constant visual and sound monitoring of the youth at all times.

   b. **Constant Supervision** refers to the continuous and uninterrupted observation of a youth by a staff member who has a clear and unobstructed view of the youth and unobstructed sound monitoring of the youth at all times.

2. The staff person assigned to observe the youth must provide one-to-one or constant supervision and must record observations of the youth’s behavior in the *secure observation room* on the form entitled “Suicide Precautions Observation Log” (see Appendix R) at intervals of 30 minutes, at a minimum. The DJJ facility/program has the option of providing stricter time limits for documentation of behavioral observations (e.g., 10 minute intervals for Secure Observation). The facility/program’s required time intervals for documentation of observations of youth behavior must be detailed in the instructions section of the “Suicide Precautions Observation Log” and must not exceed 30 minute intervals.

   a. The “Suicide Precautions Observation Log” form must be reviewed by supervisory staff while the youth is being maintained on *secure observation*.

   b. The supervisory staff’s review shall be noted on the “Suicide Precautions Observation Log” form.

   c. The shift supervisor is responsible for ensuring that a listing of youths currently placed on *secure observation* is passed on to the next shift, and that any concerns or observations regarding youths on *secure observation* have been documented and communicated to the next shift.

3. The staff person assigned to observe the youth should periodically converse with the youth, and be available to talk to the youth when he or she expresses a desire to talk. The staff person should convey an attitude and message of concern for the youth’s well-being.

4. When it is necessary to temporarily remove the youth from the *secure observation room* for any reason, the youth must be searched again before being placed back into the *secure observation room*.

5. Staff observations of behaviors flagged as “warning signs” of a mental disturbance on the “Suicide Precautions Observation Log” form must be brought to the immediate attention of the superintendent/program director or designee. Documentation of notification of the superintendent/program director or designee must be recorded on the “Suicide Precautions Observation Log” form (see Appendix R).
6. The superintendent/program director or designee is responsible for notifying the Designated Mental Health Authority or licensed mental health professional of the warning signs and/or arranging for emergency mental health services.

7. When the “Suicide Precautions Observation Log” form is completed, the form is to be placed in the youth’s individual healthcare record (mental health section).

H. DISCONTINUATION/TERMINATION OF SECURE OBSERVATION:

1. The “at risk” youth must be maintained on secure observation until he or she has received an assessment of suicide risk or follow-up assessment of suicide risk by, or under the direct supervision of, a licensed mental health professional.

   a. The assessment of suicide risk or follow-up assessment of suicide risk findings and recommendations must be reviewed by the superintendent/program director or designee. Based upon the assessment of suicide risk findings, the licensed mental health professional and facility superintendent/program director or designee will determine and document the appropriate action to be taken with regard to continued supervision and monitoring.

   b. When assessment of suicide risk findings/recommendations indicate the need for continued Suicide Precautions, the youth should be removed from the secure observation room and Suicide Precautions continued by placing the youth on Precautionary Observation unless there is a specific recommendation in the assessment of suicide risk that the youth should remain in Secure Observation. The youth must remain on Secure Observation or Precautionary Observation until subsequent assessment conducted by, or under the direct supervision of a licensed mental health indicates Suicide Precautions may be discontinued.

      (1) Documentation that the licensed mental health professional concurs with the assessment of suicide risk findings/recommendations and continued Suicide Precautions through extended placement in Secure Observation or the youth’s placement on Precautionary Observation is required.

      (2) The discontinuation of secure observation and initiation of precautionary observation must be documented by the superintendent/program director or designee in the facility log, and must be documented in the youth’s mental health file by the mental health clinical staff.

2. When Secure Observation is implemented for the youth on Suicide Precautions due to disciplinary confinement for misbehavior, the youth must be placed in a secure observation room. A licensed mental health professional must provide written concurrence for a youth to remain in a secure observation room beyond 24 hours for any reason.

3. When deemed appropriate by the licensed mental health professional and superintendent/program director or designee, the youth may be removed from Suicide Precautions (secure observation and/or precautionary observation).

   a. Documentation of the assessment of suicide risk or follow-up assessment of suicide risk findings which indicate Suicide Precautions may be discontinued must be reviewed by a licensed mental health professional prior to the youth’s removal from Suicide Precautions.
In the circumstance where the *assessment of suicide risk* or follow-up assessment of suicide risk is conducted by a non-licensed *mental health clinical staff person* but cannot be reviewed by a *licensed mental health professional* within 24 hours of the referral through face-to-face interaction, the *licensed mental health professional* may accomplish a review of the *assessment of suicide risk* or follow-up assessment of suicide risk through the following methods each of which requires **verbal consultation**:

1. **Verbal consultation** through telephonic communication (telephone, cell phone, blackberry) with the non-licensed *mental health clinical staff person* detailing the *assessment of suicide risk* or follow-up assessment of suicide risk findings. The verbal consultation and telephonic communications must be documented and summarized in the *assessment of suicide risk* or follow-up assessment of suicide risk form by the non-licensed *mental health clinical staff person*, including any instructions or recommendations made by the *licensed mental health professional*. The *assessment of suicide risk* or follow-up assessment of suicide risk form must be placed in the youth's mental health file and must be reviewed and signed “as reviewer” by the *licensed mental health professional* the next scheduled time he/she is on-site.

2. **Verbal consultation AND consultation** through electronically transmitted communications (e-mail) between the non-licensed *mental health clinical staff person* and *licensed mental health professional* detailing the *assessment of suicide risk* or follow-up assessment of suicide risk findings. The verbal consultation and e-mail communications must be documented and summarized in the *assessment of suicide risk* or follow-up assessment of suicide risk form by the non-licensed *mental health clinical staff person*, including any instructions or recommendations made by the *licensed mental health professional*. The *assessment of suicide risk* or follow-up assessment of suicide risk form must be placed in the youth's mental health file and must be reviewed and signed “as reviewer” by the *licensed mental health professional* the next scheduled time he/she is on-site.

3. **Verbal consultation AND off-site review** of an electronically transmitted or faxed copy of the completed *assessment of suicide risk* or follow-up assessment of suicide risk form. The *licensed mental health professional* would fax or electronically transmit confirmation the *assessment of suicide risk* or follow-up assessment of suicide risk was reviewed and whether he or she concurs with the findings. The faxed or electronic transmission and the *assessment of suicide risk* or follow-up assessment of suicide risk must be placed in the youth's mental health file. The original *assessment of suicide risk* or follow-up assessment of suicide risk and must be signed “as reviewer” by the *licensed mental health professional* the next scheduled time he/she is on-site.

b. Documentation that the *licensed mental health professional* concurs with the removal of *Suicide Precautions* (i.e., secure observation or precautionary observation) and the superintendent/program director or designee’s written authorization is required for removal of a youth from *Suicide Precautions*.

4. Discontinuation of *Suicide Precautions* and step-down to close supervision must be documented by the superintendent/program director or designee in the facility log, and must be documented in the youth’s mental health file by mental health clinical staff.
I. MONITORING UPON REMOVAL FROM SUICIDE PRECAUTIONS (SECURE OBSERVATION AND PRECAUTIONARY OBSERVATION): Youths removed from Suicide Precautions (Secure Observation and/or Precautionary Observation) should continue to be monitored during the transition back into the facility/program’s normal routine, until deemed stable by the Designated Mental Health Authority or licensed mental health professional.

1. The youth removed from Suicide Precautions (Secure Observation and/or Precautionary Observation) must be placed on close supervision during transition back into the facility/program’s normal routine, until deemed stable by the Designated Mental Health Authority or a licensed mental health professional.

2. Close Supervision must be initiated and maintained until the licensed mental health professional indicates that such level of supervision is no longer necessary.

3. The Designated Mental Health Authority or mental health clinical staff should maintain regular contact with the youth for support and to determine changes in his or her status during close supervision.

4. Discontinuation of close supervision must be documented by the superintendent/program director or designee as specified in the facility’s suicide prevention plan, and must be documented in the youth’s mental health file by the mental health clinical staff person and reviewed and signed by the licensed mental health professional.

J. ADMINISTRATIVE AND CLINICAL REVIEW The superintendent or program director or assistant superintendent and Designated Mental Health Authority or licensed mental health professional must review the “Suicide Precautions Observation Log” (see Appendix R) to determine whether the use of the secure observation room was appropriate. If the use of the suicide precautions method (Precautionary Observation or Secure Observation) is determined to have been inappropriate or not in compliance with this manual, the superintendent or program director will initiate corrective action.

