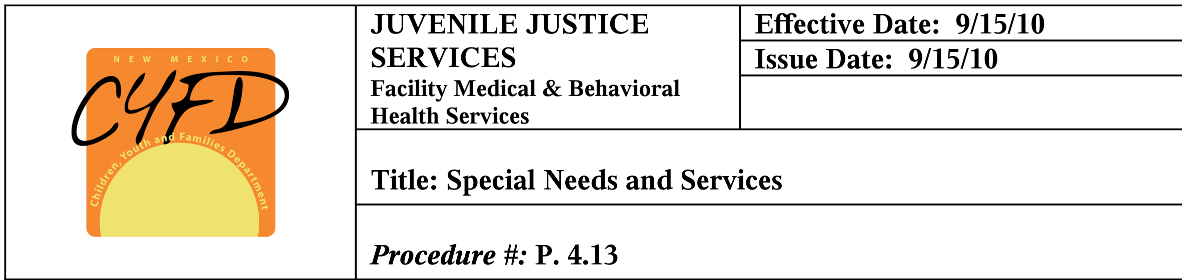

	JUVENILE JUSTICE SERVICES Facility Medical & Behavioral Health Services	Effective Date: 9/15/10 Issue Date: 9/15/10
	Title: Special Needs and Services	
	Procedure #: P. 4.13	

1. **ISSUING AGENCY:** **Children, Youth and Families Department (CYFD)**

2. **SCOPE:** **Juvenile Justice Services (JJS)**

3. **STATUTORY AUTHORITY:** **8 NMAC 14.4**

4. **FORMS:** **Suicide Intervention Plan (SIP)**
Reassessment or Change in Crisis—Suicide Observation Level
Suicide Intervention Plan Observation Log

5. **APPLICABLE POLICY:** **8.14.4.13**
Guides staff in the treatment of those clients needing close medical supervision and special monitoring.

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7. **DEFINITIONS:**

7.1 "Emergency Psychotropic Medication" is defined as medication given with or without the patient's consent in emergency situations when a client is a danger to self or others due to a medical or mental illness and used to prevent harm based on a physician's order.

7.2 "SIP" means Suicide Intervention Plan.

7.3 "Treatment Plans" Treatment Plans are the plans created by the respective content specialists to address client needs as per diagnostic assessments, testing, collateral information, committing offenses and professional judgment as it pertains to their specific discipline. The plans outline measurable goals and guide treatment.

8. Clients needing close medical supervision: A proactive program exists that provides care for special needs clients who require close medical supervision or multidisciplinary care.

8.1 Clients who require close medical supervision or multidisciplinary care include those with conditions such as chronic illness, developmental disability, pregnancy, and serious mental health needs.

8.2 Individual treatment plans are developed by qualified medical and/or behavioral health care professionals at the time the physical or mental conditions are identified, and updated when warranted.

8.3 The individual treatment plan includes, at a minimum:

8.3.1 diagnostic information and other descriptions of client needs;

8.3.2 treatment services/modalities to be provided, including the type and frequency of therapeutic regimens;

8.3.3 medication services and instructions for self-administration as appropriate;

8.3.4 frequency of follow-up for medical evaluation and adjustment of treatment modality;

8.3.5 type and frequency of ongoing diagnostic and other testing; and

8.3.6 instructions and accommodations for diet, exercise, and placement.

8.3.7 completion of required referral paperwork for Student Assistance Team (SAT) to the education department, if appropriate.

8.4 Special needs are listed on the master problem list.

8.5 The facility medical department maintains a list of special needs patients.

9. Chronic disease: clients with chronic diseases are identified and provided medical and other services with the goal of decreasing the frequency and severity of symptoms, including preventing disease progression and fostering improvement in function.

9.1 The Medical Health Authority establishes or approves clinical guidelines consistent with accepted national clinical practice guidelines promulgated by experts in the field.

9.2 Each facility has clinical protocols for the management of chronic diseases, including but not limited to:

9.2.1 Asthma;

9.2.2 Seizure disorders;

9.2.3 Psychiatric disorders requiring psychotropic intervention;

9.2.4 HIV;

9.2.5 Tuberculosis disease or infection; and

9.2.6 Hepatitis C

9.3 Documentation in the medical record confirms that clinicians are following the chronic disease protocols. When clinically indicated, deviations from the protocols are explained.

