

Division of Prevention and Behavioral Health Services

DSCYF Mental Health Criteria

Using the Criteria

The Children's Department, comprised of three service Divisions (i.e., Prevention and Behavioral Health Services, Family Services, and Youth Rehabilitation Services), was created to address the needs of children, youth, & their families from a holistic perspective. The Divisions provide defined expertise to meet the needs of each child & family in an integrated & complementary approach.

The Division of Prevention and Behavioral Health Services is charged with the responsibility for assessment and management of treatment targeting mental health and substance abuse problems of Medicaid and uninsured children and youth. Children and youth whose mental health issues necessitate treatment more intensive than outpatient alone are assigned to a Prevention and Behavioral Health Clinical Services Management Team (CSMT). The Medicaid Managed Care Organization (MCO) covers outpatient treatment for children enrolled in Medicaid. If more than the allowable outpatient benefit provided by Medicaid is needed or if there is no insurance, there is a specific Prevention and Behavioral Health outpatient team that authorizes mental health care.

A mental disorder, as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) (date),

“Is a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress ... or disability...or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, the syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual as described above.”

The diagnosis of a mental disorder must take into consideration that symptoms are not better explained by the existence of developmental, physical, cognitive, or environmental/family considerations (e.g., inadequate adult supervision; parental inability to provide for basic developmental needs; family or community sanctioned illegal activity). In addition, some behavioral or psychological syndromes or patterns identified in the DSM are more responsive to specifically designed approaches within other service systems (e.g., educational system, developmental disabilities system). Examples of these include: learning disabilities, chronic neurobehavioral syndromes, and behavior patterns which violate the rights of others and interfere with the ability to participate effectively in established mental health treatment. In light of the unique needs of the aforementioned populations and effective protocols established by alternative models of intervention, PBH works to identify and align the expertise of our sister divisions and community resources to most effectively meet the specialized needs of these children, youth, & their families.

When a child or adolescent is referred with a mental health disorder to a CSMT, the team reviews biopsychosocial information from numerous sources (e.g., parents, school, current counselor, court, probation officer, child welfare worker) to assist in determining an initial treatment service level of care. The goal is to provide safe and effective treatment that addresses the presenting issues by promoting maximally productive and developmentally appropriate functioning in the most normalized and least restrictive setting. Prevention and Behavioral Health strives to provide a treatment environment that permits children the opportunity to master the normative tasks of development. (The most normal and least restrictive setting for any child is to be living at home with his/her parents, going to a public/private school, and engaging in age appropriate play and socialization when not in school.) The potential risks of a more normative setting are continuously reviewed, and the possible safety issues are weighed against the importance of maintaining ties with family, community, culture, and supports in the child's own environment. This is an ongoing process throughout a child's involvement with the Division.

Prevention and Behavioral Health service decisions are made on an individual and case-by-case basis. While the child or adolescent is always the designated client in treatment with The Division of Prevention and Behavioral Health, it is both expected and essential that the parent or the caregiver with whom the child/youth lives, actively and regularly participates in treatment. This includes working with the therapist and even more significantly applying what is learned in therapy to the home and community setting. Treatment of young children is rarely effective without caregiver involvement and most problems presented by adolescents also cannot be effectively treated without the caregiver's participation as in any type of behavioral problem.

The Division of Prevention and Behavioral Health follows the customarily established view of mental health treatment as a dynamic process with a beginning, middle, and end. There are no predetermined durations for particular levels of care. The decision to transition from one level of care to another is based on the progress (or lack thereof) that a child or adolescent is making; and is more likely than not to be different for different children/adolescents. Complete resolution of identified issues is not expected to occur during the course of treatment in a particular service. The decision to transition to a less intensive treatment intervention is based on the clinical judgment that the presenting symptoms which necessitated that service have been reduced to a degree that they (and remaining issues) can be safely and effectively addressed in step-down services. Should symptoms not improve over time and/or risks emanating from the mental disorder become too great despite the fact that the service is being utilized as designed and there has been a good faith effort by the family, a decision may be made to consider more intensive treatment. At every juncture, treatment decisions are made in collaboration with parents/custodians and input from all stakeholders to insure that an integrated approach is used in addressing all supports, barriers, & obstacles contributing to the child, adolescent, and family reaching their full potential.

