CHAPTER 63N-1
SERVICE DELIVERY

63N-1.001 Purpose and Scope.

The Rule establishes the requirements for delivery of mental health, substance abuse and Developmental Disability services in Department of Juvenile Justice (DJJ) facilities and programs. The rule applies to Juvenile Assessment Centers, Detention Centers, residential commitment programs and day treatment programs operated by, or under contract with, the Department of Juvenile Justice.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.002 Definitions.

(1) “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.

(2) “Acute Emotional or Psychological Distress” means 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 and associated behavioral response. Examples include extreme anxiety, fear, panic, paranoia, impulsivity, agitation or rage.

(3) “Assessment of Suicide Risk” – An evaluation 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. The form MHSA 004 documents Assessment of Suicide Risk conducted in a DJJ facility or program.

(4) “At Risk” – Within this Rule, means factors or behaviors which indicate suicidal tendencies, Suicide Risk Factors or Suicide Risk Behaviors.

(5) “Authority for Evaluation and Treatment” – Form HS 002, that when signed by a parent or legal guardian, gives the Department the authority to assume responsibility for the provision of routine mental and physical healthcare to a youth within its physical custody.

(6) “Baker Act” – Within this Rule, the term Baker Act refers to Section 394.451, F.S., covering involuntary mental health examination and placement for persons with mental illness.

(7) “Behavior Analysis Services” – Within this Rule, means the use of scientific methods derived from behavioral science specifically to increase skill acquisition, reduce problematic behavior and improve socially significant behaviors.

(8) “Board Certified Behavior Analyst” – A person who has obtained certification by the Behavior Analyst Certification Board Inc.

(9) “Certified Addiction Professional” – A person who is certified through a Department of Children and Families recognized certification process for substance abuse treatment services pursuant to Chapter 397, F.S. and Chapter 65D-30, F.A.C.

(10) “Certified Behavior Analyst” – A person who is certified as a behavior analyst by the Agency for Persons with Disabilities pursuant to Chapter 393, F.S. and Chapter 65G-4, F.A.C.

(11) “Clinical Coordinator” – A Licensed Mental Health Professional or a non-licensed Mental Health Clinical Staff Person who has received training specifically in mental health and substance abuse services coordination, and who is responsible for coordinating and verifying implementation of Necessary and Appropriate Mental Health and Substance Abuse Treatment Services in the facility or program where they have been named coordinator.

(12) “Clinical Mental Health and Substance Abuse Screening” – The preliminary appraisal of a youth conducted by a Licensed Mental Health Professional or a Licensed Qualified Professional utilizing validated and reliable mental health screening instruments 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 in-depth mental health or substance abuse evaluation.

(13) “Close Supervision” – The observation by a staff member assigned to monitor a youth at intervals not to exceed five minutes throughout the youth’s stay in his/her room and/or sleeping area. 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.

(14) “Comprehensive Assessment” – The assessment defined in Rule 63D-8.001, F.A.C.

(15) “Comprehensive Mental Health Evaluation” – An in-depth assessment 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.

(16) “Comprehensive Substance Abuse Evaluation” – An in-depth assessment conducted by a Licensed Qualified Professional or a Substance Abuse Clinical Staff Person to determine the presence of, or nature and complexity of, a substance related disorder.

(17) “Constant Supervision” – The continuous and uninterrupted observation of a youth by a staff member assigned to monitor the youth who has a clear and unobstructed view of the youth, and unobstructed sound monitoring of the youth at all times.

(18) “CORE” – The department’s computer-based training system.

(19) “Crisis” – Within this rule means a state of Acute Emotional or Psychological Distress associated with a distressing event, situation or turning point in a youth’s life.

(20) “Crisis Assessment” – A detailed evaluation of a youth presenting Acute Emotional or Psychological Distress which is extreme and does not respond to ordinary intervention 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 distressing symptoms, level of risk to self or others and recommendations for treatment and follow-up.

(21) “Detention Center” – A facility operated or contracted by the department for the temporary care of youth, pending adjudication, disposition, or placement.

(22) “Designated Mental Health Clinician Authority” – A Licensed Mental Health Professional who, through employment or contract, is responsible for ensuring appropriate coordination and implementation of mental health and substance abuse services in a departmental facility or program.

(23) “Developmental Disability” – A term defined in Section 393.063, F.S. Within this Rule, the term “Developmental Disability” is used interchangeably with the term “intellectual disability” which refers to significantly subaverage intellectual functioning (an IQ score below 70) on standardized intelligence tests existing concurrently with related limitations in adaptive functioning.

(24) “Developmental Disability Clinical Treatment Services” – Within this Rule, means psychological, behavioral analysis or psychotherapeutic services designed specifically for youths with Developmental Disability provided by a Licensed Mental Health Professional, Board Certified Behavior Analyst or Certified Behavior Analyst or a non-licensed Mental Health Clinical Staff Person working under the direct supervision of a Licensed Mental Health Professional. The term does not include school instruction or school services provided under Chapter 1003, F.S.

(25) “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 individually or in group format, 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.

(26) “Direct Supervision for Substance Abuse Clinical Staff” means that a Qualified Professional has at least one hourly session per week of on-site face-to-face interaction with a non-licensed or non-certified Substance Abuse Clinical Staff Person who is an employee of a Service Provider licensed under Chapter 397, F.S., or an employee in a facility licensed under Chapter 397, F.S., individually or in group format, for the purpose of overseeing and directing the substance abuse services that he or she is providing in the facility.

(27) “Drug” means any substance listed in Section 893.03, F.S.

(28) “The Diagnostic and Statistical Manual of Mental Disorders” – A manual published by the American Psychiatric Association which presents guidelines and diagnostic criteria for various Mental Disorders, including substance related disorders. The Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition is the latest edition of this manual.

(29) “Follow-Up Assessment of Suicide Risk” – An evaluation conducted after a youth has received an Assessment of Suicide Risk and is on Suicide Precautions to evaluate the youth’s current level of suicide risk and determine whether the youth is to be maintained on or removed from Suicide Precautions. The form MHSA 005 documents Follow-Up Assessment of Suicide Risk conducted in a DJJ facility or program.

(30) “Health Status Checklist” – The form HS 08 which documents the youth’s physical condition upon his/her placement in a Secure Observation Room due to suicide risk. The Health Status Checklist is also utilized in residential commitment programs to document the youth’s physical condition upon his/her placement in a controlled observation room.

(31) “Imminent Threat of Suicide” means to present a real and present threat of suicide.

(32) “Individual Healthcare Record” – The permanent departmental file containing the unified cumulative hard-copy collection of clinical records, histories, assessments, treatments and diagnostic tests which relate to a youth’s medical, mental health, substance abuse, Developmental Disability, behavioral health and dental health which have been obtained to facilitate care or document care provided while the youth is in a Detention Center, residential commitment program or day treatment program.

(33) “Individualized Developmental Treatment Plan” – A written guide which structures the focus of a youth’s Developmental Disability Clinical Treatment Services.

(34) “Individualized Mental Health Treatment Plan” – A written guide which contains goals and objectives of mental health treatment and structures the focus of a youth’s ongoing mental health treatment, including treatment with Psychotropic Medication.

(35) “Individualized Substance Abuse Treatment Plan” – A written guide which contains goals and objectives of substance abuse treatment and which structures the focus of a youth’s ongoing substance abuse treatment.

(36) “Initial Mental Health Treatment Plan” – A written preliminary guide which contains goals and objectives of mental health treatment and structures the focus of a youth’s initial mental health treatment.

(37) “Initial Psychiatric Diagnostic Interview” – Within this Rule refers to an assessment conducted by a Psychiatrist or psychiatric advanced registered nurse practitioner (ARNP) within 14 days of referral to determine the presence of any psychiatric conditions, formulate a diagnosis, and determine suitability for particular types of therapeutic interventions.

(38) “Initial Substance Abuse Treatment Plan” – A preliminary, written plan of goals and objectives intended to inform the youth of substance abuse service expectations and to prepare him/her for substance abuse service provision.

(39) “Integrated Mental Health and Substance Abuse Treatment Plan” or “Individualized Mental Health/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.

(40) “Juvenile Assessment Center” – Section 985.135, 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.

(41) “Juvenile Justice Information System” or JJIS – The department’s electronic system used to gather and store information on youth having contact with the department.

(42) “Juvenile Probation Officer” or JPO – A person meeting the definition in Section 985.03(30), F.S. and Rule 63D-8.001, F.A.C.

(43) “Licensed Clinical Social Worker”. A person licensed pursuant to Chapter 491, F.S., to practice clinical social work.

(44) “Licensed Marriage and Family Therapist”. A person licensed pursuant to Chapter 491, F.S., to practice marriage and family therapy.

(45) “Licensed Mental Health Counselor”. A person licensed pursuant to Chapter 491, F.S. to practice mental health counseling.

(46) “Licensed Mental Health Professional” – Within this Rule 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 Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, or Licensed Clinical Social Worker licensed pursuant to Chapter 491, F.S., or a Psychiatric Nurse as defined in Section 394.455(23), F.S.

(47) “Licensed Qualified Professional” – Within this Rule means a physician or physician assistant licensed under Chapter 458 or 459, F.S., a Psychologist licensed under Chapter 490, F.S., or a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist or Licensed Mental Health Counselor under Chapter 491, F.S., who is exempt from Chapter 397, F.S., licensure pursuant to Section 397.405, F.S.

(48) “Marchman Act” – Within this Rule refers to Section 397.675, F.S., covering involuntary substance abuse assessment and admissions for persons with substance abuse impairment.

(49) “Massachusetts Youth Screening Instrument, Second Version” or MAYSI-2 – A 52-item true-false screening instrument designed to identify signs of mental disturbance or emotional distress authorized by DJJ for use at intake into the juvenile justice system and upon admission to a day treatment or residential commitment program. The MAYSI-2 is published by Professional Resource Press.

(50) “Mental Disorder” means 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.

(51) “Mental Health Alert” – A designation in the Department’s Juvenile Justice Information System (JJIS) and in the facility used to identify youths in DJJ facilities/programs who have mental health conditions, symptoms or behaviors which may pose safety or security risks.

(52) “Mental Health Clinical Staff Person” – Within this Rule means a person responsible for providing mental health evaluation and treatment who, if not otherwise licensed as a Licensed 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.

(53) “Mental Health Crisis Intervention” means short-term therapeutic processes which focus on rapid resolution of Acute Emotional or Psychological Distress 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.

(54) “Mental Health Provider” – Within this Rule means a Psychiatrist licensed under Chapter 458 or 459, F.S., a Psychologist licensed under Chapter 490, F.S., or a Licensed Mental Health Counselor, Licensed Clinical Social Worker, or Licensed Marriage and Family Therapist licensed under Chapter 491, F.S., a Psychiatric Nurse as defined in this rule, a Community Mental Health Center or Clinic as defined in Section 394.455, F.S., or a public or private mental health agency eligible to provide mental health services under Chapter 394, F.S., who through employment, contract, subcontract or agreement provides mental health services in a DJJ facility or program.

(55) “Mental Health and Substance Abuse Screening” – The brief procedures used by trained direct care staff or clinical staff 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.

(56) “Mental Health/Substance Abuse Treatment Discharge Plan” – The form, 011, 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.

(57) “Mental Status Examination” – A structured assessment of a youth’s psychological and behavioral functioning. It provides a description of the youth’s appearance, attitude, motor activity, affect, mood, speech, thought content, perception, insight and judgment based upon the examiner’s observations of the youth and the youth’s answers to specific questions.

(58) “Mental Health Supportive Services” – Within this rule refers to therapeutic activities provided by Licensed Mental Health Professional or Mental Health Clinical Staff Person for a youth who is on Suicide Precautions or Mental Health Alert. Therapeutic activities include supportive counseling, crisis counseling, Mental Status Examination and must include on-going daily examination of the youth’s risk to self or others.

(59) “Necessary and Appropriate Mental Health and Substance Abuse Treatment and Services” – 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.

(60) “One-to-One Supervision” – The supervision of one youth by one staff member who remains within five feet of the youth at all times and must maintain constant visual and sound monitoring of the youth at all times.

(61) “Positive Achievement Change Tool” or PACT – The Department-approved criminogenic risk and needs screening and assessment tool incorporated in Rule 63D-9.001, F.A.C.

(62) “PACT Mental Health and Substance Abuse Screening Report and Referral Form” – The referral form defined in Rule 63D-8.001, F.A.C., and incorporated in Rule 63D-9.004, F.A.C.

(63) “Potential Suicide Risk” – Refers to a latent possibility or likelihood of manifesting deliberate self-destructive or self-injurious behavior with possible life-threatening consequences.

(64) “Precautionary Observation” – A Suicide Precaution method which provides for the Constant Supervision of a youth with Suicide Risk Factors in designated observation areas of the facility or program which are safe and secure.

(65) “Psychiatric Nurse”. 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.

(66) “Psychiatric Services” – Within this rule refers to provision of Initial Diagnostic Psychiatric Interviews, psychiatric evaluations, prescribing Psychotropic Medications and monitoring Psychotropic Medications rendered by a Psychiatrist or psychiatric advanced registered nurse practitioner (ARNP).

(67) “Psychiatrist”. 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.

(68) “Psychologist”. A licensed Psychologist is a person licensed pursuant to Section 490.005(1), F.S., and a licensed school Psychologist is a person licensed pursuant to Section 490.006, F.S.

(69) “Psychotropic Medication” – Medications capable of affecting the mind, emotions and behavior that are used to treat mental illness. The medications, include, but are not limited to the following major categories: antipsychotics, antidepressants, antianxiety drugs, mood stabilizers and stimulants.

(70) “Qualified Professional” means a person meeting the requirements in Section 397.311(26), F.S. and Rule 65D-30.002, F.A.C.

(71) “Related Human Services Field” is a college major which includes the study of human behavior and development, counseling and interviewing techniques, and individual, group or family therapy. Examples of a college major in a Related Human Services Field include rehabilitation counseling, family studies, developmental psychology, health psychology and special education.

(72) “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 and either One-to-One Supervision or Constant Supervision of the youth in the Secure Observation Room.

(73) “Secure Observation Room” – A room used when placing a youth in Secure Observation due to At Risk or Suicide Risk Behaviors.

(74) “Serious Self-Inflicted Injury” means 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.

(75) “Significant Change in Dosage of Medication” – Any increase or decrease in dosage beyond a small increment or beyond the normal dosage range for youths of similar age.

(76) “Specialized Treatment Services” – Refers to the following mental health, substance abuse, Developmental Disability, sex offender and or behavioral health services provided in DJJ residential commitment programs: Comprehensive Services for Major Disorders; Intensive Mental Health Services; Specialized Mental Health Services; Substance Abuse Treatment Services (SAT); Developmental Disability Services; Sex Offender Treatment Services; Mental Health Overlay Services (MHOS); and Substance Abuse Treatment Overlay Services (SAT Overlay Services).

(77) “Substance Abuse Clinical Staff Person” – Within this Rule means a person who is licensed under Chapter 397, F.S., or exempt from Chapter 397, F.S., licensure under Section 397.405, F.S. or is an employee of a Service Provider licensed under Chapter 397, F.S., or in facility licensed under Chapter 397, F.S., 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.

(78) “Substance Abuse Service Provider” or “Service Provider” – Within this Rule means a public agency, a private for-profit or not-for profit agency, a physician or physician assistant 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., licensed under Chapter 397, F.S., or exempt from licensure under Chapter 397, F.S., who through employment, contract, subcontract or agreement provides substance abuse services in a DJJ facility or program.

(79) “Substance-Related Disorder” – A DSM diagnostic category which includes substance use disorders and substance-induced disorders. Substance use disorders include abuse and dependence. Substance-induced disorders include intoxication, withdrawal, and various mental states such as anxiety, mood disorder or psychosis that a substance induces when it is used.

(80) “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.

(81) “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.

(82) “Suicide Rescue Tool” – A tool utilized in DJJ facilities responding to Suicide Attempts to cut the youth free from material used in the Suicide Attempt.

(83) “Suicide Response Kit” – A designated metal or hard coated box which contains a DJJ approved Suicide Rescue Tool, wire cutters, needle nose pliers, and first aid items such as a one-way CPR mask, microshield or face shield, non-latex gloves and first aid supplies for use in the event of a Suicide Attempt or incident of Serious Self-Inflicted Injury.

(84) “Suicide Risk Alert” – A designation made in JJIS and in the departmental facility to identify youths with Suicide Risk Factors who are placed on Suicide Precautions.