9.4 The Medical Health Authority annually approves the chronic disease protocols.

9.5 The Medical Health Authority implements a system to ensure continuity

of medications for chronic diseases.

10. Prostheses and orthodontic devices: Medical and dental orthoses or prostheses and other aids to impairment are supplied in a timely manner when the health of the client would otherwise be adversely affected, as determined by a qualified health or dental health care professional. Clients are provided with one prosthesis or orthodontic device as prescribed by licensed medical or dental provider. Replacements are the responsibility of the client or their family if they are purposefully damaged, destroyed or ruined due to inappropriate client behavior.

10.1 Evidence that prescribed aids to impairment are received is confirmed through health record documentation.

10.2 Where the use of specific aids for impairment is contraindicated for security concerns, alternatives are considered so the health and educational needs of the client are met.

11. HIV/AIDS: Facilities have written plans regarding approved actions to be taken by health and facility staff concerning clients who have been diagnosed as HIV positive.

11.1 Written plans regarding approved actions to be taken by health and facility staff concerning clients who have been diagnosed as HIV-infected include:

11.1.1 when and where clients are to be tested;

11.1.2 appropriate safeguards for staff and clients;

11.1.3 when and under what conditions clients are to be separated from the general population;

11.1.4 staff and client training; and

11.1.5 issues of confidentiality.

11.2 The terms governing consent to perform an HIV test and to administer medications are specified in applicable state law. Consent to testing is not always required, nor is a court order. Factors to be considered in each case include the legal status of the persons to be tested and the means by which a suspected transmission of the virus occurred:

11.2.1 Any staff that suspect that an HIV transmission has occurred shall report the incident and all of the facts surrounding the incident immediately to the Medical Health Authority to expedite the evaluation and treatment of anyone who may have had blood exposure. Medical staff will also report the incident and all the facts surrounding the incident in writing to the Medical Health Authority;

11.2.2 In cases where an HIV test is indicated, the Medical Health Authority will attempt to obtain consent for testing from the person suspected of transmitting HIV and from the person(s) who may have been infected.

11.2.3 If consent is obtained from both/all parties in accordance with applicable law, the Medical Health Authority will proceed to have the testing done and to arrange for payment by the responsible entity.

If one or more consents are not given, the Medical Health Authority will proceed to obtain the HIV test of the non-consenting person(s). In all cases involving HIV testing, the Medical Health Authority will consult with the Department's office of general counsel to ensure compliance

with applicable law.

12. Hepatitis C: All clients who are positive for Hepatitis C will be referred to the Hepatitis Clinic at the University of New Mexico (UNM). UNM will make a medical determination whether treatment should be started while the client is in a facility. If there is a determination not to begin treatment which is based on the client's lack of ability to continue treatment after release, the cost of treatment or other reasons that can be resolved, the facility Health Services Administrator, psychiatrist and medical discharge planner will meet, with the client if necessary, to attempt to resolve those barriers.

13. Serious, infectious, and communicable disease: Facilities have written plans addressing the management of serious, infectious, and communicable disease that include control, prevention, and treatment strategies.

13.1 Serious, infectious, and communicable diseases requiring special attention include, but are not limited to, tuberculosis, hepatitis-B, hepatitis-C and HIV:

13.2 Management of serious, infectious, and communicable disease includes:

13.2.1 an ongoing education program for staff and clients;

13.2.2 control, treatment, and prevention strategies that include screening and testing;

13.2.3 special supervision and/or special housing designations, as appropriate;

13.2.4 protection of individual confidentiality; and

13.2.5 media relations.

13.3 Qualified medical health care staff does not release information concerning a client's communicable disease or indications of a communicable disease except to qualified health care and education professionals on a need to know basis, and pursuant to federal and state confidentiality laws:

13.3.1 If a client self-discloses about any medical condition, including a communicable disease, staff keep the information confidential, meaning it is not shared with other employees or any other person except as expressly provided in these procedures. Staff reports information about medical conditions to medical staff only.

13.3.2 Staff does not include the information of a communicable disease, whether by self-report or examination of a client, in any non-medical progress notes, non-medical assessments, or non-medical reports.

