**New York City Administration for Children's Services**
150 William Street, 18th Floor
New York, NY 10038

Administration for Children's Services

**To:** Provider Agency Staff
Children's Services Staff

**Date:** May 28, 2010
(Revised November 3, 2010)

**From:** John B. Mattingly, Commissioner

**Re.:** **Guidelines for the Provision of Emergency and Inpatient Mental Health Services for Children in the Foster Care and Child Protective System**

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Please find, attached, a revised version of the "Guidelines for the Provision of Emergency and Inpatient Mental Health Services for Children in the Foster Care and Child Protective System". It incorporates comments and suggestions received after the original document was released on May 28, 2010. Specifically, this revision contains clarifying details regarding required documents, submission timelines, case planning requirements around visitation and educational needs, references to existing policies and practice guidelines, and a new section on Planned or Non-Emergency Psychiatric Hospitalizations. The case practice expectations and requirements articulated in the policy are effective immediately.

Children's Services has successfully expanded the staffing for the Mental Health Coordination Unit (MHCU). On 10/21/10 MCHU issued a memo introducing the creation of *MCHU Initial Reporting Form CM-1057* which was designed for use by foster care providers and child protective staff when children in care are psychiatrically hospitalized. At this time, the MHCU staff is providing technical assistance and support related to these challenging situations. Please contact the unit at 212.347.MHTA (6482) or email to ACS.SM.MENTALHEALTH@DFA.STATE.NY.US

I would like to reiterate that psychiatric hospitalization should be used only when less restrictive placements or services are not able to meet a child's immediate safety and health needs. During in-patient treatment, planning for discharge and a less restrictive setting should begin on day one, seeking the most family oriented, stable and familiar placement that can meet the child's needs.

For any questions related to this policy, please contact Beatrice Aladin at beatrice.aladin@dfa.state.ny.us.

**City of New York**
**Administration for Children's Services**

**Policy # 2010/03**

**SUBJECT: Guidelines for the Provision of Emergency and Inpatient Mental Health Services for Children in the Foster Care and Child Protective System**

**APPROVED BY: John B. Mattingly**

**PAGES: 1of 17**

**DATE: May 28, 2010**
**(Revised November 3, 2010)**

**IMPLEMENTATION RESPONSIBILITY: Foster Care Provider Agency, Children's Services Family Permanency Services, Family Support Services, Division of Child Protection, Family Court Legal Services Division of Quality Assurance and Office of General Counsel Staff**

**PURPOSE:** When children in foster care are admitted to inpatient psychiatric units, it is critical that their inpatient care and discharge planning are well-coordinated between the child welfare and mental health systems. It is also critical that we engage any other child-serving systems that are working with the child and caregivers[1], and that parents and foster parents are involved in treatment and discharge planning whenever possible and appropriate. The purpose of this document is to clarify the responsibilities of foster care agencies and provide guidance to case planning staff when a foster child is psychiatrically hospitalized.

**SCOPE:** This policy applies to foster care provider agency staff as well as staff in the following Children's Services Divisions: Family Permanency (FPS), Family Support Services (FSS), Child Protection (DCP), Family Court Legal Services (FCLS), Quality Assurance (DQA), General Counsel (OGC), and Operations. This policy shall be utilized whenever a foster child is psychiatrically hospitalized and is effective immediately. This policy replaces the ACS Commissioner's Memorandum entitled *Contract Agencies Responsibilities for Children Re-entering Care after Psychiatric Hospitalization* dated 9/14/98

For additional information on this policy please contact Beatrice Aladin, Director Children's Services Office of Child and Family Health at Beatrice.Aladin@dfa.state.ny.us or at (212) 676-6481.

[1] Such as the NYS Office of People With Developmental Disabilities (OPWDD), NYS Office of Mental Health (OMH), NYC Department of Health and Mental Hygiene and NYC Department of Education.

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**POLICY:** Children with serious mental health issues and psychiatric diagnoses are often jointly served by the child welfare and mental health service systems. Some children enter the child welfare system with pre-existing emotional or behavioral problems that require professional attention and some conditions are identified later. Careful coordination between systems can significantly improve access to care and expedite appropriate treatment and placement for children in foster care while limiting disruption and providing services in the least restrictive setting consistent with a specific treatment plan. In most cases, the needs can be met by a foster care agency's own resources or by community providers. However, certain situations may warrant higher levels of care and in some cases, inpatient hospital care is appropriate.

Inpatient psychiatric treatment is only to be used when truly necessary. Each foster care agency is expected to have resources available to plan and coordinate appropriate mental health services for children in its care. The Child/Case Planner[2] must employ his/her agency's own resources to ensure that the use of community-based and outpatient services (including the child's own primary and/or subspecialty healthcare provider) and various resources in the community such as those under the *Planning for Discharge from Emergency Room* (page 6) section are maximized. Only if these measures prove inadequate to stabilize the child should psychiatric hospitalization be considered.