Mental Health Criteria for Hospitalization

Hospitalization that provides 24 hour medically supervised care and daily treatment should be used primarily for short term acute care to address symptoms that cannot be addressed at other levels of care. When the acute crisis is resolved, the client can continue treatment in a less restrictive program.

Primary Considerations:

I. **At least one of the following:**

- A) **Self harm:** The client has made suicide attempts or credible threats of significant self injury with a plan and means. Risk factors to be considered include, but are not limited to: suicide of significant other, disturbed sense of reality, depression, hopelessness, previous suicide attempts, substance use, and recent losses.
- B) **Life threatening risk:** The client has exposed himself or herself to life threatening risk. Examples include life threatening eating disorders, repeated drug overdoses requiring medical intervention, and extreme noncompliance with medical intervention for serious medical illnesses.
- C) **Danger to others:** The client has a serious psychiatric disorder such as psychosis, or major affective disorder and displays behavior related to the disorder that may result in serious physical assault, sexual assault, or fire setting or other major harm to others.
- D) **Severe Psychiatric disorder:** The client exhibits a severe psychiatric disorder such as an acute psychotic state, or multiple disorders that require intensive or frequent psychiatric or general medical evaluation or intervention.

II. **Least restrictive:** Care cannot be provided safely or effectively in less restrictive level of care.

Mental Health Criteria for Residential Treatment Centers (RTC)

Residential Treatment Centers (RTC) offers 24 hour structure and supervision and provide safety and a context for intense individual, family, and milieu treatment services.

Primary considerations:

I. **Mental health problems (one required):** The client exhibits clearly identifiable mental health problems or symptoms such as mood disorders, significant anxiety disorders (e.g. PTSD), and/or self injurious behavior/ideation which:

- A) Result in serious impairment in the client's functioning across settings including school, family, and community; or
- B) Make it impossible for the client to self-regulate their behavior without 24 hour support and management by mental health professionals; or,
- C) Create a high level of risk of direct injury to self or others without 24 hour supervision and therapeutic intervention by mental health staff.

II. **Least restrictive:**

Twenty four hour inpatient hospitalization is not necessary, and the client has received outpatient treatment (including office or home based services, crisis intervention, and day treatment of partial hospitalization) and has not made progress, cannot reasonably be expected to make progress, or is regressing, or there is evidence that the client could not be safely be treated in any less restrictive level of care.

III. **Family participation:** Family members and/or significant others in the client's support network (relatives, case managers, or mentors) will commit to regular participation in the treatment process and to the client's return to the community.

However, clients affected by these conditions may have mental health concerns that should be treated at the appropriate level of care. Inter-Divisional and/or interdepartmental planning and intervention will frequently be necessary to address other conditions.

Following these guidelines, based on criteria and complicating conditions, each case is reviewed individually in order to establish the most appropriate course of intervention and treatment.

Criteria for Individualized Residential Treatment (IRT)

This level of care provides a 24 hour specialized treatment in a home environment for clients whose behavior and psychiatric status precludes their ability to function in a less structured environment after receiving treatment in a residential treatment center. The client's natural home situation is unable to provide for the child and there are no identified parents, family, or friends interested in sharing their home and/or qualified in providing the level of behavior management intervention clinically necessary to maintain client in the community, home or school setting. These children, who challenging behaviors and special needs associated with their emotional and cognitive compromise, necessitate "treatment parents" who are extensively trained to manage the issues and behaviors presented by these children and are required to be available on an as needed basis to support these children in the community. The complexity of these children's problems require a team approach whereby the "treatment parents" are clinically supported by the organization employing them, there provisions for emergency clinical support and respite is provided for the "treatment parent".

Primary Considerations: (all required)

I A. Child must be

1. Over the age of 12 and
2. Currently receiving treatment in a mental health/substance abuse residential treatment center (RTC) due to a clearly identifiable and serious mental health or substance abuse disorder and
3. Having completed treatment at the residential level

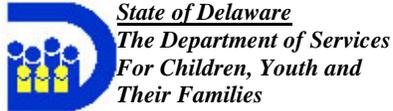
B. The child cannot function in a natural family **and** the demands presented by his/her mental health and/or substance abuse make him/her an unsuitable candidate for regular foster or group care.

