DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
DIVISION OF PREVENTION AND BEHAVIORAL HEALTH SERVICES ("DPBHS")
DPBHS Intake Unit: 302-633-2571 or 1-800-722-7710
STATEWIDE 24/7 Mobile Response and Stabilization Services (MRSS) Hotline: 1-800-969-4357 (HELP)

JUVENILE 24-HOUR EMERGENCY DETENTION FORM

For Use ONLY if Voluntary Admission to a Designated Psychiatric Facility is Not Possible

Detainment after transfer to a designated psychiatric facility shall not exceed 24 hours if a parent or legal guardian is available to the Department of Services for Children, Youth, and Their Families ("Department"). **If no parent or legal guardian is available to the Department during the 24-hour period, the time period may be extended to 72 hours**. 16 Del. C. § 5001(8)].

If the child is currently receiving DPBHS services, or this detainment will be paid in whole or in part by DPBHS, fax a copy of this completed form to the DPBHS Access/UR Unit, fax no. 302-622-4441.

REQUEST for 24-HOUR EMERGENCY DETENTION of a JUVENILE

(To be completed only by a Peace Officer or Juvenile Mental Health Screener.)

I, _____ of the _____
PRINT Full Name / Title — Unit and/or Agency

on this Date ____/____/____ and at this time ____:____ AM / PM
Date (MM/DD/YYYY) — Time HH/MM)

do hereby certify that I have knowledge that _____ ____/____/____ ____
Name of minor to be evaluated — D.O.B. (MM/DD/YYYY) — Age

of _____
Address of the residence of the person to be evaluated (Street, City, State and Zip Code)

appears to have a mental condition and is experiencing symptoms likely to cause danger to her or himself, or others, and requires immediate care, treatment, and detention.

PART 1: ASSESSMENT OF DANGEROUSNESS

Part 1, Section I shall be completed by a Peace Officer or by a State of Delaware Juvenile Mental Health Screener. The Screener must annotate as needed to reflect information obtained during the assessment process.

Section I: ASSESSMENT

"Dangerous to self" means, *by reason of mental condition,* there is a *substantial likelihood* the minor will *imminently sustain serious bodily harm to oneself.* This determination shall take into account a minor's history, recent behavior, and any recent act or threat.

"Dangerous to others" means, *by reason of mental condition,* there is a *substantial likelihood* the minor *will inflict serious bodily harm upon another person within the immediate future.* This determination shall take into account a minor's history, recent behavior, and any recent act or threat.

"Serious bodily harm" means physical injury which creates a *substantial risk* of death, significant and prolonged disfigurement, significant impairment of health, or significant impairment of the function of any bodily organ.

A. Does this minor meet the requirement for dangerousness to self? **YES ☐** **NO ☐**

B. Does this minor meet the requirement for dangerousness to others? **YES ☐** **NO ☐**

C. Describe / Justify the dangerousness finding noted above:
(e.g., Describe any stated or observed suicidal intent/action, any stated or observed homicidal intent/action, and/or any stated or observed dangerous behavior by said minor, and/or any stated or observed symptom of a mental condition which would represent a substantial danger to self or others.)

1. What is the name, relationship, and contact information for the person who placed the initial call forhelp:

_____ _____ (____) _____
First and Last name of reporting party — Relationship — Phone

Name of minor being evaluated:_____D.O.B._____/_____/ _____

2. Why does the minor require a Mental Health Assessment for a 24-Hour Emergency Detention?

(Include specific details to support a finding of dangerousness to self or others due to risk of suicide, homicide, or impaired mental condition.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

*** Please attach and sign additional sheets with additional information, names, and contact information as needed.**

_____ _____/_____/_____ _____:_____AM / PM

Signature / Title or rank of person submitting this Request for Evaluation | Date (MM/DD/YYYY) | Time (HH/MM)

(_____) _____-_____Ext: _____ _____

Contact phone number of person submitting request | Agency

Section II: STATEMENT of PEACE OFFICER or DESIGNATED TRANSPORTER

I,_____have transported, _____

with all reasonable promptness, to a designated psychiatric treatment facility,_____,
for further evaluation.

_____ _____/_____/_____ _____:_____AM / PM

Signature of Officer or Transporter | Date (MM/DD/YYYY) | Time (HH/MM)

_____ _____ _____

Print Full Name | Title | Unit or Transport Agency Name

This form is to be forwarded to the receiving hospital with the transporting officer or designee.

