

Child and Adolescent Psychiatric Care

The specific criteria for child and adolescent psychiatric care described in this chapter are meant to supplement the narrative description of levels of care in Chapter 2 of this guide - Psychiatric Care. The criteria outlined below should not be applied without first reading the the narrative description of levels of care in Chapter 2 - Psychiatric Care.

Child and Adolescent Psychiatric Inpatient Hospitalization

Medical Necessity Criteria for Admission

For admission both of the following criteria A and B must be met.

- A** For the diagnostic evaluation, have the following conditions been met?
(All answers must be **yes** for admission.)
1. Within 24 hours of admission, has a multi-axial, face to face diagnostic evaluation been done by either:
 - ▶ A licensed physician whose diagnostic evaluation is confirmed by a:
 - Child and adolescent psychiatrist?
 - Board Certified psychiatrist?

OR

 - ▶ Child and adolescent psychiatrist?
 - ▶ Board Certified psychiatrist?

AND
 2. The diagnosing psychiatrist prescribes inpatient psychiatric care

AND
 3. Documentation that psychiatric inpatient treatment is necessary because
 - ▶ The child has a severe psychiatric disorder

AND/OR

- ▶ The child has a behavioral disorder that may pose a risk for others

AND

4. Documentation that treatment in a less restrictive setting has not been successful, or has been considered as a treatment setting and rejected by the diagnosing psychiatrist as inadequate to meet the needs of the patient.

AND

5. A strengths-based evaluation has been accomplished with the strengths of the family, community and culture taken into consideration either:

- ▶ Before admission

OR

- ▶ Within 48 hours of admission, if the admission is an emergency

- B** Has the severity of the symptoms been evaluated and documented, and do they meet the following criteria?

1. There is a significant risk of danger represented by any of the following

- ▶ Child is in danger of self harm
- ▶ Child may harm others
- ▶ Child may destroy property which is
 - Life threatening

OR

- Occurs in combination with any of the following three criteria:

2. For the developmental level, the judgement of the child is impaired to a degree that the child's:

- ▶ Interpersonal skills
- ▶ Self-maintenance in the home/school/ community environment

is/are severely compromised.

3. Complications that endanger the well being of the child exist.

- ▶ The child's diminished capacity for self-care may produce complications in the child's psychiatric disorder or its treatment.
- ▶ The child's psychiatric disorder prevents the treatment of a coexisting physical illness in a less intensive level of care.

4. The inpatient psychiatric treatment is required to prevent deterioration of the child's status, or is required to increase the likelihood of improvement of the child's condition.

Requirements for Continued Stay

For a continued stay the following criteria must be met.

A Diagnostic Evaluation and Documentation

1. Has the treating psychiatrist updated and revised the initial evaluation by conducting a face to face interview with the child?

AND

2. Has the treating psychiatrist prescribed the inpatient setting as the appropriate setting for the treatment of the child?

B Severity of Symptoms

1. Does the treatment plan with updated severity of illness indicators support the continued stay because of the benefit the child is experiencing and/or is there a risk of symptoms re-emerging or worsening if the child is placed in a lower level of care?

AND

2. Is the child making progress towards goals but more progress must be made before the child can be transitioned to a lower level of care?

OR

3. Are the symptoms that made admission necessary still sufficiently severe to require continued care on an inpatient unit?

OR

4. Have new symptoms developed that meet admission criteria?

Discharge Criteria

- ◆ Does the child's status no longer meet the severity of symptoms in the continued stay criteria? (If yes, the child must be discharged.)



Child and Adolescent Residential Treatment

Admission Criteria

Must meet A and B, or C

- A** The answers to the following six questions must be yes.
1. Has a psychiatrist done a diagnostic evaluation for a JCAHO accredited facility, or if the facility is not JCAHO accredited, has a psychiatrist or a licensed psychologist done the evaluation?
 2. Has the psychiatrist or the psychologist prescribed residential treatment as the appropriate treatment for the child?
 3. Does the severity of the child's psychiatric disorder and or risk of harm to self or others require 24 hour a day supervision and observation?
 4. Has a lower level of care been tried without success or has careful consideration been given to a lower level of care, but found not able to meet the needs of the child?
 5. Has an interagency team recommended residential treatment for the child?
 6. Has a strengths-based evaluation been completed before admission?
- B** Do the presenting history and psychiatric/psychological evaluation include at least one of the following?
1. Suicidal and/or homicidal ideation
 2. Impulsivity and/or aggression
 3. Psycho-physiological disorder (for example: anorexia)
 4. Psychomotor retardation or excitement
 5. Impairment due to an affective disorder (for example: withdrawn, labile)
 6. Psychosocial functional impairment
 7. Thought disorder
 8. Cognitive impairment

- C** Does the child's condition as outlined below require further observation to clarify the child's status? (Allowable for 15 days per calendar year).
1. Have family members, school or community members described symptoms in the child that:
 - ▶ Have not been observed in an inpatient setting?