**All foster care agencies are required to notify the Mental Health Coordination Unit (MHCU) in the Administration for Children's Services (ACS) by email at MENTALHEALTH@DFA.STATE.NY.US when a child is admitted for inpatient psychiatric treatment or transferred between acute care hospitals.** The MHCU is charged with tracking psychiatric hospitalizations and related case planning activity; the MHCU's activities are described in more detail on page 12. Each foster care agency is responsible for designating a senior staff member (e.g., the Medical Director or Program Director) who will serve as a point person for the MHCU and will be responsible for, knowledgeable about, and implement all aspects of this policy. These guidelines are consistent with the Administration for Children's Services *Foster Care Quality Assurance Standards* and related procedures.

**Emergency Room Care**

Acute hospital-based mental health care is often initiated at the emergency room. The Foster Care Agency Case/Child Planner is expected to accompany a child to the psychiatric emergency room and remain with the child until s/he is either admitted or discharged.[3] If the Child/Case Planner is not available, the person accompanying the child must be an individual with responsibility for caring for that child (e.g., foster parent, Sociotherapist, Case Aide). S/he must have direct access to an emergency contact at the Foster Care Agency (or ACS Child Protective Supervisor/Manager), inform that person of the hospital visit, and provide periodic updates to the agency or ACS contact person while awaiting the arrival of the Case Planner. This person will facilitate necessary authorizations and completion of consent forms required for admission and

[2] If one foster care agency has planning responsibility for the child requiring psychiatric hospitalization and a different agency has case planning responsibility for the overall case, the *child planner* will be responsible for all activities described in this document unless otherwise indicated.

[3] ACS policy and practice prohibits leaving a foster child alone in an emergency room. In addition to the obvious safety concerns, a consenter would be needed if the child should require urgent medical or surgical care.

medical treatment. If this person is not accompanied by someone authorized to give consent for the child's care, s/he should come to the hospital with the name, phone number and pager or cell phone number (if available) of the individual(s) authorized to give consent for the child's care (e.g., a parent or Planning Agency representative).[4] For children admitted to 72-hour Extended Observation Beds (EOB), which may be part of a hospital's Comprehensive Psychiatric Emergency Program (CPEP), the expectation is that their Case/Child Planners will establish contact with the hospital treatment team to engage in planning for either the child's return to the community or transfer to longer term inpatient care. The Child/Case Planner, or other Planning Agency representative, must remain an active participant until the disposition for admission or discharge has been determined.

As soon as possible after the Child/Case Planner has been notified that a child is either presently in an emergency room or has already been admitted to inpatient psychiatric care, the Planner must provide a copy of the Medical Authorization for Routine Treatment or Emergency Care form (CM339), with the parent's signature authorizing emergency care to the hospital staff. Form CM339 should have been completed and signed upon a child's entry into foster care. The Child/Case Planner should be aware that the hospital may have a required consent form of its own. The following additional information must be provided to the hospital upon arrival at the hospital or within 24 hours:

- The child's demographic information: age, date of birth, case name, case number;
- Child/Case Planner and Supervisor information: name, agency, contact information;
- Medical Consenter information: name, relationship to the child or under what basis the person has the responsibility to consent, telephone number, mailing address and other contact information, and any information regarding visitation restrictions;
- Medications currently administered, including psychotropic medications; and
- Allergies (including to medications).

The following information must be provided to the hospital upon arrival at the hospital or on the next business day:

- Physical Status: The most recent assessment of the child's physical status, results of diagnostic procedures and relevant laboratory examinations, other significant or concomitant medical problems (such as seizure disorder or diabetes), and recent accidents or injuries.

Additionally, the Child/Case Planner will submit the information described below to the hospital treatment team on the next business day after the child's arrival at the hospital to

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[4] Each contract foster care agency has designated staff member(s) who (in addition to their Executive Directors) are authorized to give such consent. For more information on the delegation of consent to contract foster care agencies, see ACS Procedure 102/Bulletin 99-1 (amended), *Guidelines for Providing Medical Consents for Children in Foster Care.*

the extent that the information is available in the case record.[5] Any information not obtained within this period will be forwarded as soon as it is available.

- Orders of Placement, Orders of Protection, or other Court Orders as may relate to the child;

- Psychiatric Evaluation (if one exists): A copy of the most recent psychiatric report that includes current mental status, current medication(s), and history of prior psychiatric care and treatment. If the child has been previously hospitalized, a copy of the discharge summary from previous hospitalization(s) should also be provided;

- Psychological Evaluation (if one exists): A copy of the most recent psychological assessment of cognitive and affective functioning (including IQ and prognosis) and contact information for the treating psychologist, if there is one;

- Outpatient mental health treatment evaluation and progress report, outpatient medication review (if any) and contact information for the treating psychiatrist, if one exists;

- Substance Abuse/Use - Any known history of substance abuse or addiction; and

- Referral Materials: Any additional and relevant background documentation, the reason for referral to the psychiatric emergency room, and the most salient features of the case, including descriptions of the child's response to current placement and any family or foster family issues that may contribute to the behaviors leading to the current emergency room visit (e.g., parent(s) experienced or experiencing domestic violence, conflict between parents and foster parents, recent visitation with parents, parental incarceration). These materials must include current available information that addresses the following areas:
  - i Developmental history and Individualized Family Service Plan (IFSP), if applicable;
  - ii Educational/Vocational history;
  - iii. Environmental/Family/Social history;
  - iv. Individualized Educational Program (IEP), if applicable; and
  - v. Visitation Restrictions, if applicable.

