4.4 Consent for Non-Routine Health Care Procedures
Effective 10/10/00

PURPOSE
Certain decisions regarding health care for children in the legal custody of the Department may result in consequences which may likely be or perceived to be detrimental to the child, the Department, or other interested parties; these include, but are not limited to, the death of the child. Therefore, the protocol to be used to reach these decisions needs to be clear.

PURPOSE
Parental consent for health care for children in the legal custody of the Department is given by the Commissioner or by an agent of the Department delegated the responsibility unless the authority to consent is specifically given in state or federal statute.

DEFINITIONS
DNR (Do Not Resuscitate) Order: An order placed on the order sheet of the patient's medical record by the attending physician to health care provider staff to make no attempt to resuscitate the patient should cardiac or respiratory arrest occur.

Attending Physician: The individual who is licensed to practice medicine in this State or the State in which the individual practices and who has primary responsibility for the treatment and care of the patient.

Health Care Provider: A person who is licensed, certified or otherwise authorized by the law of this State or the State in which the person practices to administer health care in the ordinary course of business or practice of a profession.

Medical Record: A current and where appropriate, permanent record of the patient's diagnosis and treatment.

Terminal Condition: An incurable and irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending physician, result in death within a relatively short time.

Comfort Measures: General nursing care for comfort and palliation; these include, but are not limited to, administration of oxygen, suctioning, mouth care, body turning and lotioning, close attention by nursing staff, administration of small amounts of water if the swallow reflex is intact, application of Vaseline to moisten the lips, use of a room humidifier, elimination of pain.

Life-sustaining Procedure: Any medical procedure or intervention that, when administered, will serve only to prolong the dying process. It shall not include artificially administered nutrition

and hydration (provision of nutrients and liquids through the us of tubes or intravenous procedures).

DO NOT RESUSCITATE (DNR) ORDERS

A "Do Not Resuscitate" order for a child in the legal custody of the Department is approved only when:

1. Approval of a DNR order has been requested by the child's attending physician, and

2.a. The attending physician and a consulting physician believe that the child's medical condition is terminal and CPR other resuscitation efforts will merely prolong dying or are considered inhumane or are medically contraindicated due to the pain, suffering, or physical trauma caused the child when it is highly unlikely these efforts will prevent the child's death,

OR

b. A court of competent jurisdiction has reviewed the facts regarding the child's condition (e.g., pervasive vegetative state), the prognosis and treatment, and other relevant information and has determined that a DNR order is appropriate.

Approval for a DNR order for a child in the legal custody of the Department may be given only by the Commissioner or in his absence by the Deputy Commissioner for Programs or by the Director, Bureau of Child and Family Services respectively.

If it is anticipated that approval for a DNR order may be requested for a particular child, the Commissioner may authorize the Division Director or Regional Program Manager - Child Welfare Program, to decide in the event the Commissioner, Deputy Commissioner for Programs, and the Director, Bureau of Child and Family Services are not available and the condition of the child and/or the impact of CPR or other resuscitation efforts requires a decision prior to any of those three being available. Delegation of this responsibility may be made only after the Commissioner has reviewed the child's circumstances and is only for that particular child.

In reaching a decision to approve or disapprove a DNR order, the Commissioner or delegate, will consider the medical information (the child's diagnosis, prognosis, the risks, benefits and alternatives to CPR, etc.) and any other information necessary to make an informed decision; the age and if known, the wishes of the child; any information provided by parents or others notified of the request for approval, and other relevant information.

Approval for a DNR order shall not be given, regardless of the time frame, without access to full medical information.

Approval may be given prior to notification of parents or significant others in situations where the condition of the child and/or the impact of CPR or other resuscitation efforts are such that an approval is required before notification can be completed.

