

Suicide Prevention and Intervention Policy for Juvenile Justice Placement


<p>Approved By:  Gladys Carrión, Esq. Commissioner</p>	<p>Date Issued: <u>11/29/2016</u></p>	<p>Number of Pages: 24</p>	<p>Number of Attachments: 4</p>
<p>Related Laws: Article 3 of the Family Court Act</p>	<p>ACS Divisions/Provider Agencies: Youth and Family Justice; juvenile justice placement provider agencies</p>	<p>Contact Office /Unit: Charles Barrios Associate Commissioner Juvenile Justice Programs & Services charles.barrios@acs.nyc.gov</p>	
<p>Supporting Regulations: 18 NYCRR § 442.2(b)</p>	<p>Bulletins & Directives: NA</p>	<p>Supporting Case Law: NA</p>	
<p>Key Words: suicide, suicidal, ideation, suicidal ideation, self-harm, non-secure, limited secure, placement, juvenile justice, self-injurious, risk, special supervision, supervise, constant observation, close observation, mental health, LSP, NSP, behavior support plan, BSP</p>	<p>Related Policies:</p> <ul style="list-style-type: none"> • #2010/03 Guidelines for the Provision of Emergency and Inpatient Mental Health Services for Children in the Foster Care and Child Protective System • #2012/06 Non-Secure Placement Personal Youth Search Policy • #2015/03 Contraband Policy for Juvenile Justice Placement • #2015/10 Room Isolation for Limited Secure Juvenile Justice Placement • #2016/05 Limited Secure Placement Personal Youth Search Policy • Transfers in Juvenile Justice Placement • Log Books and Paper Files for Juvenile Justice Placement • Safe Intervention Policy for Juvenile Justice Placement 	<p>Supersedes: NA</p>	
<p>Related Forms: Special Supervision Status Checklist (Attachment A) Off-Premises Special Supervision Log (Attachment B) MHCU Form CM-1057 (Attachment C) MHCU Form CM-1058 (Attachment D)</p>			
<p>SUMMARY: This policy provides guidelines that staff for the Administration for Children's Services (ACS) and juvenile justice provider agencies must follow to minimize suicide risk potential among youth placed in non-secure placement (NSP) and limited secure placement (LSP) facilities.</p>			
<p>SCOPE: The policy applies to all facilities having care and custody of youth placed with ACS pursuant to Article 3 of the Family Court Act.</p>			

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I. INTRODUCTION

- A. The following policy was developed for use in the non-secure placement (NSP) and limited secure placement (LSP) system of the New York City Administration for Children's Services (ACS), the spirit of which rests firmly on the premise that youth placed in residential settings shall be placed in programs that are close to home, and for only as long as is necessary to maintain public safety and impart the skills and tools each youth needs to succeed in the community. All NSP and LSP settings are to prioritize youth-centered programming and strive to provide youth with a full range of individual supports they need to achieve their treatment goals. Like the youth in NSP and LSP programs, families are to be treated with utmost dignity and respect, and shall be integrated into programming and treatment as full partners throughout the period of each youth's placement and aftercare. Communities and the natural resources they possess are to be valued and relied upon as part of the formula for success in each case. The primary responsibility of all those associated with the juvenile justice placement system is to protect the safety and security of communities, and the safety and security of the youth in placement.
- B. This policy establishes guidelines for the screening and ongoing assessment of youth in juvenile justice placement to identify those who present a risk of self-harm or suicide. When such risk is identified, these procedures must be followed for prevention and intervention.

II. SUMMARY

- A. The ACS Division of Youth and Family Justice (DYFJ) and juvenile justice placement provider agency staff must be attentive to all self-injurious statements, self-injurious behaviors, and suicide attempts, regardless of how they are expressed. DYFJ and provider agency staff must be constantly alert to the possibility of self-harm and suicide, especially during periods of heightened risk.¹
- B. Beginning with intake/assessment and continuing throughout residential placement and aftercare, ACS and provider agency staff shall review evaluation paperwork and observe and monitor youth for suicide risk potential both directly and through appropriate referrals to contracted health and mental health services providers. Upon determining that such a risk exists, staff must take appropriate action to prevent, protect against, and reduce that risk.

III. DEFINITIONS

- A. Behavior Support Plan (BSP): A specific documented plan developed by the treatment team, in conjunction with the youth and the youth's family or other persons of significance to the youth, which is tailored to the youth's individual needs and is used to determine intervention strategies and/or safety procedures to defuse behavior(s) of concern. The plan

¹ For examples of heightened risk, see section IV. C.

must include any limitations on physical interventions authorized or prohibited for the youth.

- B. Self-Injurious Statement: Any statement made by a youth that suggests that the youth is contemplating self-injury. This includes, but is not limited to, non-verbal statements such as written statements or drawings. Self-injurious behavior should not be classified under this event type.
- C. Self-Injurious Behavior: Injury to oneself that is not life-threatening as assessed by a qualified mental health practitioner.
- D. Suicidal Ideation: Thinking about death and considering taking one's own life, with or without a specific plan.
- E. Suicide Statement: Any statement made by a youth that suggests that the youth is contemplating suicide. This includes, but is not limited to, non-verbal statements such as written statements or drawings.
- F. Suicide Attempt: An act intended to end one's own life, consisting of actions taken which, by virtue of the method employed and circumstances chosen, results in or could likely result in, or is believed by the person acting to be likely to result in, medically serious injuries that might threaten the individual's life or have other irreversible medical consequences.
- G. Suicide: Death caused by self-directed injurious behavior.
- H. Denial of Risk: When a youth who is suicidal misrepresents his or her condition by denying risk factors or by attempting to refute what might appear as a suicide warning sign. Although verbal responses during the intake screening and subsequent screenings are critical for assessing suicide risk, staff must not rely exclusively on a youth's denial of risk, particularly when behavior suggests otherwise.²
- I. Emergency Response Kit/Rescue Tool: A set of tools that can be used to respond to a youth's self-injurious behavior or suicide attempt. Emergency response kits shall contain, at minimum, a first aid kit, pocket mask or face shield, rescue tool (also known as "tough cut" scissors), medical gloves, bio-hazard bag, and large trauma bandages. Emergency response kits must be accessible to all staff but shall be locked or stored in a locked cabinet when not in use. Medical staff shall confirm that all equipment is in working condition, and that each kit is fully stocked with the required items.
- J. Qualified Medical Practitioner: A physician, physician assistant, nurse practitioner, licensed practical nurse, dentist or registered nurse employed by ACS, the Office of Children and

² See National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System*. Washington, DC.

Family Services (OCFS), the Office of Mental Health (OMH), or a hospital, and/or working for or contracted by an ACS-contracted juvenile justice placement provider agency to provide health care services to youth in NSP or LSP facilities.

