	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES CHILD WELFARE POLICY MANUAL			
	Chapter:	(10) Foster Care	**Effective Date:**	August 2014
	Policy Title:	Psychological and Behavioral Health Needs		
	Policy Number:	10.12	**Previous Policy #:**	1011.5, 1011.6

CODES/REFERENCES

O.C.G.A. § 49-5-220
O.C.G.A. § 49-5-225

REQUIREMENTS

The Division of Family and Children Services (DFCS) shall ensure each child five years of age and older is referred for a trauma assessment within 10 days of entering foster care.

DFCS shall collaborate with the Amerigroup Care Coordination Team (CCT) to refer a child to a licensed behavioral health provider for a mental health assessment if there is indication of a need for such an assessment.

DFCS shall monitor each child in foster care who is receiving psychotropic medication in a manner that ensures their continual safety and well-being and document the name of each medication taken, the frequency, the prescriber, etc. in the Statewide Automated Child Welfare Information System (Georgia SHINES).

DFCS shall identify children determined to have "high risk" behavioral health needs and collaborate with the Regional Well-Being Specialist (RWBS) to ensure each child is closely monitored on a regular basis, to include follow up with the caregiver and treating physician(s).

Local DFCS shall refer each child being considered for treatment in a Psychiatric Residential Treatment Facility (PRTF) to the Local Interagency Planning Team (LIPT) for staffing if one exists within the county.

DFCS shall serve as a permanent team member of each LIPT and consistently have a local representative present at each meeting to:

a. Staff cases to ensure appropriate services are recommended;
b. Review and modify, as needed, decisions about placement of children and adolescents in out-of-home treatment or placement;
c. Monitor each child's progress;
d. Facilitate prompt return to the child's home when possible;
e. Develop a reintegration plan shortly after a child's admission to a treatment program;
f. Review the individual plan for the child or adolescent and amend the plan if necessary;
g. Ensure services are provided in the least restrictive setting.

PROCEDURES

When a child enters foster care, the Social Services Case Manager (SSCM) will:

1. Collaborate with the CCT to ensure a child is referred for a trauma assessment within 10 calendar days from the date of removal as part of the CCFA.
2. Engage the parents, birth family, child, and collateral contacts to obtain as much information as possible and develop a full picture of the child's needs. Inquire as to whether or not the child has any emotional or behavioral problems, or if anyone has observed any of the following:
    a. Suicidal ideation, self-mutilating behaviors, and/or violence
    b. Substance abuse, addiction, or prenatal exposure to harmful drugs:
        1) Does the child have any issues with drugs/alcohol? Which drugs?
        2) Is there an alcohol assessment? Who completed it? Results?
        3) Has child been in treatment or is currently in treatment? Where?
        4) Date of last drug screen
    c. Risky sexual behavior:
        1) Is child sexually active or promiscuous?
        2) Is child on contraceptives?, What type and who prescribed them?
        3) Has the child had any pregnancies? What happened?
        4) Does the child have any sexualized history and what has been done to help them work through that?
        5) Has the child ever been sexually abused?
        6) Has the child been treated for any sexual related health conditions?
    d. Antisocial behavior
    e. Frequent or uncontrollable angry outbursts
    f. Excessive sadness and crying
    g. Withdrawal
    h. Lying or stealing
    i. Defiance
    j. Unusual eating habits, such as hoarding food or loss of appetite
    k. Sleep disturbances
    l. Changes in behavior at school, including truancy
3. Determine if a child has "high risk" behavioral needs and collaborate with the RWBS.
4. Collaborate with the CCT to refer a child to a licensed behavioral health provider for a mental health assessment if there is indication of a need for such an assessment.
5. Provide the evaluator sufficient background information on the child and family.
6. Obtain written information on the child's diagnosis and treatment and enter it in the child's Health Log under the Person Tab in Georgia SHINES.
7. Ensure the child's Health Log, Case Plan and Log of Contacts reflect monitoring of any mental health referral and of the child's progress in responding to the services provided.
8. Provide medical and mental health information to the child's caregiver.
9. Attend and participate in LIPT meetings, if applicable.