K. RECORDS:
1. Each facility must maintain a monthly “secure observation tracking log” on which to enter each incident of the use of secure observation. This log must contain the following data:
   a. The name of each youth placed in the secure observation room;
   b. Date and time of placement in the secure observation room;
   c. Date and time of release from the secure observation room;
2. A copy of each of the documents listed below must be placed in the youth’s individual health care record (mental health section), and a copy must also be maintained in the facility:
   a. The original Health Status Checklist (Appendix T)
   b. Suicide Precautions Observation Log (Appendix R)

VIII. IMMEDIATE RESPONSE TO A SUICIDE ATTEMPT OR INCIDENT OF SERIOUS SELF-INFLECTED INJURY

In the event of a suicide attempt and/or an incident of serious self-inflicted injury, it is essential that staff respond immediately. The facility superintendent or program director is responsible for establishing facility operating procedures and staff training which include the following:
A. Any staff who discovers a youth attempting suicide or an incident of serious self-inflicted injury shall act immediately to intervene, which shall include at a minimum:

1) Immediately survey the scene to assess the level of the emergency;

2) Notify other staff (radio or call for backup support) and alert other staff to call medical personnel and/or emergency medical services (911);

3) If the suicide attempt or self-inflicted injury is life threatening or could be life threatening, immediate action is required. Single officer cell entry is permitted to save a life.

   **Note:** A life threatening or potentially life threatening suicide attempt or self-inflicted injury includes, but is not limited to: incidents involving hanging, strangulation, suffocation, cutting, or poisoning. The need for immediate life saving measures is indicated by any of the following: respiratory arrest or distress (youth has stopped breathing or has difficulty breathing or there is a noise associated with breathing), skin or lip color changes, non-responsiveness to verbal commands or tactile stimulus (does not respond to voice or touch, or responds but speech is not clear or coherent), youth is conscious, but is not exhibiting voluntary movement, loss of consciousness (youth is not awake or is awake but is not alert or fully responsive), profuse bleeding.

4) Immediate action includes, but is not limited to:
   a. Enter the youth’s cell and begin life-saving measures;
   b. Remove any materials obstructing the youth’s airway if incident involves hanging, strangulation or suffocation;
   c. Utilize the suicide response kit and first aid kit per established protocol;
   d. Initiate first aid or cardiopulmonary resuscitation (CPR) as required.

5) The staff person discovering the youth shall never presume that the youth is dead or beyond assistance and shall continue appropriate life saving measures until relieved by arriving medical personnel.

B. All staff who come into contact with youths must be trained in standard first aid and cardiopulmonary resuscitation (CPR), and receive semi-annual “mock drill” training to ensure a prompt response to all suicide attempts and/or incidents of serious self-injury.

C. All facilities/programs shall maintain a suicide response kit and a first aid kit as follows:
   • In facilities with a control station/office, each control station/office must contain a suicide response kit and first aid kit.
   • In facilities with subcontrol stations/offices, each subcontrol station/office must contain a suicide response kit and first aid kit.
   • In small facilities with only a check–in station/office, the check-in station/office must contain a suicide response kit and first aid kit.

D. Facility operating procedures must be in place to ensure the suicide response kit and first aid kit are properly safeguarded and maintained as follows:

1. Each suicide response kit shall contain emergency rescue tools (“knife for life”, wire cutters, needle nose pliers). The suicide response kit must be sealed when not in use. Once the seal is broken, the suicide response kit must be inventoried, each emergency rescue tool recovered and then re-sealed.
2. Each first aid kit shall contain a one-way CPR mask, microshield or face shield, non-latex gloves and first aid supplies. The first aid kit must be sealed when not in use. Once the seal is broken, the first aid kit must be inventoried, missing items recovered or replenished and re-sealed.

E. All staff who come into contact with youths must know the location of the suicide response kit and first aid kit and be trained in their use.

IX. SERIOUS SUICIDE ATTEMPT OR SERIOUS SELF-INFLECTED INJURY REVIEW AND MORTALITY REVIEW

The facility superintendent or program director is responsible for establishing a review process for every serious suicide attempt or serious self-inflicted injury (i.e., requiring hospitalization or medical attention) and a mortality review for a completed suicide.

The serious suicide attempt or serious self-inflicted injury review process and mortality review process must be multidisciplinary (i.e. involve administrative, direct care, mental health and medical personnel) and include a critical inquiry of:

1) The circumstances surrounding the incident;

2) Facility procedures relevant to the incident;

3) All relevant training received by involved staff;

4) Pertinent medical and mental health services involving the victim;

5) Possible precipitating factors leading to the suicide attempt, serious self-inflicted injury or completed suicide;

6) Recommendations, if any, for changes in policy, training, physical plant, medical or mental health services and/or operational procedures.
I. INTRODUCTION

The primary goal of crisis intervention in departmental facilities and programs is to respond to youths in crisis in the least restrictive method possible, and to protect the personal safety of the youth and others while maintaining control and safety of the facility or program environment. In most instances, crisis intervention methods used by direct care and supervisory staff will quell the crisis situation. However, on occasion 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.

This chapter describes the basic elements of a mental health crisis intervention plan and provides guidelines for mental health evaluation (crisis assessment) and treatment of youths whose acute emotional problem or serious psychological distress requires mental health intervention, but do not require emergency services. Youths who, because of his or her mental illness, pose an imminent threat of harm to himself/herself or others must be treated as an emergency (see Chapter Nine of this manual).

II. MENTAL HEALTH CRISIS INTERVENTION PLAN

Each secure detention center, residential commitment program and facility based day treatment program must have a written crisis intervention plan which details crisis intervention procedures including the following:

A. ENSURING SAFETY AND SECURITY: The first step of crisis intervention is to protect the safety of the youth and others. On rare occasions, the youth in crisis will exhibit out of control behaviors or physically dangerous behaviors which require immediate attention. The DJJ Protective Action Response Policy, Number 1508-03 provides the specific verbal and physical intervention techniques and restraining devices that are approved for use in DJJ facilities and programs. Physical intervention techniques and restraining devices that are not authorized under DJJ Policy 1508-03 shall not be used.

B. NOTIFICATION AND ALERT SYSTEM: Procedures for immediately notifying the superintendent or program director, supervisors, clinical staff and/or outside authorities of crisis situations must be in place. Youths identified as having acute emotional or behavioral problems or acute psychological distress which may pose a safety/security risk must be immediately brought to the attention of the superintendent or program director and other staff via the facility’s “alert system” process (See section V., of this Chapter and section IV., of Chapter 5 for information regarding “Mental Health Alerts”). Notification procedures must also be in place to inform the youth’s parent/legal guardian and juvenile probation officer of the youth’s mental health crisis.

C. REFERRAL: The crisis intervention plan must specify the procedures for referring youths whose acute emotional or behavioral problems or psychological distress does not respond to ordinary
crisis intervention to on-site or off-site licensed mental health professionals, service providers or mental health facilities. Referrals for mental health crisis intervention may be made by facility/program staff or by the youth in crisis. Youths identified as having acute emotional or behavioral problems or acute psychological distress which may pose a safety/security risk must be immediately referred to a mental health clinical staff person.

**Youth Self-Referral:** The crisis intervention plan must include a youth self-referral process for mental health crisis intervention services. Youths experiencing an emotional crisis to such a degree that he/she perceives the need for urgent professional assistance shall be permitted to request mental health crisis intervention.

Referrals for mental health crisis intervention (including youth self-referrals) shall be recorded on a mental health referral form developed by the facility/program, or on the sample form provided in Appendix G. The mental health referral form must contain, at a minimum, all of the elements in the sample form in Appendix G.

**D. COMMUNICATION:** Procedures for communication between direct care staff, supervisory staff, administrative staff and mental health clinical staff regarding the status of the youth must exist to provide clear and current information and instructions and urgent care, as needed.

**E. SUPERVISION:** The crisis intervention plan must specify the facility’s procedures for supervising, observing, and monitoring the youth who demonstrates acute emotional or behavioral problems or psychological distress which potentially poses a threat to his/her safety or the safety of others due to a personal crisis or crisis situation. The crisis intervention plan must reflect supervision levels consistent with the following definitions:

- **One-to-One Supervision** refers to the supervision of one youth by one staff member who must remain within five feet of the youth at all times (including when the youth uses the shower or toilet). The staff member must maintain constant visual and sound monitoring of the youth at all times. A sample form for documentation of One-to-One Supervision for crisis intervention and Mental Health Alert is provided at Appendix S-2.