- K. Qualified Mental Health Practitioner: A person qualified in New York State to deliver mental health services (i.e., a psychiatrist, psychologist, social worker, psychiatric nurse practitioner, or mental health nurse employed by ACS, OCFS, OMH, or a hospital, and/or working for or contracted by an ACS-contracted juvenile justice placement provider agency to offer mental health assessment and/or treatment services to youth in care).
- L. Special Supervision Status: Two (2) levels of special supervision status shall be used to maintain the physical safety of youth who make self-injurious statements, demonstrate self-injurious behaviors, express suicidal ideation, or attempt suicide: close observation and constant observation.³
1. Any staff person may place a youth on special supervision status and when in doubt, should err on the side of caution by placing the youth on special supervision.
 2. When a youth has made a self-injurious statement or has engaged in self-injurious or suicidal behavior, staff must start the youth on constant observation.
 3. The staff person must alert the facility director or his or her designee and consult with a qualified mental health practitioner within one (1) hour after a youth is placed on special supervision status in order to confirm the appropriateness of special supervision—or hospitalization, as warranted—and the suitable level of observation.
 4. Only a qualified mental health practitioner may remove a youth from special supervision status or step a youth down from constant to close observation. The appropriateness of special supervision status must be reassessed daily.
 5. **Close Observation**: Deliberate focus on a youth who is not actively suicidal but meets one or more of the following criteria: 1) the youth has expressed suicidal ideation but without a specific plan; 2) the youth has a recent history of self-destructive behavior; and/or 3) the youth has denied suicidal ideation or has not threatened suicide but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury. Close observation should be used when a youth does not require constant observation but is not stable enough for regular program supervision. Staff shall observe such youth at staggered, unpredictable intervals not to exceed every 15 minutes between each observation throughout the day, including in a protrusion-free room when the youth is in his or her bedroom.

³ See National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System*. Washington, DC.

6. **Constant Observation:**⁴ More intensive than close observation and reserved for youth who express suicidal ideation, either forming a specific plan or engaging in suicidal behavior. The appropriate qualified mental health practitioner, as determined by the provider agency, shall decide whether constant observation or hospitalization is more appropriate based on an individualized assessment.⁵ Staff must observe youth on constant observation status on a continuous, uninterrupted basis (including when a youth is sleeping or attending to personal hygiene).⁶

Note: All staff who have direct contact with youth, including qualified mental health practitioners (where available), must assess and interact with suicidal youth on a daily basis rather than just observe them.

- M. **Mock Drills:** Rehearsals aimed at increasing the efficiency of an emergency response to a suicide attempt. Mock drills must be incorporated into pre-service and refresher training for staff and supervisors of staff who have direct contact with youth.⁷

IV. GENERAL PREVENTION STRATEGIES

A. Access to Emergency Contact Information

1. Provider agencies shall post critical emergency contact information where staff can easily access it in the event of a youth's self-injurious behavior or suicide attempt. The posted information must include a list of staff names, titles, and telephone numbers (including cell phone numbers) for all provider staff and contracted medical and mental health professional staff, as well as local emergency resources.
2. Emergency telephone lists and staff rosters shall be reviewed and updated as staffing changes occur in the facility, but no less than every six (6) months.

B. Staff Training

1. **For provider agencies:** NSP and LSP provider agencies must train all employees who have direct contact with youth or who supervise anyone who has direct contact with youth in suicide prevention and response. Training must be provided by qualified instructors, and staff attendance must be documented. This training must include eight

⁴ Staff may require assistance from colleagues when placing a youth under constant supervision. See *Safe Intervention Policy for Juvenile Justice Placement*.

⁵ The qualified mental health practitioner may determine that hospitalization is the most appropriate intervention even when a youth has not formed a specific plan or engaged in suicidal behavior.

⁶ Constant observation may be an appropriate intervention in instances when provider agency staff members attempt to take a youth to a hospital, but the hospital's clinical decision is that a psychiatric admission is not warranted.

⁷ See National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System*. Washington, DC.

(8) hours of pre-service training and two (2) hours of annual refresher training which conform to the details of this policy and shall include, but not be limited to:

- a. Staff attitudes about suicide and how negative attitudes can impede prevention efforts;
- b. Predisposing risk (e.g., substance abuse, mental illness, prior attempts) and protective factors (e.g., family support, peer support, school connectedness, religious beliefs);
- c. Strategies for recognizing verbal and behavioral cues and identifying suicidal youth despite a denial of risk;
- d. Responding to self-injurious statements, self-injurious behaviors, and suicide attempts;
- e. Responding to depressed youth;
- f. Proper monitoring and placement of youth on special supervision;
- g. Follow-up monitoring of youth who have attempted suicide;
- h. Effective communication between facility and health/mental health services personnel;
- i. Using an emergency response kit and rescue tool (in mock drills);
- j. Reporting and documentation procedures;
- k. General discussion of any recent suicides or suicide attempts in the facility;
- l. Other important information, such as the locations of emergency response kits, policy changes, and updated emergency contact lists; and
- m. Components of the provider agency's suicide prevention protocols.

Note: Standard first aid and cardiopulmonary resuscitation (CPR) training is required in addition to B. 1. a-m. above but shall not count toward the required hours for pre-service or refresher suicide prevention and response training.⁸

2. **For ACS:** ACS shall train all employees who have direct contact with youth or who supervise anyone who has direct contact with youth in suicide prevention and response as part of pre-service and refresher training.
 - a. Training must be provided by qualified instructors, and staff attendance must be documented. This training shall conform to the details of this policy and shall include strategies for identifying and responding to self-injurious statements, self-injurious behaviors, and suicide attempts.
 - b. In addition, the DYFJ Intake and Assessment team shall be trained on how to identify suicide risk through the intake and assessment process and to whom to report such risk when identified.

⁸ Standard first aid and CPR training may be offered as standalone training or added on to suicide prevention and response or safe intervention training.

C. Suicide Risk

Staff shall be vigilant at all times for behaviors or circumstances that may indicate a youth is at a heightened risk of suicide. Such behaviors or circumstances include, but are not limited to the following:⁹

1. Placement within the last 72 hours;
2. Severe loss of interest in activities or relationships previously enjoyed;
3. Depressed state indicated by withdrawal, periods of crying, insomnia, lethargy, or indifference to surroundings;
4. Active discussion of suicide plans;
5. Sudden or drastic changes in eating or sleeping habits;
6. Giving away valued possessions;
7. Fixation on alleged criminal activity or the consequences of such activity;
8. Lack of family contact or support (e.g., termination of parental rights, cancellation of family/home visits by a family member);
9. Unusual agitation, irritability, assertiveness, or aggression;
10. Previous suicidal behavior;
11. Signs of escalating distress or self-injurious behavior;
12. Recent rejection/loss of a close peer (e.g., friend or love relationship);
13. Recent death in the family or death of another person important to the youth;
14. Recent psychiatric hospitalization;
15. Recent scarring or injury indicating self-harm;
16. Receipt of negative news from the community (e.g., threats to the youth's family, incarceration of a family member);
17. Child abuse or neglect allegations made by the youth;
18. When in room isolation; and
19. Change in or introduction of new medication (e.g., starting an antidepressant).