If a child in foster care is currently receiving Bridges to Health (B2H) services (see B2H details in the *Discharge Planning* section below), the Child/Case Planner must inform the assigned Health Care Integrator (HCI) from the Health Care Integration Agency (HCIA) of any planned or imminent hospitalization. Serious Reportable Incidents such as hospitalizations and emergency room visits are monitored by the HCI. The HCI works with the Case/Child Planner, the family and the treatment team throughout the child's hospital stay, and can assist with discharge planning as well as treatment team meetings.

[5] For information regarding required information and documents in the case record, see 18 NYCRR § 428.3 and Appendix G (1999) of the Foster Care Standards.

**Planning for Discharge from Emergency Room**

In the event that a child does not warrant inpatient admission and is discharged from emergency room care, the Child/Case Planner should work with the hospital treatment team to plan for the child. The Child/Case Planner must request a psychiatric discharge evaluation report from the emergency room physician to add to the child's foster care record as this will facilitate referrals for further services. If the child is in outpatient treatment or receiving any other kind of mental health services, the mental health and primary care provider(s) shall be informed of the emergency room visit as soon as possible. **Immediate mental health support services licensed by or in contract with the New York State Office of Mental Health (OMH) or New York City Department of Health and Mental Hygiene (DOHMH) must be considered as resources to maintain the mental health stability of the child, prevent subsequent emergency room care and hospitalization, and to allow children to remain in their community while services are provided.** Other appropriate intensive support services should also be considered. These support services should be planned and implemented in collaboration with the outpatient mental health treatment providers. These services can begin following discharge from the emergency room, and may include the Home-Based Crisis Intervention (HBCI) and the Intensive Crisis Stabilization and Treatment (ICST) services (discussed below) as well as the Bridges to Health (B2H) Waiver Program (see the *Discharge Planning Process* section).

*Home-Based Crisis Intervention*

Home-Based Crisis Intervention (HBCI) programs are designed to provide in-home crisis services to families where a child is at imminent risk of psychiatric hospitalization. These programs provide intensive in-home interventions for 4 to 8 weeks with the goals of diverting hospitalization, teaching problem-solving skills to the family, providing counseling and linking the child and family with community-based resources and supports. Caseloads are small with each counselor working with only two families at any one time. A counselor is available seven days a week, 24 hours a day to work with the child and family.

*Intensive Crisis Stabilization and Treatment*

The Intensive Crisis Stabilization and Treatment program (ICST) is available in Brooklyn and the Bronx. This service has been designed to address the needs of seriously emotionally disturbed children during times of acute crisis when the risk of hospitalization seems imminent. The ICST program offers both home-based crisis intervention and mental health treatment services. Initial visits occur in the family home where clinical treatment and crisis services are provided for up to 3 times weekly for 12 weeks. The goals of the program are to prevent the hospitalization of severely emotionally disturbed children and adolescents, stabilize the child/family unit and reduce crisis symptoms, help the child and family understand crisis patterns and core treatment issues, improve individual and family coping and communication skills, as well as establish community linkages for ongoing treatment, entitlements and family support services.

When it is indicated that a referral is needed, the Child/Case Planner should request that the hospital staff make a referral to HBCI or ICST services[6] while the child is in the emergency room. If the hospital fails to make such a referral, the Child/Case Planner shall, when necessary, make a referral to these services immediately following the child's discharge from the emergency room.

Non-emergency mental health support services – such as case management or community-based residential programs – can be accessed through the Children's Single Point of Access (CSPOA). The Case Planner/Child Planner can begin the referral process by calling 1-888-CSPOA-58 (888-277-6258). Detailed descriptions of services available through the mental health system are available on DocuShare's "Clinical Programs and Services" folder.

**Planned or Non-Emergency Psychiatric Hospitalizations**

Non-emergency (i.e., planned) psychiatric hospitalizations should occur only as part of a child's overall psychiatric treatment plan, as determined by his or her primary outpatient mental health clinician(s). Planned hospitalizations are appropriate when less restrictive interventions have failed to help with a specific psychiatric or behavioral problem, or when such interventions have been requested but are unavailable within an appropriate time frame. A reasonable period to wait for the availability of such an intervention, after which progression to a psychiatric or behavioral crisis is likely, will be determined by the treating clinician. The decision to pursue a non-emergency hospitalization must involve ongoing collaboration between a child's primary outpatient mental health clinician(s) and an accepting hospital psychiatrist. Before a child is admitted, these parties must agree that a time-limited inpatient intervention may help to ameliorate a specific psychiatric, behavioral, and/or medication-related problem as defined in the child's treatment plan. The child is expected to return to the care of the outpatient provider, and his/her prior foster care placement, when s/he is ready for discharge.

