Illinois Department of Juvenile Justice	ADMINISTRATIVE DIRECTIVE	Number	04.04.102
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		Effective	10/01/2014DRAFT

Section	04	Programs and Services
Subsection	04	Mental Health
Subject	102	Emergency Mental Health Services

I. POLICY

A. Authority

730 ILCS 5/3-2.5-20

20 Ill. Adm. Code 2415

B. Policy Statement

Youth shall have access to emergency mental health services.

II. PROCEDURE

A. Purpose

The purpose of this directive is to define the responsibilities of those employees involved in the provision of emergency mental health services to youth.

B. Applicability

This directive is applicable to all youth centers.

C. Facility Reviews

A facility review of this directive shall be conducted at least annually.

D. Designees

Individuals specified in this directive may delegate stated responsibilities to another person or persons unless otherwise directed.

E. Definitions

Close Supervision - a formal treatment status which provides for verbal or visual monitoring of those youth determined by a mental health professional to be acutely disturbed or potentially suicidal.

Crisis Team Member - an individual designated by the Chief Administrative Officer to respond to a potential or actual crisis.

Crisis Team Leader - a mental health professional designated by the Chief Administrative Officer to supervise and direct crisis services.

Observation Status - a formal monitoring status which provides for verbal or visual monitoring of those youth determined by a mental health professional or Crisis Team Leader to be at increased risk for experiencing a mental or emotional crisis.

Strip Celling – the removal of all clothing and property from a youth who is placed on suicide watch and determined by a mental health professional or physician, when a mental health professional is not available, that the youth is at imminent risk for harm to self or others.

Suicide Watch Status - a formal treatment status for a youth determined by a mental health professional to be acutely suicidal.

F. Implementation

The Chief Administrative Office shall develop a written procedure implementing all provisions of this directive.

1. Crisis Intervention Team

a. A Crisis Intervention Team shall be designated by the Chief Administrative Officer which shall include:

(1) A mental health professional who shall be the Crisis Team Leader;

(2) At least one member of the security staff who is the rank of Juvenile Justice Supervisor or above.

(3) Other members who may be chosen from the administrative, chaplaincy, counseling, educational, leisure time services, medical or security staff.

b. One or more team members shall be available on site on a 24-hour basis.

c. All staff selected for the Crisis Intervention Team shall be properly trained.

(1) Mental health professionals shall not be required to receive special training unless specifically required by the Chief Administrative Officer.

(2) All other team members shall receive sixteen hours of specialized training prior to serving on the Crisis Intervention Team, unless otherwise approved, in writing, by the agency Chief of Mental Health Services.

(a) The initial 16 hours of training shall be provided through the Training Academy and shall include assessment and intervention techniques in crisis situations.

(b) A team member may provisionally serve on the team after completing four hours of orientation training as determined by the Crisis Team Leader. The team member shall receive the required training provided by the Training Academy at the next available training session.

(3) All team members shall receive an additional one hour of training quarterly by the facility Crisis Team Leader. The training shall consist of topics selected by the Team Leader which are pertinent to crisis intervention.

2. Referrals to Crisis Intervention

a. A procedure shall be established for referral to the Crisis Intervention Team of youth who exhibit disturbed behavior.

(1) All staff are responsible for promptly reporting to the Crisis Intervention Team or a mental health professional any evidence that a youth is:

(a) Threatening suicide, attempting suicide, or exhibiting other symptoms which indicate that the youth may be at risk for, or intent upon, self-harm or suicide;

(b) Threatening or attempting homicidal behavior, or exhibiting other symptoms which indicate the youth may be at risk for, or intent upon, killing another;

(c) Mentally or emotionally disturbed and potentially dangerous to others, or unable to care for himself due to confusion, disorientation, etc.; or

(d) Exhibiting acute depressive or psychotic symptoms.

b. Upon notification of the referral, the Crisis Team Member shall determine and implement the steps necessary, if any, to resolve the crisis or prevent it from escalating. This may include referral to other staff or services.

(1) The Crisis Team Member shall promptly review the case with the Crisis Team Leader or other designated mental health professional to determine if appropriate services and referrals have been provided. After normal duty hours and on weekends and holidays this review may be by telephone.

(2) The Crisis Team Leader or Member shall monitor and facilitate service delivery including, when appropriate, referral for mental health or medical examination, initiation of crisis treatment plan and recording of visual or verbal checks, and any special recommendations by mental health professionals.

(3) The Crisis Team Leader of Member shall notify the Shift Supervisor of any recommendations involving responsibility of security staff toward the youth.