D. Special Supervision of Medical Areas

Staff must be highly vigilant of youth in facility areas that are not suicide resistant, including medical rooms or any rooms that have medication or medical equipment. Medical staff should be alerted to the status of any youth for whom there is heightened concern, and high-risk youth should be accompanied during medical visits or procedures.

E. Staff Communication and Cooperation with Mental Health Practitioners

1. Provider staff shall advise a youth's assigned qualified mental health practitioner of any concerns they have about the youth's mental health. If a qualified mental health practitioner has not been assigned, provider staff shall notify the mental health professionals contracted to provide services to youth in the facility. After placing a

⁹ See Jacobs, D. (1999). *The Harvard Medical School Guide to Assessment and Intervention*. San Francisco: Jossey-Bass.

youth on special supervision status, staff shall immediately notify the appropriate mental health practitioner if a youth makes self-injurious statements, exhibits self-injurious behaviors, or attempts suicide.

2. Provider staff shall follow the directives of qualified mental health practitioners in working with and supervising youth on special supervision status. This includes, but is not limited to, recommendations about how to interact with or supervise a particular youth, how to intervene if the youth is acting out, and any restrictions on the youth's participation in regular programming as noted on the Special Supervision Status Checklist (Attachment A).

F. Safe Housing

1. All facilities must be equipped with at least one (1) emergency response kit. Emergency response kits must be accessible to all staff but shall remain locked or stored in a locked cabinet when not in use.¹⁰
2. All bedrooms shall be as suicide-resistant as is reasonably possible. Such rooms shall be free of all obvious protrusions and provide full visibility. The following features for bedrooms and bathrooms are required by OCFS for LSP facilities:
 - a. No horizontal surface may protrude from the wall of another surface more than one quarter (1/4) of an inch;
 - b. Air vents, grills, and security screens or covers may not have openings three-sixteenths (3/16) of an inch or wider;
 - c. Protrusions, gaps, or holes that could serve as anchor points for a loop, knot, or ligature are prohibited;
 - d. Furniture, fixtures, and other items that could be used as an anchor point for a loop, knot, or ligature are prohibited;
 - e. Door knobs and hinges must be suicide resistant; and
 - f. Faucets, shower heads, and water controls must be suicide resistant.
3. NSP and LSP providers shall submit to ACS a list of facility features that pose a potential suicide risk in their facilities. The list must include a detailed explanation of the steps they will take to minimize such risk (e.g., through training and enhanced monitoring).

V. **PROCEDURES**

A. Intake and Admission

ACS and provider agency staff must pay particularly close attention to the moods and behaviors of youth new to the facility, as the period of adjustment to a new environment

¹⁰ See page 4 for a description of the contents of an emergency response kit.

can be stressful and can provide important information about a youth's mental status and emerging mental health needs. In addition, ACS and provider agency staff shall take the following steps during the intake and admission process to identify and respond to each youth's mental health needs:

1. Initial Document Review by the DYFJ Intake and Assessment Unit

During the placement matching process, the DYFJ Intake and Assessment Unit shall review all reports and evaluation materials provided by the Court and other parties (e.g., Detention mental health provider staff). If Intake and Assessment staff members identify any suicide risk factors, including information about any past self-injurious statements, self-injurious behaviors, or suicide attempts, they must immediately inform the provider agency upon making the match between youth and facility.

2. Initial Screening for Suicide Risk by the Assigned Provider Agency

- a. Intake screening and continuous assessment of all youth is critical to a facility's suicide prevention efforts, and staff must view screening and assessment as an ongoing process.
- b. Within one (1) hour of admission to any juvenile justice placement facility, staff members must screen¹¹ the youth for suicide risk in consideration of the following questions:
 - i. Does anything indicate that the youth is a suicide risk now?
 - ii. Has the youth ever considered suicide?
 - iii. Has the youth ever attempted suicide?
 - iv. Has the youth ever engaged in other self-injurious behavior, such as cutting?
 - v. Is the youth being treated (or has the youth ever been treated) for mental health or emotional problems, such as depression or anxiety, or substance abuse?
 - vi. Has the youth recently experienced a significant loss?
 - vii. Has a close family member or close friend of the youth ever attempted or died by suicide?
 - viii. Is the youth expressing helplessness or hopelessness?
 - ix. Is the youth thinking of hurting or killing him/herself?
 - x. Has the youth experienced other recent trauma?
- c. If the staff member identifies any acute mental health issues including, but not limited to, suicidal ideation or intent, he or she must notify his or her supervisor and

¹¹ Provider agencies can develop their own screening tools to submit for ACS approval. For a list of screening tools, see National Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force. (2013). *Screening and assessment for suicide prevention: Tools and procedures for risk identification among juvenile justice youth*. Washington, DC.

make an immediate referral to a qualified mental health practitioner for further assessment, treatment, or additional referral where warranted.

- d. Even if a youth denies suicidal intent or a history of mental health problems, staff should not rely exclusively on the youth's report, particularly when the youth's behavior suggests otherwise or there is documentation of prior suicide risk factors. For such cases, the screening process must include referral procedures to mental health and/or medical personnel for a more thorough assessment.

B. Response to a Youth Identified as a Suicide Risk

1. When a youth has been assessed to be a suicide risk, it is critical for staff to have an unobstructed view of that youth at all times. When a facility's physical layout does not enable staff to have a clear line of sight to the youth's bedroom, ACS strongly recommends that providers explore alternate ways of achieving a clear line of sight to the youth, such as placing the youth or moving the youth to a bedroom in proximity to staff.
2. Whenever moving a youth to another bedroom, staff must be sensitive to both how the youth assessed to be a suicide risk and the youth that will be temporarily relocated will experience the move, and make every effort to minimize the disruption. When staff assess that the movement of youth will be too disruptive, temporarily relocating staff to a visually unobstructed position should be considered. Staff shall assess the room where the youth is moved for any potential hazards.

C. Response to Suicide Attempts and Self-Injurious Statements and Self-Injurious Behaviors

1. Immediate Intervention Following a Suicide Attempt

- a. Staff should never presume a youth is dead. If a youth has attempted suicide, the staff member must immediately check for breathing and a pulse and call emergency medical services (EMS). If no pulse or breathing is detected, a trained staff member must immediately initiate CPR until a medical team arrives.
- b. Any staff member who discovers a youth attempting suicide must immediately intervene to stop the youth from causing further harm. It is important for the staff person to remain calm and take all appropriate and immediate actions to protect the youth from harm including, but not limited to, untying a sheet or shoelace, elevating a suffocating youth until help arrives, using a rescue tool, taking away sharp objects, or using an emergency physical intervention.¹²

¹² See *Safe Intervention Policy for Juvenile Justice Placement*.