**Inpatient Treatment**

Planning responsibility is maintained by the Planning Agency regardless of the duration of the child's hospital stay. When a child is admitted to the hospital for inpatient treatment, the following must take place, led by the Child/Case Planner with support from other Planning Agency staff, as available and appropriate:

*24 Hour Requirements*

- The Child/Case Planner must initiate contact with hospital staff within 24 hours of the child's admission and start working with the designated hospital staff to resolve any difficulties encountered by the parties;

- Within 24 hours of the child's admission, the Child/Case Planner must notify the Mental Health Coordination Unit (MHCU) in the Children's Services' Office of

[6] Lifenet [1-800-LIFENET (English), 1-877-AYUDESE (Spanish), 1-877-990-8585 (Mandarin, Cantonese and Korean), www.800lifenet.org] can be contacted 24 hours a day for information about agencies providing these services in the child's neighborhood. Referrals are made directly to the programs. Bellevue, New York Presbyterian and Elmhurst Hospitals run their own HBCI programs.

Child and Family Health by email at: MENTALHEALTH@DFA.STATE.NY.US (see Page 12 for more information on the MHCU process);

- The Child/Case Planner must inform the child's outpatient treatment provider(s), as applicable, on the next business day after a child's hospitalization;

- If the situation that led to emergency treatment was a critical incident, per ACS policy, CS 853D Form entitled *Report of Incident, Accident, Illness, or Death Involving Child(ren) in Foster Care Services Incident Report,* needs to be completed by the Agency Child/Case Planner or any other agency staff who has knowledge of the critical incident, then sent to the Office of Special Investigations. Notification must also be made to the Office of Shared Response at (212) 676-6630.[7]

- Critical incidents that lead to an actual admission for in-patient treatment should be reported to ACS by submitting Form CM-1057 entitled *MHCU Initial Reporting Form* to the MHCU. For critical incidents that result in a psychiatric hospitalization, an 853D form need not be submitted. The Child/Case Planner shall request that the hospital staff notify the Child/Case Planner (and parents and foster parents, when applicable) within 24 hours of any incidents, clinical issues and any other relevant case activity, including, but not limited to, the following:
  i The use of restraint, including restraint by pharmacological methods or seclusion;
  ii Negative side effects of medication; and
  iii Any incident involving the child that has or may have an adverse effect on the life, health or welfare of the child and/or another person.

*Ongoing Case Activities*

- If the child is receiving B2H services, the Child/Case Planner must work collaboratively with the child's Health Care Integrator (HCI) throughout the hospitalization. This coordination is essential because hospitalizations of more than 30 days result in a "loss of enrollment" in the B2H program. The HCI is responsible for developing a transition plan in such cases, exploring all possible alternatives and avenues to maintain eligibility. (See B2H Hospitalization Procedure-ACS, Revised May 6, 2010).

- The Child/Case Planner will maintain daily phone contact with hospital treatment team on the first three (3) business days following a child's hospital admission. S/he is then required to maintain, at a minimum, weekly phone contact with the treatment team for the duration of the child's hospital stay. More frequent contacts may be required depending on the child's need and health status.

- The Child/Case Planner is also required to participate in both ongoing treatment planning and discharge planning conferences. Whenever possible and appropriate, the child's parent(s) and foster parent(s) should also be involved in planning meetings, and supported in visiting the child throughout the hospitalization. Any arrangements for post-hospitalization services should be discussed thoroughly with the parent(s) and foster parent(s).

[7] Refer to *Reporting Requirements for Psychiatric Hospitalizations* Memo dated 10/21/10.

- The Child/Case Planner is responsible for obtaining all materials relevant to any medical or psychiatric evaluations as requested and required by the hospital treatment team.

- The Child/Case Planner must request that the hospital staff notify the Child/Case Planner no less than two business days in advance of all treatment planning conferences. If a conference must be held within this two-day period (either on an emergency basis or because of a short hospital stay), the Child/Case Planner may participate by teleconference rather than in person; however, every effort should be made to attend in person. All other consultations may be done either in person or by teleconference.

- The Child/Case Planner is responsible for maintaining regular case planning activities throughout the child's hospitalization. These include:
  i Keeping in close contact with the child and his or her family as well as the child's HCI, if applicable;
  ii Making weekly visits throughout the child's hospitalization;[8]
  iii Arranging for parent and sibling visits;[9]
  iv Verifying that the hospital is addressing the child's educational needs as required by NYS Office of Mental Health regulations[10] and consulting with ACS' Education Unit as needed to address the child's educational needs throughout the hospitalization;[11]
  v Furnishing clothes, shoes, eyeglasses and other necessary items; and
  vi Participating in discharge planning.

- Additionally the Child/Case Planner must perform the following tasks in CONNECTIONS:
  i Updating the information in CONNECTIONS including completion of the Family Assessment and Service Plan (FASP)
  ii Documenting the psychiatric hospitalization in the CONNECTIONS Health Screen Module (in the FSS stage) and enter all applicable information;
  iii Entering a progress note in the CONNECTIONS Progress Note section documenting the circumstances leading to the hospitalization and all relevant details about the coordination of care of the child;
  iv If the child planning agency does not have case planning responsibility for the child, the agency must notify the case planning agency of the hospitalization by telephone as well as with a CONNECTIONS progress note.

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[8] In addition to these requirements regardless of the child's hospitalization please refer to Guidance 2007/02 *Revised Casework Contacts for Families and Children in Foster Care, 3/30/10* (revised) for information on casework contacts.

