THE APPROPRIATE MANAGEMENT OF PSYCHIATRIC EMERGENCIES

(Document update: 9-06)

I. Psychiatric emergencies requiring immediate hospitalization are extremely commonplace.

A. More than 21 % of hospital bed in the United States are occupied by patients whose primary diagnosis are psychiatric.
B. A significant number of geriatric residents living in long-term care facilities have psychiatric symptoms, such as dementia* in Alzheimer patients, in addition to chronic physical problems.
C. More and more long term care facilities specialize in psychiatric care.
D. An increasing number of emergency calls in the community and to the private residence involve emergencies of a psychiatric nature and emergencies involving active substances abuse in which patients will sometimes exhibit symptoms similar to psychotic symptoms.
E. Many calls responding to patients injured as a result of violent behavior, such as domestic disputes , will also involve persons who are sometimes psychotic and frequently highly aggressive. In these instances:
    1. Persons nearby the patient may be violent for a variety of reasons, and
    2. The patient himself may be violently aggressive.

II. Psychiatric Decompensation.

A. Mental illness is a real disease that involves a malfunction of the brain.
    1. The causes of mental illness are organic (either physiological or anatomical in nature),as opposed to environmental.
    2. Mental illness may manifest itself in a variety of symptoms not limited to disorganized thinking, speech, or bizarre, behavior --the emotions as well as all the senses can be affected.
    3. Mental illness is a chronic, as opposed to acute condition.
    4. Mental illness is incurable, but at he same time very highly treatable. Treatment modalities include:
        a. Medication
        b. Programs
        c. Environment
    5. Persons who are diagnosed with mental illness are not more violent or aggressive than others who are well, however, many mentally ill people experience emotional problems that make managing strong feeling difficult in the extreme.
    6. Patients who have a dual diagnosis, I.e., those who are diagnosed with both mental illness and substances abuse, are likely to prone to violence.
        a. People who are mentally ill are more susceptible to substance abuse.
        b. As many as 30 % of mentally ill patients have a dual diagnosis.

*Dementia is a state of mental disorientation and derangement involving severely impaired intellectual functioning of which the patient is generally unaware.

B. As in many chronic illnesses, people who are mentally ill experience long period of apparent well being , punctuated by acute crisis (decompensation or relapse) when symptoms are revealed in an exaggerated manner.
   1. Decompensation is usually triggered by stress.
   2. Depending on the effectiveness of treatment, periods between decompensation can either be long or short.
   3. Often, decompensation can be prevented through early intervention and treatment by properly trained caregivers.
   4. Sometimes no matter how quickly or well the patient is treated, Decompensation may take place.
   5. When experiencing decompensation, the patient will probably require more intense intervention such as hospitalization.
   6 The patient must recompensate to stabilize.

III. Preparing to respond to a psychiatric call.

A. Scene safety is paramount (yours, your partners, the patients and those around you)
B. Perhaps the single most important step in beginning to manage a psychiatric Emergency in an appropriate manner is to prepare carefully.
C. The call begins in dispatch. Beyond dispatch requesting general medical information, They will ask – Does the patient know they are being transported by ambulance; Is the patient an elopement (flight or run away) risk; is the patient a direct or indirect threat to themselves or others; does the patient require restraints; and, is the patient currently under the influence of any street drugs or alcohol.
C. If possible, find out as much as you can about the nature of the emergency. In addition to asking the same questions that dispatch has asked, try to learn the answer to these questions:
   1. For what specific reason is the patient being hospitalized?
   2. Is the patient compliant with the requests of his caregivers?
   3. Does the patient know he/she is to be hospitalized? Is he/she refusing to be hospitalized?
   4. Is the patient actively psychotic (hallucinating, delusional, experiencing flight of ideas, loose associations, paranoid etc.)?
   5. Does the patient have a history of substance abuse? Is he under the Influence now?
   6. Is the patient violent?
E. Knowing what to expect (hopefully), RELAX , compose yourself, and concentrate only on implementing the correct procedures-how you act will most often determine how the patient will act.
F. Respond as quickly as possible.
G. When responding on a call to a long-term care facility specializing in psychiatric care, always bring the appropriate equipment (mechanical restraints), whether or not they. are requested.
H. Recognize the unsafe situation early.
   1. The "Triad of Violence." Pacing or rapid threatening posture; Pressed speech; and, Crouched positioning.
   2. Staff waiting in the hallway or at the station with the look of–Thank goodness you're here. Or staff standing in the hallway arms folded and gesturing.
   3. Should a patient run out of a facility, call 911. Running after the patient is unsafe. It's important to alert the staff, dispatch and provide a thorough description to the police. You may request to post the facility if you sense the patient may be picked up soon.
   4. You and your partner should always stay together from initiating patient contact up to driving the loaded ambulance. Never enter the patient room