2. Stabilization After a Suicide Attempt or Self-Injurious Behavior

- a. Pursuant to CPR training, staff must immediately check for breathing and a pulse and call EMS if the youth is unable to walk or loses consciousness. If no pulse or breathing is detected, a trained staff member must immediately initiate CPR until a medical team arrives.
- b. If the youth is injured but ambulatory, he or she must immediately be examined by a qualified medical practitioner. If a qualified medical practitioner working for or contracted by the NSP or LSP provider agency is not physically present in the facility, the youth must immediately be taken to the nearest medical treatment location for a medical examination and any needed treatment.
- c. The staff member should stay with the youth to minimize danger and try to engage and calm the youth through active listening techniques, eye contact, and body language that show care and concern.
- d. Even if the youth does not appear to be physically injured, he or she shall immediately be examined by a qualified medical practitioner. If a qualified medical practitioner working for or contracted by the NSP or LSP provider agency is not physically present in the facility, the youth must immediately be taken to the nearest medical treatment location for a medical examination and any needed treatment.
- e. Under no circumstances shall a youth who attempted to harm himself or herself or who made self-injurious statements be left alone. The youth must be placed on constant observation status, and a qualified mental health practitioner shall determine whether constant observation or referral for hospitalization is more appropriate, based on an individualized assessment.

3. Assessment and Evaluation

- a. Staff shall immediately notify the shift supervisor, the facility director, and the clinical director upon hearing, observing, or learning about a youth's self-injurious statement, self-injurious behavior, or suicide attempt, verify that the youth has been placed on constant observation, is in a safe location, and is pending a safety determination from clinical staff. Staff shall arrange for the youth to be assessed and/or evaluated by a qualified mental health practitioner.
- b. Provider agency staff who witnessed or learned about the youth's suicidal or self-injurious statements or self-injurious behaviors shall place the youth on close supervision and arrange for a new or follow-up assessment of the youth either in person or over the telephone as determined by the clinical director or his or her designee, and make sure that the event is incorporated in the youth's behavior

support plan (BSP) for non-suicidal, self-injurious behavior. All follow-up assessments must include an interview with the youth, as well as discussions with the staff person(s) who witnessed or learned about the youth's suicidal or self-injurious statements or self-injurious behaviors and any other staff who may have information regarding the youth's mental health.

- c. Psychiatric evaluation at an emergency room may be required if the youth presents symptoms, exhibits behaviors, or expresses ideas that indicate an imminent risk of harm to self that requires assessment and intervention beyond the care level available in the NSP or LSP facility.

4. Post-Evaluation Follow-up

Once the youth's physical and mental health have been evaluated, provider agency staff must:

- a. Develop a safety plan with the qualified mental health practitioner who assessed the youth and comply with any recommendations. Such recommendations may include scheduling a psychiatric evaluation, placing the youth on close or constant special supervision status, making modifications to the youth's BSP, or returning the youth to his or her housing unit without special supervision.
- b. As soon as practicable, the facility director or his or her designee (who may be a staff person who has developed a rapport with the parent/guardian) must notify the parent/guardian of any self-injurious behavior which includes self-harm, self-injurious statements, suicidal ideations, and suicide statements. If the youth has attempted suicide, contact with the parent/guardian must be made immediately. All notifications must be documented in the youth's case record.
- c. In the event of any self-injurious behavior which includes self-harm, self-injurious statements, suicidal ideation, and suicide statements, provider agency staff must notify the youth's case planner, the ACS Placement and Permanency Specialist (PPS), the facility director, the youth's assigned qualified mental health practitioner, the clinical director, the youth's attorney, and any other staff who may work directly with the youth. In the event of a suicide or suicide attempt, provider agency staff must notify the above as well as the ACS Family Court Legal Services (FCLS) court liaison. If the youth is also in foster care as a result of a child welfare case, his or her child welfare foster care case planner and foster parent must also be notified. All notifications must be documented in the youth's case record.
- d. The facility director or designee must communicate with facility staff about the status of any youth on special supervision. This should occur in a briefing between shifts. The facility director or designee is also responsible for confirming that required information has been accurately documented in the Facility

Activity/Communication Log Book¹³ and the Off-Premises Special Supervision Log (Attachment B).

D. Special Supervision: Close Observation and Constant Observation¹⁴

1. **Special Supervision In General**

- a. If a qualified medical or mental health practitioner recommends that a youth be placed on or continued on a special supervision status, provider agency staff must immediately confirm that the recommending practitioner has provided clear details regarding which level of supervision the youth requires. In addition, the facility director or his or her designee must immediately confirm that the qualified mental health practitioner has completed the Special Supervision Status Checklist (Attachment A).
- b. The qualified mental health practitioner who assessed the youth shall use his or her discretion when making recommendations for the Special Supervision Status Checklist in order to protect the youth's safety. If staff members are at all uncertain about the recommendations, they shall immediately seek clarification from the qualified medical or mental health practitioner. If the qualified mental health practitioner has recommended that home visits and facility visits are prohibited, provider agency staff shall encourage other contact between the youth and his or her family.
- c. Although the details of special supervision will be individually tailored to each youth in accordance with the Special Supervision Status Checklist, the basic requirements of close observation and constant observation are detailed below in sections D. 2. and 3. **Provider agency staff must maintain the requirements of the special supervision status as detailed on the Special Supervision Status Checklist (Attachment A) at all times, including while a youth attends to his or her personal hygiene, visits with family, attends classes, and sleeps, until a qualified mental health practitioner recommends that the youth's special supervision status be modified or ended.**
- d. Once a youth is placed on special supervision status, provider agency staff shall document all observations in the Facility Activity/Communication Log Book and the Off-Premises Special Supervision Log, (Attachment B) where applicable (see section V. D. 4.).

¹³ See *Log Books and Paper Files for Juvenile Justice Placement Facilities*.

¹⁴ Youth who are on special supervision status may not be placed in room isolation. See #2015/10, *Room Isolation for Limited Secure Juvenile Justice Placement*. See also 18 NYCRR § 442.2(b), which prohibits the use of room isolation for a child that is "seriously depressed."

- e. Youth on special supervision must be reassessed every 12 hours by a qualified mental health practitioner, where available. If a qualified mental health practitioner is unable to reassess a youth on special supervision status within 24 hours, the youth shall remain on special supervision status as prescribed by the Special Supervision Status Checklist until an in-person reassessment can be conducted.

2. Close Observation

- a. The close observation level of supervision is for youth who are not actively suicidal but who express suicidal ideation and/or have a recent history of self-destructive behavior. Close observation is also for youth who deny suicidal ideation or do not threaten suicide but who demonstrate other concerning behavior through actions, current circumstances, or recent history that indicate the potential for self-injury.¹⁵
- b. For close observation, a staff member will be assigned to the supervision of an individual youth and shall observe the youth at staggered, unpredictable intervals not to exceed 15 minutes between observations. The staff member shall document observations of the youth in the Facility Activity/Communication Log Book.
- c. In supervising a youth on close observation, the assigned staff person shall check in on the youth throughout the day while the youth participates in regular programming, including school and any other activities.
- d. Close observation continues when the youth is sleeping or trying to sleep, as well as when the youth is attending to personal hygiene. When the youth is showering, the supervising staff person shall remain in the bathroom. The supervising staff person shall be of the same gender or gender identity of the youth. The shower must have a top and bottom view shower curtain that, while maintaining the youth's modesty and privacy, allows the supervising staff person to maintain a clear line of site to the youth's face and lower legs/feet.
- e. When the youth needs to use the toilet, staff must first inspect the bathroom and remove any objects that could potentially be used to inflict injury. Staff must then conduct a search of the youth, consistent with ACS personal youth search policies, when there is individualized reasonable suspicion that the youth may possess contraband.¹⁶ If the bathroom has multiple stalls, the staff person must wait immediately outside of the stall. If the bathroom is for single occupancy, the staff person must remain immediately outside the door and must verbally check in with the youth every two (2) minutes. The frequency of verbal check-ins may be

¹⁵ See National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System*. Washington, DC.