OR

 - ▶ Have been denied by the child in an outpatient or partial hospital treatment?

OR
 2. Have the child's symptoms not sufficiently improved despite comprehensive care at a lower level of care, which has included the participation of an inter-agency team?

Continued Stay

Must meet A and B

A Diagnostic Evaluation

1. Has the initial evaluation been revised and updated following a face-to-face examination by the treating psychiatrist or psychologist?
- AND**
2. Have less restrictive environments been considered in consultation with the Interagency Service Planning Team?
- AND**
3. Is there clinically determined likelihood that without continued care at the residential level, the child will experience a recurrence of symptoms?
- AND**
4. If other alternative services have been rejected in favor of continued stay at the residential treatment level have these reasons been documented?
- AND**
5. Has the treating psychiatrist/psychologist prescribed the residential treatment level as the appropriate treatment after a face-to-face examination of the child?

B Severity of Symptoms

1. Have the severity of illness indicators and the updated treatment plan supported the continued stay in residential treatment to prevent a recurrence of symptoms?
2. Has the treatment team recommended continued stay and documented the need for the child's further improvement?
3. Will more progress in the child's status be required before a transition to a lower level of care is advisable?
4. Are the symptoms or behaviors that required admission still of such severity as to warrant continued care in the residential setting?
5. Have new symptoms developed that meet admission criteria?

C Discharge Criteria

1. If the child was admitted under Admission Criteria A and C, has the child been discharged within 15 days of admission? If not has a psychiatric examination of the child documented eligibility under Criterion B of the admission criteria?
2. If the child does not meet Criterion B of Continued Stay Criteria, has the child been discharged?



Child and Adolescent Partial Hospital Treatment

Admission Criteria

Must meet A and B, or C

A Diagnostic Evaluation

1. Has a psychiatrist or a psychologist done a multiaxial diagnostic evaluation?
AND
2. Do the behaviors of the child indicate a risk of safety for self or others and/or decreased functioning?
 - ▶ Does the behavior require observation and treatment but does not require 24-hour day supervision?
 - ▶ Has treatment at a lower level of care been unsuccessful or have treatment alternatives at a lower level of care been considered and rejected?
AND
3. Has the treatment team recommended partial hospitalization as the most appropriate setting for the care of the child?
AND
4. Has an interagency planning team been incorporated into the treatment team if the child is removed from the regular schoolroom all or part of the day?
AND
5. Has a strengths-based assessment of the child been completed prior to admission or within 5 days of admission?
AND
6. Has the involvement (or non-involvement) of the parents been documented and presented to the interagency team?

B Severity of Symptoms

Has the presenting history or the psychiatric examination of the child included at least one of the following?

- ▶ Suicidal/homicidal ideation
- ▶ Impulsivity and/or aggression
- ▶ Psycho-physiological condition (for example: anorexia)
- ▶ Psychomotor retardation or excitement
- ▶ Impairment due to an Affective Disorder (withdrawal, lability)
- ▶ Psychosocial functional impairment
- ▶ Thought Disorder
- ▶ Cognitive impairment

C Observation

1. Does the behavior or impairment of the child require further observation for clarification of the nature and severity of the child's condition? Allowable for 15 days per year.

- ▶ Have problematic behaviors described by members of the family, the community or the school persisted but:
 - Have not been observed on a psychiatric inpatient unit?
 - Has the child denied the reported problematic behaviors in outpatient treatment?

OR

2. Has the child's condition not improved at a lower level of care and the inter-agency team recommended partial hospitalization?

Continued Stay**A** Diagnostic Evaluation

1. Has the initial evaluation been revised and updating following a face-to-face examination by the treating psychiatrist or psychologist?

AND

2. Have less restrictive environments been considered in consultation with the Interagency Service Planning Team?

AND

3. Is there clinically determined likelihood that without continued care at the partial hospitalization level, the child will experience a recurrence of symptoms?

AND

4. If other alternative services have been rejected in favor of continued stay at the partial hospitalization treatment level, have these reasons been documented?

B Severity of Symptoms

1. Have the severity of illness indicators and the updated treatment plan supported the continued stay in partial hospital program to prevent a recurrence of symptoms?
2. Has the treatment team recommended continued stay and documented the need for the child's further improvement?

AND

3. Will more progress in the child's status be required before a transition to a lower level of care is advisable?

OR

4. Are the symptoms or behaviors that required admission still of such severity as to warrant continued care in the residential setting?

OR

5. Have new symptoms developed that meet admission criteria?

C Discharge Criteria

1. If the child was admitted under Admission Criteria A and C, has the child been discharged within 15 days of admission? If not has a psychiatric examination of the child documented eligibility under Criterion B of the admission criteria?
2. If the child does not meet Criterion B of Continued Stay Criteria, has the child been discharged?