alone. Also be aware of the paranoid patient. It is always preferred that same sex partner be with the patient.

5. Should the patient be stable and have a psychiatric complaint as the primary issue, then unless you reasonable cause, perform your focused assessment for the psychiatric complaint only. Avoid performing detailed physical exams.
6. Even though you may have taken courses in psychology or sociology previously, this is not the time to play psychologist, we are there to provide safe & secure transportation of this patient.

I. If necessary, call for the police via 911 or call for a MedEx assist.

J. Effective communication guidelines with the psychiatric patient:

1. Being honest is a good place to start; Your body stance, Use of hands & arms, Eye contact; and Voice.

IV. Take Downs – Let the staff & P.D. do their jobs. Pointers to assist with takedowns.

V. Transporting psychiatric patients.

A. You must remember that when transporting a decompensating mentally ill Patient, whether the patient is aggressive or not, he/she will be confused, disorganized thinking, and frightened. As one of the most important links in the care-giving chain, your job is to help the patient and perform a safe transport.

B. Your primary goal in managing aggressive patients is to ensure safety-safety for the patient, safety for yourself, and safety for those in the immediately area.

1. The best way to manage hostile and aggressive behavior is to identify and eliminate the causes (stimuli or stresses) that have triggered the behavior.
   These stimuli may include:
   a. Abusive stimuli (refer to handout)
   b. Physical stimuli
   c. Psychological stimuli.
   d. Situational stimuli.
2. If this is a call out of a residence or self-help facility and staff are not present be aware of patient medications as a window of information for you.
3. Diffusing low-risk aggressive situations (refer to enclosed checklist)
4. Diffusing to high-risk aggressive situations (refer to enclosed checklist).

VI. Use of Restraints: The purpose of this outline is to provide helpful information or augment what is provided through the CEMSS and LEMSS Policy / Procedures and SMO's. Scene safety is always paramount.

A. For a safe effective take down it takes the coordinated efforts of at least four, preferably five people. Once you are at this point negotiations with your patient have probably been exhausted. There may be no negotiating left. Be honest direct but supportive. The goal again is to proved care & transportation that is safe with no harm.

B. Be professional at all times.

C. Use of restraints

1. It takes two people to safely restrain each limb: One to immobilize the other to apply the restraint. Confirm distal PMS prior to and after restraint application. You will re-assess PMS as part of your routine patient assessment.
   a. Apply restraint and secure to the upper immovable part of the frame of the stretcher. Make it snug enough so the wrist/ankle are on the stretcher cushion but just on the edge.

b. The restraint cuff should be secured to the point that you can get your finger between the cuff and the patient's skin (follow the directions provided with your restraint device (enclosed).

c. Situations when the patient may complain about the restraint: Too high / Too low = Too Tight????

d. Never loosen or undo a restraint while alone with your patient.

VII. Use of the Stretcher Belts & Psychiatric Belt (The 6th. Belt).

A. As with all other patients, you are to insure that all patients are secured in all five (5) stretcher straps at all times. In the event you are unable to do this, you are to carefully document the reason why you were unable to use all 5 straps.