¹⁶ See #2012/06, *Non-Secure Placement Personal Youth Search Policy*; see #2016/05, *Limited Secure Placement Personal Youth Search Policy*.

increased or decreased depending on risk as assessed by the clinical director or designee. If a youth does not respond to a verbal check-in, a staff person of the same gender or gender identity must enter the bathroom.

- f. Unless contraindicated by the qualified mental health practitioner monitoring the youth or by the recommendations made on the Special Supervision Status Checklist, provider agency staff shall also take the following steps while a youth is on close observation:
 - i. Arrange for staff coverage to accommodate the youth's special supervision status.
 - ii. Keep the youth in regular activities, unless removing the youth from activities has been recommended by a qualified mental health practitioner or is deemed necessary for the youth's immediate safety. If a youth is removed from his or her regular activities, staff shall continuously work with the qualified mental health practitioner to reassess whether the youth is ready to rejoin his or her normal program activities.
 - iii. Search the youth at the time he or she is placed on and during close observation (e.g., when a youth moves from one location to another) if there is individualized reasonable suspicion that the youth is in possession of contraband. All personal youth searches must be conducted in accordance with ACS policies.¹⁷
 - iv. Remove and inventory all objects from the youth's bedroom or sleeping area that could potentially be used to cause injury, including but not limited to:
 - a) Personal hygiene items;
 - b) Sheets, blankets, pillows, towels, and other linens;
 - c) Clothing and sneakers;
 - d) Pencils/pens;
 - e) Shoelaces, belts, and other potential ligatures;
 - f) Detergents, soaps, and potentially toxic liquids; and
 - g) Unsecured batteries, except those necessary for life-saving equipment.
 - v. Necessary items for basic comfort (e.g., sheet, blanket, and pillow) should remain in the youth's room or sleeping area unless a qualified mental health practitioner has recommended their removal and replacement with suicide-resistant items, such as a safety blanket. Any additional object(s) determined by a qualified mental health practitioner to be a potential risk for harm to self or others shall also be removed.

¹⁷ See #2012/06, *Non-Secure Placement Personal Youth Search Policy*; see #2016/05, *Limited Secure Placement Personal Youth Search Policy*.

- vi. As soon as practicable, notify the youth's parent/guardian of any significant events or changes related to the youth's status including, but not limited to, modifications to the youth's treatment plan or BSP, changes in the youth's medical condition or special supervision status, any further self-injurious statements or self-injurious behaviors by the youth, and/or if the youth is taken to the hospital. Document all such notification.
- vii. Document in the youth's case record and in the Facility Activity/Communication Log Book all self-injurious statements, self-injurious behaviors, and suicide attempts and all agency responses to those statements and behaviors, including all notifications to other staff and parents/guardians and all conversations with medical and mental health practitioners regarding the youth.
- viii. Maintain close observation until a qualified mental health practitioner has recommended modification or removal from close observation and has created or modified the youth's safety plan and BSP in order to address the issues which are related to the youth's suicidal ideation or self-injurious statements or self-injurious behaviors.
- ix. Immediately notify the youth's assigned qualified mental health practitioner in the event that the youth exhibits any behaviors, major changes in mood or affect, or makes any statements that indicate that the youth's close observation status should potentially be modified up to constant observation.

3. Constant Observation

- a. The constant observation level of supervision is for youth who are actively suicidal, either forming a specific plan or engaging in suicidal behavior.¹⁸ Constant observation shall consist of one-to-one (1:1) supervision such that an individual staff member will be assigned solely to the supervision of an individual youth and will maintain his or her entire attention on the identified youth as his or her sole function.
- b. In supervising a youth on constant observation, the assigned staff person shall have the exclusive responsibility for the youth and must maintain constant visual supervision of the youth. The supervising staff member shall remain within arm's length of the youth when the youth is awake (for the purposes of this policy, "arm's length" means no more than three [3] feet away from the youth). If the staff person must step away at any point, he or she must first request relief from a colleague and may not leave the youth until the colleague has arrived.

¹⁸ See National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force. (2013). *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System*. Washington, DC.

- c. When the youth is awake, the supervising staff person shall engage in a conversation with the youth in intervals not to exceed 15 minutes between observations to determine the youth's mood and attitude, and shall document such interactions in the Facility Activity/Communication Log Book. If, during these interactions, the youth exhibits concerning behaviors or statements, the supervising staff member shall immediately notify the shift supervisor and the youth's assigned qualified mental health practitioner or the agency's on-call mental health staff.
- d. When the youth is asleep or trying to sleep, the supervising staff person must maintain constant visual supervision from the youth's bedroom doorway in single bedroom settings or no farther than three (3) feet from the foot of the youth's bed in a dorm setting. The supervising staff person shall never allow a youth on constant observation to cover his or her face with blankets or pillows or otherwise obstruct the staff member's ability to observe the youth. When the youth is asleep or trying to sleep, the supervising staff person shall document the youth's status (asleep or awake) and any other observable details about his or her behavior or demeanor every 15 minutes in the Facility Activity/Communication Log Book.
- e. When the youth is showering, the supervising staff person shall remain within arm's length of the youth. The supervising staff person must be of the same gender or gender identity of the youth, except in exigent circumstances. The shower must have a top and bottom view shower curtain that, while maintaining the youth's modesty and privacy, allows the supervising staff person to maintain a clear line of sight to the youth's face and lower legs and feet.
- f. When the youth needs to use the toilet, staff must first inspect the bathroom and remove any objects that could potentially be used to inflict injury. Staff must then conduct a search of the youth, consistent with ACS personal youth search policies, when there is individualized reasonable suspicion that the youth may possess contraband.¹⁹ If the bathroom has multiple stalls, the staff person must wait immediately outside of the stall. If the bathroom is for single occupancy, the staff person must remain immediately outside the door and must verbally check in with the youth every two (2) minutes. The frequency of verbal check-ins may be increased or decreased depending on risk as assessed by the clinical director or designee. If a youth does not respond to a verbal check-in, a staff person of the same gender or gender identity must enter the bathroom.
- g. Unless contraindicated by the qualified mental health practitioner monitoring the youth or by the recommendations made on the Special Supervision Status Checklist, provider agency staff shall also take the following steps while the youth is on