[9] See memorandum *ACS Best Practice Guidelines for Family Visiting Arrangements for Children in Foster Care,* dated August 28, 2006, and the *FC O7-12 ACS Payment Bulletin-Foster Care - SPECIAL PAYMENTS (revised 2007).*

[10] See NYS Regulations, which state "If any children of legal school age are served, an appropriate instructional program approved by the New York State Education Department must be made available to them by the hospital." 14 NYCRR § 582.5(c)(1).

[11] For guidance and consultation on education services for children in care, contact Regina Schaefer at 212-442-3030 or Regina.Schaefer@dfa.state.ny.us.

- The Child/Case Planner must notify hospital staff as soon as court orders are received and inform hospital staff of any changes in court-ordered conditions that are relevant to the child's treatment (e.g., parent visitation).

**PLEASE NOTE:**
In the event that the Child/Case Planner becomes aware that the child is missing from the hospital the Child/Case Planner is responsible for ensuring that diligent efforts are made immediately to locate the child.[12] If the child is in the care and custody or custody and guardianship of the Commissioner of ACS, the child's foster care case should never be closed during hospitalization. Agencies may not discharge a child for the sole reason that s/he is hospitalized.

**Consents/Consent Refusal Overrides**

The Child/Case Planner will use his/her best efforts to provide or obtain all necessary consents within 24 hours of all emergency admissions.[13] The Child/Case Planner is responsible for providing the hospital with the name, phone number and pager or cell phone number (if available) of the people who are authorized to give consents for the child's care (e.g., a parent, guardian or Planning Agency representative). For guidelines regarding consent for medical treatment[14] and parental consent refusal, see ACS's Procedure 102/Bulletin 99-1 (amended), *Guidelines for Providing Medical Consents for Children in Foster Care.*[15]

**Inter-Hospital Transfers**

When a child is transferred from an acute care hospital to a New York State Office of Mental Health (OMH) Children's Psychiatric Center, the child will be transported to the Children's Psychiatric Center by ambulance, which will be arranged by the referring acute care hospital. The Child/Case Planner will accompany the child to the new facility, or make arrangements for another agency staff person to accompany the child. When appropriate, the Child/Case Planner will also request that the parent/guardian be present at the scheduled transfer so that they can sign all necessary discharge and admission consent forms. If the parent will not be present during the transfer, the Child/Case Planner will ensure that all consents for admission to the intermediate facility are signed before the transfer takes place.

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[12] See the *Children Missing from Foster Care Placement Procedure 2007/02*, dated November 1, 2007.

[13] New York State Public Health Law § 2504(4) states that medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health.

[14] See Mental Hygiene Law § 33.21(e) for provisions relating to consent for administration of psychotropic medication to a minor residing in a hospital.

[15] For guidance on ACS's consent process for overriding parent refusal to consent for medical treatment contact ACS's Office of Child and Family Health.

The acute care facility, in conjunction with the Case/Child Planner, will ensure that the following information accompanies the child to the receiving facility:

- Hospital discharge summary (including information on the child's current mental status/diagnosis, the child's medication(s), and recommendations for treatment), Hospitalization Certificate of Need, New York State Hospital Order of Transfer (provided by the hospital);
- Psychiatric evaluation (provided by the hospital);
- Psychological evaluation (if available; otherwise an IQ score and/or statement on the child's cognitive functioning; provided by the hospital);
- Outpatient Mental Health Treatment Progress Report (most recent);
- Summary of laboratory results and results of diagnostic tests (provided by the hospital);
- Individualized Education Program (IEP), if applicable (provided by the Case/Child Planner);
- Immunization records, including for Hepatitis A and B, and recent PPD testing (which may need to be provided by the Case/Child Planner);
- Social, developmental, educational/vocational history (provided by the Case/Child Planner); and
- Orders of Placement, Orders of Protection, or other Court Orders as may relate to the child (provided by the Case/Child Planner).

The receiving facility shall be responsible for apprising the Child/Case Planner of any changes in treatment and working with the Child/Case Planner to ensure that all necessary consents are obtained. For guidelines regarding consent, see ACS's Procedure 102/Bulletin 99-1, *Guidelines for Providing Medical Consents for Children in Foster Care,* Page 5, Section E.

**Medication Management**

Mental Health Service Providers shall prescribe, document and monitor medications consistent with Mental Hygiene Law section 33.21, ACS's *Foster Care Quality Assurance Standards,* ACS medical consent policies, and applicable regulations of OMH. As with any medical care, ACS's policy is that foster care agencies must make reasonable efforts to obtain consent for medication from the child's parent(s)/guardian(s) unless parental rights have been terminated or surrendered. If there are questions or disagreements about medications, the Child/Case Planner should contact ACS's Psychotropic Medication Unit for assistance. [16]

[16] See ACS's Procedure 102/Bulletin 99-1, *Guidelines for Providing Medical Consents for Children in Foster Care,* Page 5, Section D for complete guidelines regarding consent for psychotropic medications

If the child is being discharged with prescribed medications, the Child/Case Planner must request from the inpatient treatment team that any prescriptions for medications, including psychotropic medications, be adequately provided until the first outpatient follow-up visit (most prescriptions for psychotropic medications can be written for a minimum of 30 days unless otherwise indicated).