B. Listed below is the policy in the utilization of the "Psychiatric Belt":

Purpose: The purpose is to continue to provide transportation to our adult and pediatric clients who have psychiatric issues in the safest manner possible: Safe for our clients and safe for the EMS Team.

Procedure: This procedure will be utilized when transporting any client whose primary diagnosis or secondary diagnosis is psychiatric which may include, but may not be limited to the following: Psychiatric; Elopement Risk (Flight Risk); Homicidal; Suicidal; When restraints are used or when you get the page "possible restraints"; Drug abuse; Alcohol abuse; Confusion; Dementia; and, The Alzheimer's client who wanders. These procedures are meant to enhance safety – yours, your partner, the patient and others.

- Should a call be sent to you with the words "possible restraints," bring them in with you. There is a very strong likelihood that they will be used.
- The conveyance device will always be brought to the patient. No patient will be allowed to walk – to or from the conveyance device. The patient will be transferred directly to the appropriate location and secured into the bed. Care will be handed over to qualified staff. During transport our patients will be secured onto our stretcher only.
- As with all patients, always make sure that you both have the stretcher well in hand and in control. One of you must be with the patient and stretcher at all times.
- As with all of your patients, make sure that: Your patients are covered appropriately for the season. For example, if it's cold out, cover your patient with sheet(s), blanket(s), feet covered and head covered. Also, as with all patients, make sure that your 5 (five) point cot belts are used.
- Your 5 (five) point cot belts will never be covered. They will be in full view at all times. Blankets, sheets and clothing will be under the belts. Additionally, those patients who have the aforementioned conditions should have the cot belt buckles reversed, or facing toward the patient, making it more difficult for the patient to release the buckles.
- *We have added a 9 (nine) foot strap to your restraint bag. These straps will be used whenever transporting any of the above-identified patients. You will take the strap, bring it around the patient's chest, under the patient's arms around the back of the fowlers portion of the HOB, threading it between the HOB and the release bar for HOB movement, secure the buckle of the belt in back of the HOB – so the patient is unable to release this additional chest belt. Never apply this belt so tight that it impedes chest rise/fall. This method serves as an additional insurance for any patient that wants to get out of the stretcher to harm you or them.*

- *It is always preferred, but not required, that the same sex EMT be with the patient in back during transport. Again, not required but preferred.*
- Both crewmembers should be with the patient at all times, unless transporting.
- When performing an inter-facility transport, for example: From a hospital E/R to a private psychiatric hospital, should the patient complain of an acute medical condition consider bringing the patient back to the sending E/R for further evaluation or contact medical control and consult with them.
- Patients who spit: Use a partial non-rebreather mask and flow oxygen at the prescribe rate. Relay this information to the receiving qualified caregiver. If you should opt to use this when transporting a patient to any of the State Mental Health Facilities, take the mask off. I f you must leave it on, let the receiving State Facility know that this device was used on the patient for his/her spitting and to protect you – not for a medical condition.
- Follow MedEx and CEMSS guidelines when restraining patients. Remember safety is paramount. Never loosen a restraint alone. It takes two to loosen a restraint – one EMT to immobilize, the other EMT to loosen / re-apply the restraint.

Objectives: ***At the conclusion of this next presentation, the Med Ex Team will be able to:***

- Identify the use & purpose of the P&C (Adult & Child).
- Identify & Discuss the "Do's & Don'ts" and common misconceptions of the use of P&C's.
- Identify who can complete a P&C.
- Discuss the differences between the Voluntary & Involuntary Petition (Adult & Child).
- Identify the paperwork that is necessary for admission from Chicago Lakeshore Hospital to: State Mental Health Facilities, Direct Admission to Private Hospitals and Admission to an Emergency Room.
- Identify the paperwork that is necessary (Adult & Child) for admission to Chicago Lakeshore Hospital from: Residences, Nursing Facilities and Hospitals.
- Identify and describe the use of the Chicago Lakeshore "Welcome Forms" (enclosed).