¹⁹ See #2012/06, *Non-Secure Placement Personal Youth Search Policy*; see #2016/05, *Limited Secure Placement Personal Youth Search Policy*.

constant observation:

- i. Arrange for staff coverage to accommodate the youth's special supervision status.
- ii. Keep the youth in regular activities, unless removing the youth from activities has been recommended by a qualified mental health practitioner or is deemed necessary for the youth's immediate safety.²⁰ If a youth is removed from his or her regular activities, staff shall continuously work with the qualified mental health practitioner to reassess whether the youth is ready to rejoin his or her normal program activities.
- iii. Search the youth at the time he or she is placed on and during constant observation (e.g., when a youth moves from one location to another) if there is individualized reasonable suspicion that the youth is in possession of contraband. All personal youth searches must be conducted in accordance with ACS policies.²¹
- iv. Remove and inventory all objects from the youth's bedroom or sleeping area that could potentially be used to cause injury, including but not limited to:
 - a) Personal hygiene items;
 - b) Sheets, blankets, pillows, towels, and other linens;
 - c) Clothing and sneakers;
 - d) Pencils/pens;
 - e) Shoelaces, belts, and other potential ligatures;
 - f) Detergents, soaps, and potentially toxic liquids; and
 - g) Unsecured batteries, except those necessary to life-saving equipment.
- v. Necessary items for basic comfort (e.g., sheet, blanket, and pillow) should remain in the youth's room or sleeping area unless a qualified mental health practitioner has recommended their removal and replacement with suicide-resistant items, such as a safety blanket. Any additional object(s) determined by a qualified mental health practitioner to be a potential risk for harm to self or others shall also be removed.
- vi. As soon as practicable, notify the youth's parent/guardian of any significant events or changes related to the youth's status including, but not limited to, modifications to the youth's treatment plan or BSP, changes in the youth's medical condition or special supervision status, any further self-injurious statements or self-injurious behaviors by the youth, and/or if the youth is taken

²⁰ The youth should be involved in regular programming to the extent possible.

²¹ See #2012/06, *Non-Secure Placement Personal Youth Search Policy*; see #2016/05, *Limited Secure Placement Personal Youth Search Policy*.

to the hospital. Document all such notification.

- vii. Document in CNNX and the Facility Activity/Communication Log Book all self-injurious statements and self-injurious behaviors, and all agency responses to those statements and behaviors including all notifications to other staff and parents/guardians, and all conversations with medical and mental health practitioners regarding the youth.
- viii. Maintain constant observation until a qualified mental health practitioner has assessed the youth, recommended modification or removal from constant observation, and created or modified the youth's safety plan and BSP in order to address all issues related to the youth's suicidal ideation or self-injurious statements or self-injurious behaviors.

4. Transport of Youth on Special Supervision Status

- a. The following procedures apply any time a youth on special supervision status is transported including, but not limited to:
 - i. Movement from one facility to another;
 - ii. Transportation to or from the courthouse; or
 - iii. Transportation to or from a hospital.
- b. ACS and provider agency staff must take special precautions when transporting youth on special supervision status. Staff must document all off-premises observations of youth on special supervision in the Off-Premises Special Supervision Log (Attachment B). Upon return to the facility, the form shall be reviewed by a supervisor and placed in the youth's mental health case file by a qualified mental health practitioner.
- c. Staff shall explain expectations for the transport to the youth. The youth must be deemed stable enough for transport by a qualified mental health practitioner.
- d. Since the youth's special supervision status must be maintained throughout the transport, the provider agency shall assign one (1) staff person in addition to the driver of the vehicle to supervise the youth throughout the transport.
- e. The facility director or his or her designee shall inform the staff members responsible for transporting the youth of his or her special supervision status.
 - i. If a youth is being transferred either temporarily or permanently to a different facility, the sending facility director or designee must provide the receiving facility director with advance notification to enable the receiving facility to

make arrangements for maintaining special supervision and establishing mental health services needed prior to the youth's transfer.²²

- ii. The sending agency must provide the receiving agency with the youth's medical and mental health records, as well as a detailed account of the incident(s) that led to the youth's special supervision status prior to the youth's transfer.
- iii. The receiving agency is responsible for arranging for a qualified mental health practitioner to assess the youth upon arrival to determine the continued need for special supervision.

VI. Maintaining, Modifying, and Ending Special Supervision Status

- A. Once initiated, a youth's special supervision status must be maintained throughout all aspects of programming including, but not limited to, trips to court, off-site movement (such as medical appointments), school, recreational programs, meals, hygiene, and family visits until a qualified mental health practitioner authorizes the modification of the youth's supervision status or removal of the youth from special supervision status altogether. Such a decision must be based on a qualified mental health practitioner's assessment, which must include a face-to-face meeting with the youth.
- B. While a youth is on special supervision status, staff must adjust the requirements of the relevant special supervision status to the extent necessary to permit confidential communication between youth and clergy or between youth and legal counsel to occur safely. When accommodating such mandates, the facility director or his or her designee shall discuss the matter with the clergy or the attorney and document any safety concerns communicated to them in the youth's record. The facility shall take additional measures as necessary to maintain the requirements of the relevant special supervision status to protect the safety of the youth.
- C. Youth on special supervision status shall be seen in person by a qualified mental health practitioner to reassess the need for close observation or constant observation at the start and end of the qualified mental health practitioner's shift, but at a minimum of once during every 12-hour period while on duty.
- D. When a qualified mental health practitioner concludes that a youth is ready for removal from special supervision status, provider agency staff shall work with the practitioner to update the youth's BSP and safety plan.
- E. When a youth's status is modified from constant observation to close observation, any of the youth's possessions that were removed for safety reasons may be returned based on

²² In any transfer of a youth, the provider must adhere to the *Transfers in Juvenile Justice Placement* policy.

the recommendation of the qualified mental health practitioner, or returned entirely if a youth is removed from special supervision status altogether.

VII. DOCUMENTATION AND REPORTING

A. Documentation

1. Whenever a youth makes a self-injurious statement, engages in self-injurious behavior, or attempts suicide, all staff persons with knowledge of the incident must complete an incident report.
2. Provider staff shall carefully document all significant changes in the mood, attitude, or behavior of a youth on constant observation in the Facility Activity/Communication Log Book. Additionally, any staff member assigned to supervise a youth on constant observation shall document details regarding the youth's mood and behavior following each face-to-face interaction (every 15 minutes) and at least every 15 minutes while the youth is sleeping or attempting to sleep in the Facility Activity/Communication Log Book.
3. All relevant medical notes shall be kept in the youth's medical file.
4. For each day that a single or multiple youth are on special supervision status, a qualified mental health practitioner shall complete the Special Supervision Checklist and provide a copy to each youth's assigned PPS and PP Director.
5. When the qualified mental health practitioner adjusts a youth's special supervision status, the change of status must be documented on an updated Special Supervision Status Checklist. The form shall be placed in the youth's mental health case file and the status change shall be documented in the youth's case record. The practitioner shall then communicate to appropriate staff the changes in special supervision status, and the staff member shall document the changes in the Facility Activity/Communication Log Book.