Name of minor being evaluated:_____D.O.B._____/_____/ _____

PART 2: ASSESSMENT OF APPARENT MENTAL CONDITION

Part 2, Sections I-IV shall be completed *ONLY* By a State of Delaware Juvenile Mental Health Screener

Section I: ASSESSMENT

"*Mental condition*" means a current, substantial disturbance of thought, mood, perception or orientation that significantly impairs judgment, capacity to control behavior or capacity to recognize reality. Unless it results in the severity of impairment described herein,

"*mental condition*" *DOES NOT* mean simple alcohol intoxication, transitory reaction to drug ingestion, dementia due to various non-traumatic etiologies or other general medical conditions, Alzheimer's disease, or intellectual disability. The term mental condition is not limited to ***"psychosis"*** or **"*active psychosis*,"** but shall include all conditions that result in the severity of impairment described herein.

A. If the above-named minor is displaying behaviors meeting criteria for a mental condition, describe below.

_____

_____

_____

_____

_____

_____

_____

B. The minor is NOT ABLE to be safely treated in the community at this time. **YES ☐ NO ☐ Unknown ☐**

_____

Section II: JUVENILE SCREENER 24-HOUR EMERGENCY DETENTION STATEMENT

☐ I am a Psychiatrist licensed to practice medicine in the state of Delaware.
☐ I am a board-certified Emergency Medicine Doctor.
☐ I am a physician licensed in the State of Delaware to practice medicine or surgery.
☐ I am a Licensed Mental Health Professional, Advanced Practice Nurse or Registered Nurse. As required by Del. Administrative Code, Title 9, Reg 701, Sec. 3.2.3.3, I have consulted with another DPBHS Juvenile Mental Health Screener and provided documentation of the consultation in Section IV of this form.

I certify that I,_____am a credentialed DPBHS **Juvenile Mental Health Screener, #** _____
PRINT Full Name / Title

I personally assessed that this minor,_____ _____/_____/ _____
Name of minor evaluated D.O.B. (MM/DD/YYYY)

☐ **MEETS** ☐ DOES **NOT MEET** the standard for 24-hour detention: experiencing symptoms of mental Illness that render this minor dangerous to self and/or others by reason of mental condition, and unable to be voluntarily admitted. (See attached evaluation).

This minor was considered for voluntary in-patient treatment and:

☐ **A parent or legal guardian could not be identified or located.**
☐ **A parent or legal guardian REFUSED to provide written consent for voluntary treatment for the minor at this date and time:**

Date (MM/DD/YYYY) _____/_____/_____ ***Time (HH/MM)*** _____/_____.

☐ **A parent or legal guardian has AGREED* to voluntary treatment of the minor and provided written consent.**
*****(If a parent or legal guardian has now consented to voluntary treatment of a minor, ***please complete Part 3 and 4*** of this form.)

Name of minor being evaluated:_____D.O.B._____/_____/_____

Name and phone number of parent or legal guardian of the minor to be detained:

_____ _____ (_____)_____-_____

Name of parent or legal guardian | Relationship | Telephone Number

Has this person been notified? ☐ YES ☐ NO _____

Specify reason not contacted

This minor is being taken to: _____

Name of Facility or Address of Alternate Location

I certify that the information I am providing is true and complete to the best of my knowledge.

_____ _____/_____/_____ _____AM / PM

Signature | Date (MM/DD/YYYY) | Time (HH/MM)

_____ _____ (_____)_____-_____

Title/position | Employed by | Unit Telephone

Section III: CONFLICT of INTEREST STATEMENT

Del. Administrative Code, Title 9, Reg 701, Sec. 6.1 Conflict of Interest Statement: The intent of the law is to ensure that no person is detained for any reason other than experiencing symptoms associated with a mental condition that may result in danger to self or others, and that any potential or apparent conflicts of interest as set forth in 16 Del. C. § 5004 are disclosed on the DPBHS Juvenile 24-Hour Emergency Detention form within 24 hours of signature of the detention order. For youth whose detainments are paid in whole or in part by DPBHS, or who are otherwise currently in DPBHS services, DPBHS will collect and monitor all DPBHS Emergency Detention forms performed by juvenile mental health screeners. Such collection and monitoring will occur whether a conflict of interest is disclosed or not, for purposes of ensuring the intent of this law is met and admissions are appropriate.

Conflict of Interest Disclosure Statement: ☐ No conflicts ☐ Yes, as follows: _____

_____

By my signature, I certify I have duly disclosed any conflicts of interest and I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the minor's mental disorder.

_____ _____/_____/_____ _____:_____AM / PM

Signature | Date (MM/DD/YYYY) | Time (HH/MM)

Section IV: DELAWARE JUVENILE MENTAL HEALTH SCREENER CONSULTATION

Section IV shall be completed *ONLY* by a State of Delaware Juvenile Mental Health Screener who is a Licensed Non-Physician Mental Health Professional. Skip this section if you are a Physician.