Child and Adolescent Psychiatric Outpatient Treatment

Admission Criteria

Must meet A and B

DIAGNOSTIC EVALUATION

- A** Has a diagnosis made by a mental health professional been reviewed by a psychiatrist or a licensed psychologist?

AND

- B** Do the behaviors of the child indicate lessened risk to self or others and the child does not require inpatient or residential levels of care?

SEVERITY OF SYMPTOMS

- A** Has this level of care been recommended by the treatment team director?

AND

- B** Is there a serious and persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder?
- ▶ Is treatment required to alleviate symptoms and/or behaviors?
 - ▶ Will treatment be required to prevent relapse in the child with symptoms that are in partial or complete remission?

OR

- C** Are there significant psychosocial stressors and/or physical illness that increase the risk for a decrease in the functioning of the child?

OR

- D** Have the child's symptoms improved at a higher level of care, but outpatient care is required to sustain and reinforce the gains made at a higher level of care?

OR

- E** Is medication monitoring required to care for the child appropriately?

Continued Stay

Must meet criteria for Diagnostic Evaluation and Severity of Symptoms

DIAGNOSTIC EVALUATION

- A Have the treatment plan and diagnosis been reviewed and approved by a psychiatrist or licensed psychologist?

OR

- B Is there significant family involvement in the treatment process except where prohibited or when family involvement would be clinically counter-productive?

SEVERITY OF SYMPTOMS

- A Is the child making progress towards goals?

OR

- B Are natural community supports insufficient to stabilize the child's condition?

OR

- C Have new symptoms or behaviors developed that meet admission criteria?

DISCHARGE

- ◆ Has the child been discharged if criteria in severity of symptoms have not been met, or if indicated by progress attained?

APPENDIX T (PART B)

BEHAVIORAL HEALTH REHABILITATION SERVICES UNDER EPSDT: Home/Community Services

TABLE 1: SEVERITY LEVELS AND SERVICE CORRELATES WITH CORRESPONDING PROPORTIONAL ORDERING OF TREATMENT HOURS

All services are to be determined on an individual basis for the child or adolescent

(Table does not represent EPSDT psychosocial rehabilitative services provided on provider sites, such as After-school and Summer Therapeutic Activities Programs)

LEVEL 1 (LEAST)	LEVEL 2 (MODERATE)	LEVEL 3 (INTENSIVE)	LEVEL 4 (HIGHLY INTENSIVE)
1 to _ hours of Professional & 1 to _ hours of Therapeutic Support Services (Must meet A, B, and C; OR D)	_ to _ hours of Professional & _ to _ hours of Therapeutic Support Services (Must meet A, B, and C; OR D)	_ to _ hours of Professional & _ to _ hours of Therapeutic Support Services (Must meet A, B, and C)	_ to _ hours of Professional & _ to _ hours of Therapeutic Support Services (Must meet A, B, and C)
I. & II. [COMBINED] DIAGNOSTIC INDICATORS BY LEVEL			
<p>A Service must be recommended as the most clinically appropriate for the child, by the prescriber, as informed by the interagency team, AND</p>	<p>A Risk of harming [self, others, or property] is assessed low in the child’s current problematic behavior or functional impairment and presenting history; AND psychiatric or psychological examination must include:</p>	<p>A Severe functional impairment is assessed in the child’s problematic behavior in the home, school, or community; there is risk of an out-of-home or out-of-school placement; may be risk of danger of child harming him/ herself, others, and/or demonstrated destruction to property; AND</p>	<p>A High risk of out-of-home placement, or demonstrated risk of endangerment, involving child harming self or others, or destruction to property, due to emotional or behavioral problems, or mental illness; and/or the severe functional impairment in the home, school, or community, AND</p>
1. CHILDREN WITH A DIAGNOSTIC INDICATOR ON AXIS I			
<p>a. There is serious and/or persistent impairment of developmental progression and/ or psychosocial functioning due to a serious emotional disturbance or psychiatric disorder, requiring treatment to alleviate acute existing symptoms and/ or behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/ or behaviors which are in partial or complete remission;</p> <p style="text-align: center;">OR</p> <p>b. Significant psychosocial stressors and/ or medical condition increasing the risk that the child’s functioning will decrease for his/her developmental level require home/ community based intervention to develop resources within the child and/ or family to provide the balance to these stressors needed to continue the child in remission; OR <i>(continued on next page)</i></p>	<p>a. Assessment of at least one (1) of the following:</p> <ol style="list-style-type: none"> 1. Suicidal homicidal ideation 2. Impulsivity and/ or aggression 3. Psycho-physiological condition, (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation 5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment <p style="text-align: center;">AND/OR</p> <p>b. Presence of very impaired judgement or functional capacity and capability, for the child’s developmental level, such that interpersonal skills, and/ or self-maintenance in home/ school/ community is/ are highly compromised, are not attributable to mental retardation;</p>	<p>a. Assessment of at least one (1) of the following:</p> <ol style="list-style-type: none"> 1. Suicidal/ homicidal threats or intensive ideation 2. Impulsivity and/ or aggression 3. Psycho-physiological condition (i.e. bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation. 5. Affect/Function impairment (i. e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment <p style="text-align: center;">AND/OR</p> <p>b. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child’s developmental level, such that interpersonal skills, and/ or self-maintenance in home/school /community is/ are severely compromised, are not attributable to mental retardation;</p>	<p>a. Assessment of at least one (1) of the following:</p> <ol style="list-style-type: none"> 1. Suicidal/homicidal threatening behavior or intensive ideation 2. Impulsivity and/ or aggression 3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation. 5. Affect/Function impairment (i. e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment <p style="text-align: center;">AND</p> <p>b. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child’s developmental level, such that interpersonal skills, and/ or self-maintenance in home/school /community is/ are severely compromised, are not attributable to mental retardation;</p>

