

Behavioral Health Services SAMPLE POLICY

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| Approved By: | Date Issued: | Number of Pages: | Appendix Pages: |
| Related Laws: | Division/Office: | Contact Office/Bureau/Unit: | |
| Supporting Regulations: 18 NYCRR 441.4(a) 18 NYCRR 441.22 | | | |
| Regulatory Bulletins and Directives: | Local Operating Practice: | | |
| Related Policies: | Related Forms: | | |
| Supersedes: | | | |
| Summary: This policy describes the continuum of behavioral health services available to youth placed with the AGENCY. | | | |

I. POLICY

It is the policy of the AGENCY that all youth placed in a institutional setting have access to quality, strength-based behavioral and mental health assessments and treatment while in its care, and that appropriate linkages to follow-up behavioral health services are provided for youth returning to the community. Qualified mental health professionals (clinicians) will provide treatment services that are child- and family-focused, culturally competent, developmentally appropriate, trauma informed, empirically validated or considered promising practices, and well-integrated with other AGENCY and community services. Clinical staff will work collaboratively with families, agency staff, community staff, administrators, and other child-serving agencies, to promote emotional health and resilience in youth. Behavioral health services are designed to facilitate the successful adjustment of youth in their home community.

II. DEFINITIONS

- A. Behavioral Health Service** -- Any assessment or treatment service related to mental health concerns or disorders, substance abuse, sexually inappropriate behaviors, developmental disabilities as well as other specialized treatments.
- B. Diagnostic and Statistical Manual of Mental Disorders (DSM)** -- A manual published by the American Psychiatric Association that covers all mental health disorders for children and adults. It also includes information on etiology or causes, statistics, age of onset, and prognosis.
- C. Direct Care Staff** -- AGENCY staff who provide direct supervision of youth. These staff work in residential and community programs.
- D. Support Plan** -- The support plan is a comprehensive set of goals and objectives composed at the first support team meeting, which is held within 30 calendar days after the youth is admitted to the AGENCY. The support plan includes input from all treatment providers as well as from the youth and their family. The plan is reviewed, updated, and modified as appropriate every 30 calendar days thereafter.
- E. Support Team** -- A support team is a multidisciplinary team working collaboratively to assist the youth in achieving the youth's identified goals established to lead toward reintegration and success in their home community. Support teams include (but are not limited to) all the individuals who are engaged in the treatment and support of a particular youth (i.e., residential and community staff, the youth (when age appropriate), and the youth's family/guardian/discharge resource, as appropriate). See 18 NYCRR 441.22(a)(2)(ii)(c). The support team meets regularly to discuss progress and strategies for assisting the youth and their family members in making treatment gains.
- F. Qualified Mental Health Professional (also, Clinician)** -- The clinician is a qualified mental health professional who provides mental health assessment and/or treatment services to youth. They are employed directly by the AGENCY or are on contract.
- G. Mental Health/Psychiatric Rounds** -- Mental health rounds occur weekly; the purpose is to provide a format for information sharing between the treating psychiatrist and the members of the youth's treatment team. Rounds include a brief review of youth treated by the psychiatrist with whom support team members share their experiences, observations, and assessments of youth. Where indicated, rounds will be used to identify and address acute treatment-related issues for youth, to discuss progress and

challenges for individual youth, and to provide for ongoing discussions regarding a youth's treatment goals and discharge plans. Rounds should include the following staff: psychiatrist, clinician, case planner (if different from clinician), representatives of the direct care staff, and representatives from education and medical departments. The clinician will write a short summary note of the discussion on each youth presented and record this note in the youth's clinical contact notes.

H. Service Provider — All members of a youth's support team.

I. Therapist — A qualified mental health professional who provides psychotherapeutic treatment services.

III. PROCEDURE

A. Initial Screening and Intake Assessment

1. Initial Mental Health Contact

- a. Within 72 hours of a youth being placed within a congregate program, the youth must be screened using a validated, industry accepted instrument for, at minimum, suicidality; chemical dependence requiring immediate medical intervention; and any current prescribed medications. Also, an individualized crisis intervention plan must be developed with the youth and placed in their record as well as in the appropriate locations throughout the residential program
- b. Within 72 hours of admission to a residence, every youth is assigned a clinician who will meet with the youth for an initial interview (mental status exam), which is documented in the youth's clinical record. Prior to and during this meeting, the clinician reviews prior mental health assessments. During this meeting, the clinician also conducts and documents a clinical interview
- c. The initial level and frequency of ongoing mental health services is, in part, determined by clinical observations, reports from direct care staff regarding mental health symptoms and behaviors, a review of the youth's mental health history, and the AGENCY'S initial mental health assessment.