PROCEDURES

1. The attending physician and the consulting physician will be requested to submit a written justification for a DNR; in the case of an emergency, this written documentation may be submitted after the Commissioner's decision regarding the order is given.
2. When a physician requests approval of a DNR order, the Commissioner or his designated agents shall make reasonable efforts to notify:
    a. Any parent whose rights have not been terminated,
    b. The guardian ad litem for the child,
    c. Any other party to the child protective order pursuant to which the child came into the Department's custody if there has been no termination of parental rights or in the rare instance the individual has been retained as an interested party for judicial reviews after the termination of parental rights,
    d. The person who has filed or is in the process of filing a petition to adopt this child and the Commissioner has signed a Form A-8, Consent by Other Than Parent, for the Probate Court,

    that a physician has requested approval for a DNR order, that they may express their thoughts and feelings regarding such an order for this child, that they will be notified of the Commissioner's decision, and that if they object, their re course is to apply for injunctive or other relief from a court of competent jurisdiction.

    In addition, the Department may provide the same notification to:

    a. The attorneys of record for any parent whose rights have not been terminated or any other party to the child protective order pursuant to which the child came into the Department's custody when attempts to notify the parent(s), guardian, or other party have failed.
    b. Any parent whose rights have been terminated, but with whom the child has recently resided or otherwise had frequent contact, and an ongoing relationship is in the best interest of the child.
    c. Any foster parent who had been granted standing and intervenor status under 22 MRSA §4005-A for the most recent judicial hearing, and who maintains an ongoing relationship which is in the best interest of the child.

3. The Commissioner's decision will be conveyed in writing (or orally followed by a letter) to the attending physician along with the medical information on which the decision was based.

If approval for DNR is given, the attending physician will be requested to continue comfort measures and ensure that all DNR orders are written and entered into the medical record of the child.

4. The Adult and Children's Emergency Services (ACES) will be notified that the Commissioner has approved a DNR order for a specific child and given information needed if ACES is notified of the child's death.

5. Those notified in #2 will be notified for the decision.

6. The child's case record will include the basis of the DNR request, the decision and the basis for it, the steps taken to notify parents or other persons in #2.

CONTINUANCE/CANCELLATION OF DNR ORDER

1. The child's caseworker shall request the attending physician to notify the Department of any change in the child's condition. If there are any changes, the caseworker will ask their effect on the terminal nature of his medical condition or the impact of CPR or other resuscitation efforts.
2. If, based on a change in the child's condition or in the attending physician, the attending physician requests approval to remove the DNR order, the Commissioner will be notified for a review and decision. A written statement from the physician will be requested for the Commissioner.
3. If a DNR order is rescinded, the child's caseworker will notify those persons previously notified of the posting of the order and Adult and Children's Emergency Services (ACES).

CHANGE OF CUSTODY

If the Department ceases to have legal custody of a child for whom a DNR order is posted, the child's caseworker will notify the attending physician of this change and will provide information needed in order for the physician to contact the new legal custodian regarding continued consent for the DNR order.

SAFEGUARDS FOR ASSESSING THE APPROPRIATENESS OF NON TRADITIONAL THERAPY TECHNIQUES USING POTENTIALLY RESTRICTIVE INTERVENTIONS

PURPOSE

The intent of this policy is to provide direction to BCFS program administrators, casework supervisors, caseworkers and others who are contemplating the recommendation or approval of the use of attachment therapy for children who are in State custody. The Bureau has the responsibility and legal mandate to make the most informed decisions possible about the care and treatment received by children in Department of Human Services' custody. Representatives

of the Bureau make these decisions with the safety, permanency and well being of the child receiving foremost consideration.

DEFINITIONS

*Attachment Therapy*** *is* a comprehensive, intensive form of treatment. It is sometimes used to treat children with trauma and attachment problems, which are so significant in nature that they seriously impede the child's ability to function within the mainstream of the family, school and community (i.e. children who refuse or resist parenting). In its more intensive form, attachment therapy may involve the use of such intrusive and/or restrictive measures as holding the child against their will in order to guide the child through the therapeutic process. It requires the active involvement of the child and family (or caregiver) working intensively with a clinician thoroughly trained and skilled in current, best practice methodology. It is also essential that the child's entire treatment team be educated, knowledgeable and supportive of the treatment protocol and progression.