The Child/Case Planner must also provide the prescriptions written upon discharge to the caregiver, who will be responsible for immediately filling the prescription. As appropriate, the Child/Case Planner will enable the caregiver to fill the prescriptions as soon as possible, including providing the Medicaid Child Identification Number (CIN) to the appropriate entity if necessary.

**Notification of Child's Admission/Discharge**

When a foster child is admitted to or discharged from the hospital for psychiatric inpatient care, the Child/Case Planner must make the following notifications within 24 hours:

- The Mental Health Coordination Unit (MHCU) in the Children's Services' Office of Child and Family Health, by emailing the *Mental Health Coordination Unit – Initial Reporting Form CM-1057* to MENTALHEALTH@DFA.STATE.NY.US; and

- The parent/guardian whose rights have not been terminated or who have not surrendered their rights should be notified of the child's psychiatric admission, regardless of whether *Medical Authorization for Routine Treatment or Emergency Care - Form CM339* has been signed by parents/guardians at case initiation.

The MHCU will notify the appropriate borough-based contact for Family Court Legal Services (FCLS) by 5 p.m. of the next business day after receiving notification of the child's hospital admission. If the borough contact person cannot be reached, MHCU will contact the Director or Assistant Director of the FCLS Legal Compliance Unit (LCU) who will serve as back-up to the borough contact person.

FCLS will notify the attorney for the child by 5 p.m. of the next business day after FCLS receives notification of the child's hospital admission. If the attorney for the child is employed by an institutional provider that has a designated point person for this purpose, notification will be made to that individual.

The MHCU will be tracking all reported cases of psychiatric hospitalizations from the date of admission to the date of discharge, and will be monitoring case planning-related activity during the hospitalization and, when indicated, following the discharge until the discharge plan is fully in place. The Case/Child Planner must complete and email the *Mental Health Coordination Unit – Psychiatric Hospitalization Follow-Up Form CM-1058* to the MHCU 7 days post-admission, and every 14 days thereafter until the child's discharge, and at discharge. If the Child/Case Planner has questions about the hospitalization process or accessing post-discharge mental health services, they should utilize their agency's in-house mental health staff, then reach out for additional technical assistance to a Coordinator in the MHCU by email, or by calling (212) 374-MHTA.

**Discharge Planning Process**

In order to facilitate and expedite a seamless discharge of the child from the hospital, the Child/Case Planner is expected to begin planning for discharge at the onset of the hospitalization by ensuring the following:

- As previously specified in the *Inpatient Treatment* section, contact with the hospital must be initiated within 24 hours of a child's admission and must be maintained with the hospital treatment team by conducting the following contacts:
  i daily by phone for the first 3 days of the child's hospitalization;
  ii weekly for the duration of the child's stay in the hospital; and
  iii as frequently as needed by the treatment team depending on the child's progress and condition.

- During each contact, potential changes and contingencies in the discharge plan should be discussed and the following individuals should be involved in discussions and planning from the time of admission (those who are not able to attend in person may participate by teleconference):
  i the Child/Case Planner and/or other agency staff as needed and as appropriate;
  ii the hospital treatment team;
  iii the foster parent, whenever possible;
  iv the parent/legal guardian, as appropriate; and
  v the Health Care Integrator (HCI), if the child is receiving B2H services.
  **Note**: The Child/Case Planner must immediately inform the HCI of the child's hospitalization and must collaborate on discharge planning with the HCI for at least the first 30 days of inpatient treatment.

- *Follow-up Care*
  Discharge planning should include all the appropriate follow-up care after the child leaves the hospital. The Child/Case Planner must request that the hospital provides him/her with a written service plan that includes the following information as this is part of the hospital's responsibility in the discharge planning process:
  i information on the child's current mental status;
  ii information on the child's medication;
  iii the child's diagnosis upon discharge and treatment recommendations; and
  iv information regarding referrals for outpatient treatment and other community-based mental health services (e.g., contact information, appointment dates and times, status of referral packages). These referrals should be made by the hospital in coordination with the Planning Agency.

- *Medications*
  If the child is being discharged on medications, the Child/Case Planner must:
  i request from the inpatient treatment team that any prescriptions for medications, including psychotropic medications, be adequately provided until the first outpatient follow-up visit (most prescriptions for psychotropic medications can be written for a minimum of 30 days unless otherwise indicated); and
  ii obtain the prescriptions written upon discharge and provide the prescription to the caregiver, who will be responsible for immediately filling the prescription.

- *Linkages*
  The Child/Case Planner must work with the hospital treatment team so that the appropriate follow up mental health services and linkages are in place prior to discharge.
  i. If outpatient clinic treatment is needed, an intake appointment should be scheduled within 5 days of discharge for psychiatric follow up and medication review (unless the prescription specifies a shorter period of time);[17]
  ii. The Child/Case Planner must obtain a written service plan (see details in *Follow-up Care* ) from the discharging hospital which will be relayed to the receiving clinic prior to the outpatient clinic appointment;[18] and
  iii. The Child/Case Planner must work to ensure that the clinic appointments are kept and that the appropriate consents for outpatient treatment are obtained.