2. Initial Comprehensive Mental Health Assessment

- a. All youth newly admitted to AGENCY must receive an initial comprehensive mental health assessment completed by a qualified mental health professional. This evaluation begins within seven days of admission with a written report within 30 days of placement to be available at the youth's first support team meeting. The comprehensive mental health assessment consists of a diagnostic interview and observations of the youth, record review, and the administration of valid measures to assess for, at a minimum, suicide risk, anxiety and mood disorders, trauma, drug and alcohol use, and sexual assault/trafficking. The written report will include biopsychosocial history, behavioral observations, results of psychological testing, diagnostic impressions, and treatment recommendations, which are recorded in the AGENCY FORMS, and maintained in the youth's clinical record.
- b. When a DSM diagnosis is present, a primary or working diagnosis will be indicated in the youth's case record. This initial diagnosis is given by the evaluating

psychiatrist, psychiatric nurse practitioner, or another qualified mental health professional. The qualified mental health professional completing the initial mental health assessment must enter the DSM diagnoses into the youth's clinical record, and documented in the initial comprehensive mental health assessment, and every support plan developed with the youth. Changes to the initial DSM diagnosis will be made by consensus of the mental health professionals and recorded in the youth's clinical record and all subsequent support plans.

- c. When indicated by history, presentation, or by referral of a clinician, the mental health assessment will also include a psychiatric diagnostic evaluation completed by a psychiatrist or by a psychiatric nurse practitioner. This evaluation will include the following components: identifying data, chief complaint, history of presenting problem, review of symptoms, medical history, psychiatric history, school history, family history, substance use history, mental status, case formulation, DSM diagnoses, and treatment recommendations. The psychiatric diagnostic assessment is recorded in the youth clinical record.

B. Mental Health Treatment

1. Mental Health Staffing

- a. Mental health services are provided along a continuum of care within the AGENCY. The AGENCY must provide mental health treatment services by qualified professional staff consisting of psychologists, social workers, or psychiatric nurse practitioners. The AGENCY has treatment administrators who provide clinical and administrative supervision in the AGENCY and infuse clinical principles into the overall programming. Qualified mental health professionals will be clinically supervised by a treatment administrator. Psychopharmacological treatment must be provided by board eligible psychiatrists or psychiatric nurse practitioners.
- b. For mental health emergencies outside of the hours qualified mental health professionals are in the residence, the AGENCY will **(ENTER AGENCY PROGRAM LANGUAGE HERE FOR AFTER HOURS EMERGENCY MENTAL HEALTH CARE)**.

2. Ongoing Mental Health Contacts

- a. All youth in the congregate program will receive individual therapy from their assigned clinician at least once every other week. This service provides a basis for ongoing assessment of the youth's behavioral health needs. All services provided by clinicians are documented in a clinical contact note within five business days of the session/provision of service.
- b. The youth's assigned clinician will have contact with the youth's family/caregiver/release resource at least monthly and will provide the family with psychoeducational services as indicated. The clinician will work to engage the family in the treatment process. Contacts with the family as well as attempted contacts must be documented in the youth's case file within a week. **AGENCY MAY CHOOSE TO USE ANOTHER MEMBER OF THE YOUTH'S SUPPORT TEAM FOR FAMILY ENGAGEMENT/CONTACTS**
- c. The individualized treatment goals, objectives, and interventions used will be documented by the clinician in the youth's support plan. Changes in mental health

treatment, including frequency of contact, duration, intensity, or modality are determined by the youth's clinician in consultation with clinical supervision.