C. The child is expected to attend public school within 30 days of entering the home.

II. Least restrictive:

Twenty four hour inpatient hospitalization or residential treatment is not clinically necessary, and based on child's history the child is unlikely to be successful in a home environment that offers fewer clinical services and supervision.

III. Family participation: Family members and/or significant others in the client's support network (relatives, case managers, or mentors) will commit to regular participation in the treatment process and to the client's return to a normal home environment. The "treatment parents" will participate in treatment, school, and community meetings.



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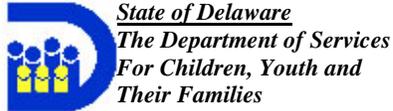
Division of Prevention and Behavioral Health Services

Crisis Intervention Services

Crisis intervention is immediate action taken to evaluate, stabilize, and intervene in critical or emergency situations that appear to involve mental health concerns. The goals are to address issues which precipitated the crisis, provide intensive short-term intervention, and identify and provide transition to any necessary follow on services.

Primary considerations:

- I. There are mental health concerns, which require an immediate evaluation and intervention.
- II. There is no apparent condition or injury requiring immediate medical attention.



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Crisis Bed Services

A crisis bed is a substitute care setting that may be utilized for a period of up to 72 hours, when such substitute care will facilitate effective implementation of crisis intervention services.

Primary Considerations:

- I. A crisis bed should not be used when other appropriate resources, e.g., extended family, are available to provide support and care.
- II. The child would be at increased risk for hospitalization or other 24 hour care if the crisis bed is not utilized.

Mental Health Criteria for Partial Hospitalization/Day Hospital

This level of care provides support and psychiatric services five days per week to clients living at home or in other residential settings. This level of care should be used for clients with severe, complex, or chronic psychiatric disorders requiring high intensity psychiatric medical services.

Primary Considerations:

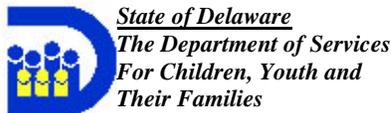
I. At least one of the following:

- A) **Self harm:** The client has made suicide attempts or credible threats with a plan and means. Risk factors to be considered include, but are not limited to: suicide of significant other, disturbed sense of reality, depression, hopelessness, previous suicide attempts, substance use, and recent losses.
- B) **Medical risk:** The client has exposed himself or herself to medical risk, for example, eating disorders, repeated drug overdoses requiring medical intervention, and noncompliance with medical intervention for serious medical illnesses.
- C) **Danger to others:** The client has a serious psychiatric disorder such as psychosis, or major affective disorder and displays behavior related to the disorder that may result in serious physical assault, sexual assault, or fire setting or other major harm to others.
- D) **Severe, Complex, or Chronic Psychiatric disorder:** The client exhibits a severe, complex, or chronic psychiatric disorder that has led to compromised functioning in multiple areas which require frequent or intensive psychiatric or general medical evaluation or intervention which cannot safely or effectively be provided in alternative programs.
- E) **Psychiatric oversight:** Is a necessary part of the client's treatment.

II. Least restrictive :

Twenty four hour inpatient hospitalization or RTC care is not necessary, and the client has received outpatient treatment (including office or home based services, crisis intervention, and day program) and has not made progress, cannot reasonably be expected to make progress, or is regressing in outpatient treatment, or there is evidence that the client could not be safely be treated in any less restrictive level of care.

III. **Family participation:** Family members and/or significant others, in the client's support network (relatives, case managers, or mentors) will commit to regular participation in the treatment process and to the client's return to the community.



Mental Health Criteria for Day Treatment

Day treatment provides intensive psychiatric services and a milieu facilitating a more successful adaptation to community and regular educational environments when 24 hour care and intensive psychiatric/medical monitoring are not necessary. Services are provided five (5) days a week.

Primary consideration:

I. At least one of the following:

- A) **Self harm:** The client within the last two years has made a significant suicide attempt or gesture and currently threatens self -harm or self -mutilation, especially in combination with a history of substance abuse, significant depression, borderline personality disorder, or other significant psychiatric conditions.