(85) “Suicide Risk Behaviors” – Refers to recent or current events, statements, or actions which suggest that the youth is a Potential Suicide Risk. Suicide Risk Behaviors include intentional self-injurious behavior; statements, notes or drawings which suggest thoughts, intent or plans to harm self; behaviors that suggest intent or plans to harm self, such as tying of clothing or sheet in a noose; statements suggesting hopelessness or preoccupation with death or dying; or extreme withdrawal or lack of interest in surroundings.

(86) “Suicide Risk Factors” – Refers to events, actions or conditions which suggest the youth is a possible suicide risk. Examples of Suicide Risk Factors include past history or recent: Suicide Attempt, Suicide Gesture, Suicide Ideation or Suicide Threat; intentional self-injurious behavior; statements, drawings or notes which suggest suicide, hopelessness or preoccupation with death or dying; extreme withdrawal or lack of interest in surroundings; serious psychiatric disturbance (particularly depression, mood swings, psychosis); substance dependence; or recent major loss such as death of parent, sibling or best friend.

(87) “Suicide Risk Screening Instrument” or SRSI – The form MHSA 002 which documents the standardized questions asked by trained designated staff at intake into the juvenile justice system and upon admission to a Detention Center to identify Suicide Risk Factors and need for referral for Assessment of Suicide Risk.

(88) “Suicidal Ideation” means thoughts, wishes or desire to deliberately take one’s own life.

(89) “Suicidal Intent” means an identified decision and/or plan to take one’s own life.

(90) “Suicide Precautions” – Use of Precautionary Observation or Secure Observation 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.

(91) “Suicide Threat” means a warning direct or indirect, verbal or non-verbal, that reasonably suggests that a youth plans to attempt suicide.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0031 Qualifications of Mental Health Professionals.

(1) Mental health services 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 Professionals. Each Licensed Mental Health Professional shall hold an active, valid license issued by the Florida Department of Health.

1. Psychiatrists. A Psychiatrist shall be a physician licensed pursuant to Chapter 458 or 459, F.S. who meets one of the following conditions:

a. Is board certified in Child and Adolescent Psychiatry or Psychiatry by the American Board of Psychiatry and Neurology; or

b. Is board eligible by virtue of having completed a training program in Psychiatry approved by the American Board of Psychiatry and Neurology for entrance into its certifying examination; or

c. Is board certified in Forensic Psychiatry by the American Board of Psychiatry and Neurology or the American Board of Forensic Psychiatry and has prior experience and training in psychiatric treatment with children or adolescents.

2. Licensed Psychologists shall be licensed pursuant to Section 490.005(1). F.S., and licensed school psychologists shall be licensed pursuant to Section 490.006, F.S.

3. Licensed Mental Health Counselors shall be licensed pursuant to Chapter 491, F.S.

4. Licensed Clinical Social Workers shall be licensed pursuant to Chapter 491, F.S.

5. Licensed Marriage and Family Therapists shall be licensed pursuant to Chapter 491, F.S.

6. Psychiatric Nurses shall be licensed registered nurses who have a master’s degree or a doctorate in psychiatric nursing and two years post-master’s clinical experience under the supervision of a physician; or shall be 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.

7. The Licensed Mental Health Professional’s license number, and a copy of an up-to-date clear and active license document must be on file in the facility or program.

(b) Non-Licensed Mental Health Clinical Staff.

1. A non-licensed Mental Health Clinical Staff Person providing mental health services in a DJJ facility or program must meet one of the qualifications in sub-subparagraphs a., through d., and meet the requirement in sub-subparagraph e., below:

a. Hold a master's degree from an accredited university or college in the field of counseling, social work, psychology, or Related Human Services Field;

b. 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 clinical experience assessing, counseling and treating youths with serious emotional disturbance or substance abuse problems;

c. 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 training in the areas described in this section prior to working with youths. The 52 hours of training must include a minimum of 16 hours of documented clinical training in their duties and responsibilities. The non-licensed person must also receive training in mental disorders and substance-related disorders, counseling theory and techniques, group dynamics and group therapy, treatment planning and discharge planning for one year by a Mental Health Clinical Staff Person who holds a Master's degree. Clinical training of the non-licensed person must cover, at a minimum, the following components: basic counseling skills, basic group therapy skills, treatment model and 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.

d. If the non-licensed Mental Health Clinical Staff Person provides mental health services in a DJJ facility or program designated for Medicaid behavioral health services, the requirements for counselors set forth by the Agency for Health Care Administration (AHCA) are provided in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook; and

e. A non-licensed person providing clinical, counseling or therapy services must meet the exemption criteria set forth in Sections 491.014(4) and 491.014 (8), F.S.

2. A Board Certified Behavior Analyst or Certified Behavior Analyst who is not a Licensed Mental Health Professional must meet the requirements in subparagraph 1., above in order to function as a non-licensed Mental Health Clinical Staff Person in a departmental facility or program.

3. A Board Certified Behavior Analyst or Certified Behavior Analyst who is not a Licensed Mental Health Professional must provide Behavior Analysis Services under the direct supervision of a Licensed Mental Health Professional in a departmental facility or program.

4. A copy of the non-licensed Mental Health Clinical Staff Person's college transcript must be on file in the facility or program.

(2) Mental health services must be provided by Licensed Mental Health Professionals and Mental Health Clinical Staff Persons who have met the background screening requirements set forth in Section 985.644, F.S.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0032 Qualifications of Substance Abuse Professionals and Service Providers.

(1) Substance abuse services must be provided by persons or entities meeting licensure requirements set forth in Chapter 397, or who are exempt from licensure under Section 397.405, F.S.

(2) Documentation of Licensure. Chapter 397, F.S., licensure or a Licensed Qualified Professional's licensure under Chapter 458, 459, 490 or 491, F.S., is required as provided below:

(a) Chapter 397, F.S. Licensure. A copy of the up-to-date Chapter 397, F.S., licensure document for the appropriate licensable service component must be on file and displayed in departmental facilities or programs.

(b) The Licensed Qualified Professional's license number, and a copy of an up-to-date clear and active license document must be on file in the facility or program.

(3) Non-licensed Substance Abuse Clinical Staff. A non-licensed Substance Abuse Clinical Staff Person may provide substance abuse services in a departmental facility or program only as an employee of a Service Provider licensed under Chapter 397, F.S. or in a facility licensed under Chapter 397, F.S.

(a) 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.

(b) A copy of the non-licensed Substance Abuse Clinical Staff Person's college transcript must be on file in the facility or program.

(4) Unless licensed under Chapter 397, F.S. or under Chapter 458, 459, 490 or 491, F.S., a Certified Addiction Professional may provide substance abuse services in a DJJ facility or program only as an employee of a Service Provider licensed under Chapter 397, F.S. or in a facility licensed under Chapter 397, F.S.

(5) Substance abuse services must be provided by Licensed Qualified Professionals and Substance Abuse Clinical Staff Persons who have met the background screening requirements set forth in Section 985.644, F.S.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0033 Clinical Supervision of Mental Health Clinical Staff.

(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 employed by, or under contract with, the departmental facility or program.

(2) Direct supervision shall be documented on the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA 019), or a form developed by the program which contains all the information required in form MHSA 019. The Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA 019, August 2006) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03773 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(3) The Licensed Mental Health Professional providing direct supervision is responsible for reviewing and signing Comprehensive Assessments, Comprehensive Mental Health Evaluations, Updated Comprehensive Mental Health Evaluations, Initial Mental Health Treatment Plans and Individualized Mental Health Treatment Plans prepared by the non-licensed Mental Health Clinical Staff Person within ten calendar days of administration of the instrument.

(4) The Licensed Mental Health Professional providing direct supervision is responsible for reviewing each Assessment of Suicide Risk and Follow-Up Assessment of Suicide Risk, Crisis Assessment and Follow-Up Crisis Assessment conducted by the non-licensed Mental Health Clinical Staff Person within 24 hours of the referral for assessment. The Assessment of Suicide Risk, Follow-Up Assessment of Suicide Risk, Crisis Assessment or Follow-Up Crisis Assessment conducted by the non-licensed Mental Health Clinical Staff must be signed by the Licensed Mental Health Professional the next scheduled time he/she is on-site.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0034 Clinical Supervision of Substance Abuse Clinical Staff.

(1) A non-licensed Substance Abuse Clinical Staff Person who is an employee in a facility licensed under Chapter 397, F.S., or an employee of a Service Provider licensed under Chapter 397, F.S., must work under the direct supervision of a Qualified Professional.

(2) Direct supervision shall be documented on the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA 019) or a form developed by the program which contains all the information required in form MHSA 019.

(3) The Qualified Professional providing direct supervision is responsible for reviewing and signing Comprehensive Assessments, Comprehensive Substance Abuse Evaluations, Updated Comprehensive Substance Abuse Evaluations, Initial Substance Abuse Treatment Plans and Individualized Substance Abuse Treatment Plans prepared by the non-licensed Substance Abuse Clinical Staff Person within ten calendar days.

(4) The requirements for documentation of clinical supervision of non-licensed Substance Abuse Clinical Staff employed in a facility licensed under Chapter 397, F.S., or employed by a service provider licensed under Chapter 397, F.S. are provided in Chapter 65D-30, F.A.C.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0035 Retaining a Designated Mental Health Clinician Authority or Clinical Coordinator.

(1) Designated Mental Health Clinician Authority.

(a) Each facility with an operating capacity of 100 or more youths, each facility providing DJJ Specialized Treatment Services and every Detention Center shall employ or contract with a single Licensed Mental Health Professional to act as the Designated Mental Health Clinician Authority for the facility or program, or if the facility or program contracts with an agency or corporate entity, rather than a single Licensed Mental Health Professional, then a single Licensed Mental Health Professional within the agency or corporate entity shall be identified as the Designated Mental Health Clinician Authority for the DJJ facility or program.

(b) The Designated Mental Health Clinician Authority must be on-site in the DJJ facility/program at least once a week for a sufficient time period to ensure that appropriate coordination and implementation of mental health and substance abuse services is taking place.

(2) Clinical Coordinator.

(a) Each facility that does not meet any of the criteria in paragraph (1)(a) above shall identify either a Designated Mental Health Clinician Authority or a Clinical Coordinator to be responsible for coordinating and verifying implementation of Necessary and Appropriate Mental Health and Substance Abuse Treatment services in the facility/program.

(b) Identification 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 provide clinical supervision of clinical staff.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0036 Referrals for Mental Health Services and Substance Abuse Services.

(1) Referrals to Mental Health Clinical Staff or Substance Abuse Clinical Staff in the facility or off-site mental health or substance abuse providers shall be documented on the Mental Health/Substance Abuse Referral Summary (MHSA 014) or a form developed by the program which contains all of the information required in form MHSA 014. The Mental Health/Substance Abuse Referral Summary (MHSA 014, August 2006) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03774 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(2) Residential commitment programs designated for Specialized Treatment Services where youths are routinely referred for a specific mental health or substance abuse service such as comprehensive mental health/substance abuse evaluation or updated evaluation as part of established procedure are exempt from the paragraph above. Such programs may utilize an existing referral process such as tracking logs for documentation of routine referrals. However, referrals for non-routine mental health and substance abuse services such as Assessment of Suicide Risk, Follow-Up Assessment of Suicide Risk or Crisis Assessment must be recorded on the Mental Health/Substance Abuse Referral Summary (MHSA 014) or a form developed by the program containing all the information required in form MHSA 014.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.004 Mental Health, Substance Abuse and Developmental Disability Services Records Management.

(1) Each Detention Center, residential commitment program and day treatment program shall develop a health care record system in accordance with Rules 63M-2.061 – 63M-2.063, F.A.C., and this rule.

(2) Entries in mental health, substance abuse or Developmental Disability services clinical records shall be legible, accurate, dated and authenticated by the writer's signature. In those instances where clinical records are generated and maintained electronically, a staff identifier will be acceptable in lieu of the writer's signature.

(3) Mental health, substance abuse or Developmental Disability services clinical records shall be kept secure from unauthorized access.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0041 Individual Healthcare Record.

(1) Mental health, substance abuse and Developmental Disability Clinical Treatment Services records collected during the youth's involvement in the juvenile justice system shall be permanently filed in the youth's Individual Healthcare Record in the Interdisciplinary Health Records Section.

(2) All mental health and substance abuse records and Developmental Disability Clinical Treatment Services records contained in the youth's Individual Healthcare Record are considered confidential.

(a) DJJ staff shall have access to a youth's Individual Healthcare Records only when such access is needed in the performance of their official responsibilities.

(b) Only individuals who, by virtue of job description and duties, require information on a youth's mental health or substance abuse or developmental disability status for the purpose of providing health care to that youth, protecting the safety of that youth, or performing auditing functions may have access to a youth's mental health, substance abuse or developmental disability clinical records and/or information. Access shall only be to that portion of the Individual Healthcare Record which is required for the above purposes.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0042 Active Mental Health/Substance Abuse Treatment File.

(1) Mental health and substance abuse records may be temporarily maintained in an Active Mental Health/Substance Abuse Treatment File during a youth's on-going mental health or substance abuse treatment.

(2) When utilized, a youth's Active Mental Health/Substance Abuse Treatment File must be maintained in a designated secure filing area. The filing area 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.

(3) The Active Mental Health/Substance Abuse Treatment File must be maintained until the Mental Health Clinical Staff Person 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. An exception is provided for facilities which provide Specialized Treatment Services or on-going mental health or substance abuse treatment services. Such facilities may maintain an Active Mental Health/Substance Abuse Treatment File throughout the youth's placement in the facility/program. The Active Mental Health/Substance Abuse Treatment File must be placed in the youth's Individual Healthcare Record prior to the youth's transition from the program.

(4) 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. Documentation of administration and management of medication and medical services provided by a physician, physician assistant or nurse must be filed in the youth's Individual Healthcare Record. It is acceptable to retain a copy of documentation of Psychiatric Services such as a psychiatric evaluation to be placed in the Active Mental Health and Substance Abuse Treatment File. However, the original psychiatric evaluation must be maintained in the youth's Individual Healthcare Record.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0051 Mental Health and Substance Abuse Screening.

(1) Screening in Juvenile Assessment Centers (JAC) or Juvenile Probation Officer (JPO) Unit.

(a) Mental Health and Substance Abuse Screening conducted upon a youth's initial intake at a JAC or JPO Unit shall include the following:

1. Administration of the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2).

2. Administration of the Suicide Risk Screening Instrument (SRSI) Form (MHSA 002, October 2014) which is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-05366 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

3. Completion of the PACT and PACT Mental Health and Substance Abuse Screening Report and Referral Form as set forth in Rule 63D-9.004, F.A.C.

(b) When the MAYSI-2 or PACT Mental Health and Substance Abuse Screening Report and Referral Form or other information at initial intake indicates the need for further mental health or substance abuse assessment, the JPO or JAC intake screener shall refer the youth for Comprehensive Assessment in accordance with the provisions of Rule 63D-9.004, F.A.C.

(2) Screening in Detention Centers.

(a) Mental Health and Substance Abuse Screening conducted upon a youth's admission to a Detention Center shall include the following:

1. Review of the youth's MAYSI-2, PACT Mental Health and Substance Abuse Screening Report and Referral Form and the SRSI sections administered by the JPO or JAC intake screener prior to the youth's admission to the Detention Center; and

2. Administration of the Suicide Risk Screening Instrument (SRSI) Form (MHSA 002).

(b) The Detention Center's intake staff must note any existing documentation of mental health or substance abuse problems, needs or risk factors and report the documentation to Mental Health Clinical Staff.

(c) Detained youths who were not referred for Comprehensive Assessment at the time of intake screening in the JAC or JPO Unit and are identified as in need of further mental health or substance abuse assessment subsequent to admission to the Detention Center must be referred for Comprehensive Mental Health Evaluation by the Detention Center's Mental Health Provider or Substance Abuse Service Provider.

(3) Screening in Residential Commitment Programs.

(a) Mental Health and Substance Abuse Screening must be conducted upon a youth's admission to a residential commitment program and when a youth that had been on inactive status re-enters a residential commitment program. "Inactive Status" means a youth has been 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.

(b) Mental Health and Substance Abuse Screening shall include a review of each youth's commitment packet information, reports and records and administration of either the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2) or Clinical Mental Health and Substance Abuse Screening.

1. Residential program intake staff administering Mental Health and Substance Abuse Screening must review each youth's commitment packet information, reports and records for existing documentation of mental health or substance abuse problems, needs or risk factors.

2. The residential program intake staff must note any existing documentation of mental health or substance abuse problems, needs or risk factors and report the documentation to appropriate Mental Health Clinical Staff.

(c) 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. If the MAYSI-2 is to be administered at intake/admission to a residential commitment program, the procedures specified in Rule 63N-1.0053, F.A.C., must be followed:

2. If Clinical Mental Health and Clinical Substance Abuse Screening are to be administered at intake/admission to a residential commitment program as an alternative to the MAYSI-2, the procedures specified in paragraphs (d) and (e) below must be followed.