3. Mental Health Services

a. General Mental Health Treatment for Youth and Families

- i. Clinical staff provide individual, group, and family therapy; crisis evaluation and intervention; and mental health discharge/transition planning. Clinicians facilitate psychiatric hospitalization or transfer to other mental health program(s), if necessary, and communicate on a regular basis with the treating hospital staff during the youth's stay.
- ii. Clinical staff provide evidence-based or evidence-supported treatments (*e.g., cognitive behavioral therapy, trauma-focused cognitive behavioral therapy, dialectical behavior therapy, etc.*) appropriate to the identified diagnostic and behavioral needs of the youth. Clinicians work to include family members, guardians, and other significant individuals in the treatment process. Every effort is made to engage the youth in treatment, using strategies that focus on the strengths and goals of the youth and their family. For each youth, the clinician will regularly assess and report on the effectiveness of interventions during the support team meetings and mental health rounds and adjust the treatment strategies as needed to facilitate progress; these will be documented in the support plans.

b. Enhanced Mental Health Services for Youth

- i. Psychiatric Services: When necessary, the AGENCY will offer/make available services including assessment, diagnosis, medication therapy, and medication monitoring. These services adhere to professional standards and are integrated within the overall behavioral health treatment of youth.
 - (a) Psychiatric evaluations include: a review of prior records, including those that document interviews with parents or guardians; an assessment of the youth's current mental status, present illness, current medications, and medication effectiveness; history of medication treatment and responses, adverse side effects or medication allergies; social history; substance abuse history; and an explanation of how the youth's symptoms meet the criteria for any diagnosis.
 - (b) Psychiatric medicine may be prescribed when clinically indicated to treat DSM disorders and symptoms. The prescription of psychiatric medicine will address the youth's symptoms, be prescribed in standard dosages, be modified as clinically indicated, and be documented with accurate and complete justification in the youth's record in both the psychiatrist's contact note and in the medication log.
 - (c) Psychiatric follow-up occurs at least monthly for youth prescribed psychiatric medication. Psychiatric follow-up appointments must include a meeting between the youth and the psychiatrist or psychiatric nurse practitioner. When possible, the clinician should also be present. The youth is

interviewed about interim history and pertinent symptoms. Medication benefits and side effects are elicited, and treatment changes are discussed.

- (d) The psychiatrist must provide a summary of the diagnostic evaluation and follow-up meetings to the mental health rounds as a subject matter for team discussion.
- (e) The psychiatrist or psychiatric nurse practitioner will seek to obtain informed consent from the parent/guardian and youth assent for prescribed medication. The clinical staff tracks symptom changes and side effects, and reports these to the psychiatrist, the clinician, and the nurse.

C. Integration and Coordination of Mental Health Treatment Services

All mental health, substance abuse, and other clinical treatment services will be integrated and coordinated within the program. Providers review relevant information and treatment progress with all members of the support team to provide effective therapeutic services to each youth.

1. Clinicians:

- a. Have, at minimum, biweekly individual clinical sessions with each youth on their caseload.
- b. Communicate on a regular basis with direct care staff and administrative staff regarding the youth's mental health treatment.
- c. Participate in the youth's psychiatric visits. If the clinician does not participate in the session, they will communicate treatment issues and progress to the psychiatrist. The treating clinician is responsible for communicating all changes to the youth's team (including medication changes, expected outcomes of medication changes, potential side effects, etc.) following the youth's psychiatric visit.
- d. Attend support team meetings (including related case reviews and emergency meetings) to provide input regarding the youth's treatment and behavioral progress and record this input in the support plan on a monthly basis. At support team meetings, all relevant treatment services are discussed and noted in the support plan, including mental health care (including psychiatry), substance abuse treatment, treatment of sexually inappropriate behaviors, and any other specialized behavioral health interventions.

2. In order to facilitate the transition for youth from the residential program to their home communities, AGENCY clinicians will do the following:

- a. Establish communication with community providers to identify and engage community reentry services. The clinician will work with the team to identify and engage necessary community providers immediately following admission of the youth to the AGENCY.
- b. Establish and maintain communication with the youth's parent/guardian and other family members. A letter must be mailed to the youth's parent/guardian providing the names of the support team members as well as a contact number

where team members can be reached at the AGENCY. Every effort is made to engage the youth's family and community-based services in follow-up support planning. Family contacts may be made in person, by video conference, or by telephone conference. Contacts are required to take place monthly, at a minimum, and must be documented in the youth's clinical record.