13.3.3 For clients in facilities, the staff member obtaining information regarding a client's communicable disease or indications of a communicable disease informs the Medical Health Authority, who identifies other individuals permitted to receive the information under the "need to know" standard.

13.3.4 The standards outlined in Section 24-2B-6 through -8 NMSA 1978 are followed for any person with HIV.

13.4 Medical staff refers a client for medical treatment, following CYFD standards of care for communicable diseases:

13.5 Medical staff isolates clients with a communicable disease only upon an order from the Medical Director:

13.6 Staff refers clients to the staff physician when a client requests testing for a communicable disease.

13.7 All staff use standard precautions to prevent the spread of communicable diseases and minimize the risk of infection.

13.7.1 All staff wear appropriate disposable gloves at any time of contact or anticipated contact with body fluids or during personal contact, including searches of a client and client property. Staff immediately and thoroughly washes their hands and other skin surfaces exposed to blood, other bodily fluids or potentially contaminated material with warm water and soap. Staff uses protective gowns, masks, and eye protection as needed.

13.7.2 All staff promptly removes blood spills and contaminated fluids using disposable paper towels, detergent and water followed by application of an EPA-approved germicide. Staff wears disposable gloves for cleanup. All biohazardous waste is placed in receptacles for biohazard storage and disposal;

13.7.3 Staff in intensive client contact situations follows the following additional precautions;

13.7.3.1 avoids direct skin contact with blood and other bodily fluids when caring for nose bleeds, other bleeding or oozing wounds, or menstrual flow;

13.7.3.2 uses appropriate disposable gloves in cases of direct contact;

13.7.3.3 carefully and promptly discards in leak-proof plastic bags all gloves, sanitary napkins, gauze pads or any other disposable material soiled with body fluids; and

13.7.3.4 prevents the use by others of items soiled by blood or other body fluids;

13.7.4 Staff with the potential for intense client contact are trained as part of their core training annually on the subject of blood-borne pathogens and standard precautions;

13.7.5 The Superintendent requires the provision of receptacles for biohazard storage, which complies with OSHA and relevant environmental standards;

13.8 Examinations are conducted of any staff suspected of a communicable disease.

13.8.1 The Superintendent contacts the Employee Relations Bureau to determine how to proceed to refer staff with indications of a communicable disease for medical examination;

13.8.2 The Superintendent determines the need for staff reassignment based on the documented evidence of communicable disease and in consultation with CYFD human resources.

14. Clients with mental illness or developmental disability: Services are provided to clients with mental illness and developmental disabilities, and referral sources are identified as needed.

14.1 At intake or at any time during commitment of a client, staff may

identify symptoms of mental illness or indications of developmental disability and refer clients to behavioral health staff for further evaluation.

14.2 A client with a suspected developmental disability is referred to education administration according to federal law and state statute. If the client is not already receiving special education services, the referring staff member will complete the necessary paperwork to refer the client to the SAT according to the Individuals with Disabilities Education Improvement Act (IDEIA).

14.3 The education SAT will meet to determine appropriate education accommodations for the student, if necessary. All accommodations will be documented and a timeline for meeting to determine efficacy of the accommodations will be determined according to Response to Intervention (RTI).

14.3.1 Appropriate education and facility staff will attend all SAT meetings.

14.3.2 If the SAT determines according to its timeline and appropriate RTI actions that a student should be evaluated by an educational diagnostician, the team will make the referral. An educational Multidisciplinary Team meeting will be held to determine the results of the diagnostic evaluations. This could be a determination of the need for special education services.

14.4 The behavioral health referral committee, which includes the Psychiatric Director, Facility Behavioral Health Authority or designee, nursing staff, social work and counseling staff, meets weekly to review youth in all facilities who may require referral to a residential community behavioral health provider.

14.4.1 When community residential treatment is recommended for youth who urgently and/or acutely need treatment for mental illness, the medical and behavioral health staff prepares a timely comprehensive referral packet for an appropriate placement so that the client can obtain the level of care and intensity of services that they need.

14.5 The Facility Behavioral Health Authority, Psychiatric Director, and facility behavioral health staff determines the need for immediate intervention due to a behavioral health crisis. When indicated, the client is:

15.5.1 transferred to a behavioral health facility appropriate for a crisis evaluation and treatment; and

15.5.2 returned to the facility after completion of the evaluation and treatment.