(d) Clinical Mental Health Screening – General Requirements:

1. Documentation of Clinical Mental Health Screening must be provided by the Licensed Mental Health Professional and clearly identified as "Clinical Mental Health/Substance Abuse Screening."

2. Clinical Mental Health Screening documentation must provide details of the information obtained by the screening such as youth statements, behavioral observations, collateral information. The specific information supporting the Clinical Mental Health Screening findings and recommendations must be documented on the screening instrument.

3. The Clinical Mental Health Screening document must be signed and dated by the Licensed Mental Health Professional conducting the screening.

(e) Clinical Substance Abuse Screening – General Requirements.

1. Documentation of Clinical Substance Abuse Screening must be provided by the Licensed Qualified Professional and clearly identified as "Clinical Substance Abuse Screening".

2. Clinical Substance Abuse Screening documentation must provide details of the information obtained by the screening such as youth statements, behavioral observations, collateral information. The specific information supporting the Clinical Substance Abuse Screening findings and recommendations must be documented on the screening instrument.

3. The Clinical Substance Abuse Screening document must be signed and dated by the Licensed Qualified Professional conducting the screening.

(f) When the MAYSI-2 or Clinical Mental Health and Substance Abuse Screening indicates the need for further in-depth mental health or substance abuse evaluation, the youth shall be referred for a Comprehensive Mental Health Evaluation or Comprehensive Substance Abuse Evaluation.

(4) Admission Screening in Day Treatment Programs.

Mental Health and Substance Abuse Screening conducted upon a youth's admission to a day treatment program shall include a review of each youth's referral information and administration of the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2).

(a) Day treatment program staff administering the MAYSI-2 must review each youth's referral packet information, reports and records for existing documentation of mental health or substance abuse problems, needs or risk factors.

(b) The day treatment program staff shall note any existing documentation of mental health or substance abuse problems, needs or risk factors and report the documentation to the program's Mental Health Provider or Substance Abuse Provider and appropriate administrative staff.

(c) When the MAYSI-2 or other intake/admission information indicates the need for referral for Comprehensive Mental Health Evaluation or Comprehensive Substance Abuse Evaluation, the program director or designee must be notified and referral made to the program's Mental Health Provider or Substance Abuse Provider as set forth in Rule 63N-1.0036, F.A.C.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14, Amended 7-9-15.

63N-1.0052 Intake/Admission Suicide Risk Screening.

(1) All youths shall be screened for Suicide Risk Factors during the initial intake process in a Juvenile Assessment Center (JAC) or Juvenile Probation Officer (JPO) Unit and upon admission to a Detention Center, residential commitment program or day treatment program in accordance with Rules 63N-1.0092 and 63N-1.00921, F.A.C.

(2) When suicide risk screening, collateral information or staff observations indicate the need for an Assessment of Suicide Risk, an Assessment of Suicide Risk shall be conducted in accordance with Rule 63N-1.0093, F.A.C.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0053 Massachusetts Youth Screening Instrument, Second Version (MAYSI-2) Procedures.

(1) The MAYSI-2 shall be administered to the youth upon initial intake at a JAC or JPO Unit and on the day of the youth's admission to a day treatment program or residential commitment program.

(2) The MAYSI-2 shall be administered only by staff who have successfully completed the Department's CORE training module on the MAYSI-2.

(3) The MAYSI-2 shall be administered and scored using JJIS.

(4) When the MAYSI-2 or other intake or admission information indicates the need for referral for in-depth mental health or substance abuse evaluation, Assessment of Suicide Risk, crisis intervention or emergency services, the facility superintendent, program director or designee must be notified and referral made as set forth in Rule 63N-1.0036, F.A.C.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0054 Comprehensive Assessments.

(1) If a detained youth who was referred for Comprehensive Assessment by the JAC or JPO has not received an assessment by the community-based Service Provider within 30 days of screening, the Detention Center's Mental Health Provider shall administer a Comprehensive Mental Health Evaluation to the youth by the youth's 31st day in the Detention Center.

(2) When Comprehensive Assessment indicates the youth is in need of treatment, the youth shall receive an Initial or Individualized Mental Health/Substance Abuse Treatment Plan and appropriate treatment services.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0055 Comprehensive Mental Health Evaluations.

(1) Comprehensive Mental Health Evaluations shall be administered by a Licensed Mental Health Professional or a Mental Health Clinical Staff Person working under the direct supervision of a Licensed Mental Health Professional.

(2) Comprehensive Mental Health Evaluations shall reflect consideration of the following:

(a) Identifying Information;

(b) Reason for Evaluation;

(c) Relevant Background Information, including home environment and family functioning; history of physical abuse, sexual abuse, neglect, witnessing violence and other forms of trauma; behavioral functioning; physical health mental health and substance abuse history and educational functioning.

(d) Behavioral Observations;

(e) Mental Status Examination;

(f) Interview or Procedures Administered;

(g) Discussion of Findings;

(h) Diagnostic Impression/Formulation including DSM diagnoses; and

(i) Recommendations.

(3) Comprehensive Mental Health Evaluations shall 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 as determined by a Licensed Mental Health Professional. When the Comprehensive Mental Health Evaluation indicates the youth is in need of treatment, the youth shall receive an Initial or Individualized Mental Health Treatment Plan and appropriate treatment services.

(4) Updated Comprehensive Mental Health Evaluation.

(a) When the youth's file contains a Comprehensive Mental Health Evaluation completed within twelve months of the youth's admission, the previous corresponding Comprehensive Mental Health Evaluation may be utilized to conduct an updated Comprehensive Mental Health Evaluation.

(b) The updated Comprehensive Mental Health Evaluation must be administered by a Licensed Mental Health Professional or a Mental Health Clinical Staff Person working under the direct supervision of a Licensed Mental Health Professional in accordance with the provisions below:

1. The updated Comprehensive Mental Health Evaluation must be clearly identified as such and must be attached to the previous comprehensive evaluation which is being updated.

2. The updated Comprehensive Mental Health Evaluation must provide any new or additional information applicable to each area specified in subsection (2) above, based upon current information provided by the youth, his or her family/legal guardians and the youth's records.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0056 Comprehensive Substance Abuse Evaluations.

(1) Comprehensive Substance Abuse Evaluation General Requirements.

(a) Chapter 65D-30, F.A.C., establishes requirements for substance abuse assessments provided in facilities licensed under Chapter 397, F.S. and by Service Providers licensed under Chapter 397, F.S.

(b) In DJJ facilities and programs wherein substance abuse services are provided by a Licensed Qualified Professional, the Comprehensive Substance Abuse Evaluation must reflect consideration of the following:

1. Reason for Assessment;

2. Pertinent Background Information, including home environment and family functioning; history of physical abuse, sexual abuse, neglect, witnessing violence and other forms of trauma; behavioral functioning; physical health, mental health and substance abuse history 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 including DSM diagnoses;

9. Recommendations.

(c) 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 as determined by a Qualified Professional.

(d) When the Comprehensive Substance Abuse Evaluation indicates the youth is in need of treatment, the youth shall receive an Initial or Individualized Substance Abuse Treatment Plan and appropriate treatment services.

(2) Updated Comprehensive Substance Abuse Evaluations.

(a) Chapter 65D-30, F.A.C., establishes the requirements for updated substance abuse assessments and evaluations provided in facilities licensed under Chapter 397, F.S. or by service providers licensed under Chapter 397, F.S.

(b) In DJJ facilities and programs where substance abuse services are provided by a Licensed Qualified Professional, an updated Comprehensive Substance Abuse Evaluation shall be conducted in accordance with the following:

1. An updated Comprehensive Substance Abuse Evaluation may only be conducted when the youth's file contains a Comprehensive Substance Abuse Evaluation completed within twelve months of the youth's admission.

2. The updated Comprehensive Substance Abuse Evaluation must be clearly identified as such and must be attached to the previous Comprehensive Substance Abuse Evaluation which is being updated.

3. The updated Comprehensive Substance Abuse Evaluation must provide any new or additional information applicable to each area specified in subsection (1) above, based upon current information provided by the youth, his or her family/legal guardians and the youth's records.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.006 Suicide Risk Alerts and Mental Health Alerts.

(1) Suicide Risk Alerts.

(a) A "Suicide Risk Alert" designation shall be made by direct care or clinical staff when a youth is identified during screening or by staff observations as having Suicide Risk Factors.

(b) 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. If a youth exhibits behaviors which require both a "Suicide Risk Alert" and "Mental Health Alert," the procedures for a "Suicide Risk Alert" must be followed.

(c) Youths on Suicide Precautions shall be coded as a "Suicide Risk Alert" until Suicide Precautions are removed.

(d) An exception is provided for residential commitment programs designated for Specialized Treatment Services where a Mental Health Clinical Staff Person conducts mental health screening at admission, and if a youth is identified with Suicide Risk Factors, immediately administers an Assessment of Suicide Risk. Based upon Assessment of Suicide Risk findings, the Mental Health Clinical Staff Person will determine whether a "Suicide Risk Alert" will be placed in JJIS.

(2) Mental Health Alerts.

(a) A "Mental Health Alert" designation shall be made by direct care or clinical staff when a youth is identified as having mental health conditions and factors which may pose a safety or security risk.

(b) Mental Health Alert indicators include the following:

1. Recent history of self-injurious behavior such as self-mutilation, carving or cutting self, ingestion of objects, or head banging which required emergency medical services within the previous 3 months;

2. Recent history of psychosis and symptoms such as auditory or visual hallucinations or delusions which required hospitalization within the previous 3 months;

3. Recent history of examination or placement under the Baker Act within the previous 3 months;

4. Recent history of Drug or alcohol detoxification, overdose or withdrawal symptoms within the previous 3 months;

5. Recent history of evaluation, or admission under the Marchman Act within the previous 3 months;

6. Severe Developmental Disability.

(c) An exception is provided for residential commitment programs designated for Specialized Treatment Services where a Mental Health Clinical Staff Person administers mental health screening at admission, and if a youth is identified with mental health conditions or factors which may pose a safety or security risk, immediately administers a Crisis Assessment at admission. In such instances, the Mental Health Clinical Staff Person will determine whether a "Mental Health Alert" will be placed in JJIS, based upon the Crisis Assessment findings.

(d) Youths coded as a "Mental Health Alert" must be maintained on one of the following levels of supervision:

1. One-to-One Supervision.

2. Constant Supervision.

3. Close Supervision.

(e) Documentation of One-to-One supervision or Constant Supervision of youths on Mental Health Alert must be recorded on the Mental Health Alert – Observation Log (MHSA 007), or a form developed by the program which contains all the information required in form MHSA 007. The Mental Health Alert – Observation Log (MHSA 007, August 2006) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03776 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(f) Documentation of close supervision is recorded on the Close Supervision-Visual Checks Log (MHSA 020) or a form developed by the program which contains all the information required in form MHSA 020. The Close Supervision-Visual Checks Log (MHSA 020, August 2006) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03777 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(3) A current listing of youths on Suicide Risk Alert or Mental Health Alert in JJIS must be maintained and provided to direct care and clinical staff on a daily basis.

(4) Direct care or clinical staff may place a youth on Suicide Risk Alert or Mental Health Alert in JJIS.

(5) A Licensed Mental Health Professional or non-licensed Mental Health Clinical Staff Person must downgrade or discontinue a youth's alert status.

(a) If the downgrade of discontinuation of alert status is made by a non-licensed Mental Health Clinical Staff Person, the concurrence of a Licensed Mental Health Professional must be documented by the Mental Health Clinical Staff Person in a progress note and JJIS.

(b) A copy of the documented concurrence of the Licensed Mental Health Professional must be permanently filed in the youth's individual healthcare record.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.007 Mental Health and Substance Abuse Treatment Planning.

(1) Each Detention Center, residential commitment program and day treatment program shall develop a treatment planning process for youths in need of mental health and/or substance abuse treatment.

(2) Each youth's Individualized Mental Health Treatment Plan shall be based on an in-depth Comprehensive Assessment, Comprehensive Mental Health Evaluation or updated Comprehensive Mental Health Evaluation.

(3) Each youth's Individualized Substance Abuse Treatment Plan shall be based on an in-depth Comprehensive Assessment, Comprehensive Substance Abuse Evaluation or updated Comprehensive Substance Abuse Evaluation.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0071 Mental Health and Substance Abuse Treatment Planning in Detention Centers.

(1) Each youth who is determined by a Mental Health Clinical Staff Person or Substance Abuse Clinical Staff Person 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 is responsible for developing, reviewing and updating Initial and Individualized Mental Health Treatment Plans or Initial and Individualized Substance Abuse Treatment Plans for youths receiving mental health or substance abuse treatment while in the Detention Center.

(a) The mini-treatment team must be composed of at least a Mental Health Clinical Staff Person or Substance Abuse Clinical Staff Person and one other staff person from a different service area such as administrative, supervisory or medical staff.

(b) The mini-treatment team meetings must include the youth. The youth's parent or legal guardian must also be included in the mini-treatment team meeting when possible.

(2) An Initial Mental Health Treatment Plan must be developed by the mini-treatment team and youth within 7 days of initiation of mental health treatment, or for youths receiving Psychotropic Medication within 7 days of the Initial Psychiatric Diagnostic Interview. An Initial Mental Health Treatment Plan is not required if an Individualized Mental Health Treatment Plan is already developed within 7 days of initiation of mental health treatment, or within 7 days of the Initial Psychiatric Diagnostic Interview for youths receiving Psychotropic Medication.

(3) Initial Substance Abuse Treatment Plan.

(a) Chapter 65D-30, F.A.C., establishes the requirements for initial substance abuse treatment plans provided in facilities licensed under Chapter 397, F.S. or by Service Providers licensed under Chapter 397, F.S.

(b) In Detention Centers where substance abuse services are provided by a Licensed Qualified Professional, the Initial Substance Abuse Treatment Plan must be developed by the multidisciplinary treatment team and youth within 7 days of initiation of substance abuse treatment.

(4) An Individualized Mental Health Treatment Plan is required when a youth enters on-going mental health treatment, including treatment with Psychotropic Medication. The Individualized Mental Health Treatment Plan must be developed by the mini-treatment team for a youth in mental health treatment whose stay in a Detention Center exceeds 30 days, and must be completed by the 31st day the youth is in the Detention Center.

(5) An Individualized Substance Abuse Treatment Plan is required when a youth enters on-going substance abuse treatment.

(a) Chapter 65D-30, F.A.C., establishes the requirements for individual substance abuse treatment plans provided in facilities licensed under Chapter 39, F.S. or by Service Providers licensed under Chapter 397, F.S.

(b) In Detention Centers where substance abuse services are provided by a Licensed Qualified Professional, an Individualized Substance Abuse Treatment Plan must be developed by the mini-treatment team for a youth in substance abuse treatment whose stay in a Detention Center exceeds 30 days, and must be completed by the 31st day the youth is in the Detention Center.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0072 Mental Health and Substance Abuse Treatment Planning in Residential Commitment Programs and Day Treatment Programs.

(1) Each youth in a residential commitment program or day treatment program must be assigned to a treatment team upon admission.

(a) The multidisciplinary treatment team in residential commitment programs must be composed of the youth and representatives from the program's staff as set forth in paragraph 63E-7.010(4)(b), F.A.C.

(b) The multidisciplinary treatment team in day treatment programs must be composed of direct care, mental health and substance abuse counseling components and may also include administration, medical, educational, and vocational staff.

(c) Multidisciplinary treatment team meetings must include the youth. The multidisciplinary treatment team must also include the youth's parent or legal guardian when possible.

(d) The multidisciplinary treatment team is responsible for developing, reviewing and updating the youth's Initial Mental Health Treatment Plan and Individualized Mental Health Treatment Plan and/or Initial Substance Abuse Treatment Plan and Individualized Substance Abuse Treatment Plan.

(2) Initial Mental Health Treatment Plan.

(a) An Initial Mental Health Treatment Plan must be developed with participation of multidisciplinary treatment team members and the youth within 7 days of initiation of mental health treatment, or for youths receiving Psychotropic Medication within 7 days of the Initial Psychiatric Diagnostic Interview.

(b) DJJ residential commitment programs designated for Specialized Treatment Services where youths receive an Individualized Mental Health/Substance Abuse Treatment Plan within 30 days of admission as part of established procedure are exempt from paragraph (a) above. Such programs may utilize an Initial Mental Health Treatment Plan or treatment note to document the initiation of a youth's mental health treatment.

(3) Initial Substance Abuse Treatment Plan.

