DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health
1901 North DuPont Highway, New Castle, Delaware 19720

24-HOUR EMERGENCY DETENTION FORM

(Detainment after transfer to a designated psychiatric facility shall not exceed 24 hours. Del. Code Title 16 §5122 rev. 10/09/2014)

Eligibility & Enrollment Unit 302.255.9458 **Crisis Intervention Services 800.652.2929**

Fax copy of this completed form to DSAMH Eligibility and Enrollment Unit during business hours, Mon.-Fri., 7 a.m.-3 p.m. to 302.622.4162. Outside business hours, please fax to 302.622.4162.

Section I. REQUEST for 24-HOUR EMERGENCY DETENTION of an ADULT

(To be completed only by a Peace Officer or Credentialed 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 person to be evaluated — D.O.B (mm/dd/yyyy) — Age

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

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

Section I, Questions 1 and 2 shall be completed by a Peace Officer or by a Credentialed Mental Health Screener. The Screener must annotate as needed to reflect information obtained during the assessment process.

1. Assessment of Dangerousness:

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

"Dangerous to others" means that *by reason of mental condition* there is a *substantial likelihood* that the person *will inflict serious bodily harm upon another person within the immediate future.* This determination shall take into account a person's history, recent behavior, and any recent 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 person meet the requirement for dangerousness to self? **YES** ☐ **NO** ☐

and / or

b. Does this person meet the requirement for dangerousness to others? **YES** ☐ **NO** ☐

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

2. Describe / justify the dangerousness finding noted in page one:

(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 person, and/or any stated or observed symptom of a mental condition which would represent a substantial danger to self or others.)

a. What is the **name, relationship, and contact information** for person who placed the initial call for help:

_____ _____ (_____) _____

First and Last name of reporting party | Relationship | Phone

b. Why does the person 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

Sections II-VII are to be completed *ONLY* by a State of Delaware Credentialed Mental Health Screener.

Name of Person being evaluated: _____ D.O.B._____/_____/_____

Section II. Assessment of Apparent Mental Condition

"*Mental condition*" means a current, substantial disturbance of thought, mood, perception or orientation which 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.

☐ **YES, the above-named person is displaying behaviors meeting criteria for a mental condition** (see above) as described here (and/or in SECTION 1, on page 1 and 2 of this form, above)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. ☐ **YES, the person is NOT WILLING or ABLE** to seek safe, appropriate treatment on his/her own at this time.

3. Does this person have an Advanced Mental Health Care Directive? **YES** ☐ **NO** ☐ **Unknown** ☐

4. a. Has the person been admitted to a psychiatric hospital before? **YES** ☐ **NO** ☐ **Unknown** ☐

b. If ***YES*,** where and when (if known) was the person previously admitted?: _____

5. a. Is the person receiving current out-patient mental health treatment? **YES** ☐ **NO** ☐ **Unknown** ☐

b. If ***YES*,** provide the doctor and/or therapist and/or provider's names and phone numbers: _____

6. a. Does the person have a care manager? _____ **YES** ☐ **NO** ☐ **Unknown** ☐

b. If ***YES*,** name of manager, phone number, and agency: _____

c. Has Provider been contacted? **YES** ☐ **NO** ☐ If ***NO***, please explain why not: _____

7. a. Does the person currently use mind-altering substances (drugs, alcohol, meds, etc.) YES ☐ **NO** ☐ **Unknown** ☐

b. If ***YES*,** what substances and when last used**:** _____

8. a. Name and phone number of spouse, closest relative, or peer support (if known) of person to be detained:

_____ _____ (_____)_____-_____

Name of emergency contact person | Relationship | Telephone Number

b. Has this person been contacted? YES ☐ NO ☐ If ***NO*,** please explain why not: _____

Section III. CREDENTIALED SCREENER 24-HOUR EMERGENCY DETENTION STATEMENT

I certify that I,_____ am a **Credentialed Mental Health Screener, #** _____
PRINT Full Name / Title

personally assessed that this person, _____ ____/____/ _____
Name of person 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 person dangerous to self and/or others by reason of mental condition. (See attached evaluation).