VIII. Listed below is the policy on transporting patients both out of and into ***"Chicago Lakeshore Hospital."*** There is a vide that accompanies this presentation:

Purpose: The purpose of this presentation is to provide the Med Ex Team essential information regarding Chicago Lakeshore Hospital: Overall Operations: Gaining access; Client pickup & drop off points; and, Facility orientation. Additionally, this presentation will provide basic information on the use of Petitions & Certificates (P&C's); and, Paperwork necessary for a successful client transfer.

A. Overall Operations:

B.

Ambulance personnel → never walk your clients; stretcher will transfer them. Wheelchair van personnel → There will usually be a client escort that will meet you or bring the client from the floor to the lobby.

1. Main (Front) Entrance: To be used in most situations. It is open M->F 0700 to @ 2200. If the front door is locked, ring the doorbell – you may be asked to talk into the speaker.

Rear Entrance: Dispatch will let you know if you have to use this door, or the person talking through the speaker at the Main (Front) Entrance may advise you to use it. To gain entry, just buzz and talk into the speaker.

The "Blue Door:" To be used with C-4 & SASS clients. Dispatch will notify you when to use this entrance.

2. Tell the front desk reception the first name of your client you're there to pickup or drop off. Hand the paperwork over to the receptionist. If you have a client on your stretcher or wheelchair, pull further on a short distance toward the elevator (out of view of the lobby). The receptionist will direct you from there. The receptionist will control the elevator.

3. Posting: Chicago Lakeshore Hospital has allowed Med Ex the opportunity to use their parking lot at their outpatient center at 850 West Lawrence Ave. Please respect the use of their parking lot.

IX. Always follow CEMSS Policy & Procedures when using and applying restraints. Carefully document all aspects of the care and transportation of patients with restraints.

X. Transportation to State Mental Health Facilities (Madden, Charles Read; Tinley Park; et.al.)– Patients going to these facilities have to be medically cleared – for example they cannot be on oxygen.

The following is routinely required for the successful admission of the psychiatric patient into a state facility:

1. Qualification for Admission – This will be found with the rest of the patient's admission paperwork. It will identify that the patient is medically cleared for admission to the state facility.
2. Lab work of the patient being transported.
3. Routine Patient Transfer Sheet (Form)
4. Completed Petition for Admission – The original and two clean copies
5. Completed Certificate of Admission – The original and two clean copies (The courts; A physician; Licensed clinical psychologist; or RN with an MSN or licensed clinical social worker who is a qualified examiner).

Accurately document *all* of your times on the PCR for any/all patients being admitted to any of the State Mental Health facilities.

XI. Transporting the psychiatric patient to private psychiatric hospitals or units

1. Are P&C's required?
2. Admission to/through the ER
3. Direct admissions
4. Patient rights

XII. Transportation of the psychiatric patient from private residences.

1. Safety of major concern – be careful
2. Very low frequency

XIII. Transportation of Minors

1. DCFS – S.A.S.S. Forms
2. Unique challenges in the care & transportation of the minor.

XIV. Petitions & Certificates

1. Petitions
    a. Who can complete it?
    b. Is the behavior consistent
    c. 24 hours
    d. When do you request one?
2. Certificates
    a. Who can complete it?
    b. Is the behavior consistent
    c. 72 hours
    d. When do you request one?

XV. Medical Control

1. You are the eyes & ears of the base station physician – paint a clear picture. In order to do this, have you gotten all of the information regarding your patient? What would happen if you were to leave the patient?

AGITATED PERSON NOT EXPECTED TO ATTACK
(LOW RISK)

SCATS: A Mnemonic

SCATS is a helpful mnemonic when faced with a situation where you should employ Confrontation Avoidance Techniques. As you approach the agitated person, use the letters SCATS to help key your behavior.