(a) Chapter 65D-30, F.A.C., establishes the requirements for initial substance abuse treatment plans provided in facilities licensed under Chapter 397, F.S. or by Service Providers licensed under Chapter 397, F.S.

(b) In residential commitment programs and day treatment programs where substance abuse services are provided by a Licensed Qualified Professional, the Initial Substance Abuse Treatment Plan must be developed by the multidisciplinary treatment team and youth within 7 days of initiation of substance abuse treatment.

(4) An Individualized Mental Health Treatment Plan is required when a youth enters on-going mental health treatment, including treatment with Psychotropic Medication.

(a) In DJJ residential commitment programs or day treatment programs designated for Specialized Treatment Services the Individualized Mental Health Treatment Plan must be developed by the multidisciplinary treatment team and youth with mental health treatment needs within 30 days of the youth's admission.

(b) For youths identified with mental health treatment needs subsequent to admission to a residential commitment program or day treatment program, the Individualized Mental Health Treatment Plan must be developed within 30 days of the youth receiving a Comprehensive Mental Health Evaluation or updated Comprehensive Mental Health Evaluation in the program. If the youth is not on-site or available to participate in development of the mental health treatment plan on the 30th day, the treatment team meeting may be postponed until the youth is on-site or available to participate in development of the plan.

(5) An Individualized Substance Abuse Treatment Plan is required when a youth enters on-going substance abuse treatment.

(a) Chapter 65D-30, F.A.C., establishes the requirements for individual substance abuse treatment plans provided in facilities licensed under Chapter 397, F.S. or by Service Providers licensed under Chapter 397, F.S.

(b) In residential commitment programs and day treatment programs where substance abuse services are provided by a Licensed Qualified Professional, an Individualized Substance Abuse Treatment Plan must be developed by the multidisciplinary treatment team as follows:

1. In residential commitment programs designated for Specialized Treatment Services, the Individualized Substance Abuse Treatment Plan must be developed by the multidisciplinary treatment team and youth within 30 days of the youth's admission.

2. For youths identified with substance abuse treatment needs subsequent to admission to a general offender residential commitment program, the Individualized Substance Abuse Treatment Plan must be developed within 30 days of the youth receiving a Comprehensive Substance Abuse Evaluation or updated Comprehensive Substance Abuse Evaluation in the program. If the youth is not on-site or available to participate in development of the substance abuse treatment plan on the 30th day, the treatment team meeting may be postponed until the youth is on-site or available to participate in development of the plan.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0073 Initial Mental Health Treatment Plans and Initial Substance Abuse Treatment Plans – General Requirements.

(1) An Initial Mental Health Treatment Plan must be recorded on the Initial Mental Health/Substance Abuse Treatment Plan Form (MHSA 015) or a form developed by the program which contains all the mental health information in form MHSA 015. The Initial Mental Health/Substance Abuse Treatment Plan Form (MHSA 015, October 2014) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-05370 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399. The Initial Mental Health Treatment Plan must be signed and dated by the Mental Health Clinical Staff Person, youth and treatment team members who participated in development of the plan.

(2) Initial Substance Abuse Treatment Plan.

(a) Chapter 65D-30, F.A.C., establishes the requirements for initial treatment plans provided in facilities licensed under Chapter 397, F.S. or by Service Providers licensed under Chapter 397, F.S.

(b) In facilities and programs where substance abuse services are provided by a Licensed Qualified Professional, the Initial Substance Abuse Treatment Plan must be developed as follows:

1. An Initial Substance Abuse Treatment Plan must be recorded on the Initial Mental Health/Substance Abuse Treatment Plan Form (MHSA 015), or a form developed by the facility or program which contains all the substance abuse information in form MHSA 015.

2. An Initial Substance Abuse Treatment Plan must be signed and dated by the Substance Abuse Clinical Staff Person, youth and treatment team members who participated in development of the plan.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14, Amended 7-9-15.

63N-1.0074 Individualized Mental Health Treatment Plans and Individualized Substance Abuse Treatment Plans – General Requirements.

(1) An Individualized Mental Health Treatment Plan must be recorded on form MHSA 016 or a form developed by the program which contains all the mental health information in form MHSA 016. The Individualized Mental Health/Substance Abuse Treatment Plan Form (MHSA 016, October 2014) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-05368 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399. The Individualized Mental Health Treatment Plan must be signed and dated by the Mental Health Clinical Staff Person, the treatment team members who participated in development of the plan and the youth.

(2) An Individualized Substance Abuse Treatment Plan is required when a youth enters on-going substance abuse treatment.

(a) Chapter 65D-30, F.A.C., establishes the requirements for individual substance abuse treatment plans provided in facilities licensed under Chapter 397, F.S. or by Service Provider licensed under Chapter 397, F.S.

(b) In facilities and programs where substance abuse services are provided by a Licensed Qualified Professional, the Individualized Substance Abuse Treatment Plan must be developed as follows:

1. An Individualized Substance Abuse Treatment Plan must be recorded on the Individualized Mental Health/Substance Abuse Treatment Plan Form (MHSA 016), or a form developed by the program which contains all the substance abuse information in form MHSA 016.

2. An Individualized Substance Abuse Treatment Plan must be signed and dated by the Substance Abuse Clinical Staff Person, the treatment team members who participated in development of the plan and the youth.

(3) Development of an Individualized Mental Health Treatment Plan, Individualized Substance Abuse Treatment Plan or Integrated Mental Health and Substance Abuse Treatment Plan must include the youth's parent or legal guardian, unless there documentation of a reason for the parent or legal guardian's non-involvement in treatment planning.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14, Amended 7-9-15.

63N-1.0075 Integrated Mental Health and Substance Abuse Treatment Plans.

(1) Youths diagnosed with both Mental Disorder and Substance-Related Disorder shall receive integrated treatment services based upon an Integrated Mental Health/Substance Abuse Treatment Plan.

(a) The Integrated Mental Health and Substance Abuse Treatment Plan shall be developed with the input of both Mental Health Clinical Staff and Substance Abuse Clinical Staff.

(b) The Integrated Mental Health and Substance Abuse Treatment Plan shall provide interventions and strategies demonstrated effective in treatment of dual diagnosis and co-occurring disorders.

(2) The Integrated Mental Health and Substance Abuse Treatment Plan must be recorded on the Individualized Mental Health/Substance Abuse Treatment Plan Form (MHSA 016), or a form developed by the program which contains all the mental health information and substance abuse information required in MHSA 016.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0076 Review and Updating of Individualized Mental Health Treatment Plans, Individualized Substance Abuse Treatment Plans and Integrated Mental Health and Substance Abuse Treatment Plans.

(1) Review and Updating of Individualized Mental Health Treatment Plans.

(a) Individualized Mental Health Treatment Plans must be reviewed and updated by the Mental Health Clinical Staff Person, treatment team and youth, and include the procedures in subsection (3) below.

(b) The review and updating of Individualized Mental Health Treatment Plans must be recorded on the Individualized Mental Health/Substance Abuse Treatment Plan Review Form (MHSA 017) or a form developed by the program which contains all the mental health information required in form MHSA 017. The Individualized Mental Health/Substance Abuse Treatment Plan Review Form (MHSA 017, October 2014) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-05367 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(2) Review and Updating of Individualized Substance Abuse Treatment Plans.

(a) Chapter 65D-30, F.A.C., establishes requirements for updating individual substance abuse treatment plans provided in facilities or by Service Providers licensed under Chapter 397, F.S.

(b) In facilities and programs where substance abuse services are provided by a Licensed Qualified Professional, a review and updating of the Individualized Substance Abuse Treatment Plan or Integrated Mental Health/Substance Abuse Treatment Plan must include the procedures in subsection (3) below.

1. The review and updating of Individualized Substance Abuse Treatment Plans must be recorded on the Individualized Substance Abuse Treatment Plan Review Form (MHSA 017), or a form developed by the program which contains all the substance abuse information required in form MHSA 017.

2. The review and updating of Integrated Mental Health and Substance Abuse Treatment Plans must be recorded on form (MHSA 017), or a form developed by the program which contains all the mental health and substance abuse information required in form MHSA 017.

(3) Review of Individualized Mental Health Treatment Plans, Individualized Substance Abuse Treatment Plans or Integrated Mental Health/Substance Abuse Treatment Plans must be conducted by the treatment team every 30 days.

(a) Based upon the review of the treatment plan, necessary updates will be made to the plan.

(b) Review and updating of treatment plans must include the parent or legal guardian, unless there is clear documentation of a reason for the parent's or legal guardian's non-involvement.

(c) The Individualized Mental Health Treatment Plan, Individualized Substance Abuse Treatment Plan or Integrated Mental Health/Substance Abuse Treatment Plan must be signed and dated by the Mental Health Clinical Staff Person, Substance Abuse Clinical Staff Person and treatment team members that updated the form and the youth. The parent or legal guardian must also sign the treatment plan unless there is clear documentation of the parent's or legal guardian's non-involvement in the review and updating of the treatment plan.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4),, 985.64(2) FS. History–New 6-20-14, Amended 7-9-15.

63N-1.0081 Mental Health Treatment Services.

(1) Mental health treatment services shall 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.

(2) Mental health treatment shall be based on the youth's symptoms and DSM diagnosis identified by a Comprehensive Assessment, Comprehensive Mental Health Evaluation or updated Comprehensive Mental Health Evaluation, and shall seek to reduce the youth's symptoms of Mental Disorder and the negative effects of symptoms on the youth's behavior and accomplish the measurable goals and objectives specified in the youth's Initial or Individualized Mental Health Treatment Plan.

(3) Treatment techniques which constitute mental health treatment include the following:

(a) Individual therapy or counseling, which is 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. Individual counseling or therapy shall be a planned and structured face-to-face therapy session designed to address the youth's symptoms and accomplish the goals and objectives in the youth's Initial or Individualized Mental Health Treatment Plan. Individual counseling or therapy shall be based on evidence based therapy models such as cognitive behavioral therapy, reality therapy, gestalt therapy or rational emotive therapy, or identified as promising practices in published quantitative research showing positive outcomes and demonstrated effectiveness in mental health treatment.

(b) Group therapy or counseling, which is an assembly of 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.

1. Group therapy/counseling shall be a planned and structured face-to-face therapy session designed to address the youths' symptoms and accomplish the goals and objectives in the youths' Initial or Individualized Mental Health Treatment Plans.

2. Group therapy/counseling shall be based on evidence based treatment models such as cognitive behavioral therapy, reality therapy, gestalt therapy or rational emotive therapy and evidence based curricula or curricula identified as promising practices in published quantitative research showing positive outcomes and demonstrated to be effective in mental health treatment.

3. Group therapy/counseling provided in DJJ residential commitment programs designated for Specialized Treatment Services shall not exceed a group size of 10 youths with mental health diagnoses.

(c) Family counseling or therapy, which is an assembly of a youth with acute or chronic Mental Disorder, his/her family members such as the youth's parents or 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. Family counseling or therapy must be based on effective treatment approaches such as family systems therapy, functional family therapy and multi-systemic therapy or identified as promising practices in published quantitative research showing positive outcomes and demonstrated to be effective in family counseling.

(d) Behavior therapy, which is a mode of treatment 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, for the purpose of 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.

1. Behavior therapy shall be designed to address the effects of the youth's symptoms on his/her behavior and accomplish the goals and objectives in the youth's Individualized Mental Health Treatment Plan.

2. Behavior Analysis Services must be provided by a Licensed Mental Health Professional, Board Certified Behavior Analyst or Certified Behavior Analyst.

(e) Psychosocial Skills Training, which is a face-to-face therapeutic activity designed to address specific skill deficits or maladaptive behaviors and promote skill development and improved functioning of youths with Mental Disorder. Psychosocial Skills Training must 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 Initial of Individualized Mental Health Treatment Plan.

(f) Juvenile sexual offender therapy and juvenile sexual offender treatment shall be conducted, managed or supervised in accordance with Section 490.012(8) or 491.012(1)(n), F.S.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14, Amended 6-15-17.

63N-1.0082 Substance Abuse Treatment Services.

(1) Chapter 65D-30 F.A.C., established the requirements for substance abuse treatment services provided in facilities licensed under Chapter 397, F.S. or by Service Providers licensed under Chapter 397, F.S.

(2) In facilities and programs where substance abuse services are provided by a Licensed Qualified Professional, substance abuse treatment shall be provided as follows:

(a) Substance abuse treatment shall be based on the youth's symptoms and DSM diagnosis identified by a Comprehensive Assessment, Comprehensive Substance Abuse Evaluation or updated Comprehensive Substance Abuse Evaluation, and shall seek to reduce the youth's

symptoms of Substance-Related Disorder and the negative effects of the symptoms on the youth's behavior and accomplish the measurable goals and objectives specified in the youth's Initial or Individualized Substance Abuse Treatment Plan.

(b) Treatment techniques which constitute substance abuse treatment utilized for youths with Substance-Related Disorder include the following:

1. Individual substance abuse counseling or therapy, which is one-to-one counseling between a youth with Substance-Related Disorder and a Licensed Qualified Professional. Individual substance abuse counseling shall be a planned and structured face-to-face counseling session designed to address the youth's Substance-Related Disorder and accomplish the goals and objectives in the youth's Initial or Individualized Substance Abuse Treatment Plan. Individual substance abuse counseling must be based on evidence based therapy models such as cognitive behavioral therapy, reality therapy, rationale emotive therapy or identified as promising practices in published quantitative research showing positive outcomes and demonstrated to be effective in substance abuse treatment.

2. Group substance abuse counseling or therapy, which is an assembly of youths with Substance-Related Disorder and a Licensed Qualified Professional who meet at least once a week for the purpose of promoting abstinence from all mood-altering Drugs and recovery from addiction.

a. Group counseling/therapy shall be a planned and structured face-to-face group counseling session designed to address the youths' symptoms and accomplish the goals and objectives in the youths' Initial or Individualized Substance Abuse Treatment Plan.

b. Group substance abuse counseling must be based on evidence based treatment models such as cognitive behavioral therapy, reality therapy, or rational emotive therapy or identified as promising practices in published quantitative research showing positive outcomes and demonstrated to be effective in substance abuse treatment.

c. Group substance abuse counseling provided in DJJ residential commitment programs designated for Specialized Treatment Services must not exceed a group size of 15 youths with substance abuse diagnoses.

3. Family substance abuse counseling or therapy, which is an assembly of a youth with substance abuse impairment, members of his/her family and a Licensed Qualified Professional, for the purpose of involving the family in the youth's alcohol/Drug treatment. Family counseling or therapy must be based on effective treatment approaches such as family systems therapy, functional family therapy and multi-systemic therapy, or identified as promising practices in published quantitative research showing positive outcomes and demonstrated to be effective in family substance abuse counseling.

4. Psychosocial Skills Training, which is a face-to-face therapeutic activity provided by a Licensed Qualified Professional designed to address specific skills deficits or maladaptive behaviors and improve the social, emotional and behavioral functioning and life skills of the youth with Substance-Related Disorder. Psychosocial Skills Training must address the specific deficits or maladaptive behaviors identified in the youth's Initial or Individualized Substance Abuse Treatment Plan.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0083 Integrated Mental Health and Substance Abuse Treatment Services.

(1) Youths diagnosed with both Mental Disorder and Substance-Related Disorder shall receive Integrated Mental Health and Substance Abuse Treatment services in the DJJ facility or program when possible, or through community-based Mental Health Providers and Substance Abuse Service Providers.

(2) Mental health treatment services shall 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.

(3) Substance abuse treatment shall be provided by a Licensed Qualified Professional or by a Substance Abuse Clinical Staff Person who is an employee in facility licensed under Chapter 397, F.S., or an employee of a service provider licensed under Chapter 397, F.S.

(4) Integrated Mental Health and Substance Abuse Treatment shall consist of evidence based mental health and substance abuse treatment, and therapy models demonstrated effective in treatment of co-occurring Mental Disorder and Substance-Related Disorder.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0084 Documentation of Mental Health and Substance Abuse Treatment Services.

(1) Mental Health Treatment Services shall be documented in a progress note or treatment note in the youth's Active Mental Health/Substance Abuse Treatment File or mental health section of the youth's Individual Healthcare Record.

(a) Recording of progress notes/treatment notes shall be carried out either on the day the treatment service/activity is provided or on a weekly basis.

1. The daily note must be recorded on the Counseling/Therapy Progress Note Form (MHSA 018) or a form developed by the program which contains all the information required in form MHSA 018. The Counseling/Therapy Progress Note Form (MHSA 018, August 2006) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03782 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

2. If the progress notes/treatment notes are recorded weekly, the progress note/summary must include the following information:

a. Summary of the mental health treatment interventions delivered to the youth, based on the youth's mental health treatment plan;

b. The youth's response to the interventions and progress toward reaching individualized treatment goals;

c. Significant events occurring during the week and contact with family and other agencies.

d. Signature of the Mental Health Clinical Staff Person who provided the treatment, and the date note was signed.