When a child is prescribed psychotropic medication, the SSCM will:

1. Review the *Authorization of Psychotropic Medication for Children in Foster Care* (consent form) submitted by the prescribing physician.
    a. Contact the prescriber if additional information is needed.
    b. Contact the RWBS if questions/concerns are not resolved.
    c. Submit the consent form to the County Director or Designee for review and

approval.

2. If consent is granted:
    a. Fax completed/signed consent to the prescriber.
    b. Contact the caregiver to inform them of the consent.
    c. Upload the consent form and document in Georgia SHINES.
    d. Inform the child's parent(s) within 72 hours of consent being given to administer psychotropic medication.
    e. Ensure the prescription is filled.
    f. Update the child's Health Log under the Person tab in Georgia SHINES.
3. If consent is not granted, inform the prescriber of the decision by faxing the consent form with an explanation.
    a. Inform prescriber of decision by faxing the consent form with an explanation.
    b. Inform caregivers of decision/reason and direct them to destroy the prescription slip.
    c. Work with the prescriber and caregiver to establish an alternative treatment plan to address the needs of the child.
    d. Upload the consent form showing consent was not given and document in Georgia SHINES.
4. Ensure the child's caregiver understands the requirements and agrees to:
    a. Notify the prescriber of DHS rules regarding consent.
    b. Have Medication Consent Packets taken to all mental health appointments.
    c. Delay filling prescriptions until consent is given by DFCS.
    d. Follow DHS rules regarding the administration of psychotropic medications.
    e. Completes and continually updates the Foster Care Individual Child Medication Log so that it remains accurate and current at all times.

To collaborate with the Regional Well-Being Specialists (RWBS), the Social Services Supervisor (SSS) or SSCM will:

1. Staff all cases involving children identified by the CCFA or any other assessment as having behavioral health, serious medical or developmental needs with the RWBS. The staffing should occur within five business days of identifying the need(s) and include the child's current caregiver when applicable.
2. Provide the contact information for the Core Providers for each child placed in a Maximum Watchful Oversight (MWO) level Child Caring Institution (CCI) or receiving treatment in a Psychiatric Residential Treatment Facility (PRTF).
3. Immediately notify the RWBS once a child has been approved for a determination of MWO.
4. Notify the RWBS of all treatment team meetings held for children in a PRTF or CCI and provide copies of treatment team notes or treatment plans. The RWBS will participate in treatment team meetings to the extent possible.
5. Invite the RWBS to all Permanency Roundtables held for children identified as "high need" and add the RWBS as a secondary worker on the case.

PRACTICE GUIDANCE

Georgia Families 360˚

On March 03, 2014, DFCS transitioned from a standard fee-for-service Medicaid program to a statewide Medicaid Care Management Organization (CMO) through Amerigroup Georgia Managed Care Company. The transition impacted children in DFCS custody and children

receiving AA as they became members of a new program called *Georgia Families 360˚* which is separate from *Georgia Families*, the general Medicaid program administered by the Georgia Department of Community Health (DCH). *Georgia Families 360˚* is designed to provide coordinated care across multiple services and focus on the physical, dental, and behavioral needs of member children. The program is designed to ensure each member has a medical and dental home, access to preventive care screenings, and timely assessments. It also seeks to ensure medical providers adhere to clinical practice guidelines and evidence-based medicine.

Amerigroup Care Coordination Teams (CCT) and Care Managers
Each *Georgia Families 360˚* member is assigned to a regional Care Coordination Team with a specified Care Manager. The CCT members are Masters level staff, the majority of whom hold a professional license to practice in their respective field. The CCT completes a Health Risk Screening (HRS) on youth in care to identify medical and/or behavioral needs. The CCT ensures each child is assigned to a behavioral health services provider as needed. The CCT is responsible for coordinating the health components of the Comprehensive Child and Family Assessment (CCFA), including the initial physical assessment, dental screening, and trauma assessment.

Care Managers are the primary partner of the SSCM for identifying and making referrals for needed services. Care Managers ensure each youth has an individualized care plan that addresses both physical and behavioral health needs. They work with community agencies to ensure appropriate services are provided.