(4) The crisis response shall be terminated as determined by the Crisis Team Leader or other involved mental health professional.

3. Crisis Care Services

Upon the recommendation of a Crisis Team Member or a mental health professional, the Chief Administrative Officer may order that a youth be housed in a crisis care area. Youth who are assigned to a crisis care area shall be placed on observation status, close supervision status, or suicide watch status in accordance with this directive. In extreme emergencies, a youth may be placed in therapeutic restraints in accordance with Administrative Directive 04.04.103.

a. Crisis Care Area.

(1) The Chief Administrative Officer shall designate an area or areas for housing a youth who is determined by a mental health professional or Crisis Team Member to require removal from the regular housing assignment for mental health treatment or observation. Removal from the general population must comply with the provisions in Administrative Directive 04.04.100.

(2) Crisis care rooms or housing areas shall be equipped to provide for:

(a) Single celling or housing

(b) Control of outside stimuli, especially contact with other youth.

(c) Adequate lighting or lighting controlled from outside of the room or housing area.

(d) Opportunities for observation by staff from as many points in the area as possible.

(e) Opportunities for staff to conveniently hear activities within the room or area.

(f) Access to health services.

(g) Prompt access by staff into the area.

(3) Close supervision or suicide watch may be provided at a community health care facility pending evaluation or transfer to an appropriate Department facility.

(4) Clothing or other personal property removed from the youth's crisis care room or housing area shall be placed in a secure area.

b. Observation Status

(1) If it is determined by a mental health professional or Crisis Team Leader that a youth is at increased risk to experience a mental or emotional crisis, the individual may be placed on observation status. No youth meeting

criteria for close supervision or suicide watch may be placed on this status.

(2) The Chief Administrative Officer shall establish the procedures for this status through a local written procedure. At minimum these procedures shall include:

(a) The procedure for placing a youth on observation status.

(b) Notification of the Crisis Team Leader and Duty Administrative Officer.

(c) Checks by staff at least every 10 minutes and method of documentation.

(d) Daily evaluation by designated staff.

(e) A provision that observation status shall not exceed 72 hours, unless extended by a mental health professional following a formal evaluation.

(f) A provision that termination of this status shall be upon the written or verbal order of a mental health professional.

c. Close Supervision Placement

(1) A youth who is determined by a mental health professional to be acutely disturbed, potentially suicidal or who may pose a threat of serious physical harm to self or others in the near future may be placed on close supervision. When a mental health professional is not on site, this determination shall be made by the Crisis Team Member who shall promptly review the situation with the Crisis Team Leader.

(2) Monitoring of youth who are placed in close supervision shall be documented and shall include the following:

(a) Checks by staff at least every 10 minutes, which include verbal or visual contact with the youth. It is recommended that these checks include a notation on the youth's behavior or speech.

(b) Daily contacts made by a crisis Team Member or an individual from the mental health, medical or psychiatric staff. Additional contacts shall be made as frequently as determined necessary by a mental health professional or medical staff.

(c) A check of the youth's vital signs shall be taken by the health care staff within 24 hours of placement on Close Supervision.

NOTE: Contacts in (b) and (c) above shall include an assessment of a youth's response to treatment and current mental health status. This shall be documented in the medical record and may additionally be noted in the

crisis record.

(3) The youth shall remain in close supervision until transferred to a mental health treatment setting or until the crisis is resolved as determined by the Crisis Team Leader or any other involved mental health professional. If release from close supervision is authorized via the telephone, a follow-up evaluation by a mental health professional shall be conducted within 72 hours.

d. Suicide Watch Placement

(1) A youth who is determined by a mental health professional to be acutely suicidal or who poses a threat of serious physical harm to self or others may be placed on suicide watch. Strip celling may be authorized. A physician may make this determination if a mental health professional is not available. Determinations shall be made after the psychiatrist, physician, or mental health professional has personally observed and examined the youth. Clinical reasons for such placement shall be documented.

(2) In the absence of a psychiatrist, physician, or other mental health professional, suicide watch may be temporarily initiated in an emergency upon the recommendation of the Crisis Team Member and with the approval of the Chief Administrative Officer or Duty Administrative Officer. Strip celling may be authorized. If approval is given verbally, the Crisis Team Member shall ensure that Medical Staff document this approval in the medical record and may additionally note it in the crisis record.

(a) A medical or mental health professional order for suicide watch placement or strip celling must be obtained within two hours. This order must clearly specify the clinical reason for the order.