(b) Documentation requirements for a facility or program designated for Medicaid behavioral health services are set forth by the Agency for Healthcare Administration (AHCA) in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

(c) Documentation of Off-Site Mental Health Treatment which is provided to the facility or program must be filed in the youth's Individual Healthcare Record or Active Mental Health and Substance Abuse Treatment File.

(2) Substance Abuse Treatment Services shall be documented in a progress note/treatment note in the youth's Active Mental Health/Substance Abuse Treatment File or the substance abuse section of the youth's Individual Healthcare Record.

(a) Rule 65D-30 F.A.C., establishes requirements for documentation of substance abuse treatment provided in a facility licensed under Chapter 397 or by a service provider licensed under Chapter 397, F.S.

(b) In facilities and programs where substance abuse services are provided by a Licensed Qualified Professional, substance abuse progress notes or treatment notes shall be recorded either on the day the treatment service/activity is provided or on a weekly basis.

1. The daily note must be recorded on the Counseling/Therapy Progress Note Form (MHSA 018) or a form developed by the program which contains all the information required in form MHSA 018.

2. If the progress notes/treatment notes are recorded weekly, the progress note/summary must include the following information:

a. Summary of the substance abuse treatment delivered to the youth, based on the youth's substance abuse treatment plan;

b. The youth's response to the interventions and progress toward reaching individualized treatment goals;

c. Significant events occurring during the week and contact with family and other agencies;

d. Signature of the Licensed Qualified Professional who provided the treatment and the date note was signed.

(c) Documentation requirements for a facility or program designated for Medicaid behavioral health services are set forth by the Agency for Healthcare Administration (AHCA) in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

(d) Documentation of Off-Site Substance Abuse Treatment which is provided to a facility or program must be permanently filed in the substance abuse section of the youth's Individual Healthcare Record.

(3) Integrated Mental Health and Substance Abuse Treatment shall be documented as follows:

(a) Mental health treatment services shall be documented by the Licensed Mental Health Professional or Mental Health Clinical Staff Person who provided the service.

(b) Concurrent substance abuse treatment shall be documented by the Licensed Qualified Professional or Substance Abuse Clinical Staff Person who provided the service.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4),, 985.64(2) FS. History–New 6-20-14.

63N-1.0085 Psychiatric Services.

(1) Each Detention Center and residential commitment program shall have available, either within the facility, or by written agreements or contracts with off-site providers, provision of Psychiatric Services for treatment of serious Mental Disorders.

(2) Psychiatric Services shall be provided by a Psychiatrist or by a licensed and certified psychiatric advanced registered nurse practitioner (ARNP) under Chapter 464, F.S., who works under the clinical supervision of a Psychiatrist as specified in the collaborative practice protocol with the supervising Psychiatrist filed with the Florida Department of Health.

(a) The Psychiatrist or psychiatric advanced registered nurse practitioner (ARNP) providing Psychiatric Services in a departmental facility or program must comply with Rules 63M-2.010-2.023 and 63M-2.025-2.027, F.A.C., provisions regarding medication management whenever a youth is considered for, prescribed or receiving Psychotropic Medication.

(b) The Psychiatrist or psychiatric advanced registered nurse practitioner (ARNP) shall only prescribe Psychotropic Medications, which address the youth's specific diagnoses and target symptoms.

(c) If Psychotropic Medications are required, the lowest dose of medication necessary to achieve therapeutic effect shall be used bearing in mind potential benefits and risks.

(d) The use of more than one Psychotropic Medication as part of a mental health treatment regimen requires documented clinical justification for each Psychotropic Medication utilized by the Psychiatrist or psychiatric advanced registered nurse practitioner (ARNP).

(e) Psychotropic Medication shall be only one component of the therapeutic program. Additional treatment modalities such as individual, group and family therapy, behavioral therapy substance abuse counseling and psychosocial skills training shall be utilized in conjunction with the use of Psychotropic Medication.

(f) Psychotropic Medication shall not be used as punishment, for staff convenience, discipline, coercion, or retaliation, as a substitute for meaningful psychosocial, rehabilitative services or in quantities that lead to a loss of functional status.

(g) There shall be no pro re nata (PRN) or standing orders for Psychotropic Medications.

(h) There shall be no emergency treatment orders for use of Psychotropic Medication as a chemical restraint. Chemical restraint means a medication used to control behavior or restrict the youth's freedom of movement and is not a standard treatment for the youth's psychiatric condition.

(3) Each Detention Center's and residential commitment program's intake screening process must determine whether a youth is taking Psychotropic Medications. If so, the youth is to be referred for an Initial Diagnostic Psychiatric Interview to be conducted within fourteen days of the youth's admission. The Initial Diagnostic Psychiatric Interview must be identified as such and documented on the Clinical Psychotropic Progress Note (HS 006), or a form developed by the program which contains all the information required in form HS 006. The Clinical Psychotropic Progress Note (HS 006, October 2014) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-05365 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(4) Each youth who is currently receiving Psychotropic Medications at the time of admission or is prescribed Psychotropic Medication subsequent to admission must receive a psychiatric evaluation or an updated psychiatric evaluation. Youths currently receiving Psychotropic Medications at the time of admission must receive psychiatric evaluation within 30 days of admission. Youths prescribed Psychotropic Medication subsequent to admission must receive psychiatric evaluation within 30 days of the initiation of Psychotropic Medication.

(a) The Psychiatric Evaluation must be identified as such and documented on the Clinical Psychotropic Progress Note Form (HS 006) or a form developed by the program which contains all the information required in form HS 006.

(b) If the youth's file contains a psychiatric evaluation which was completed within the past 6 months, the previous psychiatric evaluation may be utilized by the facility's Psychiatrist or psychiatric advanced registered nurse practitioner (ARNP) to conduct an updated psychiatric evaluation. The updated psychiatric evaluation must be identified as such and documented on the Clinical Psychotropic Progress Note Form (HS 006) or a form developed by the program which contains all the information required in form HS 006.

(5) Each youth who is receiving Psychotropic Medication shall be seen for medication review by the Psychiatrist or psychiatric advanced registered nurse practitioner (ARNP), at a minimum, every 30 days. Medication review shall include evaluating and monitoring medication effects and the need for continuing or changing the medication regimen.

(6) Psychotropic Medication that is prescribed or Significantly Changed shall be documented on page 3 of the Clinical Psychotropic Progress Note Form (HS 006). Psychotropic Medication that is continued without Significant Change shall be documented either on page 3 of form HS 006 or a form developed by the program that contains all the information required on page 3 of form HS 006.

(7) Whenever a new Psychotropic Medication is prescribed, Psychotropic Medication is discontinued, or the drug dosage is Significantly Changed, parent/guardian notification and consent must be obtained unless the youth is 18 years of age or older or is emancipated as provided in Section 743.01 or 743.015, F.S., and is responsible for authorizing his or her own health care, or a physician determines that immediate treatment is needed as set forth in Section 985.18(7), F.S.

(8) Parental/guardian consent for Psychotropic Medication shall be accomplished through the following action:

(a) The Psychiatrist or psychiatric advanced registered nurse practitioner (ARNP) must attempt to contact the parent or legal guardian by telephone to obtain his or her verbal consent for the Psychotropic Medication.

(b) The Psychiatrist or psychiatric advanced registered nurse practitioner (ARNP) must document the parent or guardian's verbal consent, when obtained, on page 3 of the Clinical Psychotropic Progress Note Form (HS 006), or a form developed by the program that contains all the information required on page 3 of form HS 006.

(c) A copy of the 3rd page of the Clinical Psychotropic Progress Note (HS 006) or a form developed by the program that contains all the information required on page 3 of form HS 006, and the Acknowledgment of Receipt of CPPN Form or Practitioner Form (HS 001) shall be mailed to the parent/guardian. The Acknowledgment of Receipt of CPPN Form or Practitioner Form (HS 001, August 2007) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03784 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(d) The parent or legal guardian's signature on the Acknowledgment of Receipt of CPPN Form or Practitioner Form (HS 001) provides written consent for the Psychotropic Medications as recorded on page 3 of the CPPN form HS 001 mailed to the parent or legal guardian.

(9) Consent requirements for provision of Psychotropic Medication for youths in foster care whose parent or legal guardian's rights have been terminated, or the parent/legal guardian refuses to participate in the youth's treatment or the parent/legal guardian's location or identity is unknown is addressed in Chapter 65C-35, F.A.C.

(10) The Psychiatrist or psychiatric advanced registered nurse practitioner (ARNP) must brief the facility's 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 a representative of the treatment team, or through a detailed progress note submitted by the Psychiatrist or psychiatric advanced registered nurse practitioner (ARNP) prior to the treatment team meeting.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4),, 985.64(2) FS. History–New 6-20-14, Amended 7-9-15.

63N-1.0086 Mental Health and Substance Abuse Transition/Discharge Planning.

(1) Mental Health Transition/Discharge Planning.

(a) During the final phase of mental health treatment, the Mental Health Clinical Staff Person, treatment team and youth shall establish a transition/discharge plan whereby improvements made during mental health treatment will be maintained upon the youth's movement from one facility to another, or return to the community.

(b) A transition/discharge plan shall be documented on the Mental Health/Substance Abuse Treatment Discharge Plan Form (MHSA 011, October 2014) which is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-05371 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

1. The mental health information contained in the Mental Health/Substance Abuse Treatment Discharge Plan shall be discussed with the youth, parent/legal guardian (when available) and Juvenile Probation Officer prior to the youth's release from the facility or program.

2. A copy of the Mental Health/Substance Abuse Treatment Discharge Plan Form (MHSA 011) will be provided to the youth, the youth's assigned Juvenile Probation Officer, and also to the parent/legal guardian when the youth's written consent for release of substance abuse information to the parent/guardian has been obtained in accordance with consent provisions in Rule 63N-1.015, F.A.C.

(c) Transition planning for youths on Suicide Risk Alert/Suicide Precautions immediately prior to discharge to the community shall include notification of the youth's parent/legal guardian and Juvenile Probation Officer in accordance with Rule 63N-1.0097, F.A.C.

(d) Transition planning for youths on Suicide Risk Alert/Suicide Precautions immediately prior to transfer to another DJJ facility or program shall include notification of the facility superintendent/program director where the youth is to be transferred in accordance with Rule 63N-1.0097, F.A.C.

(2) Substance Abuse Transition/Discharge Planning.

(a) During the final phase of substance abuse treatment, the Licensed Qualified Professional or Substance Abuse Clinical Staff Person the treatment team and youth shall establish a transition/discharge plan whereby improvements made during substance abuse treatment will be maintained upon the youth's movement from one facility to another, or return to the community.

(b) The transition/discharge plan shall be documented on the Mental Health/Substance Abuse Treatment Discharge Plan (form MHSA 011).

1. The substance abuse information contained in the Mental Health/Substance Abuse Treatment Discharge Plan shall be discussed with the youth, parent/legal guardian (when available) and Juvenile Probation Officer prior to the youth's release from the facility or program.

2. A copy of the Mental Health/Substance Abuse Treatment Discharge Plan Form (MHSA 011) will be provided to the youth, the youth's assigned Juvenile Probation Officer and also to the parent/legal guardian when the youth's written consent for release of substance abuse information to the parent/guardian has been obtained in accordance with consent provisions in Rule 63N-1.0097, F.A.C.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14, Amended 7-9-15.

63N-1.009 Suicide Prevention.

(1) Each Detention Center, residential commitment program and day treatment program shall develop procedures for implementing the facility's suicide prevention plan and Suicide Precautions.

(2) The facility superintendent or program director must assure that a youth identified with Suicide Risk Factors or determined to be a Potential Suicide Risk is placed on Suicide Precautions until he/she receives Assessment of Suicide Risk by a Licensed Mental Health Professional or Mental Health Clinical Staff Person working under the direct supervision of a Licensed Mental Health Professional.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0091 Suicide Prevention Plans.

(1) Each Detention Center, residential commitment program and day treatment program must have a written plan that details suicide prevention procedures. The suicide prevention plan must be reviewed annually.

(2) A facility/program's plan for suicide prevention must include the following elements:

(a) Youths identified through screening or alert processes as having Suicide Risk Factors must be classified as a Suicide Risk Alert on JJIS and referred for an Assessment of Suicide Risk. An exception is provided in residential commitment programs designated for Specialized Treatment Services where a Mental Health Clinical Staff person administers mental health screening at admission and immediately administers an Assessment of Suicide Risk as specified in Rule 63N-1.006, F.A.C.

(b) 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.

(c) Each facility or program must provide at least 6 hours of staff training annually on suicide prevention and implementation of Suicide Precautions which shall include quarterly "mock drill" trainings (every shift) on response to a Suicide Attempt and/or incident of serious self-injury. The training provided in the facility or program must be documented and on file in either the employee's personnel file or staff training file.

(d) The areas of the facility designated for Precautionary Observation and Secure Observation.

(e) Use of levels of supervision in the following manner:

1. One-to-One Supervision. 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 Suicide Precautions Observation Log (MHSA 006).

2. Constant Supervision. A staff member shall maintain continuous and uninterrupted observation of the youth. The staff member must have 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 form MHSA 006.

3. Close Supervision shall 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. A staff member shall conduct visual checks of the youth's condition while in his/her room or sleeping area at intervals not to exceed five minutes. For example, the staff member will observe the youth's outward appearance, behavior and position in the room or area. Visual checks must be documented in writing at intervals not to exceed five minutes on the Close Supervision – Visual Checks Log (MHSA 020) or a visual checks form developed by the program which contains all the required information in form MHSA 020.

(f) The procedures for referring At Risk youths to mental health care providers or emergency facilities.

(g) Procedures for immediate and timely communication between Mental Health Clinical Staff and facility staff regarding the status of the youth to provide clear and current information and instructions. Procedures for communication with the youth's parent or legal guardian to obtain information regarding Suicide Risk Factors.

(h) Procedures for notifying the parent/legal guardian that 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.

(i) Procedures for both verbal and written notification of 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 of a youth's attempted suicide in the facility or program, must also be in place.

(j) The procedures for documenting the identification, referral, monitoring, assessment and follow-up of a youth identified as a Potential Suicide Risk or who has attempted suicide. The forms or formats cited in this Rule and the facility log must be utilized for documentation of suicide prevention processes and procedures.

(k) The procedures for immediate staff response to a Suicide Attempt or incident of Serious Self-Inflicted Injury.

(l) The procedures for the Licensed Mental Health Professional's and facility superintendent or program director's 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 requiring hospitalization or medical attention and mortality review process for a completed suicide.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0092 Screening for Suicide Risk.

(1) Suicide risk screening conducted by the JPO or in the JAC shall include a review of available youth records, review of the PACT Mental Health and Substance Abuse Screening Report and Referral Form suicide category, administration of the MAYSI-2 which contains a suicide ideation subscale and administration of the Suicide Risk Screening Instrument (SRSI) (MHSA 002) sections denoted for the JAC or JPO unit. If further assessment is indicated by the SRSI, MAYSI-2 suicide ideation subscale or the PACT Mental Health and Substance Abuse Screening Report and Referral Form suicide category, or information obtained at initial intake suggests the youth is a Potential Suicide Risk, the following action must be taken in these circumstances:

(a) 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.

(b) 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 Factors were disclosed during screening and that an Assessment of Suicide Risk should be conducted by a Mental Health Provider in the community.

1. The parent or guardian must be provided the Suicide Risk Screening Parent/Guardian Notification Form (MHSA 003, August 2006) which is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03786 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

2. The parent or guardian's signature is to be recorded on form MHSA 003.

3. A copy of form MHSA 003, signed by the parent or guardian, is to be permanently filed in the youth's case management record and Individual Healthcare Record.

(2) Suicide Risk Screening in Detention Centers.

(a) Suicide risk screening conducted in a Detention Center shall include the following:

1. Review of Alerts in JJIS and available youth records, including the MAYSI-2 suicide ideation subscale, PACT Mental Health and Substance Abuse Screening Report and Referral Form suicide category and SRSI sections administered in the JAC or JPO Unit prior to the youth's admission to the Detention Center.

2. Administration of the Suicide Risk Screening Instrument (SRSI) (MHSA 002) upon the youth's admission to the Detention Center.

(b) If further assessment is indicated by the Suicide Risk Screening Instrument (MHSA 002) administered by the detention officer, detention nurse or Mental Health Clinical Staff Person or by the screening conducted by the JAC or JPO Unit or other information obtained at intake suggests the youth may be a Potential Suicide Risk, the procedures specified in Rule 63N-1.00921, F.A.C., shall be followed.