LEVEL 1 (LEAST)	LEVEL 2 (MODERATE)	LEVEL 3 (INTENSIVE)	LEVEL 4 (HIGHLY INTENSIVE)
1. CHILDREN WITH A DIAGNOSTIC INDICATOR ON AXIS I (continued)			
<p>c. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of direct home/community based treatment to reinforce stability; OR</p> <p>d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;</p> <p>MEETS 1. AND/OR</p>	<p>MEETS 1. AND/OR</p>		
2. CHILDREN WITH A DIAGNOSTIC INDICATOR ON AXIS II (without a diagnosis on Axis I)			
<p>a. There is an onset of remarkable behaviors that could escalate to a crisis.</p> <p>b. Behavior presents serious risk of self injury, or injury to others, or destruction of environment; AND</p> <p>c. There is significant change from baseline behavior, or amplification in exhibited behaviors, as indicated by the frequency, intensity, duration, of the behavior(s), and/or locations where the behavior(s) occur(s); AND/OR</p> <p>d. Requires medication and home/community based monitoring of medications to help the family, and the child, consistent with the child's age and cognitive abilities, to understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;</p>	<p>a. There is an onset of remarkable or crisis behaviors.</p> <p>b. Behavior has resulted in self-injury, or injury to others, or destruction to environment; AND</p>		
<p>B Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, AND effectively reduced by the implementation of a behavior management plan in the professional judgment of the advising physician or mental health professional, as a result of:</p> <p>1. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; AND</p> <p>2. there is documented commitment by the primary care givers (usually parent/ guardian) to the therapeutic plan. AND</p> <p>3. If endangerment/ destruction is a relevant feature of the presenting problem, both adolescent and primary caregiver develop a safety plan that at least the caregiver signs.</p>			
<p>AND</p> <p>C The severity and expression of the child's symptoms are such that:</p> <p>1. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above;</p> <p>AND</p> <p>2. on-site intervention in the home or community offers a more effective preventive to longer term consequences.</p>			

LEVEL 1 (LEAST)	LEVEL 2 (MODERATE)	LEVEL 3 (INTENSIVE)	LEVEL 4 (HIGHLY INTENSIVE)
<p>D OBSERVATION - 15 days</p> <p>1. Troubling symptoms of the child (described by family/school/others) persist though</p> <ul style="list-style-type: none"> • not observed on a psychiatric inpatient unit, OR • they are denied by the child in outpatient or partial hospitalization treatment, such that observation of the child in natural settings provides the opportunity to assess and treat the child; OR <p>2. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment in other levels of care, involving the interagency team.</p>			

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integration objectives including development of the child/ adolescent's network of personal, family, and community support.

IV. CONTINUED CARE

Whenever service is provided for a term greater than three (3) months, there must be at least a quarterly review of the child being served which clarifies the child's progress, progress toward developing community linkages, and the necessity for continuing home/community service.

1. Child must be reevaluated and continue to meet criteria for admission (I);

AND

2. Child shows:

a. measured improvement and/ or begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation);

OR

b. increased or continued behavioral or emotional disturbance with continued expectation for improvement (show rationale in the treatment plan);

AND

3. Review includes consideration/ evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources.

4. Treatment plan must be updated addressing the presenting problem within the context of the psychosocial stressor(s)/event(s); indicating that service should be:

a. continued with a reduced number of hours as a result of the amelioration of original indication for service, and/ or activity of community members and services, and/ or the child's network of family and friends;

OR

b. increased due to changes in the context and/ or adjustments in the treatment plan;

AND

5. Interagency service plan must be updated to reflect the recommendation to continue care and be attached to the treatment plan