Stand: Distance, Posture, and Stance

____ Stands within 3-4 feet of the agitated patient
(Close enough so that a low, conversational tone can be heard).

____ Keeps areas low and open
(Hands below waist, and hands open).

____ avoids cornering the patient
(Avoids coming between the patient and his/her route to an exit).

Calm: Voice and Body

____ Speaks in a calm voice, lowered in pitch and volume
(Voice should be softer and lower in tone in tone than normal speaking voice)

____ Appears calm and relaxed throughout
(Appears to have control of self-being calm makes those around area calm).

Attention: Staff attends to patient; Gets and holds the patient's attention

____ Inquires as to the cause of the agitation
(Tries to gently find out what is making the patient upset).

____ Shows concern and caring in speaking
(Uses voice and manner to show concern and desire to help).

____ Converses
(Talks together, shoots the breeze. Does whatever seems right to hold the patient's attention).

Talk: Converses calmly

____ Varies Content of talk
(Does not keep repeating the same thing over and over).

____ Does not ask why the patient was upset
(Asking why can easily seem argumentative, and should be avoided).

____ Avoids confrontational talk
(Says nothing that makes the patient more agitated. Does not press a point, argue, etc.).

____ Suggests appropriate action to end situation, if possible
(Settles the manner if it is appropriate to do so)

____ Makes no promises that cannot reasonably be kept. Don't lie to the patient.
(Does not tell person that he/she (trainee) will do something unless absolutely certain it can be done).

Sit: Optional

____ Invites agitated person to sit down – preferably on your stretcher
(Sitting makes talking easier and private. Does not tell the patient to sit-invites them).

____ Sits down with the patient (you on squad bench or captain's chair), and stands with him/her if necessary –arms length away
(Makes sure to sit at the same time, and stand at the same time, if necessary and only if it's safe to do so).

____ Sits appropriately
(Side by side: Appropriate safe distance proper place on sent to stand).

AGITATED PERSON LIKELY TO ATTACK
(HIGH RISK)

SCAT: A MNEMONIC

SCAT is a helpful mnemonic when faced with a situation where you should employ Confrontational Avoidance Techniques. As you approach the agitated patient, use the letters SCAT to help your behavior.

Stand: Distance, Posture, and Stance

____ Takes proper line of approach to patient
(Does not approach directly "head on"-approaches from side if possible).

____ Stands proper distance away and off to one side (at least 3-4 feet)
(Slightly more than the agitated person's arm length away).

____ Feet properly positioned and body center lowered
(Feet in the modified "T" stance, and slightly crouched).

____ Move without unnecessary lifting or crossing of feet
(Takes short, sliding steps when moving. Does not cross feet).

____ Keeps proper distance and position throughout
(As much as possible, stays about the same relative distance at all times).

____ Avoids cornering the patient
(Avoids coming between the patient and his/her route to an exit).

____ Avoids being cornered
(When the patient moves, does not let the patient move staff into a corner).

____ Keeps arms low and open
(Keeps hands below waist and keeps hands open)

Calm: Voice and Body

____ Speaks in a calm voice, slower & lowered in pitch and volume
(Voice should be softer and lower in tone than normal speaking voice).

____ Appears calm and relaxed throughput
(Appears to have control of self-being calm makes those around area calm).

____ Shows no emotion or tension in face and body
(Keeps face and body calm and unexpressive)

Attention: Staff attends to patient; Gets and holds patient's attention

____ Inquires as to the cause of the agitation
(Tries to gently find out what is making the patient upset).

____ Converses
(Talks together & shoots the breeze. Does whatever seems right to hold the patient's attention).

Talk: Converses calmly

____ Varies content of talk
(Does not keep repeating the same thing over and over).

____ Does not ask why the person is upset
(Asking why can easily seem argumentative, and should be avoided).

____ Avoids confrontational talk
(Says nothing that makes the patient more agitated. Does not press a point, argue, etc.).

____ Suggests appropriate action to end situation -- if possible
(Settles the matter if it is appropriate to do so).

____ Makes no promises that cannot reasonably be kept. Don't lie to the patient.
(Does not tell patient that staff will do something unless absolutely certain it can be done).