(3) Suicide Risk Screening in Residential Commitment Programs.

(a) Suicide risk screening conducted upon a youth's admission to a residential commitment programs shall include:

1. Review of each youth's commitment packet information; youth records and reports which document mental health or substance abuse problems, needs or risk factors; the PACT; MAYSI-2; and Alerts on JJIS.

2. Administration of the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2) or Clinical Mental Health/Substance Abuse Screening which includes administration of a suicide risk screening questionnaire which has been confirmed to be valid and reliable in published research.

(b) When Suicide Risk Factors are identified by the MAYSI-2 suicide ideation subscale, Clinical Mental Health/Substance Abuse Screening or other information obtained at intake or after admission to the residential commitment program, the procedures specified in Rule 63N-1.00921, F.A.C., shall be followed.

(4) Suicide Risk Screening in Day Treatment Programs.

(a) Suicide risk screening conducted upon a youth's admission to a day treatment programs shall include:

1. Review of available youth records and reports which document mental health or substance abuse problems, needs or risk factors, the PACT Mental Health and Substance Abuse Screening Report and Referral Form suicide category and Alerts on JJIS.

2. Administration of the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2).

(b) When Suicide Risk Factors are identified by the MAYSI-2 suicide ideation subscale or other information obtained at intake or after admission to the day treatment program, the procedures specified in Rule 63N-1.00921, F.A.C., shall be followed.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.00921 Suicide Risk Screening – General Requirements.

(1) If further assessment is indicated by suicide risk screening administered in the facility or program, or information obtained at intake or admission or staff observations identify Suicide Risk Factors or Potential Suicide Risk, 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.

(b) The facility superintendent, program director or designee must be notified of the youth's Suicide Risk Factors. The facility superintendent, program director or designee is responsible for contacting the Designated Mental Health Clinician Authority or the Licensed Mental Health Professional who is to conduct or supervise the Assessment of Suicide Risk to discuss the case and refer the youth for Assessment of Suicide Risk.

(c) The facility superintendent, program director or designee and the Designated Mental Health Clinician Authority or other Licensed Mental Health Professional 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, shall implement procedures for emergency mental health services in accordance with Rule 63N-1.011, F.A.C.

(d) The youth must be placed on Suicide Precautions in the facility or program until the youth receives an Assessment of Suicide Risk or is transported for emergency mental health services.

(2) If a youth identified with Suicide Risk Factors is released, transferred or discharged from the facility or program prior to an Assessment of Suicide Risk being conducted, notification of the youth's suicide risk status and need for Assessment of Suicide Risk must be provided as set forth in Rule 63N-1.0097, F.A.C.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0093 Assessment of Suicide Risk and Follow-Up Assessment of Suicide Risk Procedures.

(1) Assessment of Suicide Risk.

(a) An Assessment of Suicide Risk shall be conducted within 24 hours of referral, or immediately if the youth is in Crisis.

1. Any youth with current Suicide Ideation shall be immediately referred to a Mental Health Clinical Staff Person who will confer with a Licensed Mental Health Professional to determine whether an Assessment of Suicide Risk is to be conducted in the facility or program within 24 hours or immediately. If the youth is an imminent threat of suicide, the youth must be transported for emergency mental health services as set forth in Rule 63N-1.011, F.A.C.

2. Any youth who makes a Suicide Attempt or attempts Serious Self-Inflicted Injury shall receive an immediate Assessment of Suicide Risk in the facility or be transported for emergency mental health services.

(b) An Assessment of Suicide Risk shall be documented on the Assessment of Suicide Risk Form (MHSA 004, August 2006) which is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03787 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

1. 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.

2. If an Assessment of Suicide Risk conducted by a non-licensed Mental Health Clinical Staff Person indicates the youth is not a Potential Suicide Risk, documentation of the Licensed Mental Health Professional's concurrence with the Assessment of Suicide Risk findings is required prior to the youth's removal from Suicide Precautions.

(c) Youths determined to be a Potential Suicide Risk through an Assessment of Suicide Risk must be maintained on Suicide Precautions until a Follow-Up Assessment of Suicide Risk determines that the youth is not a Potential Suicide Risk.

(d) The Assessment of Suicide Risk Form (MHSA 004) must be filed in the Active Mental Health/Substance Abuse Treatment File until permanently filed in the youth's Individual Healthcare Record.

(2) Follow-Up Assessment of Suicide Risk.

(a) When a youth has received an Assessment of Suicide Risk and has been determined to be a Potential Suicide Risk and is being maintained on Suicide Precautions, a Follow-Up Assessment of Suicide Risk must be conducted by a Mental Health Clinical Staff Person prior to a youth's removal from Suicide Precautions.

(b) Documentation of Follow-Up Assessment of Suicide Risk shall be provided by the Mental Health Clinical Staff Person on the Follow-Up Assessment of Suicide Risk Form (MHSA 005, August 2006) which is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03788 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

If a Follow-Up Assessment of Suicide Risk conducted by a non-licensed Mental Health Clinical Staff Person indicates the youth is not a Potential Suicide Risk, documentation of the Licensed Mental Health Professional's concurrence with Follow-Up Assessment of Suicide Risk findings is required prior to the youth's removal from Suicide Precautions and transition to normal routine.

(c) The Follow-Up Assessment of Suicide Risk Form (MHSA 005) must be filed in the Active Mental Health/Substance Abuse Treatment File until permanently filed in the youth's Individual Healthcare Record.

(3) Assessment of Suicide Risk or Follow-Up Assessment of Suicide Risk shall 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) A non-licensed Mental Health Clinical Staff Person conducting an Assessment of Suicide Risk or a Follow-Up Assessment of Suicide Risk shall meet the education and training requirements specified in Rule 63N-1.0031, F.A.C., 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, individual one-to-one, Assessments of Suicide Risk or Crisis Assessments conducted on-site in the physical presence of a Licensed Mental Health Professional.

(b) The non-licensed Mental Health Clinical Staff Person's 20 hours of training and supervised experience shall be provided by a Licensed Mental Health Professional and shall be documented on the Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk Form (MHSA 022) or a form developed by the program which contains all the information required in form MHSA 022. The Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk Form (MHSA 022, October 2007) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03789 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(c) An Assessment of Suicide Risk and a Follow-Up Assessment of Suicide Risk must include the following:

1. Face-to-face interview of the youth;

2. Review of available collateral information;

3. Details of the information obtained by the assessment, including youth statements, behavioral observations, and collateral information;

(d) The Mental Health Clinical Staff Person conducting the Assessment of Suicide Risk or Follow-Up Assessment of Suicide Risk shall notify the facility superintendent or program director or his/her designee of the assessment findings and any instructions or recommendations made by the Licensed Mental Health Professional.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.00931 Licensed Mental Health Professional's Off-Site Review of Assessment or Follow-Up Assessment of Suicide Risk.

In the circumstance where an Assessment of Suicide Risk or Follow-Up 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 shall accomplish a review of the Assessment of Suicide Risk or Follow-Up Assessment of Suicide Risk within 24 hours of the referral through one of the following methods:

(1) Verbal consultation through telephonic communication with the non-licensed Mental Health Clinical Staff Person detailing the Assessment of Suicide Risk or Follow-Up Assessment of Suicide Risk findings.

(a) The verbal consultation shall be documented and summarized in the Assessment of Suicide Risk Form (MHSA 004) or Follow-Up Assessment of Suicide Risk Form (MHSA 005) by the non-licensed Mental Health Clinical Staff Person, including any instructions or recommendations made by the Licensed Mental Health Professional.

(b) The form MHSA 004 or form MHSA 005 shall be reviewed and signed by the Licensed Mental Health Professional the next scheduled time he/she is on-site.

(2) Verbal consultation through telephonic communication and electronically transmitted communications such as 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.

(a) The verbal consultation and e-mail communications shall be documented and summarized in the Assessment of Suicide Risk Form (MHSA 004) or Follow-Up Assessment of Suicide Risk Form (MHSA 005) by the non-licensed Mental Health Clinical Staff Person, including any instructions or recommendations made by the Licensed Mental Health Professional.

(b) The form MHSA 004 or form MHSA 005 and e-mail must be reviewed and signed by the Licensed Mental Health Professional the next scheduled time he/she is on-site.

(3) Verbal consultation through telephonic communication and off-site review of an electronically transmitted or faxed copy of the completed Assessment of Suicide Risk Form (MHSA 004) or Follow-Up Assessment of Suicide Risk Form (MHSA 005).

(a) The Licensed Mental Health Professional shall fax or electronically transmit confirmation the Assessment of Suicide Risk Form (MHSA 004) or Follow-Up Assessment of Suicide Risk Form (MHSA 005) was reviewed and whether he or she concurs with the findings.

(b) The faxed or electronic transmission of form MHSA 004 or form MHSA 005 shall be placed in the youth's mental health file.

(c) The original form MHSA 004 or form MHSA 005 must be signed as reviewer by the Licensed Mental Health Professional the next scheduled time he/she is on-site.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0094 Assessment of Suicide Risk Performed Off-Site of the Facility or Program.

(1) When an Assessment of Suicide Risk is conducted off-site of the facility or program, documentation of the assessment shall be requested by the juvenile justice representative responsible for the youth during the off-site assessment.

(2) Upon the youth's return from an off-site Assessment of Suicide Risk, the youth must be placed on Constant Supervision until a Mental Health Clinical Staff Person reviews the off-site assessment document and determines the mental health status of the youth based on the off-site assessment findings and administration of a Mental Status Examination by the Mental Health Clinical Staff Person.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0095 Suicide Precaution Methods.

Detention Centers, residential commitment programs and day treatment programs must utilize either Precautionary Observation or Secure Observation as a Suicide Precaution method when a youth is identified as having Suicide Risk Factors, or determined to be a Potential Suicide Risk. The decision whether to use Secure Observation or Precautionary Observation as a Suicide Precaution method for a particular youth shall be made by the superintendent or program director and Designated Mental Health Clinician Authority or other Licensed Mental Health Professional.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.00951 Precautionary Observation.

(1) Precautionary Observation shall be utilized as a Suicide Precaution method in Detention Centers, residential commitment programs and day treatment programs.

(2) A youth shall 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 and the youth's Suicide Risk Behaviors indicates that his/her condition requires observation and monitoring beyond that which is normally provided, but is not in need of Secure Observation. Precautionary Observation shall not be used for youth who present an Imminent Threat of Suicide. Such youth shall be referred for emergency mental health services as set forth in Rule 63N-1.011, F.A.C.

(3) A youth on Precautionary Observation shall be limited to activities in the safe housing areas in the facility or program. The safe housing areas must meet the following specifications:

(a) The areas must be designed to eliminate or prohibit 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 or substances which would enable the youth to burn or poison him/herself.

(b) The areas must be immediately accessible to the direct care staff maintaining Constant Supervision of the youth.

(c) The safe housing areas 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.

(d) The safe housing areas of the facility shall be regularly inspected to ensure that the area is safe and secure. Documented daily safety/security checks of the facility will suffice as an inspection provided that the daily safety/security checks include the areas of the facility designated for Precautionary Observation.

(4) The At Risk youth shall be permitted to participate in selected activities with other youths in the DJJ facility/program while being maintained on Precautionary Observation.

(5) Youth Placement on Precautionary Observation.

(a) The superintendent/program director or designee shall confer with the facility's Designated Mental Health Clinician Authority or Licensed Mental Health Professional as to the whether Precautionary Observation is appropriate for a specific youth.

(b) When the decision has been made to place a youth on Precautionary Observation, the superintendent/program director or designee shall identify in writing the specific safe housing 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 areas of the facility and activities will be documented on the Suicide Precautions Observation Log (MHSA 006, August 2006) which is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03790 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(6) Youths placed on Precautionary Observation shall receive Mental Health Supportive Services, based upon the individualized needs of the youth as determined by the Mental Health Clinical Staff Person. Mental Health Supportive Services shall be documented in the youth's Active Mental Health/Substance Abuse File and reviewed and signed by a Licensed Mental Health Professional if provided by a non-licensed Mental Health Clinical Staff Person.

(7) Supervision Requirements for Precautionary Observation.

(a) The staff person assigned to monitor the youth in a Precautionary Observation area shall maintain One-to-One Supervision or Constant Supervision of the youth and document his/her observations of the youth's behavior on the Suicide Precautions Observation Log (MHSA 006) at 30 minute intervals. The Suicide Precautions Observation Log (MHSA 006) is reviewed and signed by the shift supervisor each shift and by a Mental Health Clinical Staff Person daily.

(b) 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 shall be documented and communicated to the next shift.

(8) Discontinuation of Precautionary Observation.

(a) The Assessment of Suicide Risk findings and recommendations must be reviewed by the superintendent/program director or designee and Licensed Mental Health Professional. Based upon the Assessment of Suicide Risk findings, the Licensed Mental Health Professional and facility superintendent/program director or designee will determine whether Suicide Precautions are continued.

(b) If the Assessment of Suicide Risk findings and recommendations indicate the need for continued Suicide Precautions, the youth shall be maintained on Precautionary Observation until subsequent Follow-Up Assessment of Suicide Risk indicates Suicide Precautions may be discontinued and the facility superintendent, program director or and the Licensed Mental Health Professional concurs with the findings.

(c) If the Assessment of Suicide Risk or Follow-Up Assessment of Suicide Risk findings and recommendations indicate Suicide Precautions can be discontinued, and deemed appropriate by the Licensed Mental Health Professional and superintendent or program director or designee, the youth may be removed from Precautionary Observation and transitioned to normal routine as specified in Rule 63N-1.00953, F.A.C.

(d) Discontinuation of Precautionary Observation and supervision upon removal from Precautionary Observation shall be documented by Mental Health Clinical Staff and superintendent/program director, or designee, on the Assessment of Suicide Risk Form (MHSA 004) or the Follow-Up Assessment of Suicide Risk Form (MHSA 005), as applicable.

(9) Youths removed from Precautionary Observation shall continue to be monitored during the transition back into the facility/program's normal routine, until deemed stable by the facility's Designated Mental Health Clinician Authority or Licensed Mental Health Professional. The procedures set forth in Rule 63N-1.00953, F.A.C., shall be followed.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.00952 Secure Observation.

(1) When less restrictive means of control are not effective, facilities and programs are authorized to utilize a Secure Observation Room for observation of an At Risk or Potential Suicide Risk youth who manifests behavior which 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, agitated, fearful, or his/her behavior appears unpredictable, volatile or highly impulsive.

(a) 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.

(b) The Secure Observation Room shall not be used for youth who present an Imminent Threat of Suicide. Such youth shall be transported for emergency mental health services as set forth in Rule 63N-1.011, F.A.C.

(2) If a Potential Suicide Risk youth requires placement in an individual cell, whether locked or unlocked, due to potentially self-injurious behavior or behavior which threatens the safety of others, Secure Observation shall be implemented.

(3) When a youth on Precautionary Observation requires placement in behavioral confinement or controlled observation, the youth must be placed in a Secure Observation Room. When a youth already on Secure Observation requires placement in behavioral confinement due to misbehavior, the youth must remain in the Secure Observation Room during behavioral confinement.

(4) Procedures for Placement in a Secure Observation Room.

(a) The superintendent, program director or designee shall confer with the Designated Mental Health Clinician Authority or other Licensed Mental Health Professional as to whether Secure Observation is appropriate for a specific youth. The superintendent, program director or designee's consultation with the Licensed Mental Health Professional shall be documented on the Mental Health/Substance Abuse Referral Summary (MHSA 014) or a form developed by the program which contains all the information required in form MHSA 014.

(b) When the decision has been made to place a youth in a Secure Observation Room, the following shall occur:

1. The Secure Observation Room shall be inspected immediately prior to the youth's placement to ensure that it is safe and secure.

2. 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.

a. The Health Status Checklist (MHSA 008, August 2006) which is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03791 shall be completed to document the youth's physical condition. The form MHSA 008 may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

b. 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 shall be immediately notified for an assessment and treatment prior to placement in a Secure Observation Room.

3. The youth must be searched by a staff member of the same sex.

a. At the time of the search, all jewelry, pocket items, hair ties, and hair pins must be removed.

b. All clothing items which could be used for self-injury such as shoes, shoelaces, socks, and belt must be removed. However, the youth shall not be stripped.

c. The youth shall not to be required to dress in any garment or put on any covering that is sexually revealing.

(5) A youth shall 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. 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, including behavioral confinement.