(b) Verbal orders must be confirmed in writing in the medical record within 72 hours by the ordering physician or mental health professional or, if unavailable, by another mental health professional. Verbal orders reviewed by another mental health professional must be confirmed in writing by the ordering physician or mental health professional on the next scheduled working day.

(3) A youth's personal property, particularly the clothing, shall be returned as soon as practical, consistent with the mental health professional's assessment of the inmate's mental health status. Orders for return of property or clothing may be given verbally by a mental health professional in consultation with on-site health care staff or a Crisis Team Member.

(4) Monitoring of youth who are placed in suicide watch shall be documented in writing and shall include the following:

(a) Checks by staff at least every 5 minutes which shall include verbal

or visual contact with the youth. It is recommended that these checks include a notation on the youth's behavior or speech.

(b) Daily assessments of a youth's mental health status conducted by a mental health professional. On weekends and holidays, the mental health professional may consult by telephone with on-site health care staff or a Crisis Team Member. Additional contacts shall be made as frequently as determined necessary by a mental health professional or medical staff.

(c) A check of the youth's vital signs shall be taken by health care staff within 24 hours of placement on Suicide Watch.

NOTE: Contacts in (b) and (c) above shall include an assessment of the youth's response to treatment and current mental health status. This shall be documented in the medical record and may additionally be noted in the crisis record.

(5) The youth shall remain on suicide watch until the youth is transferred to a mental health treatment setting, community health care facility, or until a mental health professional determines that the crisis has been resolved or that the youth can be placed in a less restrictive crisis care status.

(6) A youth shall be placed in close supervision status for at least 24 hours after the suicide watch status has been terminated unless the psychiatrist, physician, or other mental health professional documents that such observation is not clinically indicated.

e. Emergency Mental Health Services Records

(1) Upon placement in observation, close supervision, or suicide watch, a treatment plan for emergency services to be rendered to the youth shall be developed. Upon termination of the emergency, the plan, including a notation of the termination and planned follow-up, shall be placed in the youth's medical and master files.

(2) An individualized record or records shall be kept to document security checks, medical checks, treatment visits and other care provided to youth while they are on observation, close supervision, or suicide watch status. These records shall be reviewed regularly by the facility medical director to ensure compliance with this Administrative Directive. A copy of these records shall be placed in the youth's medical file.

NOTE: Logs and forms used to document staff observation times will not have pre-printed check times printed on them. Staff making observations on youth on crisis watches shall record the actual time observations are conducted.

4. **Admission to Psychiatric Hospitals**

a. If a youth who has been placed on crisis status has shown little or no improvement

within the timeframe reasonably expected based upon the individual youth's diagnosis and prescribed treatment or psychotropic medications, but in no event longer than 72 hours after placement on crisis status, he or she shall be assessed for admission to a community psychiatric hospital.

b. A youth diagnosed with an acute mental illness ~~who~~ has shown little or no progress~~.~~ in response to mental health treatment, psychiatric treatment, and psychopharmacological services shall be assessed for admission to a community psychiatric hospital if:

(1) He or she is reasonably expected to inflict serious physical harm upon self or others in the near future;

(2) Due to his or her severe mental illness, he or she is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm; or

(3) He or she has been found unfit to stand trial and requires placement in a psychiatric hospital in order to attain fitness to stand trial.

NOTE: The analysis of the youth's progress in response to treatment, for purposes of part F 4. ~~(~~a.~~)~~ above, shall be whether the youth has shown some level of improvement within the timeframe reasonably expected based upon the individual youth's diagnosis and prescribed treatment or psychotropic medications, but in no event longer than 72 hours. ~~If a youth with an acute mental illness has shown no response to treatment or prescribed medications after 72 hours, analysis of factors set forth in F (4)(a) (1) (3) above shall occur.~~

~~b~~c. If a mental health professional finds ~~believes~~ that a youth meets the criteria for community psychiatric hospitalization in paragraph 4.a. or 4.b., he or she shall immediately inform the Treatment Unit Administrator (TUA) or his or her designee who will immediately contact the Chief Administrative Officer and the Chief of Mental Health, who will notify the Deputy Director of Programs and ensure a licensed psychiatrist is available for consult. ~~.~~

~~c~~d. ~~If~~The TUA, in consultation with ~~after consulting with the TUA,~~ the Chief of Mental Health and a licensed psychiatrist, shall assess youth identified under paragraph 4.c. and decide whether to ~~determines hospitalization~~seek hospitalization. ~~is the best course of action,~~

e. If the TUA determines that hospitalization should be sought:

(1) For those youth who are not eligible for Screening, Assessment, and Support Services (SASS), the TUA shall initiate hospitalization.