PETITION FOR INVOLUNTARY/JUDICIAL ADMISSION

STATE OF ILLINOIS

CIRCUIT COURT FOR THE ______________ JUDICIAL CIRCUIT

______________________ COUNTY

IN THE MATTER OF)
)
)
______________________)
(name of person))

Docket No. ____________

Who is asserted to be a person subject to ______________________ admission to a facility and for whom
(judicial/involuntary)
this petition is initiated by reason of:

☐ Emergency admission by certificate. (405 ILCS 5/3-600)

☐ Admission by court order. (405 ILCS 5/3-700)

☐ Voluntary admittee submitted written notice of desire to be discharged (405 ILCS 5/3-403)

☐ Voluntary admittee failed to reaffirm a desire to continue treatment. (405 ILCS 5/3-404)

☐ Person continues to be subject to involuntary admission. (405 5/3-813)

☐ Emergency admission of the mentally retarded. (405 ILCS 5/4-400)

☐ Judicial admission of the mentally retarded. (405 ILCS 5/4-500)

☐ Developmentally disabled client or an interested person on behalf of the client submitted written objection to admission. (405 ILCS 5/4-306)

☐ Administrative client (or person who executed application) failed to authorize continued residence. (405 ILCS 5/4-310)

☐ Client continues to meet standard for judicial admission. (405 ILCS 5/4-611)

I assert that ______________________________ is:
(name)

☐ A person who is mentally ill and who because of his or her illness is reasonably expected to inflict serious physical harm upon himself or herself or another in the near future, which may include threatening behavior or conduct that places another individual in reasonable expectation of being harmed.

☐ A person who is mentally ill and who because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious physical harm, without the assistance of family or outside help.

☐ A person who is mentally retarded and is reasonably expected to inflict serious physical harm upon himself or herself or others in the near future.

☐ In need of immediate hospitalization for the prevention of such harm.

I base the foregoing assertion on the following (provide a detailed statement including a description of the signs and symptoms of a mental illness and of any, acts threats or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence. Additional pare(s) may be attached as necessary):

____

____

____

____

____

____

____

Below is a list of all witnesses by whom the facts asserted may be provided (include addresses and phone numbers):

____

____

____

____

I ☐ do ☐ do not have a legal interest in this matter.

I ☐ do ☐ do not have a financial interest in this matter.

I ☐ am ☐ am not involved in litigation with the respondent.

☐ No certificate is attached because after diligent effort it was impossible to locate someone legally authorized to issue the certificate.

☐ Although I have indicated that I have a legal or financial interest in this matter or that I am involved in litigation with the respondent, I believe it would not be practicable or possible for someone else to be the petitioner for the following reasons:

____

____

I have read and understood this Petition and affirm that the statements made by me are true to the best of my Knowledge. I further understand that knowingly making a false statement of the Petition is a Class A misdemeanor.

Date ____________________ Signed ____
(Signature)

Printed Name ____

Relationship to respondent Address ____

____________________ ____

Listed below are the names and addresses of the spouse, parent, guardian, or surrogate decision maker, if any, and Close relative or, if none, a friend of the respondent whom I have reason to believe may know or have any of the other names and addresses. If names and addresses are not listed below, the following describes my efforts to identify and locate these individuals.

____

____

____

____

Signed ____

Title ____

Within 12 hours after admission to the facility under this status I gave respondent a copy of this Petition. I have explained the "Rights of Admittee" to the respondent and have provided him or her with a copy of it. I have also provided him or her with a copy of "Rights of Individuals" and explained those rights to him or her (405 ILCS 5/3-609).

Date ____________________ Signed ____

Time ____________________ Title ____

RIGHTS OF ADMITTEE

1. If you have been brought to this facility on the basis of this petition alone, you will not be immediately admitted, but will be detained for examination. You must be examined by a qualified professional within 24 hours or be released.

2. When you are first examined by a physician, clinical psychologist, qualified examiner, or psychiatrist, you do not have to talk to the examiner. Anything you say may be related by the examiner in court on the issue of whether you are subject to involuntary or judicial admission.