(6) Each youth placed in a Secure Observation Room due to At Risk or Suicide Risk Behaviors shall be immediately referred for an Assessment of Suicide Risk. The youth in Secure Observation must receive an Assessment of Suicide Risk or Follow-Up Assessment of Suicide Risk 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 shall be conducted during the following morning shift.

(7) Structural Specifications of a Secure Observation Room. The structure of a Secure Observation Room shall meet the following specifications:

(a) 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.

(b) 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.

(c) Floors/Walls: Solid, smooth and high impact resistant without protrusions.

(d) 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.

(e) 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.

(f) Lighting: Light fixtures should be recessed and covered with shatter-resistant material such as lexan.

(g) Windows: Must be made of shatter-resistant material or glass windows that are not shatter resistant must be covered with security-rated screens or other materials that prevent access to the glass.

(h) 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.

(i) Electrical Switches/Outlets: Electrical outlets are not permitted and switches must be located outside the room.

(j) 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.

(8) Mental Health Supportive Services shall be provided to the youth being maintained on Secure Observation, based upon the individualized needs of the youth as determined by Mental Health Clinical Staff.

(9) Youths placed in a Secure Observation Room shall be maintained on One-to-One Supervision while in the Secure Observation Room.

(a) The staff person assigned to observe the youth in Secure Observation must record observations of the youth's behavior in the Secure Observation Room on the Suicide Precautions Observation Log (MHSA 006). The Suicide Precautions Observation Log (MHSA 006) is reviewed and signed by the shift supervisor each shift and by a Mental Health Clinical Staff Person daily.

(b) The shift supervisor shall be 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.

(c) When it is necessary to temporarily remove the youth from the Secure Observation Room for any reason, the youth shall be searched again before being placed back into the Secure Observation Room.

(10) Discontinuation/Termination of Secure Observation.

(a) The At Risk youth shall 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.

(b) The Assessment of Suicide Risk or Follow-Up Assessment of Suicide Risk findings and recommendations shall 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 whether Secure Observation is to be continued.

(c) When Assessment of Suicide Risk findings/recommendations indicate the need for continued Suicide Precautions, the following shall occur:

1. Documentation that the Licensed Mental Health Professional concurs with the Assessment of Suicide Risk findings/recommendations and that continued Suicide Precautions through either a limited time extension of placement in Secure Observation or placement of the youth on Precautionary Observation is required.

2. Unless there is a specific recommendation in the Assessment of Suicide Risk that the youth shall remain in Secure Observation, the youth shall be removed from the Secure Observation Room and Suicide Precautions continued by placing the youth on Precautionary Observation.

3. The youth shall remain on Secure Observation or 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.

(d) The discontinuation of Secure Observation and initiation of Precautionary Observation shall be documented by the superintendent or program director or designee on the Suicide Precautions Observation Log (MHSA 006) and in the facility log, and must be documented in the youth's Active Mental Health/Substance Abuse File by the Mental Health Clinical Staff.

(e) If an At Risk youth in Secure Observation due to behavioral confinement receives a Follow-Up Assessment of Suicide Risk which indicates that the youth is no longer a suicide risk, he/she may be removed from the Secure Observation Room and transitioned to a normal routine. However, if the youth cannot be transitioned to a normal routine because he/she must continue behavioral confinement, then the youth must remain in Secure Observation and on Suicide Precautions until behavioral confinement is concluded.

1. A Licensed Mental Health Professional shall provide written concurrence for a youth to remain in a Secure Observation Room beyond 24 hours for any reason, including behavioral confinement.

2. If the youth is in Secure Observation due to behavioral confinement and the Licensed Mental Health Professional does not concur with a youth's continued placement in Secure Observation due to his/her deteriorating mental health status, the Licensed Mental Health Professional shall immediately notify the facility superintendent or designee of his/her recommendation that Secure Observation and behavioral confinement be discontinued, and the youth must either be placed on Precautionary Observation with One-to-One Supervision or transported for emergency mental health services.

(f) When deemed appropriate by the Licensed Mental Health Professional and superintendent/program director or designee, the youth shall be removed from Suicide Precautions (Secure Observation and/or Precautionary Observation).

1. Documentation of the Assessment of Suicide Risk or Follow-Up Assessment of Suicide Risk findings which indicate Suicide Precautions may be discontinued shall be reviewed by a Licensed Mental Health Professional prior to the youth's removal from Suicide Precautions.

2. Documentation that the Licensed Mental Health Professional concurs with the removal of Suicide Precautions (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.

(g) Discontinuation of Secure Observation and step-down to Close Supervision must be documented on the Assessment of Suicide Risk Form (MHSA 004) or Follow-Up Assessment of Suicide Risk Form (MHSA 005).

(11) The youth being removed from Secure Observation shall be placed on Close Supervision during transition back into the facility/program's normal routine, until deemed stable by the Designated Mental Health Clinician Authority or a Licensed Mental Health Professional. The procedures set forth in Rule 63N-1.00953, F.A.C., shall be followed.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.00953 Monitoring of Youth Upon Removal from Precautionary Observation or Secure Observation – General Requirements.

(1) Transition to Standard Supervision. 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) Step-Down to Close Supervision and Normal Routine.

(a) Close Supervision shall be initiated for any youth who had been placed or maintained on Precautionary Observation following an Assessment of Suicide Risk which identified the youth as a Potential Suicide Risk.

(b) Close Supervision shall be initiated for any youth being removed from Secure Observation or who was in a Secure Observation Room at any time during Suicide Precautions.

(c) Close Supervision shall be maintained until determined no longer necessary by the Designated Mental Health Clinician Authority or other Licensed Mental Health Professional in the facility or program.

(d) The facility or program's Mental Health Clinical Staff shall maintain regular contact with the youth for support and to determine changes in his or her status during Close Supervision.

(3) Discontinuation of Close Supervision shall be documented in the youth's Active Mental Health/Substance Abuse File or mental health section of the Individual Healthcare Record by a Mental Health Clinical Staff Person and reviewed and signed by a Licensed Mental Health Professional if documented by a non-licensed Mental Health Clinical Staff Person. The superintendent or program director or designee shall document discontinuation of Close Supervision in the facility log.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.00954 Administrative and Clinical Review of Suicide Precautions.

(1) The superintendent/program director or assistant superintendent/assistant program director and a Licensed Mental Health Professional must review the Suicide Precautions Observation Log (MHSA 006) to determine whether the use of Suicide Precautions was appropriate in each instance.

(2) If the use of Precautionary Observation or Secure Observation is determined to have been inappropriate or not in compliance with this rule, the superintendent or program director shall initiate corrective action to address any deficiencies in implementation of Suicide Precautions.

(3) Each facility must maintain a monthly log which tracks each incident of the use of Secure Observation. This log must contain the name of each youth placed in the Secure Observation Room and the date and time of the youth's placement in and release from the Secure Observation Room.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0096 Immediate Response to a Suicide Attempt or Incident of Serious Self-Inflicted Injury.

(1) Each facility's quarterly mock drills of a Suicide Attempt or Incident of Serious Self-Inflicted Injury must include action to be taken by staff in such circumstances as follows:

(a) Methods for contacting other facility staff by radio or call for backup support, medical personnel and emergency medical services (911);

(b) Provision of life saving measures such as cardiopulmonary resuscitation (CPR) and use of the Suicide Response Kit per established protocol;

(2) Facilities and programs shall maintain a Suicide Response Kit as follows:

(a) In facilities with a control station/office, each control station/office must contain a Suicide Response Kit.

(b) In facilities with subcontrol stations/offices, each subcontrol station/office must contain a Suicide Response Kit.

(c) In small facilities with only a check–in station/office, the check-in station/office must contain a Suicide Response Kit.

(d) The Suicide Response Kit shall be properly safeguarded and maintained as follows:

1. Each Suicide Response Kit shall contain emergency rescue tools: "Suicide Rescue Tool", wire cutters, and needle nose pliers. The Suicide Response Kit shall also contain first aid items such as a one-way CPR mask, microshield or face shield, non-latex gloves and first aid supplies.

2. The Suicide Response Kit shall be sealed when not in use. Once the seal is broken, the Suicide Response Kit shall be inventoried, each emergency rescue tool recovered, and any missing first aid items recovered or replenished and then re-sealed.

3. All staff who come into contact with youths must know the location of the Suicide Response Kit and be trained in its use.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0097 Notifications When a Youth on Suicide Precautions is Released, Transferred or Discharged.

For youths on Suicide Risk Alert or Suicide Precautions immediately prior to release, transfer or discharge from a Detention Center, residential commitment program or day treatment program, verbal and written notification of the youth's suicide risk status and need for Assessment of Suicide Risk must be provided and documented as follows:

(1) Youth is to be released or transferred from a Detention Center.

(a) If the youth is being released to the parent or guardian, the parent or guardian must be provided the Detention Suicide Risk Parent/Guardian Notification Form (MHSA 009) and the parent or guardian must sign the form. The Detention Suicide Risk Parent/Guardian Notification Form (MHSA 009, October 2007) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03792 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399. A copy of form MHSA 009, signed by the parent or guardian, is to be permanently filed in the youth's case management record and Individual Healthcare Record.

(b) If the youth is to be transferred to another DJJ facility, a jail or hospital, the facility superintendent or program director where the youth is to be transferred must be notified verbally and by e-mail of the youth's suicide risk status prior to discharge from the Detention Center. The notification of suicide risk must be documented and permanently filed in the youth's Individual Healthcare Record.

(2) Youth is being released or transferred from a residential commitment program.

(a) If the youth is to be released to the parent or guardian, the parent or guardian must be verbally informed and provided written notification of the youth's suicide risk status prior to discharge from the residential commitment program. The notification of suicide risk must be documented and permanently filed in the youth's Individual Healthcare Record.

(b) If the youth is to be transferred to another DJJ facility, a jail or hospital, the facility superintendent or program director where the youth is to be transferred must be notified verbally and by e-mail of the youth's suicide risk status prior to discharge from the Detention Center. The notification of suicide risk must be documented and permanently filed in the youth's Individual Healthcare Record.

(3) Youth is being released from a day treatment program.

(a) If the youth is released to the physical 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 Mental Health Provider within 24 hours.

1. The parent or guardian must be provided the Suicide Risk Screening Parent/Guardian Notification Form (MHSA 003) and the parent or guardian must sign the form.

2. A copy of form MHSA 003, signed by the parent or guardian, is to be permanently filed in the youth's case management record and Individual Healthcare Record.

(b) If the parent/guardian is responsible for obtaining an off-site Assessment of Suicide Risk for the youth, the following action must be taken upon the youth's return to the day treatment program:

1. The parent/guardian must either provide a copy of the off-site assessment documentation to the day treatment program, or sign consent for release of the assessment documentation to the program.

2. When the parent/guardian provides an off-site Assessment of Suicide Risk, the off-site assessment must be reviewed by Mental Health Clinical Staff to determine if there are any recommendations regarding increased supervision or service delivery for the youth while he/she is in the program.

3. When the parent/guardian provides written consent for release of the off-site Assessment of Suicide Risk, the program must obtain a copy of the off-site assessment as soon as possible, and provide it to Mental Health Clinical Staff for review.

4. If the parent/guardian has not obtained an off-site Assessment of Suicide Risk for the youth, the youth must be placed on Suicide Precautions and referred to the facility's Mental Health Provider for administration of an Assessment of Suicide Risk in accordance with Rule 63N-1.0093, F.A.C.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0098 Serious Suicide Attempt or Serious Self-Inflicted Injury Review and Mortality Review.

(1) The facility superintendent or program director shall establish a review process for every Suicide Attempt or Serious Self-Inflicted Injury requiring hospitalization or medical attention and a mortality review for a completed suicide.

(2) The serious Suicide Attempt or Serious Self-Inflicted Injury review process and mortality review process shall be multidisciplinary, involving administrative, direct care, mental health and medical personnel and include a critical inquiry of the following:

(a) The circumstances surrounding the incident;

(b) Facility procedures relevant to the incident;

(c) All relevant training received by involved staff;

(d) Pertinent medical and mental health services involving the victim;

(e) Possible precipitating factors leading to the Suicide Attempt, Serious Self-Inflicted Injury or completed suicide;

(f) Recommendations, if any, for changes in policy, training, physical plant, medical or mental health services and/or operational procedures shall be made in writing.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.010 Mental Health Crisis Intervention Services.

(1) Each Detention Center, residential commitment program and day treatment program must have a written crisis intervention plan which includes the following:

(a) Verbal de-escalation and Protective Action Response as defined and set forth in Chapter 63H-1, F.A.C. Physical intervention techniques and restraining devices that are not authorized under DJJ Chapter 63H-1, F.A.C., shall not be used.

(b) Notification of the facility superintendent, program director or designee and Mental Health Clinical Staff of a youth's Acute Emotional or Psychological Distress which may pose a safety/security risk through the facility's alert process in accordance with Rule 63N-1.006, F.A.C. Notification procedures must also be in place to inform the youth's parent/legal guardian and Juvenile Probation Officer of the youth's Crisis.

(c) The procedures for referring youths whose Acute Emotional or Psychological Distress does not respond to ordinary crisis intervention to on-site or off-site Licensed Mental Health Professionals, Mental Health Providers or mental health facilities.

1. Referrals for Mental Health Crisis Intervention may be made by facility/program staff or by youth self-referral.

2. Youths identified as having Acute Emotional or Psychological Distress which may pose a safety/security risk must be immediately referred to a Mental Health Clinical Staff Person.

3. 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.

4. Referrals for Mental Health Crisis Intervention, including youth self-referrals, shall be recorded on the Mental Health/Substance Abuse Referral Summary Form (MHSA 014), or a form developed by the program containing, all the information required in form MHSA 014.

(d) 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) For youths in Crisis placed on Mental Health Alert, the crisis intervention plan must reflect supervision levels provided in Rule 63N-1.006, F.A.C.

(f) 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) The crisis intervention plan must specify the procedures for administrative and clinical review of crises which require mental health intervention.

(2) Integrated Mental Health Crisis Intervention and Emergency Mental Health/Substance Abuse Plan. 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 Rule 63N-1.011, F.A.C.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0101 Mental Health Crisis Assessment.

(1) The superintendent/program director or designee is responsible for consulting the Designated Mental Health Clinician Authority or Licensed Mental Health Professional who conducts or supervises mental health evaluations at the facility to discuss the youth's Crisis and associated behaviors.

(a) The superintendent/program director or designee and Designated Mental Health Clinician Authority or other Licensed Mental Health Professional shall confer on those cases viewed as urgent and if it is determined that a mental health emergency exists, the youth shall be transported for emergency mental health services as set forth in Rule 63N-1.011, F.A.C.

(b) The superintendent/program director or designee must document consultation with the Designated Mental Health Clinician Authority or other Licensed Mental Health Professional and referral for Crisis Assessment on form MHSA 014 or a form developed by the program containing all the information required in form MHSA 014.

(c) A Crisis Assessment is utilized only when the youth's Acute Emotional or Psychological Distress or Crisis is not associated with Suicide Risk Factors or Suicide Risk Behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk instead of a Crisis Assessment.

(2) The Crisis Assessment must be documented on the Crisis Assessment Form (MHSA 023) or a form developed by the program which contains all the information required in form MHSA 023. The Crisis Assessment Form (MHSA 023, September 2010) is incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03793 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(a) The Crisis Assessment must include a face-to-face interview of the youth and review of available collateral information. The Crisis Assessment shall provide details of the information obtained by the assessment (i.e., youth statements, behavioral observations, collateral information).

(b) 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.

(c) 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.

(d) In the circumstance where the Crisis Assessment is conducted by a 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 in-person, telephonic or electronic consultation.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0102 Crisis Intervention Services and Mental Health Alerts.

(1) When a youth has received a Crisis Assessment and has been determined to exhibit behaviors which pose a potential safety or security risk in the facility or program, the following must occur:

(a) The youth must be maintained or continue to be coded as a "Mental Health Alert" and Mental Health Supportive Services provided.

(b) 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 a subsequent Mental Status Examination determines that the youth's mental health Crisis is resolved and no longer poses a potential safety or security risk.

(2) Follow-up Mental Status Examination of the youth must be conducted by a Licensed Mental Health Professional or a Mental Health Clinical Staff Person working under the direct supervision of a Licensed Mental Health Professional.

(a) The Follow-up Mental Status Examination must be documented in the youth's Crisis Assessment Form (MHSA 023) or a form developed by the program which contains all the information required in form MHSA 023.

(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.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.0103 Off-Site Crisis Assessments.

(1) When a Crisis Assessment is conducted outside of the facility, documentation of the assessment shall be requested by the juvenile justice representative responsible for the youth during the off-site assessment.

(2) 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 determines the mental health status of the youth based on the off-site assessment findings and administration of a follow-up Mental Status Examination to the youth.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.011 Emergency Mental Health and Substance Abuse Services.