- **Constant Supervision** refers to the continuous and uninterrupted observation of a youth by a staff member who has a clear and unobstructed view of the youth and unobstructed sound monitoring of the youth at all times. Constant supervision shall not be accomplished through video/audio surveillance. If video/audio surveillance is utilized in the facility, it shall be used only to supplement physical observation by staff. A sample form for documentation of Constant Supervision for crisis intervention and Mental Health Alert is provided at Appendix S-2.

- **Close Supervision** requires supervision of youths at five-minute intervals throughout their stay in their rooms. Visual checks must be made of the youth’s condition (i.e., outward appearance, behavior, position in the room) while in his/her room at intervals not to exceed five minutes. Visual checks must be documented, in writing, at intervals not to exceed five minute. A sample form entitled “Close Supervision-Visual Checks Log” is provided at Appendix S-1.

- **Standard Supervision** for youths who have been assessed by a mental health clinical staff person and have been transitioned to standard supervision.

**F. DOCUMENTATION:** Procedures for documenting the crisis situation or event, staff response to the crisis, referral to and consultation with a mental health clinical staff person, and instructions of the licensed mental health professional, the crisis assessment, and mental health support services.
G. REVIEW: The crisis intervention plan must specify the procedures for administrative and clinical review of crises which require mental health intervention (in accordance with the Protective Action Response and applicable Departmental policies).

NOTE: The facility/program may develop an integrated mental health crisis intervention and emergency mental health and substance abuse services plan which contain and meet all of the elements listed in this section and section II of Chapter 9.

III. MENTAL HEALTH EVALUATION: CRISIS ASSESSMENT

The superintendent/program director is responsible for ensuring that youths in crisis who are in need of mental health evaluation are referred to the Designated Mental Health Authority or a mental health clinical staff person for mental health evaluation (i.e., crisis assessment) and intervention. Referrals for mental health crisis intervention may be made by facility/program staff or by the youth in crisis. Youths experiencing an emotional crisis to such a degree that he/she perceives the need for urgent professional assistance shall be permitted to request mental health crisis intervention. The youth’s request shall be recorded on a mental health referral form developed by the facility/program, or on the sample form provided in Appendix G. The mental health referral form must contain, at a minimum, all of the elements in the sample form in Appendix G.

Crisis Assessments: A crisis assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., extreme anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional or an non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional, to determine the severity of his/her symptoms, and level of risk to self or others. When staff observations indicate that a youth’s acute psychological distress is extreme/severe and does not respond to ordinary intervention, the superintendent/program director or his/her designee must be notified of the crisis situation and need for crisis assessment.

A. The superintendent/program director or his/her designee is responsible for consulting the Designated Mental Health Authority or licensed mental health professional who conducts or supervises mental health evaluations at the facility. The mental health professional should be provided enough information to assist him or her in making recommendations which may assist the staff in supervising and monitoring the youth until an crisis assessment is conducted.

B. The mental health clinical staff person performing the crisis assessment should be provided information such as:
   1. A clear description of the crisis situation or event;
   2. A description of any events or circumstances which appeared related to the crisis;
   3. Action taken to intervene;
   4. Youths’ symptoms or behaviors necessitating mental health referral;
   5. Relevant medical or mental health history;
   6. Current behavioral observations;
   7. Current level of staff supervision.

C. The superintendent/program director or his/her designee must document consultation with the Designated Mental Health Authority or other licensed mental health professional on the Mental Health/Substance Abuse Referral Summary (see sample, Appendix G).

   1. The superintendent/program director or his/her designee must document the timeframe for crisis assessment and any recommendations made by the licensed mental health
professional regarding level of supervision to be taken until the crisis assessment is conducted.

2. The superintendent/program director or his/her designee and Designated Mental Health Authority or other licensed mental health professional shall confer on those cases viewed as urgent and if it is determined that an emergency exists, act according to the facility emergency care plan.

D. Components of a Crisis Assessment: A crisis assessment must reflect consideration of the following:

1. Reason for the Crisis Assessment (identify presenting problem and precipitants to the crisis)
2. Mental Status Examination and Interview
3. Determination of Dangerousness to Self and/or Others
   - Imminence of behavior,
   - Intent of behavior,
   - Clarity of danger (Definiteness of danger posed to the youth or others),
   - Lethality of behavior.
4. Initial Clinical Impression (symptoms, sources of stress or concern, coping abilities)
5. Supervision Recommendations (see supervision levels provided at page 8-2)
6. Treatment Recommendations
7. Recommendations for follow-up or further evaluation
8. Notification to parent/legal guardian of follow up recommendations.

E. The crisis assessment must be conducted by a licensed mental health professional or a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional. A crisis assessment conducted by a non-licensed mental health clinical staff person must be reviewed by a licensed mental health professional within 24 hours of the referral.

In the circumstance where the crisis assessment is conducted by an non-licensed mental health clinical staff person but cannot be reviewed by a licensed mental health professional within 24 hours through face-to-face interaction, the licensed mental health professional may accomplish a review of the crisis assessment within 24 hours of the referral through the following methods each of which requires verbal consultation:

1. Verbal consultation through telephonic communication (telephone, cell phone, blackberry) with the non-licensed mental health clinical staff person detailing the crisis assessment findings. The verbal consultation and telephonic communications must be documented and summarized in a progress note by the non-licensed mental health clinical staff person, including any instructions or recommendations made by the licensed mental health professional. The crisis assessment and consultation progress note must be placed in the youth's mental health file and both documents must be reviewed and the crisis assessment signed “as reviewer” by the licensed mental health professional the next scheduled time he/she is on-site.

2. Verbal consultation AND consultation through electronically transmitted communications (e-mail) between the non-licensed mental health clinical staff person and licensed mental health professional detailing the crisis assessment findings. The consultation must be documented and summarized in a progress note by the non-licensed mental health clinical staff person, including any instructions or recommendations made by the licensed mental health professional. The crisis assessment and consultation note must be placed in the youth's
mental health file and both documents must be reviewed and the crisis assessment signed "as reviewer" by the licensed mental health professional the next scheduled time he/she is on-site.

3. Verbal consultation AND off-site review of an electronically transmitted or faxed copy of the completed crisis assessment form or instrument. The licensed mental health professional would fax or electronically transmit confirmation the crisis assessment was reviewed and whether he or she concurs with the findings. The faxed or electronic transmission and the crisis assessment must be placed in the youth’s mental health file. The original crisis assessment and must be signed “as reviewer” by the licensed mental health professional the next scheduled time he/she is on-site.

F. The facility superintendent or program director or his/her designee is responsible for reviewing crisis assessment findings and recommendations and ensuring that procedures are in place to follow findings and recommendations pertaining to monitoring and supervision. Administrative and/or supervisory staff instructions with regard to the crisis assessment findings and recommendations must be documented in the facility log in accordance with facility operating procedures.

1. When a crisis assessment is conducted outside of the facility, documentation of the assessment should be requested by the juvenile justice representative responsible for the youth during the off-site assessment. For example, if a youth is seen in a community mental health center or emergency room by a psychiatrist or other licensed mental health professional, the community mental health center or emergency room discharge summary or other form of documentation of the assessment should be requested by the juvenile justice representative for review upon the youth’s return to the facility.

2. The superintendent or program director is responsible for ensuring that crisis assessment documents conducted outside of the facility are reviewed by designated administrative or supervisory staff and designated mental health clinical staff upon the youth’s return to the facility, and that recommendations contained in the crisis assessment regarding monitoring are followed. Administrative or supervisory staff’s instructions regarding supervision and monitoring of the youth must be documented in the facility log in accordance with facility operating procedures.

Note: Upon the youth’s return from an off-site crisis assessment, the youth must be placed on constant supervision until a mental health clinical staff person reviews the off-site assessment documents and provides a follow-up assessment.

IV. MENTAL HEALTH CRISIS INTERVENTION TECHNIQUES

Mental health crisis intervention refers to short-term therapeutic processes which focus on the rapid resolution of acute psychological distress or an acute emotional or behavioral problem which is severe and does not respond to ordinary intervention. The degree of urgency associated with a crisis is ascertained by the youth’s level of distress and/or severity of symptoms such as depression, anxiety, fear, panic, paranoia, confusion, anger, agitation, impulsivity or aggressive behavior that is increasingly out of control. A rapid response to the crisis is often required to prevent an escalation of the youth’s symptoms and deterioration of the youth’s functioning. In rare instances, the crisis may be sufficiently severe to warrant urgent and intense treatment attention.
After the mental health clinical staff person conducts a crisis assessment, he or she may assist the youth in employing strategies to cope more effectively and control his/her anger, anxiety, fear, as the situation warrants. The mental health clinical staff may utilize a variety of treatment strategies in response to a youth’s crisis. Two examples, crisis counseling and environmental intervention are described below:

Crisis Counseling: Crisis counseling (e.g., crisis intervention therapy or brief psychotherapy) focuses on identification of the specific event(s) precipitating the crisis, alleviating the youth’s specific distressing symptoms, and restoring the youth’s coping and adaptation to an appropriate level of functioning. Although the youth’s symptoms may subside quickly, continued crisis counseling (i.e., crisis intervention therapy or short-term counseling or psychotherapy) may be necessary in order to maintain the youth at an appropriate level of functioning and prevent the return of a crisis state.