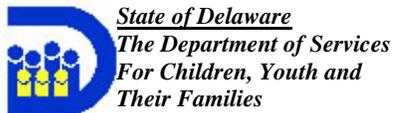
- B) **Danger to others:** The client has a serious psychiatric disorder such as psychosis, or major affective disorder and displays behavior related to the psychiatric condition that may result in serious physical assault, sexual assault, or fire setting, or other major harm to others.

- C) **Severe or Chronic Psychiatric disorder:** The client exhibits a psychiatric disorder such as major depression or chronic conditions that compromises functioning in multiple areas, and requires intensive psychotherapeutic intervention and/or a milieu that facilitates social skill development and reintegration into a regular community school environment.

II. Least restrictive:

Twenty four hour inpatient hospitalization or RTC or partial hospital care is not necessary and outpatient treatment (including office or home based services, or crisis intervention) has been attempted or considered and the youth has not made progress, or cannot reasonably be expected to make progress.

III. Family participation: Family members and/or significant others, in the client's support network (relatives, case managers, mentors) will commit to regular participation in the treatment process and to the client's return to the community.



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Intensive Outpatient (IOP) Services

Intensive Outpatient Treatment is focused, professionally directed evaluation and treatment of at least 3 hours per week. It is designed for the client who needs intensive treatment including services at school, in the client's home, and in the community in addition to the therapist's office, but can live at home and attend school or work during the day.

Payment Considerations

I. Mental health problems that significantly compromise functioning.

II. Least restrictive (one of the following required):

A. Twenty four hour inpatient hospitalization, RTC or Day Treatment is no longer necessary and more intensive services than traditional outpatient are required, or

B. The client has received lower intensity outpatient treatment and has not made progress, cannot reasonably be expected to make progress, is regressing in outpatient treatment, or is not likely to benefit from outpatient treatment.

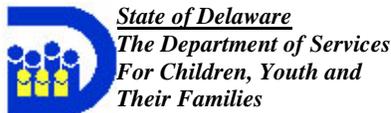
III. **Family participation:** Family members or, in exceptional cases significant others, in the client's support network (relatives, case managers, mentors) will commit to regular participation in the treatment process and to maintaining the client in the community.

Mental Health Outpatient

Mental health outpatient treatment is the least restrictive level of mental health intervention. It is designed for children/youth who have been identified as exhibiting mental health symptoms requiring evaluation and/or treatment, most typically on a scheduled basis. Although the frequency of appointments might range from once a month to several times a week, the typical client would be seen once or twice a week for a period of three to six months. Family participation and utilization of community resources are emphasized.

Primary considerations:

- I. The child has at least one mental health symptom requiring evaluation or treatment.
- II. The child or youth can be maintained in the family and school setting within this level of care.
- III. The child's or youth's family or support system should be willing to participate in treatment.



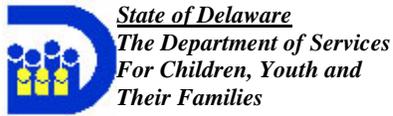
Criteria for Aide Services

(Wrap Around/Behavioral Intervention)

Aide services are designed to augment mental health services provided directly by mental health providers through the use of a paraprofessional working directly with the client and family to carry out elements of the mental health treatment plan. Generally the aide would be available to help generalize treatment efforts to other settings. The service should generally be time limited, focused on specific goals, and used to aid in transition between levels of care or to facilitate adjustment to developmental tasks.

Primary consideration:

- I. The client must be engaged in mental health treatment at least at the outpatient level. (Aide services are not a stand-alone treatment.)
- II. The goals for the aide must be integrated into the mental health treatment plan.
- III. There should be an attainable goal with a time limited period of intervention for each goal. Goals should be stated in concrete behavioral or skills terms.
- IV. The client has mental health symptoms that are severe, chronic, and/or pervasive, and are not responding or cannot reasonably be expected to respond to traditional outpatient treatment alone.
- V. Without the aide service, the client would require a higher level of service provision.



Division of Prevention and Behavioral Health Services
Substance Abuse Criteria

For Substance Abuse Disorders, DPBHS uses the criteria developed by the American Society of Addiction Medicine, Inc. Since these are copyrighted they can not be reprinted. The reference is:

American Society of Addiction Medicine. (2001). *ASAM PPC-2R: ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders. Second Edition –Revised.* Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Web Address for American Society of Addiction Medicine: <http://www.asam.org/>