**Attachment Therapy is a term that is used broadly across different specialty groups and whose meaning may vary substantially depending on the groups focus. This policy is concerned with the more intensive techniques, which are sometimes used as part of this therapy, and acknowledges that this is typically a very small subset of attachment therapy.

Dysregulation: A child is dysregulated when they are not able to regulate their affect, behavior, and/or cognition. Affect is extreme and reactive, behavior is impulsive and out-of-control, and cognition is unfocused and rigid. When a child cannot self-regulate their functioning, they require co-regulation with an empathic, accepting and calm adult.

Play Therapy

The systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development.

Association for Play Therapy

Containment Holding

Holding a child who has become dysregulated and needs to co-regulate his affect, behavior and/ or cognition with the caregiver or therapist as part of an approved treatment plan. Involves holding child physically against her/his will as part of therapeutic process of containment. Used after less restrictive forms of co-regulation have been tried unsuccessfully.

Therapy Foundation

Treatment or therapy is derived from a framework of empathy, acceptance, and nurturing for the child. The intent should never be one of retribution, punishment or harm.

INTERVENTIONS

A. Interventions that need DHS Caseworker verbal approval with supervisory consultation:

1. Voluntary holding of a child during therapy and in foster home by approved therapist and foster parent for purposes of nurturance, support, comfort, and relaxed reciprocal interactions. *** *Nothing in this description is meant to get in the way of foster parent/child interactions that are not part of a structured program of treatment and which fall within the normative range of typical family interactions (examples: hugging, hand holding, expressions of warmth and affection that are normative for the age and situation).*

2. Interactions with child that allow him/her to regress and accept care consistent with his/her emotional age. Activities include rocking, feeding, singing to, combing hair. Such activities are entirely voluntary.

3. Physical presence: Providing extensive eyes-on supervision to greatly reduce failures by having parent structure activities, make choices for child and approve his activities. This is never a punishment and is presented with empathy, acceptance, and opportunities to develop greater self-reliance and to learn to make more appropriate choices.

B. Interventions that need written approval from DHS Administrative designate with review every three months at a minimum (level B interventions):

1. Use of restrictive/containment holding during therapy by an approved therapist, over a specified period of time (not to exceed three months) with written documentation. This is used only if the child is becoming dysregulated emotionally, behaviorally and /or cognitively due to their intense compulsion to control all situations and to avoid any stressful content (See procedures section of this policy for additional information).
   *** *Initially, there may be occasions when the child begins treatment but is so disruptive that it is necessary to briefly, physically hold the child to prevent her/him from destroying the treatment space. Nothing in this description is meant to prevent 'common sense' approaches to situations like this that are outside the fully developed or structured treatment plan.*
2. Use of restrictive/containment holding by an approved foster parent with written documentation and with review at least every three months. As above, this is used only in conjunction with therapy and if the child is becoming dysregulated due to his compulsion to control all situations and to avoid the frustrations of limits and directives.

C. Interventions that will not be approved by DHS:
   1. Intrusive holding of a child during which time he is yelled at or provoked in any manner in order to elicit an intense emotional response.
   2. Intrusive holding whose purpose is to elicit an intense emotional response from the child.
   3. Blanket Wraps
   4. Rebirthing Techniques
   5. Interventions that are presented as reflecting the child's "refusal to be a part of the family". These would include but not be limited to:
      a. Extended isolation.
      b. Extended emotional and verbal withdrawal
      c. Extended deprivation of valued objects/activities
      d. Deliberately causing discomfort and distress
      e. Forced experience of shame-for-its-own-sake
      f. Extensive respites and separations.
      g. Violations of DHS foster care licensing regulations
      h. Restrictive Sitting (examples: mandatory sitting or kneeling for extensive periods of time)

PROCEDURES
(Applicable to B level interventions)

Holding techniques and other restrictive, non-traditional interventions for children are not to be used without the expressed, written, approval of the District Program Administrator. See level B interventions.