Environmental Intervention: In order to maintain the youth at an appropriate level of adaptation, environmental intervention specifically designed for the youth by the mental health professional/staff may be recommended for implementation in the facility or program. For example, a youth who is depressed and withdrawn may be scheduled for more time out of his or her room in order that he/she may have maximum contact with staff and others. The superintendent or program director’s authorization is required for implementation of environmental intervention in response to crises.

IV. CRISIS INTERVENTION FOLLOW-UP AND “MENTAL HEALTH ALERTS”

The superintendent/program director or his or her designee is responsible for ensuring that youths experiencing acute emotional or behavioral problems which are extreme and pose a potential safety/security risks are brought to the attention of the facility administrative, direct care and mental health staff through the facility/program alert system process.

1. When a youth has received a crisis assessment and has been determined to exhibit behaviors which pose a potential safety or security risk the following must occur:
   a. The youth must be maintained or continue to be coded as a “Mental Health Alert” and mental health and support services provided as determined necessary by mental health clinical staff.
   b. The mental health clinical staff person who conducted the crisis assessment must develop a written follow-up plan which is discussed with the youth. The follow-up plan must be documented in the youth’s clinical record.
   c. A mental health clinical staff person must continue to follow the youth to assure that the crisis is resolved and to monitor the youth’s mental status until the youth is determined stable.

2. A youth determined through crisis assessment to exhibit behaviors which pose a potential safety or security risk must remain on “Mental Health Alert” status until subsequent follow-up mental status examination, by or under the supervision of, a licensed mental health professional determines that the youth’s mental health crisis is resolved and no longer poses a potential safety or security risk.
   a. The follow-up mental status examination of the youth on “Mental Health Alert” must be documented in the youth’s individual healthcare record,
b. The follow-up mental status examination, if conducted by a non-licensed mental health clinical staff person must be reviewed and signed “as reviewer” by a licensed mental health professional.
CHAPTER 9
EMERGENCY MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES

I. INTRODUCTION

Mental health emergencies and substance abuse emergencies may occur in juvenile justice settings. The initial critical consideration when there is reason to believe that a youth may be dangerous to self or others because of mental illness or substance abuse impairment, is to determine whether the youth requires emergency care. The prevailing standard of care is that individuals who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment require emergency mental health or substance abuse services.

This chapter describes the essential components of an emergency mental health/substance abuse care plan. Procedures for emergency mental health evaluation and treatment, and emergency substance abuse assessments and admissions as permitted by Florida law are discussed.

II. MENTAL HEALTH AND SUBSTANCE ABUSE EMERGENCY CARE PLAN

Each detention center and residential commitment program must have a written plan which outlines mental health and substance abuse emergency response procedures. Essential components of an emergency mental health or substance abuse care plan are as follows:

A. IMMEDIATE STAFF RESPONSE: Staff training and procedures must be in place for an immediate staff response to mental health or substance abuse emergencies. This includes 911 calls, calls for back-up security and/or medical assistance, initial first aid or use of protective action response (in accordance with the current DJJ protective action response policy 1508-03) if necessary. See Chapter 7, Section VIII for procedures regarding immediate staff response to a suicide attempt or incident of serious self-injury.

B. NOTIFICATION: Procedures must be in place within the facility to ensure that designated on-site facility personnel (e.g., direct care, supervisory, administrative, medical, mental health and/or substance abuse staff) are immediately notified of a mental health emergency or substance abuse emergency. Procedures must also be in place to immediately notify designated personnel (e.g., superintendent or program director, Designated Mental Health Authority) who are off-site at the time of the emergency. The youth’s parent or legal guardian and juvenile probation officer must also be immediately notified of the youth’s mental health or substance abuse emergency.

NOTE: (Parent Notification When a Suicide Attempt or Self-Inflicted Injury Requires Emergency Medical Services or is Life Threatening)

When the youth’s suicide attempt or self-inflicted injury requires emergency medical services or is life threatening (after necessary medical treatment is obtained for the youth) the facility superintendent or program director must make every effort to immediately notify the parent/legal guardian. If the parent or legal guardian cannot be contacted, the following steps must be taken:
1) Use alternative contact methods as documented in the youth’s record. Such alternative methods may include, but are not limited to, contact via the parent’s or legal guardian’s work address, pager/cell phone or electronic notification or contact via a relative or neighbor.

2) Contact the youth’s juvenile probation officer to request assistance with notification. In the case where the youth’s family lives in close proximity to the JPO’s work location or area, request that the JPO drive by the parent’s or legal guardian’s home, place of work, school or other known location outside of the home.

3) Contact law enforcement to request assistance in locating the parent or legal guardian.

The facility superintendent or program director must document all efforts to contact the parent or legal guardian.

C. COMMUNICATION: Procedures for communication between facility staff and mental health or substance abuse professionals and/or medical staff regarding the status of the youth must exist to provide clear and current information and instructions.

D. SUPERVISION: Procedures must be in place which ensure that the youth is maintained on one-to-one supervision during a mental health or substance abuse emergency. One-to-One Supervision MUST be maintained while the youth is in the DJJ facility or program until authorized release to emergency personnel.

E. AUTHORIZATION OF TRANSPORT FOR EMERGENCY MENTAL HEALTH OR SUBSTANCE ABUSE SERVICES: Procedures must be in place which ensure that staff immediately contact emergency medical services (911) in the event of a mental health or substance abuse emergency that requires emergency medical treatment. Procedures must also be in place which ensure that the superintendent/program director or his/her designee’s authorization for transportation for an emergency mental health evaluation under Chapter 394, F.S., or emergency substance abuse assessment under Chapter 397, F.S., be immediately obtained. Procedures must also be in place which provide for on-site supervisory staff to immediately authorize and arrange for the youth’s transport for emergency mental health of substance abuse services, as needed.

F. TRANSPORT FOR EMERGENCY MENTAL HEALTH EVALUATION AND TREATMENT UNDER CHAPTER 394 F.S., (the Baker Act): Procedures must be in place for contacting the designated law enforcement agency and arranging for transportation of a youth believed to be mentally ill from the facility to a mental health receiving facility. Section 394.462, F.S. requires that each county in the State designate a law enforcement agency(s) to take persons into custody upon the entry of an ex parte order or execution of a certificate for Baker Act involuntary examination by an authorized professional and to transport that person to the nearest receiving facility for examination. If a law enforcement officer believes that a person has an emergency medical condition as defined in s. 395.002, the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.

When a member of a mental health overlay program or a mobile crisis response service is a professional authorized to initiate an involuntary examination pursuant to s. 394.463, and that professional evaluates a person and determines that transportation to a receiving facility is needed, the mobile crisis response service, at its discretion, may transport the person to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.
G. TRANSPORT FOR EMERGENCY SUBSTANCE ABUSE ASSESSMENT AND TREATMENT UNDER CHAPTER 397 F.S., (the Marchman Act): Procedures must also be in place for transporting a youth who is believed to be substance abuse impaired for emergency admission to a hospital, licensed detoxification facility or addictions receiving facility. If involuntary substance abuse admission (Section 397.675, F.S.) is initiated, a law enforcement officer may implement protective custody measures as described in Section. 397.677, F.S., and take the youth to a hospital or to a licensed detoxification or addictions receiving facility. If a physician’s certificate for emergency substance abuse admission has been obtained, the applicant for the youth’s emergency admission (guardian, a law enforcement officer, or health officer) may deliver the youth named in the physician’s certificate for emergency admission to a hospital, licensed detoxification facility or addictions receiving facility. If an ex parte order authorizing involuntary substance abuse assessment and stabilization is issued, the court may order a law enforcement officer or other designated agent of the court to take the youth into custody and deliver him or her to the nearest appropriate licensed service provider.

H. DOCUMENTATION: Procedures for documenting the mental health or substance abuse emergency, staff response to the mental health emergency, instructions of mental health and/or medical staff, and authorization for transfer must be detailed.