Each Detention Center, residential commitment program and day treatment program must have a written mental health and substance abuse emergency response plan which includes the following components:

(1) Direct care staff and other facility staff shall be trained to immediately respond to mental health or substance abuse emergencies. Training shall include:

(a) Recognition of signs and symptoms of a mental health or substance abuse emergency;

(b) Methods of obtaining back-up security and/or medical assistance in the facility;

(c) Methods for contacting emergency medical services (EMS) and/or law enforcement;

(d) Administration of first aid and cardiopulmonary resuscitation.

(e) Staff access to and use of the Suicide Response Kit and cut down tools as specified in Rule 63N-1.0096, F.A.C.

(2) Procedures for notification of on-site facility personnel of the mental health or substance abuse emergency and to notify the superintendent or program director and Designated Mental Health Clinician Authority if he/she is off-site at the time of the emergency. The youth's parent/legal guardian and Juvenile Probation Officer (JPO) must also be notified of the youth's mental health or substance abuse emergency. Documentation of parent/legal guardian and JPO notification of the youth's emergency and attempts to contact the parent/legal guardian or JPO must be filed in the youth's Individual Healthcare Record.

(3) Procedures for communication between facility staff and Mental Health Clinical Staff or Substance Abuse Clinical Staff and/or medical staff regarding the status of the youth must exist to provide clear and current information and instructions.

(4) One-to-One Supervision of the youth shall be maintained while the youth is in the DJJ facility or program until authorized release to emergency personnel.

(5) Staff shall immediately contact emergency medical services (911) in the event of a mental health or substance abuse emergency that requires emergency medical treatment.

(6) 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 as specified in Section 394.462, F.S.

(7) Procedures 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 as specified in Sections 397.675 and 397.677, F.S.

(8) Procedures for documenting the mental health or substance abuse emergency, staff response to the mental health or substance abuse emergency, instructions of Mental Health Clinical Staff, Substance Abuse Clinical Staff and/or medical staff, and authorization for transfer.

(9) 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.

(10) Procedures for administrative review and a Licensed Mental Health Professional's review of mental health and substance abuse emergency procedures and critical incidents.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.012 Off-Site Emergency Evaluations.

(1) Off-Site Emergency Mental Health Evaluations. Upon the youth's return from an off-site mental health receiving facility, the youth must be placed on Constant Supervision until a Mental Health Clinical Staff Person, working under the direct supervision of a Licensed Mental Health Professional, reviews the off-site mental health evaluation or discharge summary and provides a follow-up Mental Status Examination of the youth.

(2) Off-Site Emergency Substance Abuse Evaluations. Upon the youth's return from a hospital, licensed detoxification facility or addictions receiving facility, the youth must be placed on Constant Supervision until a Qualified Professional reviews the off-site substance abuse evaluation or discharge summary and determines the substance abuse status and needs of the youth based on the off-site assessment documents.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.013 Services for Youths with Developmental Disability.

(1) Facility staff shall be trained to recognize signs and symptoms of Developmental Disability. Examples of information and behaviors which suggests Developmental Disability include:

(a) Psychological testing or mental health evaluation indicate an Intelligence Quotient (IQ) below 70.

(b) School exceptional education classification of "Intellectual Disabilities" or "Autism Spectrum Disorder" as specified in Rules 6A-6.03011 and 6A-6.03023, F.A.C.

(c) DSM diagnosis of "mental retardation" or "intellectual disability".

(d) The youth has difficulty understanding and answering age appropriate questions;

(e) The youth has difficulty understanding and following age appropriate directions; or

(f) The youth's abilities appear far below other youths his/her age.

(2) Youths identified as possibly having a Developmental Disability must be placed on Constant Supervision until assessed by Mental Health Clinical Staff. Youths determined by Mental Health Clinical Staff to have Developmental Disability based on review of intelligence testing or administration of intelligence testing who are placed in a Detention Center or residential commitment program must be referred to the facility/program treatment team for development of an Individualized Mental Health Treatment Plan with behavior oriented goals.

(3) Determination of Developmental Disability.

(a) Assessment findings and recommendations regarding Developmental Disability shall be based upon administration or review of intelligence testing which includes the current edition of the Wechsler Intelligence Scale for Children (WISC), Wechsler Adult Intelligence Scale (WAIS) or Stanford-Binet Intelligence Scale (SB), and administration or review of adaptive behavior functioning testing. Accepted tests for adaptive behavior functioning include: Vineland Adaptive Behavior Scales, Adaptive Behavior Scale, Adaptive Behavior Assessment System, Adaptive Behavior Evaluation Scale, or Scales of Independent Behavior.

1. An exception is provided in the circumstance where a Licensed Mental Health Professional authorized to administer intelligence tests as specified in paragraph (b) below determines that administration of the current edition of the Wechsler Intelligence Scale for Children (WISC), Wechsler Adult Intelligence Scale (WAIS) or Stanford-Binet Intelligence Scale (SB) is not appropriate due to the youth's condition or impairment. An alternative standardized intelligence test, administered and interpreted in conformance with instructions provided by the producer of the test, may be used. The results of the alternative standardized intelligence test must include reference to published validity and reliability data for the specified test, and justification for use of the alternative test for the youth. Examples of alternative standardized intelligence tests include the Leiter International Performance Scale and Comprehensive Test of Non-Verbal Intelligence.

2. If an alternative standardized intelligence test is utilized, an adaptive behavior functioning test must also be administered as set forth in paragraph (a) above.

(b) Intelligence testing and adaptive behavior functioning tests shall be administered by a Licensed Mental Health Professional who is qualified by training, education and experience to render such evaluations and is authorized under their licensing board to provide such evaluations.

(c) Concurrent significant deficits in intellectual and adaptive behavior functioning must be present in the intelligence testing and adaptive behavior functioning testing in paragraph (a) above for findings of Developmental Disability.

(4) Treatment Services for Youth with Developmental Disability.

(a) Youths who are placed in a residential commitment program designated for Developmental Disability treatment services shall be referred to the facility's multidisciplinary treatment team for development of a Developmental Treatment Plan and Developmental Disability Clinical Treatment Services as specified in this section:

(b) Behavior Analysis Services shall be provided by a person who is a Board Certified Behavior Analyst, a Certified Behavior Analyst, a Psychologist licensed under Chapter 490, F.S., or a Licensed Clinical Social Worker, Licensed Mental Health Counselor or Licensed Marriage and Family Therapist licensed under Chapter 491, F.S., with more than three years experience post certification or licensure.

(c) Therapy to promote social skills and life skills of youths with Developmental Disability. For example, therapy focusing on improved coping skills or interpersonal problem solving skills or anger replacement therapy shall be provided 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.

(d) Mental health services for youths with Developmental Disability and Mental Disorder shall be provided 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 as specified in Rules 63N-1.0033 and 63N-1.0081, F.A.C.

(e) Substance abuse services for youths with Developmental Disability and Substance-Related Disorder shall be provided by a Licensed Qualified Professional or a Substance Abuse Clinical Staff Person as specified in Rules 63N-1.0034 and 63N-1.0082, F.A.C.

(f) Developmental Disability Clinical Treatment Services shall be documented in a progress note/treatment note written by the clinician who provided the service.

(5) Treatment Planning and Discharge Planning.

(a) An Individualized Developmental Treatment Plan is required when a youth enters Developmental Disability treatment.

(b) The Individualized Developmental Treatment Plan shall be developed by a multidisciplinary treatment team, including a Board Certified Behavior Analyst, Certified Behavior Analyst, or person licensed under Chapter 490 or 491, F.S., and the youth. Development of an Individualized Developmental Treatment Plan must include the youth's parent or legal guardian, unless there is documentation of a reason for the parent or legal guardian's non-involvement in treatment planning.

(c) The Individualized Developmental Treatment Plan must be completed within 30 days of the youth's admission to the program.

(d) The Individualized Developmental Treatment Plan must contain the following elements:

1. The specific developmental, behavioral, and life skills needs that will be the focus of treatment;

2. Developmental Disability Clinical Treatment goals and objectives, written in achievable and measurable terms, which are responsive to the youth's Developmental Disorder and address specific behaviors, symptoms, skill deficits, strengths and needs of the youth;

3. The Developmental Disability interventions/strategies to be provided and target dates for completion;

4. The youth's functional strengths/abilities and needs which may affect his/her success in treatment;

5. The plan must contain the signature of the youth, the multidisciplinary treatment team members who participated in the development of the plan and a Board Certified Behavior Analyst, Certified Behavior Analyst, a Psychologist licensed under Chapter 490, F.S., or a Licensed Clinical Social Worker, Licensed Mental Health Counselor or Licensed Marriage and Family Therapist licensed under Chapter 491, F.S.

a. When a youth in a residential commitment program is identified as an Agency for Persons with Disabilities (APD) client, the residential commitment program shall request and encourage the APD waiver support coordinator to participate in the youth's multidisciplinary treatment team meetings.

b. When a youth in a residential commitment program has a current behavior support plan or case plan through the Agency for Persons with Disabilities (APD), the program shall coordinate the youth's Individualized Developmental Treatment Plan with the youth's APD plan for related issues.

(6) Integrated Developmental and Mental Health/Substance Abuse Treatment Plans. Youths diagnosed with Developmental Disability and Mental Disorder and/or Substance-Related Disorder shall receive integrated treatment services based upon an integrated developmental and mental health/substance abuse treatment plan.

(a) The integrated developmental and mental health/substance abuse treatment plan shall be developed with the input of Developmental Disability and Mental Health Clinical Staff and/or Substance Abuse Clinical Staff.

(b) The integrated developmental and mental health/substance abuse treatment plan shall include the elements described in paragraph (d) above and Rule 63N-1.007, F.A.C.

(7) A review of the Individualized Developmental Treatment Plan must be conducted by the multi-disciplinary treatment team every 30 days as set forth in Rule 63N-1.007, F.A.C.

(8) During the final phase of Developmental Disability treatment, the multidisciplinary treatment team and youth shall establish a discharge plan whereby improvements made during treatment will be maintained upon the youth's movement from one facility to another, or return to his/her community.

(a) The discharge plan shall document the focus and course of the youth's Developmental Disability treatment, and recommendations for services upon the youth's movement out of the facility.

(b) The discharge plan shall be discussed with the youth, parent/legal guardian (when available) and Juvenile Probation Officer prior to the youth's release from the facility or program. For committed youths served by the Agency for Persons with Disabilities (APD) or the Department of Children and Families (DCF), the residential commitment program shall invite representatives from APD or DCF to the youth's transition and exit conferences in accordance with subparagraphs 63E-7.010(10)(a)1. and 63E-7.010(10)(b)1., F.A.C.

(c) A copy of the discharge plan will be provided to the youth, the youth's assigned Juvenile Probation Officer and to the parent/legal guardian, unless there is documentation of a reason for the parent or legal guardian's non-involvement in treatment planning.

(9) Suicide Prevention, Mental Health Crisis Intervention and Emergency Mental Health and Substance Abuse Services provisions in this rule apply to the provision of Developmental Disability services.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.014 Consent Requirements Applicable to Mental Health Services and Psychotropic Medication.

(1) The Authority for Evaluation and Treatment (AET) Form (HS 002) incorporated in Rule 63M-2.0051, F.A.C., is the means by which the department obtains the consent of the parent or legal guardian for routine health and mental health evaluation and treatment.

(2) The AET (HS 002) authorizes the department to provide physical health and mental health information to healthcare providers that are or will be treating a youth. It also authorizes healthcare providers to release physical health and mental health records to the department. The AET procedures provided in Rule 63M-2.0051, F.A.C., must be followed to obtain the parent or legal guardian's consent for release of physical health and mental health information and records.

(a) The AET authorizes the department to arrange for, make available and facilitate mental health assessments and treatment with licensed Mental Health Providers or mental health facilities, including diagnostic assessment, psychological testing, and individual, group, and family therapy and/or counseling.

(b) The AET shall not authorize the commitment of a child to a residential facility licensed under Chapter 393 or 394, F.S., but is acknowledging commitment under Chapter 985, F.S.

(3) Unless revoked or modified by a youth's parent or guardian or superseded by a court order addressing the provision of routine mental healthcare, an AET (HS 002) remains current and valid while the youth remains under the department's supervision or custody or for one year after it is signed, whichever comes later. However, if a youth reaches 18 years of age while in the program and is not incapacitated, or is otherwise emancipated as provided in Section 743.01 or 743.015, F.S., the youth is responsible for authorizing his/her health care and authorizing release of his/her healthcare records.

(a) Except in the case of an incapacitated youth for whom the court has appointed a parent as the guardian, the facility or program shall not release any health or mental health information to a parent of a youth who is 18 years of age or older, or is otherwise emancipated as provided in Section 743.01 or 743.015, F.S., without the youth's written consent.

(b) The program shall request the youth who is 18 years of age or older, or is otherwise emancipated as provided in Section 743.01 or 743.015, F.S., provide written consent for his or her parent or legal guardian to be contacted in the event of an emergency. If the youth does not provide consent for the parent or legal guardian to be contacted, the program shall request the youth designate in writing the person or persons who are to be contacted in the event of an emergency.

(4) The AET (HS 002) provides the parent/legal guardian's authorization to continue administration of only those 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, as long as there are no changes in the Psychotropic Medication dosage or route of administration.

(5) Whenever a new Psychotropic Medication is prescribed, Psychotropic Medication is discontinued, or the drug dosage is significantly changed, parental/legal guardian verbal consent for Psychotropic Medication is documented through the CPPN (form HS 006) at page 3 or a form containing all the information require in HS 006 at page 3, and written consent is documented on the Acknowledgment of Receipt of CPPN Form or Practitioner Form (HS 001) in accordance with Rule 63N-1.0085, F.A.C.

(6) Consent requirements for provision of Psychotropic Medication for youths in foster care whose parent or legal guardian's rights have been terminated are addressed in Chapter 65C-35, F.A.C.

(7) The department's Office of the General Counsel shall be notified in the following circumstances:

(a) The parent or legal guardian declines to sign the Authority for Evaluation and Treatment, or the parent or legal guardian's location or identity is unknown;

(b) The parent or legal guardian verbally revokes the Authority for Evaluation and Treatment and is unwilling, unable or unavailable to provide written revocation.

(c) The parent or legal guardian declines to authorize the provision of Psychotropic Medication or withdraws consent for provision of Psychotropic Medication which the Psychiatrist determines is medically necessary for a youth.

(d) The youth requests the discontinuation of Psychotropic Medication or refuses Psychotropic Medication which the Psychiatrist determines is medically necessary for a youth.

(8) A copy of any court order authorizing mental health treatment or provision of Psychotropic Medication must be placed in the youth's Individual Healthcare Record.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.

63N-1.015 Special Consent Requirements For Substance Abuse Evaluation and Treatment.

(1) Youth Consent for Substance Abuse Evaluation and Treatment.

(a) A youth must consent to substance abuse evaluation and treatment unless such treatment is ordered by the court.

(b) Youth consent for substance abuse evaluation and treatment shall be obtained through the Youth Consent for Substance Abuse Treatment Form (MHSA 012) or through a form developed by the program which contains all the information required in form MHSA 012. The Youth Consent for Substance Abuse Treatment Form (MHSA 012, August 2006) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03794 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(c) If a youth refuses to provide consent for substance abuse evaluation and treatment, the department shall determine the need for a court order for the provision of such services.

(2) Youth Consent for Release of Substance Abuse Records.

(a) Substance abuse records of service providers pertaining to the identity, diagnosis, and prognosis of and service provision to a youth may not be disclosed without the written consent of the youth to whom they pertain. However, appropriate disclosure may be made without written consent as specified in Section 397.501(7), F.S.

(b) Any written consent for disclosure may be given only by the youth. This restriction on disclosure includes any disclosure of youth identifying information to the parent, legal guardian or custodian for the purpose of obtaining financial reimbursement.

(c) Youth consent for release of substance abuse records shall be provided on the Youth Consent for Release of Substance Abuse Treatment Records Form (MHSA 013) or on a form developed by the program which contains all the information required in form MHSA 013. The Youth Consent for Release of Substance Abuse Treatment Records Form (MHSA 013, August 2006) is incorporated by reference and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-03795 or may be obtained by contacting: DJJ, Office of Health Services, 2737 Centerview Drive, Tallahassee, FL 32399.

(3) A copy of any court order authorizing substance abuse treatment must be placed in the youth's Individual Healthcare Record.

Rulemaking Authority 985.64(2) FS. Law Implemented 985.601(3)(a), 985.14(3)(a), 985.145(1), 985.18, 985.48(4), 985.64(2) FS. History–New 3-16-14.