1. The caseworker shall obtain a written proposal from the agency or practitioner recommending the provision of attachment therapy which includes, at a minimum, the following information:
   a. Description of the child's trauma history, relationship history and differential diagnosis.
   b. Description of the child's strengths.
   c. Description and definition of the behavior(s) that will be addressed by the treatment.
   d. Description and definition of other measures used to address behavior and assessment of why those measures were unsuccessful.
   e. Description of individuals, other than child and treating clinician, who will need to be involved in treatment along with assessment of their abilities and treatment specific training/education needs. *Specific attention needs to be directed to an assessment of*

the parent's capacity to carry out the treatment methods and to implement them correctly in high stress situations.

f. Assessment of length of time and level of intensity for treatment proposed as well as description of how progress in treatment, home, school and community will be measured and documented (By whom, When and How)
g. Description of how child's reaction to treatment will be measured and documented (By Whom, When and How).
h. Description of qualifications and credentials of professional(s) available to design, deliver and oversee treatment. The same information must be documented for the involved foster parents. Must include information on trainings, supervision, consultations and other professional experiences specific to attachment therapy.

2. The proposal will be reviewed and approved by the treatment team prior to submission to the casework supervisor.

3. A copy of the child's proposal will also be shared with their primary care physician and psychiatrist (if the child has one) for review and comment (caseworker/guardian or designee will forward these documents for review).

4. Once the above review and approval processes are completed and provided to the Casework Supervisor she/he will forward the information packet along with her/his own recommendation(s) to the Program Administrator for approval.

5. Program Administrator approval will be documented and will indicate the period of time the approval covers as well as specifies any expectations for follow-up documentation of progress.

APPENDIX ONE
Documentation

Topic	Recommendations
What should be in DHS caseworker file?	Current multi-modal psychosocial assessment. Assessor should be asked to address cognitive, emotional and behavioral development as well as the child's relationship capacities, parental management and school needs. Assessment should be specific in terms of identifying what we are trying to treat for. Standardized measure such as Achenbach Child Behavior Checklist (CBCL) prior to therapy and at 6-month intervals (preferred) Independent psychological evaluation including intellectual assessment to be completed within three months of starting therapy. Include Achenbach Child Behavior Summary as well as summary of cognitive, emotional and behavioral development. Guardian/clinician should provide foster parent's agency/ treatment team clear documentation of recommended techniques, signed by clinician. This should include clear information about the context (s) in which the technique(s) are to be implemented. Essential to account for any PTSD issues in proposed tx. Therapist and foster parent select and define 4-6 salient target behaviors. Rate at 3-month intervals by foster parent and relevant caretakers. Brief written/therapy summary with space for comments by foster parent every 3 months. Attach critical incident to these summaries. A chart for Containment Holding to include: Date, time, duration, held by, intensity, trigger, (if any), early signs, resolution (affect/behavior/ cognition). Sample log attached. Include self-assessment of foster parents on…space I was in at the time intervention was used.

Patterns of change will be monitored closely. Efforts to develop interventions that might enable avoiding the containment holdings will be documented.

School Progress records.

Minutes of network team meeting – Presumption that team meets twice during first three months and a minimum of every three months thereafter. Team leader will call emergency meetings when warranted.

Treatment summaries from other involved professionals (e.g. child psychiatrist, school guidance counselor, etc) (every 3 months).

Progress along objectives in treatment plan.