I. TRAINING: All staff who work with youths must be trained in emergency response procedures. Each facility or program must provide semi-annual training on emergency response procedures which include “mock” training in emergency response to a suicide attempt or incident of serious self-inflicted injury.

J. REVIEW: The mental health emergency care plan must specify the procedures for administrative review and a licensed mental health professional’s review of mental health and substance abuse emergency procedures and critical incidents.

III. EMERGENCY MENTAL HEALTH EVALUATIONS

An emergency mental health evaluation may be conducted at a mental health receiving facility or hospital emergency room to determine whether a youth requires inpatient psychiatric treatment or hospitalization. Such evaluation may involve involuntary or voluntary examination. The criteria for involuntary examination are as follows:

INVoluntary MENTAL HEALTH EXAMINATION (Baker Act)

A. Criteria for Involuntary Examination. Section 394.463, F.S. states that an individual may be taken to a receiving facility for involuntary examination if there is reason to believe that he/she is mentally ill and because of his or her mental illness:

1. a. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or
2. a. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided
through the help of willing family members or friends or the provision of other services; 
or
b. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future as evidenced by recent behavior.

Thus, for involuntary examination there must be: reason to believe the youth is mentally ill and because of his or her mental illness 1(a) or (b) listed above applies and 2 (a) or (b) listed above applies.

B. Baker Act Involuntary Examination: An involuntary examination may be initiated by any one of the following three means:

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination. A law enforcement officer or other designated agent of the court shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination.

2. A law enforcement agency may be contacted, and a law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to the nearest receiving facility for examination. The law enforcement officer shall execute a written report detailing the circumstances in which the person was taken into custody.

3. A [licensed] physician, clinical psychologist, psychiatric nurse, mental health counselor, or clinical social worker may execute a Baker Act certificate stating that he or she has examined the person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, and stating the observations upon which that conclusion is based. (See Section 394.463(2)(a)3, Florida Statutes)

A law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest receiving facility for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances in which the person was taken into custody.

4. A person may not be held in a receiving facility for involuntary examination for more than 72 hours. Within the 72 hour examination period, or if the 72 hours ends on a weekend or holiday, no later than the next working day, one of the following must occur:

a. The person shall be released, unless he or she is charged with a crime, in which case, the person shall be returned to the custody of a law enforcement officer;

b. The person shall be released, subject to the provisions for voluntary outpatient treatment;

c. The person (adult), unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary placement, and is such consent is given, the person shall be admitted as a voluntary patient; or

d. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary.
IV. EMERGENCY MENTAL HEALTH PLACEMENT:

Emergency mental health treatment generally requires admission to a receiving facility or treatment facility. A receiving facility is a public or private facility designated by the Department of Children and Families to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short term treatment. A treatment facility is a state-owned, state-operated or state-supported hospital, center or clinic designated by the Department of Children and Families for the extended treatment and hospitalization, beyond that provided for by a receiving facility, of persons who are mentally ill. Involuntary placement in a receiving facility or treatment facility requires a court order finding the criteria in Section 394.467, F.S. are met.

INVoluntary Placement (Baker Act)

A. Criteria for Involuntary Placement. A person may be involuntarily placed for treatment upon a finding of the court by clear and convincing evidence that he or she is mentally ill and because of his or her mental illness:

1. a. He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and of the purposes of placement for treatment; or

   b. He or she is unable to determine for himself or herself whether placement is necessary; and

2. a. He or she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and without treatment is likely to suffer from neglect or refuse care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or

   b. There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and

3. All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

Thus, for involuntary placement, there must be a court order finding 1(a) or (b) listed above and 2(a) or 2(b) listed above, and criteria 3 listed above.

V. EMERGENCY SUBSTANCE ABUSE ADMISSIONS:

A. Criteria for Involuntary Admissions, Including Involuntary Assessment and Treatment: (Marchman Act)

Section 397.675, F.S., states that a person meets the criteria for involuntary admission if there is good faith reason to believe the person is substance abuse impaired and, because of such impairment:
1. Has lost the power of self-control with respect to substance use; and either

2. a. Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or

   b. Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services.

B. Emergency Admission: A person who meets the criteria for involuntary admission set forth in paragraph A, above, may be admitted to a hospital or to a licensed detoxification facility or addictions receiving facility for emergency assessment and stabilization, or to a less intensive component of a licensed service provider for assessment only, upon receipt by the facility of the physician's certificate and the completion of an application for emergency admission.

C. Persons Who May Initiate Emergency Admissions: Section 397.6791 F.S., states the following persons may request an emergency admission:

1. In the case of an adult, the certifying physician, the person's spouse or guardian, any relative of the person, or any other responsible adult who has personal knowledge of the person's substance abuse impairment.

2. In the case of a minor, the minor’s parent, legal guardian, the Department as legal custodian, or other legal custodian.

D. Alternative Involuntary Assessment Procedures for Minors:

1. In addition to protective custody, emergency admission, and involuntary assessment and stabilization, an addictions receiving facility may admit a minor for involuntary assessment and stabilization upon the filing of an application to an addictions receiving facility by the minor’s parent, guardian, or legal custodian. The application must establish the need for involuntary assessment and stabilization based on the criteria for involuntary admission in s. 397.675. Within 72 hours after involuntary admission of a minor, the minor must be assessed to determine the need for further services. Assessments must be performed by a qualified professional.

2. An application for alternative involuntary assessment for a minor must establish the need for immediate involuntary admission and contain the name of the minor to be admitted, the name and signature of the applicant, the relationship between the minor to be admitted and the applicant, and factual allegations with respect to:

   a. The reason for the applicant’s belief that the minor is substance abuse impaired; and

   b. The reason for the applicant’s belief that because of such impairment the minor has lost the power of self-control with respect to substance abuse; and either

1. The reason the applicant believes that the minor has inflicted or is likely to inflict physical harm on himself or herself or others unless admitted;
Or

2. The reason the applicant believes that the minor’s refusal to voluntarily receive substance abuse services is based on judgment so impaired by reason of substance abuse that he or she is incapable of appreciating his or her need for such services and of making a rational decision regarding his or her need for services.
CHAPTER 10
GLOSSARY

I. INTRODUCTION TO GLOSSARY

The continuum of mental health and substance abuse services in the Department of Juvenile Justice affects a wide range of staff and clinicians who have varying experiences in and understanding of mental health and substance abuse issues and information. The terminology used in this manual may be unfamiliar to some readers. The definitions used in this manual were derived from multiple professional references, statutes, rules and regulations, or in certain instances developed specifically for the Department. For clarification and to facilitate understanding, the terms in this manual are defined below. Terms specific to Residential Substance Abuse Treatment (RSAT) and Residential Substance Abuse Treatment Overlay Services (RSAT Overlay Services) in designated residential commitment programs are provided in Section III of this glossary.

II. THE GLOSSARY

**Active Mental Health/Substance Abuse Treatment File:** A temporary file maintained in a designated area of the DJJ facility or program which contains mental health and substance abuse information collected during the course of a youth’s on-going mental health or substance abuse treatment in the facility or program. The active mental health/substance abuse treatment file must be readily accessible to mental health and substance abuse clinical staff working in the facility/program and also to designated administrative, supervisory or medical staff who have a need for the information in connection with their duty to monitor the youth’s progress or to participate in the assessment or treatment of the youth. The Active Mental Health/Substance Abuse Treatment File or a copy of the file must be placed in the youth’s individual healthcare record when mental health and/or substance abuse treatment is completed and prior to his/her transition from the DJJ facility or program.

**Acute Emotional or Psychological Distress:** The rapid onset of an intense mental state of arousal, unrest and/or disorganization which is often accompanied by an intense sense of being unable to cope with or control the mental state.

**Assessment of Suicide Risk:** An assessment of a youth’s suicide risk factors or suicide risk behaviors to determine whether the youth is a potential suicide risk and the level of risk. An assessment of suicide risk must be conducted by a mental health clinical staff person who is a licensed mental health professional or works under the direct supervision of a licensed mental health professional.

**Authority for Evaluation and Treatment:** A document, that when signed by a parent or legal guardian gives the Department the authority to assume responsibility for the provision of necessary and appropriate mental and physical healthcare to a youth within its physical custody, in most circumstances.

**Baker Act:** The Florida statute governing mental health services is Chapter 394 which is known as the Florida Mental Health Act or Baker Act (named after Maxine Baker, former State representative...
from Miami who sponsored the Act). The “Baker Act” provides Florida law covering voluntary and involuntary mental health examination and placement for persons with mental illness.

**Certified Addiction Professional:** A person who is certified through a State of Florida recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor’s degree.