- *Bridges to Health (B2H)*
  If the child will need intensive ongoing support upon discharge, the Child/Case Planner should consider a referral to the B2H program.[19] B2H provides in-home, community-based services to children with serious and complex emotional needs who are at risk of psychiatric hospitalization, placement disruption or placement in a residential setting. These services are provided in the child's foster home or group home (of 12 children or fewer).

  The B2H Waiver Program consists of three waivers: B2H for children with serious emotional disturbance, B2H for children with developmental disabilities and B2H for medically fragile children. The B2H program is based on an individualized care model that emphasizes collaborating with the child, family and other child-serving systems to develop a service plan for each child and family. Individualized Care is strengths-based, and recognizes that even the child with the most challenging problems, and the family that is most stressed, have strengths, assets and coping skills.

- *Placement Planning*
  Discharge planning also includes appropriate placement after the child leaves the hospital. The Planning Agency is responsible for immediately accepting the child back into care once the child is stabilized and medically cleared for hospital discharge.

  If the hospital is recommending a change in placement upon discharge – within either the foster care or mental health system – the Child/Case Planner is responsible for requesting a Placement Change Conference to be held at the hospital, facilitated by the ACS Office of Family Permanency Team Conferencing (OFPTC) and inclusive of hospital staff (unit social worker and attending physician).[20] This

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[17] A child's final foster care placement may not be known at the time of discharge from the hospital, and temporary placements (within the same Planning agency) may occur. In such cases, the Child/Case Planner will work with the hospital and other mental health service providers to provide appropriate outpatient treatment during interim placement(s) and upon final placement.

[18] Mental Hygiene Law § 29.15(h)

[19] For more information about B2H or to make a referral, contact ACS B2H at 212-676-6406 or email at b2hacs@dfa.state.ny.us.

[20] See Administration for Children's Services, *Office of Family Permanency Team Conferencing Protocol Phase II* Spring 2009 (April 1, 2009).

conference should be used to review the child's needs and to develop a plan to support such needs.

If the result of the Placement Change Conference results in a recommendation for a new placement, the Planning Agency should work with the OFPTC-Child Evaluation Team so that the necessary referrals are made to the Office of Placement Services (OPS). The Planning Agency is responsible for maintaining the child either until a new placement is identified within that agency or until ACS has obtained a re-placement and the agency is notified to transport the child to the new placement.

If the child has been accepted into another residential or therapeutic placement prior to hospitalization and is hospitalized while waiting for placement, the hospital should provide updated materials to the child's Child/Case Planner. The Child/Case Planner will then forward the documentation to the OFPTC-Child Evaluation Unit and the OPS worker. The OPS worker will forward the information to the relevant agencies.

In order to adequately plan for placement changes, the Child/Case Planner must work closely with the hospital to obtain all necessary materials for re-placement from the time re-placement is deemed necessary; these materials should include:

i A current psychiatric evaluation, psychosocial history and medical history;
ii The child's most recent psychological evaluation, including IQ; and
iii The child's IEP, if available.

*Under no circumstances should the Child/Case Planner wait until the discharge date to obtain or forward these materials.*

When all options within the Planning agency or mental health system are determined to be inappropriate or non-existent, placement at the Children's Center must be considered. Transfer of a child to the Children's Center must have as much advance notice as possible and have the approval of the ACS Assistant Commissioner for Placement-Division of Child Protection.

- *Intensive Mental Health Programs*

Children who have been diagnosed with a serious emotional disturbance that requires on-going psychiatric treatment and a therapeutic supportive living environment may need a higher level of care than can be provided in the foster care system. These children should be strongly considered for referral to one of the following intensive mental health programs:

i. Family Based Treatment Services

Family-Based Treatment (FBT) services are provided in a surrogate family's home. Family Based Treatment Parents care for children and adolescents with serious emotional disturbance, ages 5-18, in their own homes overseen by an OMH contracted agency. Treatment in this program is transitional and the average length of stay is one year to eighteen months. The FBT parents are highly trained and are provided intensive support to care for their children. It is optimal that the child's family, foster family, and/or other discharge resource are active

partners in the treatment, when available. The FBT parent serves as a role model for the child's family, foster family or other discharge resource in how to handle the difficult behaviors. A Family Counselor provides counseling and support to the child's family, foster family or other discharge resource. The service plan goals usually relate to teaching social and daily living skills, modeling positive social behaviors, and modifying maladaptive behaviors. Clinical treatment services are provided in the community and each FBT program is linked to clinic and day treatment programs, which have lead responsibility for developing, implementing and monitoring each child's treatment plan.

ii. Community Residences

Community Residences (CRs) are small, community-based settings that provide a therapeutic residential program for children and adolescents (age 5-18) with serious emotional disturbances. The program includes structured daily living activities, problem-solving skills training, a behavioral management system (level system), and caring consistent adult relationships. A CR is a transitional treatment facility with an average length of stay of one year to eighteen months. Clinical treatment services are provided in the community and each CR is linked to clinic and day treatment programs, which have lead responsibility for developing, implementing and monitoring each child's treatment plan. As with clinical services, education and recreation are provided in the community.