(2) For those youth who are eligible for Screening, Assessment, and Support Services (SASS):

(i) ~~t~~The TUA or his or her designee shall~~:~~ (~~1~~a)Notify the youth's parent or guardian (if the youth is under the age of 18), ask if the

youth is covered by private insurance, and tell the parent or guardian what hospital the youth will be transported to, if known; and (b) . (2) Contact Crisis and Referral Entry Services (CARES), request an evaluation from ~~Screening, Assessment, and Support Services (~~SASS~~)~~, ~~get~~obtain the name of the assessor who will be coming to the youth center to make the assessment, and prepare a visitor pass for the assessor.

(ii) ~~NOTE:~~ A SASS assessor will in most cases meet the youth and the TUA at the youth center within 2 hours. In the event of a medical emergency, the TUA will inform CARES that the evaluation shall take place at the hospital. ~~The youth will then be transported by ambulance to the hospital along with a Juvenile Justice Specialist and a mental health professional, in accordance with Administrative Directive 05.03.124.~~

~~d. If the SASS assessor determines that hospitalization is not required, the youth shall remain in crisis status.~~

(iii)~~e.~~ If the assessor recommends hospitalization the assessor will designate which hospital the youth should be transported to. ~~The TUA or his or her designee shall notify the following of the assessors' determination:~~

~~The Chief Administrative Officer;~~

~~The Records Office;~~

~~The Chief of Mental Health, who will notify the Deputy Director of Programs; and~~

~~The youth's parent or guardian (if the youth is under the age of 18), and~~

(iv) If the SASS assessor does not recommend hospitalization, the youth should still be hospitalized if, in consultation with the Chief of Mental Health and a licensed psychiatrist, the TUA believes hospitalization should still be sought.

e. If a decision has been made to hospitalize the youth, the TUA or his or her designee shall immediately notify the following individuals:

(1) The Chief Administrative Officer;

(2) The Records Office;

(3) The Chief of Mental Health, who will notify the Deputy Director of Programs; and

(4) The youth's parent or guardian (if the youth is under the age of 18)

hf. If the assessor or TUA a decision is made decides to hospitalize the youth:

(1) TheThe youth shall be transported to the hospital in accordance with Administrative Directive 05.03.124. Additionally, a A mental health professional shall be transported with the youth, along with 3 days of clothing, a crisis log, documentation from Health Care and Records Office, and a black box, if needed.

i.(2) For youth who are age 18 and over, the hospital may determine that he or she will require transfer to a Department of Human Services (DHS) facility. If a youth is transferred to a DHS facility, the TUA shall inform the Chief of Mental Health.

j. (3) Prior to return from the psychiatric hospital, the Treatment Unit Administrator shall ensure that the hospital has provided a discharge plan which should include discharge diagnosis, level of stability, and current medications. If a discharge plan has not been provided, staff shall document the efforts they made to obtain one and the reason it was not provided.

k.(4) Upon return from the psychiatric hospital, the youth shall be assessed by a Mental Health Professional to determine if, based on the youth's current mental status, continued crisis placement is needed.

(5)l. Within three days of a youth's return from a psychiatric hospital, the Health Care Unit Administrator shall submit a request for medical and mental health records to the hospital. These records shall be placed in the youth's medical file. If the records are received after the youth has been transferred to another youth center, the Health Care Unit Administrator shall forward the records to the Health Care Unit Administrator at the youths current assigned youth center.

g. If the assessor and TUA final decision is to de not to hospitalize the youth, a multidisciplinary treatment team which includes a licensed psychiatrist, shall meet within 24 hours to create a specific treatment plan likely to end the mental health crisis. Immediately after the plan is created, it shall be discussed with the youth and then implemented. The TUA shall ensure notice to the Chief Administrative Officer and the Chief of Mental Health, who shall ensure the Deputy Director of Programs is notified.

h. Anytime a decision regarding hospitalization is made, the TUA or designee who evaluated the youth for hospitalization shall document the evaluation and decision in writing. The documentation shall include the youth's treatment in the prior three days, the youth's response to that treatment, and the reasons why hospitalization was or was not needed.

i. Once per quarter, the Department Medical Director, Child and Adolescent Psychiatrist, Chief of Mental Health, Deputy Director of Programs, and Deputy Director of Quality Assurance shall conduct a quality assurance review of all assessments and decisions regarding psychiatric hospitalization made pursuant to

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the provisions of this Administrative Directive.

Authorized by:

Candice Jones
Director

Supersedes:

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