**Clinical Coordinator:** A designated licensed mental health professional or a designated non-licensed mental health clinical staff person who has received training specifically in mental health services coordination, and who is responsible for coordinating and verifying implementation of necessary and appropriate mental health and substance abuse services in a DJJ facility with an operating capacity of less than 100 youths.

**Clinical Mental Health Screening:** An in-depth screening conducted by a licensed mental health professional utilizing valid and reliable mental health screening instruments (e.g., Diagnostic Interview Schedule for Children (DISC), Diagnostic Interview for Children and Adolescents (DICA), Symptom Checklist-90) and suicide risk screening instruments (e.g., Suicide Ideation Questionnaire, Suicide Probability Scale).

**Clinical Substance Abuse Screening:** An in-depth screening conducted by a “qualified professional” as defined in Section 397.311(25) F.S., [in accordance with Rule 65D-30.003(15) F.A.C.] utilizing valid and reliable screening instruments (e.g., Substance Abuse Subtle Screening Inventory-3 (SASSI-3), Problem Oriented Screening Instrument for Teenagers (POSIT)).

**Close Supervision:** The supervision of youths at intervals not to exceed five minute throughout their stay in their rooms. Visual checks must be made of the youth’s condition (i.e., outward appearance, behavior, position in the room) at intervals not to exceed five minutes. For youths removed from suicide precautions, close supervision is to be used only as a step-down method of supervision of an “at risk” youth who has received an Assessment of Suicide Risk, has been removed from Suicide Precautions, and is being transitioned back into a normal routine.

**Comprehensive Assessment:** Within the context of this manual, the term “comprehensive assessment” generally refers to the assessment under Section 985.21(1)(a)4 regarding the child’s need for substance abuse treatment services, mental health services, retardation services, literacy services, or other educational or treatment services. The comprehensive assessment is accomplished through administration of the instrument entitled: “Substance Abuse and Mental Health Assessment–2” (SAMH-2) and completion of the SAMH-3 which is a summary of SAMH-2 findings and recommendations, or the administration of a Department-approved equivalent instrument.

**Comprehensive Evaluation (Pre-Disposition Comprehensive Evaluation):** Within the context of this manual, the term “comprehensive evaluation” generally refers to the pre-disposition evaluation for physical health, mental health, substance abuse, academic, educational or vocational problems required under Section 985.229, Florida Statutes, for any child for whom a residential commitment disposition is anticipated or recommended by an officer of the court or by the Department.

**Comprehensive Mental Health Evaluation:** An in-depth evaluation conducted by a licensed mental health professional or a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional to determine the presence of, or nature and complexity of a mental disorder.
**Comprehensive Substance Abuse Evaluation:** An in-depth evaluation conducted by a “qualified professional” as defined in Section 397.311(25), F.S., or a non-licensed substance abuse clinical staff person, who is an employee in a DJJ facility licensed under Chapter 397 or an employee of a service provider licensed under Chapter 397, working under the direct supervision of a “qualified professional” to determine the presence of, or nature and complexity of a substance related disorder.

**ComStat:** A term used by the Department to refer to “computer statistics” generated from the DJJ central communications center (CCC) and Juvenile Justice Information System (JJIS).

**Constant Supervision:** The continuous and uninterrupted observation of a youth by a staff member who has a clear and unobstructed view of the youth, and unobstructed sound of the youth at all times. Constant supervision shall not be accomplished through video/audio surveillance. If video/audio surveillance is utilized in a facility, it shall be used only to supplement physical observation by staff.

**Crisis Assessment:** A detailed evaluation of a youth presenting an acute emotional or behavioral problem or psychological distress (e.g., extreme anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional or a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional to determine the severity of his/her symptoms, level of risk to self or others and recommendations for treatment and follow-up.

**Crisis Counseling:** Counseling (e.g., crisis intervention therapy or brief psychotherapy) focusing on identification of the specific event(s) precipitating the crisis, alleviating the youth’s specific distressing symptoms, and restoring the youth’s coping and adaptation to an appropriate level of functioning. Although the youth’s symptoms may subside quickly, continued crisis counseling (i.e., crisis intervention therapy or short-term counseling or psychotherapy) may be necessary in order to maintain the youth at an appropriate level of functioning and prevent the return of a crisis state.

**Designated Mental Health Authority:** The Designated Mental Health Authority is a licensed mental health professional (a psychiatrist licensed pursuant to Chapter 458 or 459, F.S., psychologist licensed pursuant to Chapter 490, F.S., mental health counselor, clinical social worker, or marriage and family therapist licensed pursuant to Chapter 491, F.S., or psychiatric nurse as defined in Section 394.455(23), F.S.) who, through employment or contract, is designated as accountable to the facility superintendent for ensuring appropriate coordination and implementation of mental health and substance abuse services in a departmental facility or program.

**Detention Screening (JAC and JPO Unit Intake Screening):** A term used in Chapter 985, F.S., to describe the screening which takes place during the initial intake process. Detention Screening begins when a law enforcement officer delivers a juvenile who has been taken into custody to the Department, and may occur at a detention center, law enforcement agency, Juvenile Assessment Center, or case management unit. Within the context of this Manual, the term refers to intake screening conducted in a Juvenile Assessment Center (JAC) or Juvenile Probation Officer Unit.

**Developmental Disability:** Under Florida law, a “developmental disability” means a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida or Prader Willi syndrome and that constitutes a substantial handicap that can be expected to continue indefinitely. Within the context of this Manual, the term “developmental disability” is used interchangeably with the term “mental retardation.”
Direct Supervision for Mental Health Clinical Staff: Means that a licensed mental health professional has at least one hour per week of on-site face-to-face interaction with a non-licensed mental health clinical staff person for the purpose of overseeing and directing the mental health services that he or she is providing in the facility (as permitted by law within his or her state licensure).

Direct Supervision for Substance Abuse Clinical Staff: Means that a “qualified professional” as defined in Section 397.311(25) F.S., has at least one hour per week of on-site face-to-face interaction with a non-licensed/non-certified substance abuse clinical staff person who is an employee of a service provider licensed under Chapter 397 or an employee in a facility licensed under Chapter 397, for the purpose of overseeing and directing the substance abuse services that he or she is providing in the facility (in accordance with Rule 65D-30.003(15) F.A.C.).


Imminent Threat of Suicide: Means to present a real and present threat of suicide.

Inactive Status: When a youth is removed from a residential program and identified in the Juvenile Justice Information System (JJIS) to be in jail, secure detention, escape status or in a medical or mental health facility (see DJJ Residential Services Manual).

Individual Healthcare Record: The permanent departmental file containing the unified cumulative hard-copy collection of records, histories, assessments, treatments, diagnostic tests, and the like, which relate to a youth’s medical, mental/behavioral and dental health which have been obtained to facilitate care or document care provided while in the youth is in a detention center or residential commitment program.

Individualized Mental Health Treatment Plan: A written, individualized guide which structures the focus of a youth’s ongoing mental health treatment (including treatment with psychotropic medication). The individualized mental health treatment plan must specify the youth’s DSM IV-TR mental disorder, symptoms that will be the focus of treatment, the goals and objectives of his or her mental health treatment, treatment methods and interventions/strategies to be provided and the youth’s functional strengths and needs (including psychiatric service needs for youths receiving psychotropic medication or other psychiatric services).

Individualized Substance Abuse Treatment Plan: A written, individualized guide which structures the focus of a youth’s ongoing substance abuse treatment. The individualized substance abuse treatment plan must specify the youth’s DSM IV-TR substance related disorder, symptoms that will be the focus of treatment, the goals and objectives of his or her substance abuse treatment, treatment methods and interventions/strategies to be provided and youth’s functional strengths and needs (including psychiatric service needs for youths receiving psychotropic medication or other psychiatric services).

Initial Mental Health Treatment Plan: A written guide which structures the focus of a youth’s short-term or initial mental health treatment. The plan specifies the youth’s initial DSM-IV-TR diagnosis or presenting symptoms, initial treatment methods (including psychiatric services (for youths receiving psychotropic medication) and the short-term or preliminary goals and objectives of mental health treatment.
**Initial Substance Abuse Treatment Plan:** A written guide which structures the focus of a youth’s short-term or initial substance abuse treatment. The plan specifies the youth’s initial DSM-IV-TR diagnosis or presenting symptoms, initial treatment methods (including psychiatric services for youths receiving psychotropic medication) and the short-term or preliminary goals and objectives of substance abuse treatment.