- c. Refer any youth who requires community-based mental health care, including substance abuse treatment and/or any other clinically indicated services, to appropriate agencies and programs (e.g., Clinic, Intensive Case Management, Residential Treatment Facility, OMH-Licensed Community Residence, OMH- or OASAS-licensed Day Treatment). These programs may require application to the youth's county of origin, e.g., Single Point of Access (SPOA) or for New York City (C-SPOA). In other cases, referrals may be for wraparound services. The referring clinician obtains required written consent from the parent/person with capacity to consent prior to sending copies of behavioral health records to any treatment provider.
 - d. For youth who are receiving psychiatric medication at the time of discharge, the clinician will refer that youth to a community psychiatrist and an outpatient treatment provider.
3. Consultation and Training for Staff:
- a. Mental health clinicians must provide consultation to direct care staff, consisting of case-specific consultation, consultation and training at support team meetings and case reviews, or otherwise as needed to promote an integrated, learning environment.

D. Mental Health Observations, Referrals, and Response to Crisis

1. Trained direct care staff must follow the recommendations provided by qualified mental health professional staff indicated on the youth's individualized crisis intervention plan, for individual youth de-escalation and mental health crisis response interventions. Individualized crisis intervention plans will be reviewed and, when necessary, updated by the clinician following any mental health related crisis experienced by youth on their caseload. Changes to this plan are reviewed as needed at unit/staff meeting and support team meetings.

E. Refusal of Mental Health Services

Staff will document a youth's refusal of mental health services and will develop objectives designed to engage youth in accepting care. Youth may not be removed from a clinician's caseload due to refusal of treatment; however, the support team and administration can make a decision to transfer a youth to another clinician's care if it is agreed that another clinician can better meet the youth's needs. Ongoing efforts to engage youth in treatment services must be implemented and recorded in the youth's clinical record. The treating clinician must also document efforts to continue to engage family or legal guardians who refuse to participate in the youth's treatment.

F. Substance Abuse Interventions and Treatment

1. Substance abuse services will be provided along a continuum of care within AGENCY

residences. The varying levels of intervention are designed to meet the identified needs of each youth, as assessed.

- a. During the initial assessment of any youth, he/she will receive assessments to assist in determining substance abuse treatment needs, using evidence-based instruments endorsed or approved by OASAS.
 - b. As part of the evaluation process, clinicians will assess each youth for the presence of a substance use disorder, resulting in a diagnosis (or lack thereof) and treatment recommendations.
2. All youth in AGENCY residences will receive *educational and* treatment services regarding substance abuse along the following continuum of care: prevention and education, and treatment.
- a. Prevention and Education - AGENCY staff must provide a comprehensive substance abuse education and prevention program. This curriculum will be administered by trained direct care staff.
 - b. Treatment - Interventions will be provided to youth requiring substance abuse services during their stay in a residence. Youth identified with substance abuse treatment needs must be provided services by an AGENCY clinician with experience and training in the provision of substance abuse services, or a contracted clinician where necessary. The need for substance abuse assessment or for treatment services will be identified via a screening tool utilized during the intake process or at any time during the course of placement. Youth who are identified as having substance abuse treatment needs must be referred to the qualified substance abuse clinician for a comprehensive substance abuse assessment. If determined to meet criteria for services, the youth will receive treatment, relapse prevention, and release planning services from a clinician.
3. Relapse Prevention Plan: The challenges faced by youth with substance use disorders as they return to their families, schools, and communities will be addressed in a Relapse Prevention Plan developed by the youth and their support team, and documented within the last support plan. The Relapse Prevention Plan will be developed for all youth with substance use disorders prior to discharge from the residence.