Any services not authorized by the CCT will not be paid for out of Medicaid. Therefore, it is imperative that all behavioral health and developmental care be coordinated with the CCT to avoid any uncovered expenses. If a child is ineligible for Medicaid, then the Department of Behavioral Health and Developmental Disabilities (DBHDD) will provide behavioral health services to the child.

Amerigroup Notification Form (E-Form)
DFCS communicates with Amerigroup utilizing an electronic notification form (E-Form). It is the primary means for communicating information about a member enrolled in Georgia Families 360˚. The E-Form must be completed and sent to Amerigroup within 24 hours of a youth entering foster care. It should be completed thoroughly to include demographic information, medical information, placement information, the identified CCFA provider and other referrals (e.g., Babies Can't Wait). The E-Form is also used to report updates such as placement changes, a youth exiting care, etc. If there is information not available at the time of the initial referral to Amerigroup, submit an E-Form (update) as soon as the information is obtained. Accurate and timely communication with Amerigroup is vital to the Medicaid eligibility determination and the assignment of a CCT and service providers. Important decisions regarding the assignment of primary care providers and referrals are made based upon the information submitted on the E-Form.

Child & Adolescent Functional Assessment Scale (CAFAS)
The CAFAS assesses the degree of impairment in functioning due to emotional, behavioral, or psychiatric problems.

Trauma Assessments
Trauma can affect many aspects of a child's life and may lead to secondary problems that negatively impact safety, permanency, and well-being (e.g., peer relationships, problems in school, health related problems).The Administration for Children and Families (ACF), a federal agency in the Department of Health and Human Services, has informed state child welfare agencies of the need to implement trauma-focused screening, assessment and treatment for children in foster care. The emotional well-being of our children is of the utmost importance and is directly correlated to their ongoing safety and success of permanency plans.

The trauma assessment identifies all forms of traumatic events experienced directly or witnessed by a child to determine the best type of treatment for that specific child. In addition to the trauma history, trauma-specific evidence-based clinical tools assist in identifying the types and severity of symptoms the child is experiencing. Examples of evidence-based, trauma-specific clinical tools include:

1. UCLA PTSD Index for DSM-IV
2. Trauma Symptom Checklist for Children (TSCC)
3. Trauma Symptom Checklist for Young Children (TSCYC)
4. Child Sexual Behavior Inventory

The trauma assessment must provide recommendations and actions to be taken by DFCS to coordinate services and meet a child's needs. Behavioral health providers who conduct a trauma assessment will provide a report which includes:

1. Trauma history, which informs the agency of information concerning any trauma the child may have experienced or been exposed to, as well as how they have coped with the trauma in the past and present
2. A standardized trauma screening tool
3. Summary and recommendations for treatment (if needed)

The inclusion of a trauma assessment as part of the CCFA does not mean there will not be situations in which other specialized assessments (e.g., psychological evaluations, psycho-sexual evaluations, psychiatric evaluations, neuropsychological evaluations, substance abuse assessments, psycho-educational evaluations, etc.) will be warranted. The decision to refer a child for additional assessments must be made on a case-by-case basis in coordination with the CCT after an overall assessment of the child's needs has been completed. If it is determined that a psychological evaluation is needed, prior authorization must be obtained from the CCT in order for Medicaid to pay for it.

Psychological Evaluation
Psychological evaluations are not required for every child who enters care. However, the results of the trauma assessment may recommend a psychological evaluation. If so, the SSCM should collaborate with the CCT to refer a child to a licensed evaluator. The CCT must provide prior authorization for any psychological evaluation; otherwise, Medicaid cannot be used to pay for the evaluation. In addition, the SSCM can submit a request to the CCT for psychological evaluation of a child at any time, not just every two years or any other interval. The CCT will evaluate the medical necessity for the psychological evaluation based on the needs of the child and information already available. The CCT will coordinate any evaluation deemed necessary. For 24 Hour Emergency Assistance regarding mental health or addictive disease services, call 1-800-715-4225.