**Integrated Mental Health and Substance Abuse Treatment Plan:** A written, individualized guide which structures the focus of a dually diagnosed youth’s ongoing mental health and substance abuse treatment. The integrated mental health and substance abuse treatment plan (may also be referred to as an “individualized mental health/substance abuse treatment plan”) must specify the youth’s DSM IV–TR mental disorder and substance related disorder, symptoms that will be the focus of treatment, the goals and objectives of his or her mental health and substance abuse treatment, treatment methods and interventions/strategies to be provided and the youth’s functional strengths and needs (including psychiatric service needs for youths receiving psychotropic medication or other psychiatric services).

**Juvenile Assessment Center:** Section 985.209, F.S. establishes juvenile justice assessment centers which are designed to serve as a point of intake and screening for juveniles referred to the Department. Each juvenile assessment center must provide services needed to facilitate initial screening for juveniles.

**Least Restrictive Alternative:** Within the context of this manual, least restrictive alternative means that the treatment and conditions of treatment are no more intrusive or restrictive of freedom than reasonably necessary to achieve a substantial therapeutic benefit or to protect the youth or others from physical injury.

**Licensed Mental Health Professional:** Within the context of this manual, the term "licensed mental health professional" means a psychiatrist licensed pursuant to Chapter 458 or 459, F.S., who is board certified in Child and Adolescent Psychiatry or Psychiatry by the American Board of Psychiatry and Neurology or has completed a training program in Psychiatry approved by the American Board of Psychiatry and Neurology for entrance into its certifying examination, a psychologist licensed pursuant to Chapter 490, F.S., a mental health counselor, marriage and family therapist, or clinical social worker licensed pursuant to Chapter 491, F.S., or a psychiatric nurse as defined in Section 394.455(23), Florida Statutes.

**Marchman Act:** The Florida statute governing substance abuse services is Chapter 397 which is known as the Hal S. Marchman and Other Drug Services Act of 1993 or the “Marchman Act”. The “Marchman Act” provides Florida law covering voluntary and involuntary substance abuse assessment and admissions for persons with substance abuse impairment.

**Massachusetts Youth Screening Instrument, Second Version (MAYSI-2):** The mental health and substance abuse screening instrument authorized by DJJ for use at intake into the juvenile justice system and upon admission to a residential commitment program. The MAYSI-2 is a 52-item true-false screening instrument designed to identify signs of mental/emotional disturbance or distress.

**Mental Disorder:** A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or impairment in one or more important areas of functioning, or with a significantly increased risk of suffering death, pain, disability, or significant loss of freedom. This term is not applied to behavior or conflicts which arise
between a person and society unless such conflicts are clearly an outgrowth of a dysfunction within that person.

**Mental Health Alert:** A designation of “Mental Health Alert” is used to identify youths in DJJ facilities/programs who have mental health conditions, symptoms or behaviors which may pose safety or security risks.

**Mental Health Clinical Staff Person:** A person who, if not otherwise licensed as a mental health professional, must hold, at a minimum, a Bachelor’s degree from an accredited university or college with a major in psychology, social work, counseling or related human services field. Related human services field is one in which major course work includes the study of human behavior and development, counseling and interviewing techniques, and individual, group or family therapy. A mental health clinical staff person providing mental health services in a DJJ facility or program must have received training in mental health assessment processes and procedures and mental health treatment strategies and techniques in accordance with this Manual.

**Mental Health Crisis Intervention:** Short-term therapeutic processes which focus on rapid resolution of acute psychological distress or an acute emotional or behavioral problem which is extreme and does not respond to ordinary intervention. The purpose of such intervention is generally to determine the severity of the problem, potential for harm, and to prevent harm to the individual or others.

**Mental Health and Substance Abuse Screening:** The brief procedures used to determine the presence of a mental health or substance abuse problem, substantiate that the youth is positive in respect to some mental health or substance abuse factor and to identify the need for further mental health or substance abuse evaluation.

**Mental Health/Substance Abuse Referral Summary:** The document which summarizes communication between program staff and the mental health or substance abuse clinical staff with regard to the youth’s mental health or substance abuse history, problem, condition, or symptoms which indicate the need for mental health or substance abuse services.

**Mental Health Treatment Discharge Summary/Substance Abuse Treatment Discharge Summary:** A form which summarizes the focus and course of a youth’s mental health and/or substance abuse treatment, and provides recommendations for mental health and/or substance abuse treatment or services upon the youth’s movement out of a DJJ facility or program.

**Necessary and Appropriate Mental Health and Substance Abuse Treatment and Services:** Within the context of this manual, a term used to refer to essential mental health or substance abuse care or services which are reasonably expected to become necessary in the course of custody and care of juveniles, and which are consistent with generally acceptable professional standards for mental health and substance abuse services.

**One-to-One Supervision:** Within the context of this manual, one-to-one supervision refers to the supervision of one youth by one staff member who remains within five feet of the youth at all times. If the youth is in a secure observation room, the staff member assigned to one-to-one supervision of the youth must be stationed at the entrance to the room, no further than five feet from the door. The staff member must maintain constant visual and sound monitoring of the youth and have immediate access to the youth at all times.
Positive Achievement Change Tool (PACT): The Department-approved risk and needs tool utilized by juvenile probation officers and Juvenile Assessment Center screening staff to guide case management. The PACT Mental Health and Substance Abuse Screening Report and Referral form provide findings and indicate the need for further mental health and substance abuse assessment.

Potential Suicide Risk: Within the context of this manual, refers to a potential for manifesting deliberate self-destructive or self-injurious behavior with potentially life-threatening consequences.

Precautionary Observation: A suicide precaution method which provides for the constant supervision of a “suicide risk” youth in designated observation areas of the facility/program which are safe and secure.

Preliminary Screening: Within the context of this manual, preliminary screening refers to the gathering of preliminary information to be used in determining a youth’s need for further mental health or substance abuse assessment or evaluation or for referral for other mental health or substance abuse services.

Protective Action Response: The Department-approved verbal and physical intervention techniques and the application of mechanical restraints used in accordance with current DJJ policy.

Psychotropic Medication: Medications capable of affecting the mind, emotions and behavior that are used to treat mental illness. These medications may reduce the severity and duration of mental disorder.

Qualified Professional: A term defined by Chapter 397, F.S., which means a physician licensed under Chapter 458 or Chapter 459; a professional licensed under Chapter 490 or 491; or a person who is certified through a Department of Children and Families recognized certification process for substance abuse treatment services and who holds, at a minimum, a bachelor’s degree.

Secure Observation: A suicide precaution method which provides for the use of a Secure Observation Room for placement of youths demonstrating “at risk” or “suicide risk behaviors”. For example, the “at risk” youth appears extremely restless, fearful, agitated, depressed or his/her behavior appears unpredictable, volatile or highly impulsive.

Secure Observation Room: A safe, empty, protrusion-free, suicide resistant and impact-resistant room used when placing a youth in secure observation due to “at risk” or suicide risk behaviors. For example, the “at risk” youth appears extremely restless, fearful, agitated, depressed or his/her behavior appears unpredictable, volatile or highly impulsive.

Serious Self-Inflicted Injury: Any deliberate action taken by the youth to harm himself/herself with potentially serious or life-threatening consequences, but is not associated with suicide ideation or suicide intent.

Specialized Treatment Services: Within the context of this Manual “specialized treatment services” are mental health services, substance abuse services, developmental disability services, sex offender treatment services or behavioral health services provided in designated DJJ residential commitment programs through DJJ beds/slots funded by general revenue, FDLE subgrant or Medicaid funding specifically for provision of these services. Specialized treatment services include the following: Comprehensive Services for Major Disorders; Intensive Mental Health Services; Specialized Mental Health Services, Residential Substance Abuse Treatment Services (RSAT); Developmental Disability Services; Sex Offender Treatment Services, Mental Health Overlay
Services (MHOS), Residential Substance Abuse Treatment Overlay Services (RSAT Overlay Services); Behavioral Health Overlay Services (BHOS).

**Substance Abuse Clinical Staff Person:** A person who, if not otherwise licensed in accordance with Chapter 397, F.S., is an employee of a service provider licensed under Chapter 397 or in facility licensed under Chapter 397, Florida Statutes, who holds, at a minimum, a Bachelor’s degree from an accredited university or college with a major in psychology, social work, counseling or related human services field. Related human services field is one in which major course work includes the study of human behavior and development, counseling and interviewing techniques, and individual, group or family therapy. A substance abuse clinical staff person providing substance abuse services in a DJJ facility or program must have received training in accordance with Rule 65D-30 F.A.C.