I certify I have consulted with_____a credentialed DPBHS Juvenile Mental Health

PRINT Full Name / Title

Screener, # _____, regarding my assessment of the above-named minor; and

(1) This consultant agrees with my determination whether this minor child meets the standard for 24-hour detention, as is stated above in Section III; and

(2) This consultant has provided the following **Conflict of Interest Disclosure Statement:** ☒ No conflicts ☐ Yes, as follows:

_____.

By my signature, I certify I have provided the consultant with all the facts necessary to render a professional opinion as to the nature and quality of the minor's mental disorder, and as to any potential conflict of interest for the consultant.

_____ _____/_____/_____ _____AM / PM

Signature | Date (MM/DD/YYYY) | Time (HH/MM)

This form is to be forwarded to the receiving hospital with the transporting officer or designee.

Name of minor being evaluated:_____D.O.B._____/_____/ _____

PART 3: CHANGE IN STATUS

Part 3 shall be completed *ONLY* By a State of Delaware Juvenile Mental Health Screener

A. Certification of Understanding:

This section shall only be used if the parent or legal guardian of a minor who is currently emergently detained makes a written request for voluntary admission for inpatient mental health treatment of the minor. If a minor is found to meet the criteria for voluntary admission pursuant to this section, that minor shall have the status of "voluntary" upon arrival at a designated psychiatric treatment facility. A minor who is emergently detained shall not have his or her status converted to "voluntary" if the minor continues to be a danger to self or danger to others due to an apparent mental condition and such minor's parent or legal guardian is unwilling to allow the minor to remain in care, seeking to end the minor's placement at designated psychiatric treatment facility. A change in status pursuant to this section shall not be used to discharge a minor from care. Only a psychiatrist has the authority to discharge a minor who is emergently detained.

I have read the above statement and certify that I understand.

_____ Signature

_____/_____/_____ Date (MM/D/YYYY)

_____:_____AM / PM Time (HH/MM)

_____ Position / Title

_____ Facility / Hospital

B. Assessment for Voluntary Admission:

☐ **I certify that I have informed the minor and the minor's parent or legal guardian of the terms of voluntary admission for inpatient mental health treatment, including:**

(1) The minor will not to be allowed to leave the hospital grounds without permission of the treating psychiatrist;

(2) If the minor's parent or legal guardian seeks discharge of the minor prior to the discharge recommended by the minor's treatment team, the minor'streating psychiatrist may initiate the involuntary inpatient commitment process if the psychiatrist believes the minor presents a danger to self or a danger to others; and

(3) Unless the involuntary commitment process is initiated, the minor will not have the hospitalization reviewed by the court.

The minor's parent or legal guardian understands and is in agreement with the above terms and consequences ☐YES ☐NO. ***If "No" is selected, the 24-hour emergency detention may not be converted to a voluntary admission.***

C. My assessment is based upon the following direct observations: _____

_____

_____

_____

_____

This form is to be forwarded to the receiving hospital with the transporting officer or designee.

Name of minor being evaluated:_____D.O.B._____/_____/ _____

PART 4: PLAN FOR CONTINUATION OF CARE

Part 4 shall be completed *ONLY* By a State of Delaware Juvenile Mental Health Screener

Please describe the steps being taken to ensure the above-named minor will be transferred to a designated psychiatric treatment facility for continued care and treatment.

_____

_____

_____

_____

_____

I certify, based upon my personal assessment of the above-named minor and my consultation with the minor's parent or legal guardian about the need for inpatient mental health treatment, that the emergency detention may be converted to a voluntary admission.

_____ _____/_____/ _____ _____:_____ AM / PM

Signature Date (MM/DD/YYYY) Time (HH/MM)

_____ _____

Position / Title Facility / Hospital

This form is to be forwarded to the receiving hospital with the transporting officer or designee.

Name of minor being evaluated:_____D.O.B._____/_____/ _____

PART 5: DISCHARGE: (May ONLY be COMPLETED by a PSYCHIATRIST)

I certify that the above-named minor no longer meets the criteria for emergency detention, for the following reasons:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____/_____/ _____ _____:_____AM / PM

Signature Date (MM/DD/YYYY) Time (HH/MM)

_____ _____

Position / Title Facility / Hospital

If the child is currently receiving DPBHS services, or this detainment will be paid in whole or in part by DPBHS, fax a copy of this completed form to the DPBHS Information and Referral Unit, fax no. 302-622-4441.

This form is to be forwarded to the receiving hospital with the transporting officer or designee.