14.6 During the off-site evaluation period, the Behavioral Health Authority and/or the Medical Health Authority consults with the hospital staff to coordinate the client's service needs and follow-up plans.

14.7 The client's parent or legal guardian and the Court are notified of the client's transfer no later than the next working day. If the client is 18 or over, the client's consent is required.

14.8 For non-secure facilities the Behavioral Health Authority, Psychiatric Director, and facility behavioral health staff determines the need for immediate intervention due to a behavioral health crisis. Staff transports clients to the emergency room of a hospital for initial medical treatment. If indicated, the client is transferred to a behavioral health facility appropriate for a crisis evaluation and treatment.

14.9 Services are provided to victims of sexual assault.

14.9.1 The medical and psychological trauma of a sexual assault is minimized by prompt and appropriate health and behavioral health intervention.

14.9.2 Victims of sexual assault are referred to the Sexual Assault Nurse Examiner (SANE) program for treatment and the gathering of evidence.

14.9.3 Follow-up counseling at a community rape crisis center will be considered as part of the long-term treatment plan.

15 Clients in need of behavior management and crisis intervention: Any time use of force is applied to a client, only approved methods in compliance with approved Department intervention programs are enforced. The least restrictive element of the process is used in every situation.

15.1 Mechanical restraints are used to prevent bodily injury to clients or others when a client is engaging in self-injurious and/or assaultive behavior and when all other approaches to prevent injury have failed, or when the immediate risk of harm is so great that other methods are not clinically indicated.

15.2 Facilities maintain a comprehensive plan and protocol for the use of mechanical restraints.

15.3 Medical and behavioral health staff (if present at the facility) will attempt to assist the client in gaining behavioral control by less restrictive interventions prior to considering application of mechanical restraints.

15.4 The use of mechanical restraints complies with accepted mental health standards, federal and state laws and regulations.

15.5 The use of mechanical restraints will not occur without the appropriate equipment available.

15.6 Mechanical restraints will be used only by facility staff trained in the proper application of the restraint devices pursuant to JJS use of force procedure.

15.7 Documentation of medical, behavioral health and security staff training is available.

15.8 If the facility cannot employ mechanical restraints for any reason, the client will be transferred to a local emergency room for evaluation and treatment.

16. USE OF EMERGENCY PSYCHOTROPIC INTERVENTION

16.1 Whether or not a client is a psychiatric patient, or currently on medication, nursing will call psychiatry at the time of a restraint if:

16.1.1 the client is markedly distressed;

16.1.2 the client is threatening or attempting self-injury; or

16.1.3 the restraint has continued for more than fifteen minutes.

16.2 If oral PRN medications are currently ordered in the patient's chart, then these may be offered at the nurse's recommendation or at the patient's request:

16.3 Behavioral Health is also on call for such events and will be alerted if a restraint takes place. Behavioral Health also may call the psychiatrist for consultation.

16.4 The psychiatrist on call will always order that voluntary oral medications be offered at least once before involuntary medications are considered, and at least once again prior to any administration of an involuntary medication.

16.5 If the psychiatrist believes that the administration of involuntary psychotropic medication is necessary to protect the client from serious harm, the psychiatrist or person authorized by the psychiatrist may administer psychotropic medication on an emergency basis.

16.6 No medication may be administered unless at the written order of a psychiatrist or by a verbal order noted promptly in the client's medical record.

16.7 Medical staff needs to document the reason no treatment less drastic than administration of psychotropic medication would have protected the client from serious harm.

16.8 Involuntary medications are never administered:

16.8.1 For convenience of staff or program:

16.8.2 In the place of routine behavioral health or psychiatric care for underlying causes;

16.8.3 Before alternative de-escalation methods have been strenuously applied; or

16.8.4 Before alternative voluntary medications have been offered more than once.

16.9 The responsibility to ensure that involuntary medication is ordered only according to this protocol rests solely with the psychiatrist, who is the only person who can order involuntary medication.