**Substance Abuse Service Provider:** A term defined by Chapter 397, F.S., which means a public agency, a private-for-profit or not-for-profit agency, a person who is a private practitioner, or a hospital, which agency, person or hospital is licensed under Chapter 397 or exempt from licensure under Chapter 397. This definition includes physicians licensed under Chapter 458 or 459, psychologists licensed under Chapter 490, and clinical social workers, marriage and family therapists and mental health counselors licensed under Chapter 491, Florida Statutes.

**Suicide Attempt:** Any action deliberately undertaken by the youth with suicide ideation or suicide intent which, if carried out, would result in his/her death.

**Suicide Gesture:** Any action deliberately undertaken by the youth with suicide ideation or suicide intent which, if carried out, would not result in his/her death.

**Suicide Response Kit:** A designated box (preferably a metal or hard coated box) which contains a DJJ approved “knife for life”, wire cutters and needle nose pliers for use in the event of a suicide attempt or incident of serious self-inflicted injury.

**Suicide Risk Alert:** A designation of “Suicide Risk Alert” is used to identify youths in DJJ facilities/programs who are identified with suicide risk factors and are placed on suicide precautions. A “Suicide Risk Alert” must be entered on the Department’s Juvenile Justice Information System (JJIS).

**Suicide Risk Behaviors:** Within the context of this manual, refers to events, statements, behaviors or actions which indicate that the youth is a potential suicide risk.

**Suicidal Ideation:** Thoughts, wishes or desire to deliberately take one’s own life.

**Suicidal Intent:** Identified decision and/or plan to take one’s own life.

**Suicide Precautions:** Within the context of this manual, refers to methods utilized for supervising, observing, monitoring and housing the youth who has been identified as a potential suicide risk. Suicide precautions require that specific action be taken within a DJJ facility or program to protect a youth considered “at risk” of suicide from potential self-injury or suicide. In DJJ facilities and programs, either Precautionary Observation or Secure Observation must be used as a Suicide Precautions method when the youth has been identified as a potential suicide risk.

**Suicidal Threat:** A warning direct or indirect, verbal or non-verbal, that reasonably suggests that the youth plans to attempt suicide.
III. TERMS SPECIFIC TO RSAT/RSAT OVERLAY SERVICES IN DESIGNATED DJJ RESIDENTIAL COMMITMENT PROGRAMS

**Alcohol** - For the purpose of the policy provided in Chapter 5 section C. of this Manual: ethyl alcohol, the intoxicating element of whiskey, wine, beer, and other fermented or distilled liquors.

**Drug Test Chain of Custody** - The procedures that govern collection, handling, storage, transportation and testing of a urine specimen and dissemination of test results in a manner that ensures the specimen and the results are correctly matched to the person who donated the specimen and that the specimen is not altered or tampered with from the point of collection through the reporting of test results.

**Drug** - For the purpose of the policy provided in Chapter 5 section C. of this Manual: alcohol (as defined above); and any substance listed in Section 893.03 Florida Statutes, including but not limited to, amphetamines; cannabinoids; cocaine, barbiturates, benzodiazepines; or a metabolite of any of the substances listed herein.

**Drug Test** - For the purpose of the policy provided in Chapter 5 section C. of this Manual: drug testing refers solely to the chemical analysis of urine to determine the presence or absence of a drug (including alcohol) or its metabolites.

**Drug Testing Coordinator** - A licensed healthcare professional designated by the facility superintendent/program director to be responsible for the coordination, monitoring, and directing of all necessary duties related to the collection, labeling, control, and transportation of urinalysis drug testing in the DJJ RSAT/RSAT Overlay Services facility.

**Random Drug Testing:** Obtaining juvenile urine specimens for drug testing without the juvenile's prior knowledge that a specimen will be requested.

**Reasonable Suspicion Drug Testing:** Drug testing based on a reasonable belief a juvenile offender is using or has used drugs in violation of the Department's policy, drawn from specific objective evidence and articulable facts and reasonable inferences drawn from those facts. Among other things, such facts and inferences may be based upon:

- Observable phenomena such as direct observation of drug or alcohol use or the physical symptoms or manifestations of being under the influence of a drug or alcohol. For example, slurred or incoherent speech, erratic or violent behavior, uneven gait, or other behaviors or physical symptoms unusual for the youth based on the staff member's knowledge of the youth.
- Evidence that a youth has altered or attempted to alter a drug test in the DJJ designated RSAT/RSAT Overlay Services program.
- Evidence or reliable reports that a youth has used, possessed, sold, solicited, or transferred drugs or alcohol while in, or on temporary release from the DJJ RSAT/RSAT Overlay Services programs.
- History of drug abuse or prior positive urine test while in the DJJ designated program.
Routine Drug Testing - Routine collection of urine specimens for drug testing of all juveniles participating in the DJJ designated substance abuse treatment program. Routine urine drug testing will be conducted a minimum of once per month.
### UPDATES
**(APRIL 2007)**

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>TITLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Services for Youths with Developmental Disabilities</td>
<td>1-6</td>
</tr>
<tr>
<td>2</td>
<td>Qualifications of Mental Health and Substance Abuse Professionals</td>
<td>2-9</td>
</tr>
<tr>
<td>3</td>
<td>Note: Youth in the Care of the Department of Children and Families</td>
<td>3-2</td>
</tr>
<tr>
<td></td>
<td>(Updated March, 2007)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Mental Health/Substance Abuse Section of the Individual Healthcare</td>
<td>4-4</td>
</tr>
<tr>
<td></td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Mental Health Treatment Techniques</td>
<td>6-9</td>
</tr>
<tr>
<td></td>
<td>Psychiatric Services – Treatment Planning</td>
<td>6-18</td>
</tr>
<tr>
<td>7</td>
<td>Suicide Prevention Plan</td>
<td>7-1</td>
</tr>
<tr>
<td></td>
<td>Assessment of Suicide Risk</td>
<td>7-10</td>
</tr>
</tbody>
</table>

### UPDATED FORMS

**Appendix**

<table>
<thead>
<tr>
<th>N</th>
<th>DJJ Suicide Risk Screening Instrument (SRSI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-2</td>
<td>Sample, Mental Health Alert- Observation Log</td>
</tr>
</tbody>
</table>
FORMS
APPENDIX

This manual contains both standardized forms and forms designated as "Samples". Standardized forms are designed to be uniformly used in all detention centers, residential commitment programs and day treatment programs. Sample forms delineate the minimum elements required by the Department, but may be expanded or reformatted to meet facility or program needs. Any alternative form, at a minimum, must contain all the elements of the Sample form unless the Manual provides an exception for a specific Sample form. The alternative form must be provided on facility/program or provider stationary.

Copies of all these forms are available on the DJJ Health Services webpage of the DJJ internet or in the DJJ Forms Library also located on the DJJ internet.
Appendix

A-1 Authority for Evaluation and Treatment
A-2 Guidelines for Obtaining Parental Signatures on the AET
B-1 Clinical Psychotropic Progress Note
B-2 Acknowledgement of Receipt of CPPN Form or Practitioner Form
C Parental Notification of Health-Related Care
D Youth Consent for Substance Abuse Treatment in RSAT or RSAT Overlay Services Program
E Sample, Youth Consent for Substance Abuse Treatment
F Sample, Youth Consent for Release of Substance Abuse Treatment Records
G Sample, Mental Health/Substance Abuse Referral Summary
H Sample, Initial Mental Health/Substance Abuse Treatment Plan
I-1 Sample, Individualized Mental Health/Substance Abuse Treatment Plan
I-2 Sample, Individualized Mental Health/Substance Abuse Treatment Plan Review
J Sample, Counseling/Therapy Progress Note
K Sample, Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log
L-1 MAYSI-2 Questionnaire
L-2 PACT Pre-Screen
L-3 PACT Full Assessment
L-4 PACT Mental Health and Substance Abuse Screening Report and Referral
M-1 SAMH-2
M-2 SAMH-3
N DJJ Suicide Risk Screening Instrument (SRSI)
O Suicide Risk Screening Parent/Guardian Notification
P Assessment of Suicide Risk
Q Follow-Up Assessment of Suicide Risk
R Suicide Precautions – Observation Log
S-1 Sample, Close Supervision – Visual Checks Log
S-2 Sample, Mental Health Alert – Observation Log
T-1 Health Status Checklist
T-2 Male Body Chart
T-3 Female Body Chart
U Sample, Mental Health/Substance Abuse On-Site Tracking Log
V Mental Health/Substance Abuse Treatment Discharge Summary
W General Information Regarding Specialized Treatment Services in DJJ Residential Commitment Programs