This person was offered voluntary in-patient treatment and:

☐ **is UNABLE to self-determine need for treatment.**
☐ **REFUSED voluntary treatment** at this date/time: ____/____/_____ **@** _____:_____AM / PM
Date (mm/dd/yyyy) Time (hh / mm)

☐ **has AGREED* to voluntary treatment.** ***(If person is now voluntarily agreeing to treatment, ***please complete page 5*** of this form.)***

☐ I am a Psychiatrist licensed to practice medicine in the state of Delaware.
☐ I am a licensed Emergency Medicine Doctor and a DSAMH Credentialed Mental Health Screener.
☐ I am a physician licensed in the state of Delaware to practice medicine or surgery and a DSAMH Credentialed Mental Health Screener.
☐ I am a Licensed Mental Health Professional or Registered Nurse and also a DSAMH Credentialed Mental Health Screener.
☐ I am an unlicensed mental health professional, a DSAMH credentialed Mental Health Screener supervised by a psychiatrist.

This person is being taken to: _____
Name of Facility or Address of Alternate Location

I have notified the nearest known relative,_____, _____
Name of relative / significant other and phone (if different than page 2)

☐ **YES** ☐ **NO** _____
Specify reason not notified

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 IV. CONFLICT of INTEREST STATEMENT

Del. Administrative Code, Title 16, Reg 6002, 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 conflicts of interest as set forth in 16 Del.C. §5122 are disclosed on the DSAMH Crisis Intervention Assessment Tool and
24-hour Emergency Admission form filed with DSAMH within 24 hours of signature of the detention order. DSAMH will collect and monitor all assessments, detentions and non-detentions performed by credentialed mental health screeners, whether a conflict of interest is disclosed or not, for purposes of ensuring that the intent of this law is met and that admissions are appropriate.

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

_____

By my signature, I certify that 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 person's mental disorder**.**

_____ _____/_____/_____ _____:_____AM / PM
Signature Date (mm/dd/yyyy) Time (hh / mm)

SECTION V. CHANGE in STATUS

Name of Person being evaluated:_____ D.O.B._____/_____/_____

a. Certification of Understanding:

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

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

_____ _____/_____/_____ _____:_____AM / PM

Signature Date (mm/dd/yyyy) Time (hh / mm)

_____ _____

Position/ Title Facility / Hospital

b. Assessment for Voluntary Admission:

I have personally assessed the individual and I certify that the individual has the capacity to fully understand and appreciate the terms of voluntary admission for inpatient mental health treatment, including:

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

Yes ☐ **No** ☐

(2) If the person seeks discharge prior to the discharge recommended by the person's treatment team, the person's treating psychiatrist may initiate the involuntary inpatient commitment process if the psychiatrist believes the individual presents a danger to self or danger to others

Yes ☐ **No** ☐

(3) Unless the involuntary commitment process is initiated, the person will not have the hospitalization reviewed by the Superior Court

Yes ☐ **No** ☐

If "NO" is selected for any of the above questions the 24-hour emergency detention may not be converted to voluntary admission

(Continue to next page)

Name of Person being evaluated:_____ D.O.B._____/_____/_____

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

SECTION VI. PLAN for CONTINUATION of CARE

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

I certify that based upon my personal assessment the above-named individual has the capacity to consent to voluntary admission for inpatient mental health treatment and the 24-hour emergency detention may be converted to voluntary admission.

Yes ☐ **No** ☐

_____ _____/_____/_____ _____:_____AM / PM

Signature Date (mm/dd/yyyy) Time (hh / mm)

_____ _____

Position/ Title Facility / Hospital

Name of Person being evaluated:_____ D.O.B._____/_____/ _____

SECTION VII. DISCHARGE: (May ONLY be COMPLETED by a PSYCHIATRIST)

I certify that the above-named individual 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

Fax copy of this completed form to DSAMH Eligibility and Enrollment Unit during business hours, Mon.-Fri., 7 a.m.-3 p.m. to 302.622.4162. Outside business hours, please fax to 302.622.4162.

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

Section VIII. 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) and Time (hh / mm)

_____ _____ _____

Print Full Name Title Unit or Transport Agency Name

Attach Request for Transportation Reimbursement Form, if required.