16.10 Appropriate documentation in the client's medical record to justify the use of involuntary medication should include:

16.10.1 The client's condition;

16.10.2 The threat posed;

16.10.3 The reason for forcing the medication; and

16.10.4 Other treatment modalities attempted, if any.

16.11 The ordering psychiatrist or an RN evaluates the client's situation every fifteen minutes for the first hour, every thirty minutes for the next two hours, and every hour for the next two hours following administration of the emergency psychotropic intervention.

16.12 If emergency psychotropic medications are used more than one time in a three-month period with any one client, a treatment guardian or other formal process for obtaining consent prior to administration must be sought.

17. Care of clients physically separated from population: Any time separation is implemented, only approved methods are used, in compliance with approved Department separation procedures at 8.14.5.43. The least restrictive element of the process is used in every situation. When a client is physically separated from the rest of the population, medical and behavioral health staff monitors medical and behavioral health status and ensures that the client has the opportunity to request care for medical, dental, or behavioral health problems.

17.1 Upon notification that a client is physically separated from the rest of the population:

17.1.1 A qualified health professional reviews the client's medical and behavioral health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation.

17.1.2 The review is documented in the health record.

17.1.3 When medical staff is not on duty, the medical health staff member on call is notified.

17.1.4 Medical staff reviewing the record notifies behavioral health staff when the client is under the care of behavioral health services.

17.2 Medical separation is used upon a written direct order from medical staff for a specified medical care issue that cannot be managed in general population. The direct order has specified start and end times and dates.

17.2.1 Medical staff releases clients placed in separation for direct medical orders when the order(s) expire(s).

17.2.2 All services provided are documented in the client master file and the relevant program logs.

18. Clients with a terminal illness: The health and mental health needs of the terminally ill client are met.

18.1 Medical treatment and care are provided according to current community standards. Adequate and appropriate pain management is provided and documented in the medical record.

18.2 In keeping with the requirements of the jurisdiction regarding end-of-life decision for clients:

18.2.1 Evidence exists, through documentation in the health record, that the client's guardian has been provided with sufficient and appropriate information to make informed decisions, including specialty and second-opinion consultations, and that appropriate to the age and maturity of the patient, the patient is involved in the process.

18.3 Where the facility is not equipped to provide needed services, the client is transferred to another facility, hospital, or hospice that is able to meet his or her health needs.

18.4 If the Medical Health Authority determines that care in a community setting is medically preferable, he or she recommends to the appropriate legal authority the client's transfer or early release in a timely manner consistent with federal and state laws.

19. Suicide prevention and crisis response: JJS facilities have a crisis response and suicide prevention protocol that provides for the identification and response to suicidal clients and clients in crisis; all staff are trained in the protocol as well as the identification of warning signs or indicators.

19.1 Initial and annual Crisis Response and Suicide Prevention Training are mandatory for all direct care staff including medical, behavioral health, education, and facility staff.

19.2 Within the first three hours of arrival at a facility, all clients receive a medical assessment, which includes screening for suicidality.

19.3 If medical and/or behavioral health staff concludes from the screening and assessments that there is a risk of suicide or another crisis, the client is placed on suicide/crisis precautions immediately using the Suicide Intervention Plan (SIP) form.

19.4 Following the Central Intake Process, and throughout the entire period of incarceration, all staff members shall be constantly alert for signs of potential self-injurious or suicidal behaviors in juveniles and are expected

to promptly communicate such information to behavioral health staff and/or other medical/security and supervisory staff.

19.5 All juveniles returning from the hospital for emergency or inpatient treatment following a suicide attempt/gesture are held in the medical area until they receive an evaluation by behavioral health staff.

19.6 If security staff concludes that there is a risk of suicide or other crisis, the juvenile is to be kept in a safe environment under constant observation by security staff until an evaluation is completed by medical or behavioral health staff.

19.7 If medical and/or behavioral health staff concludes from the screening and assessment that there is a risk of suicide or other crisis, the client is placed on suicide/crisis precautions immediately.

19.8 Only a psychiatrist, independent licensed clinician, or licensed clinician (in consultation with supervisor) can make changes in suicide precautions or release a client from suicide precautions. In these cases, the Reassessment or Change in Crisis—Suicide Observation Level form is used.