APPENDIX TWO
Credentials

Topic	*Comments*
Clinician/ Therapist	Therapist must be licensed to practice within their clinical degree (minimum of masters prepared clinician).
	Must be a Maine licensed mental health professional.
	Professional practice includes on-going clinical supervision /consultation. (describe).
	Therapist will list the interventions for which they are seeking approval.
	Therapist will list workshops, courses, and readings, supervisors, which led to the development of their skills in providing specific attachment interventions.
	Review of resume should indicate: Evidence of significant training, experience and supervision with traumatized, neglected, and abused children and their families. Evidence of experience with the foster care system. Continued education relevant to this population. Specialized knowledge, clinical training and experience concerning attachment relationships.
	Therapist must be approved by DHS to employ the interventions, which they indicate they may be employing during the course of treatment.
	Therapist is agreeable to requirements of documentation and regular participation with foster parent and full treatment network.

Foster Parent	List training in attachment therapy interventions, including courses, workshops, readings, or previous therapists who supervised parenting. If the foster parent has had little prior training/experience in these interventions, the professional who is overseeing the parenting will provide initial training prior to the onset of the attachment program.

APPENDIX THREE
Peer Review

Topic	Comments
Recommendations regarding peer review.	Regular case network team meetings (including DHS caseworker, therapist, foster parent, birth parent, school representative and other relevant service providers) @ three month intervals. Documentation that therapist has reviewed the case with a qualified clinical supervisor or consultant (also trained and experienced in use of interventions therapist is employing) @ three month intervals.

APPENDIX FOUR
Roles in Relation to Therapy

Topic	Recommendation
Foster Parent	Weekly communication with clinician about child's progress and/or the foster parent's use of non-traditional techniques from one session to the next.
	Submit documentation of critical incident/progress at home.
	Accompany child to all therapy sessions at the discretion of the clinician.
	Willing to collaborate with therapist in trying new methods of relating to and managing the child (including detailed discussions of such things as daily routine, family rules, rewards and consequences).
	Willing to examine own behavior and feelings as they may impinge on the care taking relationship with the child.
	Consult with agency clinical supervisor as needed or requested to ensure ongoing awareness of therapeutic approach and client progress (especially in crisis situations when therapist might not be available for consultation).
	Willing and able to be regular participant in network team meetings.
Clinician	Provide initial orientation to specific orientation program. Length of training to depend on amount of prior training and experience.
	Approve all attachment interventions that will be employed, including circumstances of their employment and their review and modification.

	Be available by phone, including evenings and weekends, in the event of a crisis and need to modify program.
	Meet with parent at every treatment session to assess parent's commitment, implementation of the program, management of stress, willingness to acknowledge difficulties, mistakes, and the need for additional help, and ability to maintain a consistent level of empathy, nurturance, and containment for the child.
	Provide treatment team with clear documentation of recommended techniques, signed by clinician (with appropriate signed releases) to include clear information about the context(s) in which techniques are to be implemented.
	Alert foster parent and agency to any quality of care concerns.
Team Members	Share any quality of care concerns about foster placement directly with foster parent, guardian and clinician.
Caseworker	Provide highest level of caseworker service, observation and support.
	Provide ongoing evaluation of the impact of this intensive therapy upon the entire foster family.
	Make available appropriate support or intervention as needed for other family members (e.g., respite, or special programs which might ease the negative impact upon another foster child in the home).
	Make available such specific foster home supports as treatment team deems necessary (e.g., skilled in-home child-care worker to provide relief for foster parents if child requires exceptional structure and supervision).

APPENDIX FIVE
Therapeutic Holding Notes

Client: _____

Held by: Name Initials Name Initials

Scale of Intensity:

1	Weak	Fussing, complaining
2	Mild	Crying, wailing, writhing
3	Moderate	Accusing, complaining
4	Strong	Screaming, spitting, bucking
5	Intense	Shrieking, hurting, kicking, biting, pinching, scratching

Date	Held by	Start Time	End Time	Duration	Intensity	Trigger	Topic Discussed