B. Reporting to Provider Agency Staff

Any external services providers as well as provider agency interns, volunteers, and contracted staff must notify provider agency staff immediately upon witnessing any self-injurious statements, self-injurious behaviors, and suicide attempts by a youth regardless of how they are expressed.

C. Reporting to the DYFJ Movement Communication and Control Unit (MCCU)

1. Suicide attempts must be reported to the DYFJ MCCU within one (1) hour.

2. Self-injurious statements and behaviors must be reported to MCCU by the end of the shift.

D. Reporting to OCFS

Any death or near death that occurs resulting from a suicide attempt or self-injurious behavior must be reported to OCFS in accordance with OCFS policy about notification of death or near death.

E. Reporting to the Justice Center For Protection of People with Special Needs (Justice Center)

1. Any death that occurs resulting from a suicide attempt or self-injurious behavior must be reported to the Justice Center immediately. The facility director or his or her designee must follow the specific protocol for reporting a death of a vulnerable person, which includes, but is not limited to, calling the VPCR Death Reporting Line at 1-855-373-2124.
2. All suicide attempts are considered significant incidents and must be reported to the Justice Center immediately.

F. Reporting to the Mental Health Coordination Unit (MHCU)

If a youth is admitted to a hospital for inpatient psychiatric treatment, staff shall notify the MHCU within 24 hours by filling out and submitting via email CM-1057, Mental Health Coordination Unit – Initial Reporting Form (Attachment C). Staff shall also notify the MHCU within 24 hours of when a youth is discharged from the hospital by filling out and submitting via email CM-1058, Mental Health Coordination Unit – Acute Psychiatric Hospitalization Follow-Up Form (Attachment D).

VIII. DEBRIEFING, REVIEW, AND SUPPORT

- A. Whenever youth and staff are exposed to a suicidal event, it is imperative to consider providing support and possibly treatment to those that have been impacted including debriefing, individual and group counseling, and other external crisis supports.
- B. For every suicide and suicide attempt requiring medical treatment or hospitalization, the facility director shall initiate a debrief with staff, including the involved qualified mental health practitioner(s) and the PPS and/or PP Director assigned to the youth. All such debriefs shall be communicated to provider agency senior administrative staff and all Close to Home stakeholders. The debriefs shall address the following:
 1. Circumstances surrounding the suicide or serious suicide attempt;
 2. Factors that led or may have led to the suicide or serious suicide attempt;
 3. Medical and mental health services provided to the youth;
 4. Training of staff involved;

5. Implementation of special supervision status and safe housing;
6. Communication between and among facility staff and medical/mental health provider staff;
7. Thorough review of log books and paper files; and
8. Recommendations for changes in policy, the physical environment, medical or mental health services, and training.

DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME SPECIAL SUPERVISION CHECKLIST



Youth Name: _____ Date: _____

Provider Agency: _____

Facility Name: _____

Facility Address: _____

Medical/Mental Health Provider's Name: _____

Telephone Number: _____

Recommendation (circle one and initial to indicate start and end or continuation):

1. **Constant Observation:** Reserved for youth who are actively suicidal, either forming a specific plan or engaging in suicidal behavior. Staff shall observe such youth on a continuous, uninterrupted basis (including when a youth is sleeping or attending to personal hygiene). More intensive than close observation.

Initiate: _____ **Continue:** _____ **Discontinue:** _____

2. **Close Observation:** Deliberate focus on a youth who is not actively suicidal but meets one or more of the following: 1) has expressed suicidal ideation; 2) has a recent history of self-destructive behavior; and 3) has denied suicidal ideation, or has not threatened suicide but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury. Staff shall observe such youth in a protrusion-free room at staggered, unpredictable intervals not to exceed every 10 minutes (e.g., five minutes, 10 minutes, seven minutes).

Initiate: _____ **Continue:** _____ **Discontinue:** _____

The following modifications shall be made to the youth's programming/educational activities:

1. School: _____

2. Sports/Recreational activities: _____

3. Other: _____

DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME SPECIAL SUPERVISION CHECKLIST



This youth shall/shall not be permitted to leave the facility for home visits and/or planned facility program activities based on the mental health professional's assessment of the safety of the youth.

Explain: (include any reasons why changes are needed for the youth's safety)

Additional recommendations/instructions regarding the care of this youth:

Medical/Mental Health Provider Signature: _____

Date Signed: _____

DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME OFF-PREMISES SPECIAL SUPERVISION FORM



Provider Agency: _____ Facility Name: _____

Facility Address: _____ Facility Type (Circle One): NSP LSP

Youth Name: _____ Supervision Status (Circle One): Constant Observation Close Observation

Staff Person That Placed Youth on Special Supervision: _____ Date Special Supervision Began: _____

Name of On-Duty Supervisor At time Youth Placed on Special Supervision: _____

Date	Time	Observation	Staff Signature (legible)

Facility Director Signature: _____

Date: _____

Mental Health Clinician Signature of Receipt: _____

Date of Receipt: _____

Mental Health Coordination Unit – Initial Reporting Form

This form is used to bring a child to the attention of the ACS Mental Health Coordination Unit (MHCU); please complete all appropriate sections. Please note that submission of this form is required within 24 hours of a foster child's admission to an acute psychiatric inpatient unit.

This form must be submitted by email to mentalhealth@dfa.state.ny.us. If any information does not fit in the space provided below, please use the "Notes" section at the end. Also, please note any additional information that will be submitted by fax (send to 212-227-4010). For questions please call 212-374-MHTA.

MHCU Referral Type: (check all that apply) acute psychiatric hospitalization assistance with existing mental health services
 service information request assistance with mental health program referral

Date form submitted: _____

Section A: Child's Information

Name: _____ DOB: _____ CNX #: _____

Case Name: _____ M F CIN: _____

Foster Care Agency/Boro Office: _____ Case Planner: _____

Case Planner Email: _____ Case Planner Phone #: _____

Supervisor Email: _____ Supervisor Phone #: _____

Parent(s)' name(s): _____ Borough of Family Court Case: _____

Child's Legal Status: _____ Is this child freed for adoption? Yes No

Who provides medical consent for this child: _____

Person Completing Form (Name, Title & Phone #): _____

Section B: Placement Information

Current Foster Care Placement Type: _____ Borough of placement: _____

Child's Current Location: _____

Is this placement in jeopardy? No Yes (please explain why): _____

Section C: Mental Health Treatment Information

Current outpatient mental health provider: _____ Unknown Phone #: _____

Treating outpatient psychiatrist: _____ Unknown Phone #: _____

Other mental health support services child is currently receiving (check all that apply):

B2H Day Treatment Medicaid Service Coordination Mental Health Case Management None
 Other: _____

Mental health support services contact name/phone # (e.g., B2H HCI): _____

Current diagnosis/es: _____ Unknown

Current medication(s): _____ Unknown

Are there signs/symptoms/history of developmental delay? No Yes (current full-scale IQ): _____