G. Sexually Inappropriate Behaviors: Intervention and Treatment

1. Treatment services for youth who have engaged in sexually inappropriate behaviors will be provided using nationally recognized standards along a continuum of care. Treatment consists of an integrated approach combining cognitive-behavioral, psychoeducational, and psychodynamic treatment with appropriate adjunctive therapies, augmented by family and community support. Treatment will be directed specifically toward resolving and rehabilitating the youth's presenting sexually inappropriate behavior. AGENCY programs that treat sexually inappropriate behaviors must provide empirically supported treatment for youth adjudicated for an act which is a sex offense and youth who are not so adjudicated but exhibit sexually inappropriate behaviors in the areas of: moral decision-making, developing a sense of empathy and compassion, increasing the youth's capacity for both emotional and behavioral self-regulation, and disengaging from patterns of victimizing and sexually abusive behavior.
2. Any youth who has been adjudicated for a sex offense or who is assessed to potentially require treatment for sexually inappropriate behavior must receive a comprehensive assessment by a qualified sexually inappropriate behavior treatment clinician. A qualified clinician will administer the assessment within 30 calendar days of

admission. Sexually inappropriate behavior treatment clinicians report their findings on the AGENCY Sexually Inappropriate Behavior Treatment Assessment form. The assessment will inform support planning by identifying risk levels and will provide guidance regarding individual treatment needs.

3. Clinicians who treat sexually inappropriate behaviors will coordinate with other members of the support team to provide individual and group treatment. Core strategies include the provision of a safe, predictable, and consistent environment that provides external controls and is conducive to positive growth, as well as utilization of a strength-based, trauma-informed, developmentally appropriate treatment model, which treats the youth in a broad interpersonal and social context. All treatment interventions will be individualized to recognize the youth's strengths, needs, and progress toward treatment goals. Sexually inappropriate behavior treatment clinicians will contribute to the support plan specific goals and objectives pertaining to the treatment of sexually inappropriate behaviors
4. The youth's family members will be actively engaged in the treatment process whenever possible through family meetings and/or through video conferencing and regular phone calls.
5. When a youth who has received treatment for sexually inappropriate behaviors in residential care is being considered for another level of care, the support team will develop a transition plan.

The transition recommendation must include:

- A clinical determination focusing on the youth's readiness for the recommended transition plan
- Victim impact potential
- Risk assessment
- Educational/vocational plans
- Community safety plan
- A clearly written aftercare plan, including confirmation of acceptance to outpatient treatment for sexually inappropriate behavior treatment, when appropriate
- Positive home assessment in place, and if necessary, a signed family safety plan
- An established permanency plan goal

H. Clinical Documentation of Mental Health Treatment

1. Mental health documentation reflecting assessment, support planning, treatment progress, mental health contacts, and treatment outcomes will be completed by clinical staff for each youth and will include the following:
 - a. The initial screening and intake assessment reports (Mental Health, Sexually Inappropriate Behaviors, Intellectual/Development and Alcohol and Other Drug Service's Needs). These reports are placed into the youth's clinical file.
 - b. The support plan is completed for all youth at the time of the support team meeting and is recorded on the AGENCY SUPPORT PLAN FORM. Monthly reviews/updates reflecting the youth's and family's progress in treatment as well as the support team's interventions are noted.
 - i. For youth 12 years of age and younger, support team meetings and subsequent support plans must be completed by days: 30, 90, 180, and every 30 days thereafter. However, in the months when a full support team

meeting is not held the AGENCY TEAM MEMBER must meet with the youth and their family to review, and where necessary, update the support plan goals and objectives.

- ii. For youth 13 years of age and older, support team meetings and subsequent support plans must be completed by days: 30, 90, 210, 330, and then every 30 days thereafter. However, in the months when a full support team meeting is not held the AGENCY TEAM MEMBER must meet with the youth and their family to review, and where necessary, update the support plan goals and objectives.
 - c. A Clinical Contact Note, reflecting the content of any clinical session, must be completed each time a youth is seen by a clinician. Every youth contact or collateral contact must be reflected on an electronic Clinical Contact Note. Clinical Contact Notes are stored electronically in a secure clinical progress note format.
 - d. A community reentry plan (the final support plan conducted in the residence) must be completed prior to discharge for each youth transitioning to the community. The plan must include a summary of the youth's course of treatment while in the program, diagnosis, medications, and future treatment recommendations.
2. The youth's case record will include records and documents of previous mental health services obtained prior to the youth's placement in AGENCY. The mental health record that reflects the provision of mental health services throughout the youth's stay in AGENCY is maintained in ELECTRONIC CASE RECORD.
 3. The confidentiality of both the physical and electronic mental health records must be maintained by the mental health clinician and the support team, in keeping with generally accepted professional standards and applicable laws and regulations.