Regional Well-Being Specialist (RWBS)
The Regional Well-Being Specialist acts as an educator, advocate, mentor, and role model in multiple areas of permanency and well-being including:

1. Training
2. Engaging partners
3. Data tracking and analysis
4. Roundtable or staffing of high end cases
5. CCI/CPA treatment team/ semi-annual reviews
6. Waiver requests
7. Transitional & discharge planning
8. Psychotropic medication monitoring

Staffings with the RWBS are used for information sharing, resolution of case management issues, decision making regarding the selection of service providers, transitional/discharge planning, and assessing diagnosis/treatment plans.

Local Interagency Planning Team (LIPT)
A LIPT should be established on behalf of children in each community. The team may be single or multi-county teams depending upon the size of the community and geographic availability of needed resources. The underlying purpose for the development of the LIPT is to improve and facilitate the coordination of services to children with severe emotional disorders (SEDs) and/or addictive diseases. LIPTs have the following goals:

1. To assure children with severe emotional disorders (SEDs) and/or addictive diseases (ADs), and their families, have access to a system of care in their geographic area;
2. To assure the provision of an array of community therapeutic and placement services;
3. To decrease fragmentation and duplication of services and maximize the utilization of all available resources in providing needed services; and
4. To facilitate effective referral and screening systems that will assure children have access to the services they need to lead productive lives.

O.C.G.A § 49-5-225 requires permanent membership of the LIPT to include a local representative from each of the following agencies:

1. Department of Behavioral Health and Developmental Disabilities (DBHDD);
2. Division of Family and Children Services (DFCS);
3. Department of Juvenile Justice (DJJ);
4. Department of Public Health (DPH);
5. Georgia Vocational Rehabilitation Agency (GVRA);
6. Local education agency (i.e., Public schools representative).

In addition to the permanent members, the local interagency committee reviewing the case of a child or adolescent may include, as ad hoc members, the special education administrator of the school district serving the child or adolescent, the parents of the child or adolescent, and caseworkers from any involved agencies.

High Risk: Behavioral Health
“High risk” youth in regard to behavioral health are those who have been designated as having a severe emotional disturbance or substance use/abuse. This would include:

1. A condition of severe emotional disturbance

a. A mental or emotional disturbance listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM V);
b. Adult diagnostic categories appropriate for children and adolescents:
    i Substance related disorders
    ii Schizophrenia and other psychotic disorders
    iii Mood disorders
    iv Anxiety disorders
    v Somatoform disorders
    vi Dissociative disorders
    vii Sexual and gender identity disorders
    viii Impulse control disorders
    ix Adjustment disorders
    x Personality disorders
c. Disorders usually first evident in infancy;
d. Childhood and adolescent disorders (including pervasive development disorders);
e. Attention Deficit and disruptive behavior disorders;
f. Tic disorders;
g. Stereotypic movement disorder;
h. Feeding and eating disorders;
i. Separation anxiety disorder;
j. Selective mutism and reactive attachment disorder.

2. Functional Symptoms and Impairment:
    a. Serious mental illness (e.g., schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions;
    b. Psychotic symptoms;
    c. Danger to self, others and/or property as a result of emotional disturbance: The individual is self-destructive (e.g., at risk for suicide, runaway, promiscuity, and/or at risk for causing injury to persons or significant damage to property).
3. Functional Impairment in two (2) of the following capacities (compared with expected developmental level):
    a. Self-care - manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
    b. Community - manifested by a consistent lack of age appropriate behavioral controls, decision making and judgment, or involvement in the juvenile justice system.
    c. Social Relationships - manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
    d. Family - manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for the safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations, which may result in removal from the family or its equivalent).
    e. School and/or work:
        i Inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage, or violence towards others).
        ii Inability to remain consistently employed at a self-sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor

and other workers, hostile behavior on the job).

FORMS AND TOOLS

Guidelines for Psychotropic Medication Use in Children and Adolescents
Psychotropic Medication Management-Consent Process Flow Chart
Authorization of Psychotropic Medication for Children in Foster Care
Foster Care Individual Child Medication Log (**NOTE:** A Medication Administration Record (MAR) may be used by some Child Caring Institutions and Child Placing Agencies and is an appropriate substitute)
Local Interagency Planning Teams (LIPT) team handbook