19.9 Two levels of observation will be followed:

19.9.1 Close Observation: this level is used when the client is not actively suicidal or in crisis, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent history of self-destructive behavior and is now viewed as potentially suicidal or harmful to others.).

19.9.1.1 Using the Suicide Intervention Plan Observation Log, facility staff will observe a client under close observation status at staggered intervals not to exceed every 15 minutes, as detailed on SIP form.

19.9.1.2Observation log is to be kept by line staff and after it is completed it will be taken to medical records and placed in the behavioral health file.

19.9.1.3 Regardless of level of observation or change in clinical status, behavioral health care staff will assess the client on a daily basis;

19.9.2 Constant observation: This level is reserved for the client who is actively in crisis or is suicidal, either threatening or engaging in suicidal or other harmful behaviors;

19.9.2.1 Facility staff will observe a client placed on this level on a continuous, uninterrupted basis.

19.9.2.2Observation log is to be kept by line staff and after it is completed it will be taken to medical records and placed in the behavioral health file.

19.9.2.3 Regardless of level of observation or change in clinical status, behavioral health staff will assess the client on a daily basis.

19.9.3 Requests for reassessment of change in level of observation are submitted on the Reassessment form. Only a psychiatrist, licensed independent practitioner (LIP), or licensed clinician(in consultation with supervisor), has authority to approve requests for change in observation status;

19.10 Any staff member who discovers a client engaging in self-harming behavior will stay with the client, alert other staff, call for medical personnel immediately, and begin standard first-aid or CPR as necessary.

19.11 If staff initiates appropriate life-saving measures, they will continue to do so until relieved by medical personnel:

19.12 Once emergency medical treatment is completed, behavioral health staff will perform a clinical evaluation.

19.13 In the event of a suicide attempt or suicide, the following steps will be taken.

19.13.1 All appropriate CYFD officials (JJS Director, JJS Deputy Director, Superintendent, Health Services Administrator)-Will be notified through the SIR process. Behavioral Health Director, Shift supervisor- will be notified immediately by Behavioral Health Therapist. The client's family and/or guardian-will be immediately notified by a doctor or nursing supervisor. Email will be sent by Behavioral Health clinician to Behavioral Health team of the facility.

19.13.2 If a client is 14 years or older permission needs to be given by client to contact their parent or guardian unless it is an emergency situation where notification is needed to provide necessary services.

19.13.3 When a client commits suicide or attempts suicide, the other clients on the unit are provided appropriate support services from behavioral health staff within 48 hours of the event. When staff is affected by traumatic events, they are offered assistance by CYFD Employee Support Services within 48 hours of the event.

19.14 Clients at risk of suicide or another crisis are not to be segregated/isolated or restrained; they are supervised and maintained within their assigned living area.

19.14.1 EXCEPTION**:** When a client is actively engaging in self-destructive behavior, physical restraint or isolation may be used as a brief intervention in order to stop the self-harming behavior.

19.15 Clients at risk of suicide or another crisis are to attend all scheduled activities and programming, including education unless otherwise suspended, as a part of general population. Behavioral Health may make restrictions on activities as part of the SIP intervention.

19.16 Clothing restrictions, excluding belts and shoelaces, and the use of physical restraints, should be avoided whenever possible.

19.17 Multidisciplinary team meetings, inclusive of direct care and behavioral health, occur weekly to discuss the status of each client on crisis-suicide watch. Such meetings will occur for at least one week following the youth being on or removed from a crisis-suicide watch.

19.18 Original documents are to be filed immediately in Medical Records in the behavioral health file and copies can be kept on the unit for informational purposes. After the client has been removed from SIP, copies are to go to Medical Records immediately.

19.19 In the event of a suicide, serious suicide attempt, or other significant crisis, a mortality review committee from the state will be requested to examine:

19.19.1 the circumstances surrounding the incident.
19.19.2 facility procedures relevant to the incident.
19.19.3 all relevant training received by involved staff.
19.19.4 pertinent medical, education and mental health services/reports involving the victim, and possible precipitating factors leading to the suicide.

20. AUTHORIZED SIGNATURE:

APPROVED: ______________________________
Bill Dunbar, Cabinet Secretary
Children Youth and Families Department

HISTORY NOTES:
Issued in replacement of any and all previous procedures and or directives.