3. At the time that you have been certified you will be admitted to the facility and a copy of the petition and certificate will be filed with the court. A copy of the petition shall also be given to you.

4A. If you are alleged to be subject to involuntary admission (mentally ill) you must also be examined within 24 hours excluding Saturdays, Sundays, and holidays by a psychiatrist (different from the first examiner) or be released. If you are alleged to be subject to involuntary admission the court will set the matter for a hearing.

4B. If you are alleged to be subject to judicial admission (mentally retarded) the court will set a hearing upon receipt of the diagnostic evaluation which is required to be completed within 7 days.

5A. If you are alleged to be subject to involuntary admission (mentally Ill) and if the facility director approves, you may be admitted to the facility as a vo9luntary admittee upon your request any time prior to the court hearing.

The court may require proof that voluntary admission is in your best interest and in the public interest.

6. You have the right to request a jury.

7. You have the right to request an examination by an independent physician, psychiatrist, clinical psychologist, or qualified examiner of your choice. If you are unable to obtain an examination, the court may appoint an examiner for you upon your request.

8. You have the right to be represented by an attorney. If you do not have funds or are unable to obtain an attorney, the court will appoint an attorney for you.

9. You have the right to be present at your court hearing.

10. As a general rule, you do not lose any of your legal rights, benefits, or privileges simply because you have been admitted to a mental health facility (see your copy of the "Rights of Individuals". However, you should know that persons admitted to mental health facilities will be disqualified from obtaining Firearm Owner's Identification Cards, or may lose such cards obtained prior to admission.

11. Information about the health care services you receive at a mental health or developmental disabilities facility is protected by the privacy regulations under the Health Insurance Portability and Accountability Act of 1969 (HIPAA) (P.O. 104-191) at 45 CFR 160 and 164. Your personally identifiable health information will only be used and/or released in accordance with HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110).

A GUARDIANSHIP AND ADVOCACY COMMISSION IS A STATE AGENCY WHICH CONSISTS OF THREE DIVISIONS: LEGAL ADVOCACY SERVICES, HUMAN RIGHTS AUTHORITY AND THE OFFICE OF THE STATE GUARDIAN. THE COMMISSION IS LOCATED AT:

Egyptian Regional Office
#7 Cottage Drive
Anna, Illinois 62906
618/833-4897

East Central Regional Office
423 South Murray Road
Rantoul, Illinois 61866-2125
217/892-4611

North Suburban Regional Office
9511 Harrison Avenue FA101
Des Plaines, Illinois 60016
847/294-4264

Metro East Regional Office
Pine Cottage
4500 College Avenue
Alton, Illinois 62002
618/462-4561

Peoria Regional Office
5407 North University, Suite 7
Peoria, Illinois 61614
309/693-5001

Rockford Regional Office
4302 North Main Street
Rockford, Illinois 61103
815/987-7657

West Suburban Regional Office
P.O. Box 7009
Hines, Illinois 60141-7009
708/338-7500

Equip for Equality, Inc. is an independent, not –for-profit organization that administers the federal protection and advocacy System for people with disabilities in Illinois. Equip for Equality, Inc., provides self-advocacy assistance, legal services, education, public policy advocacy, and abuse Investigations. The offices are located at:

Northeastern Regional Office
11 East Adams Street, Suite 1200
Chicago, Illinois 60603
800/537-2632; 312/341-0022
TTY: 800/610-2779 Se habla Espanol

Central/Southern Region
427 East Monroe Street P.O. Box 276
Springfield, Illinois 62705
800/758-0464 (Voice/TTY)217/544-0464

Northwestern Region
1612 Second Avenue P.O. Box 3753
Rock Island, Illinois 61204
800/758-6869(Voice/TTY) 309/786-6868

Website: www.Equipforequality.org

I certify that I provided the respondent with a copy of this form.

☐ English ☐ Spanish ☐ Other, ______________________ on ______________________
(Specify language) (Date)

______________________ ______________________
(Signature) (Title)

(MHDD-5)
IL462-2005 (R-10-03)