Is there substance abuse? No Yes, current Yes, by history Unknown

Is there a co-occurring medical disorder? No Yes (specify): _____ Unknown

Has the child recently exhibited any of the following behaviors (check all that apply):

Aggression/violence Inappropriate sexualized behavior Fire-setting behavior Running away
 Other high-risk behavior (explain): _____ None

Mental Health Coordination Unit – Initial Reporting Form

Section D: Psychiatric Hospital Admission Information (only complete for psychiatrically hospitalized children)

Name of Hospital: _____

Hospital contact: _____ Hospital contact title: _____

Hospital contact phone #: _____ Date of current hospital admission: _____

Symptoms/behaviors that led to the child being brought to the hospital for assessment (check all that apply):

- Dangerous to self/suicidal
- Dangerous to others (violence, aggression, threatening behavior)
- Acute psychiatric symptoms
- Other: _____

Please indicate strategies used to avoid hospitalization (check all that apply):

<input type="checkbox"/> B2H referral/services	<input type="checkbox"/> Crisis management/response	<input type="checkbox"/> Crisis Residence
<input type="checkbox"/> CSPOA referral/services	<input type="checkbox"/> HCBI/ICST/FBTI	<input type="checkbox"/> Medication adjustment
<input type="checkbox"/> Mobile Crisis Team	<input type="checkbox"/> Respite services	<input type="checkbox"/> Urgent outpatient visit
<input type="checkbox"/> Other: _____		<input type="checkbox"/> None

Has child been psychiatrically hospitalized in the past three months? Yes No Unknown

Has the parent provided consent for this hospitalization? Yes No (if so, complete Section E)

Will the child likely require additional mental health services when he/she is ready to leave the hospital?

No Yes (explain): _____

Section E: Consent Requests for Hospital Admission (only complete when parents have not provided consent)

Was the child already admitted to the hospital on an emergency basis?¹ Yes No

If yes, did the foster care agency give consent for the emergency admission? Yes No N/A

Foster Care Agency or Emergency Room Psychiatrist who evaluated this child and determined the need for hospitalization (please attach clinical note):

Name: _____ Location: _____

Please provide the name of the Inpatient Hospital psychiatrist or administrator who has authorized this hospitalization:

Name: _____ Location: _____

Has the child's current outpatient mental health provider been consulted about this hospitalization?

Yes – recommendation: _____

No

Section F: Assistance needed

Please provide more information about what assistance you are requesting from the MHCU:

Notes

¹ For emergent hospitalizations, if an evaluating psychiatrist has documented that a delay in admission would pose a substantial risk to the life, health, or safety of the child or others, then a signed consent is not necessary. If the admitting hospital insists on obtaining a signed consent before admitting the child in such an emergency, the foster care agency's designated authority may sign the consent. EMERGENCY HOSPITALIZATIONS MUST BE SUBMITTED FOR OVERRIDE REVIEW WITHIN 24 HOURS OF THE ADMISSION.



Mental Health Coordination Unit – Acute Psychiatric Hospitalization Follow-Up Form

This form is used to provide an update to the Mental Health Coordination Unit (MHCU) for children who have been psychiatrically hospitalized in acute care hospitals.

This form must be submitted by email to mentalhealth@dfa.state.ny.us. If any information does not fit in the space provided below, please use the "Notes" section at the end. Also, please note any additional information that will be submitted by fax (send to 212-227-4010). For questions please call 212-374-MHTA.

Type of follow-up form:

- 7 days post-MHCU Notification
- 21 days (3 weeks) post-MHCU Notification
- 35 days (5 weeks) post-MHCU Notification
- Hospital discharge
- Other time period: _____

Date form submitted: _____

Person Completing Form (Name, Title & Phone #): _____

Section A: Child's Information

Name: _____ DOB: _____

CNNX FSS Stage ID #: _____ CIN: _____

Section B: Hospital-Related Information (if changed since last report)

Name of Hospital: _____

Hospital contact: _____ Hospital contact title: _____

Hospital contact phone #: _____ Date of current hospital admission: _____

Child's known prior hospitalizations (include location and admission/discharge dates):

The child has been receiving visits from (check all that apply):

- Parent(s)
- Sibling(s)
- None (state reason why): _____
- Foster Parent(s)
- Other: _____

Section C: Child's Clinical Status

Describe the child's mental health status (i.e., status of symptoms that led to psychiatric hospitalization):

Has the child's diagnosis/es changed while hospitalized? Yes (provide detail below) No Unknown

Has the child received the following evaluations while hospitalized (check all that apply)?

- psychiatric (date: _____)
- psychological (date: _____)
- educational/IEP (date: _____)
- other: _____ (date: _____)

Has the child been prescribed new medication while hospitalized? Yes No

Has the hospital spoken with the following individuals regarding the child's treatment (check all that apply):

- B2H staff
- Outpatient psychiatrist
- others: _____
- Case planner
- Outpatient therapist
- Foster parent(s)
- Parent(s)

Do you need assistance in resolving medical consent issues? Yes (provide detail below) No



Mental Health Coordination Unit – Acute Psychiatric Hospitalization Follow-Up Form

Section D: Discharge Planning

Has a potential discharge date been set? No Yes (date): _____

Is there a hospital discharge plan that addresses the child's placement, clinical and educational needs?
 Yes Partial No

Which of the following are not yet in place, but need to be prior to discharge from the hospital?

- New foster care placement
- Mental health treatment (individual and/or family)
- Mental health supportive services (e.g., B2H, CSPOA, HCBI)
- Admission to mental health treatment setting (e.g., FBT, CR, RTF, "state" hospital)
- Educational placement/services – specify:
- Other clinical services (e.g., medical, substance abuse) – specify:
- Vocational training/VESID
- Other - specify:

Are the following stakeholders in agreement with the proposed discharge plan?

Case planner: Yes No Child: Yes No Parent(s): Yes No Foster parent(s): Yes No

Has a conference been held? Yes (type): __ Date: _____ No

Is there a conference scheduled? Yes (type): __ Date: _____ No

Section E: Post-Discharge Information (for children who have been discharged)

Discharge date: _____

The child was discharged to: _____

This setting is: _____

Contact at current setting _____

Contact email: _____ Contact phone #: _____

Referrals made prior to discharge (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> B2H | <input type="checkbox"/> CSPOA | <input type="checkbox"/> Day treatment |
| <input type="checkbox"/> HCBI/ICST/FTI | <input type="checkbox"/> Medication management | <input type="checkbox"/> Outpatient treatment |
| <input type="checkbox"/> Partial hospitalization | <input type="checkbox"/> RTF | <input type="checkbox"/> Sexual abuse-related treatment |
| <input type="checkbox"/> Sexually exploited youth services | <input type="checkbox"/> Sexual offender services | <input type="checkbox"/> Substance abuse treatment |
| <input type="checkbox"/> Supportive housing | <input type="checkbox"/> Others: _____ | |

Section F: Assistance needed

Please provide information about any additional assistance you need from the MHCU:

Notes