**Note:** Children participating in these programs remain in foster care and the case planning agency retains full case management/planning responsibility during these out-of-home treatments. To refer a child for a FBT or CR placement, applications must be made to C-SPOA at 888-CSPOA-58 (888-277-6258).

iii. Residential Treatment Facilities

Residential Treatment Facilities (RTF) are OMH-licensed residential programs with fully integrated mental health services for seriously mentally ill children and youth between ages 5–21. Treatment and educational services are on-site. If it is determined that the child needs to be placed in a Residential Treatment Facility (RTF), the child must first be referred to – and approved by – the Pre-Admission Certification Committee (PACC).[21]

- If the PACC determines that the child does not require RTF care and that he/she can be maintained in the community with supportive services, then the Case Planning Agency should refer the child for B2H or other appropriate home- or community-based services (see above).

- The Child/Case Planner is responsible for making sure that the hospital-based treatment team is sending the referrals promptly. The referral should be made by the hospital in close collaboration with the Planning Agency. The hospital will be responsible for providing all necessary updated clinical information documenting the need for a higher level of care.

[21] Guidelines and referral forms for RTF/PACC are available on DocuShare.

- The Child/Case Planner must ensure that periodic (every 30 days) updates from the treating psychiatrist are sent to the PACC while the child awaits discharge to inform the committee that the RTF placement is still appropriate for the child's needs.

- If the child has already been RTF-certified prior to hospitalization and is waiting for RTF admission, the Child/Case Planner must obtain updated materials from the hospital treatment team and send the updates to the PACC.

- When the child has been RTF-certified, is awaiting admission to a RTF, but no longer needs acute hospitalization and is ready for discharge, lower-level services – such as Home-Based Crisis Intervention (HBCI) or Intensive Crisis Stabilization and Treatment (ICST), or services accessed through CSPOA– may help him/her leave the hospital and be maintained in the community in the interim. In these circumstances, the Planning Agency should make this clear to the PACC, and should periodically send updates to the PACC (every 30 days), including reports from the treating psychiatrist to document the child's continued need for the intensive structure and treatment provided by a RTF while maintaining stability and readiness for RTF admission.

- During interim placements, if the child improves given the support services, s/he may be found to be ineligible for RTF placement, making it appropriate for the Child/Case Planner to submit an application to a lower-level mental health program(s) and/or for B2H services. In such cases, the frequent communication with the PACC would provide the Child/Case Planner with some guidance from the PACC coordinator and the committee's OMH liaison regarding appropriate lower-level mental health programs.

- *Prevention of Re-hospitalizations*

  In order to reduce re-hospitalization and to ensure ongoing continuity of care, if the child is in crisis within 30 days of discharge, the Case Planner/Child Planner should contact the leader of the discharging hospital's treatment team for consultation and, as appropriate, for screening and admission to the same hospital if re-hospitalization is necessary and a bed is available.

  Each agency is expected to have internal or contracted staff and resources available for assistance in appropriate mental health service planning. It is understood that the Child/Case Planner will maximize utilization of his/her agency's own resources for help and guidance while s/he is involved with the hospital treatment team in ongoing inpatient care, subsequent discharge planning and in accessing post-hospitalization services. Case/Child Planners may also seek technical assistance from the MHCU by emailing MENTALHEALTH@DFA.STATE.NY.US or by calling (212) 374-MHTA.

**Children for Whom the Division of Child Protection Has Case Planning Responsibility**

If ACS has removed a child from his or her parent's custody and takes him or her to the hospital before there is a legal order remanding the child into foster care, or if ACS has obtained a remand order but the child has not been referred to a foster care agency, a Child Protective Specialist (CPS) or Child and Family Specialist (CFS) from the appropriate Division of Child Protection (DCP) Borough Office will serve as ACS's contact person during regular office hours. That CPS/CFS will serve as the contact person while the child is in the hospital pending placement into foster care. If a member of the hospital treatment team needs to reach a CPS/CFS after office hours, s/he may contact Emergency Children's Services (ECS) at (646) 935-1466 [alternate number (212) 966-8000] for assistance. An ECS worker will provide assistance and will update the assigned worker by the next business day. If a child leaves the hospital prior to foster care placement, technical assistance for accessing post-hospitalization services will be provided to the borough office CPS/CFS by the assigned Mental Health Consultant from the Clinical Consultation Program.

If a child is brought into the hospital by his or her parents and is *not* in ACS custody, his or her parents remain responsible for any and all of the child's medical treatment, even if there has been a Child Safety Conference that has resulted in a plan for voluntary foster care placement and the parents plan to sign a voluntary placement agreement upon the child's discharge. The child is not in ACS's custody until a remand is obtained or a voluntary placement agreement is signed. The voluntary placement will not be signed until after an investigation is conducted, a Child Safety Conference is held (preferably at the hospital), a foster care placement is secured, and the child is about to be discharged.[22] In these situations, ACS will assist the child's parents in developing a plan for securing appropriate services for the child after discharge, which will include securing a foster care placement. Once a child is in foster care, this policy, as described above, applies. When the plan is to discharge the child from the hospital to a treatment setting – either in the mental health, OPWDD or educational systems – a voluntary placement agreement is not needed for the child to access such treatment options.

[22] For more information about voluntary placements, see ACS's *Voluntary Placement Agreement Protocol* dated October 1, 2003.