

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA

CHILDREN AND ADOLESCENTS

**Behavioral Health Rehabilitation
Services Under EPSDT:
Home/Community Services
(2nd Edition)**

- ⊙ **Serious Emotional Disturbance**
- ⊙ **Mental Retardation**

INTRODUCTION:

Generally absent in both regulation and the literature on behavioral health, are admission guidelines for behavioral health services delivered to children in their homes, schools, and daily community activities. The availability of these services is required under the federal ruling titled the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) as specifically described in the section called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Implementation of OBRA '89 in Pennsylvania was established through the Medical Assistance Bulletin 1241-90-02 of October 15, 1990. While there has been a strong focus on development and expansion of needed services to respond to children with behavioral health treatment needs in multiple child serving systems, more work is required to regulate use of services. Clearly, with concerns about containing cost while enhancing the efficacy of treatment affecting decisions on service delivery, guidelines are needed to bridge the purpose, function, and expectations of these services with actual service delivery. Up to now, the primary connection has been the determination of medical necessity, in combination with the application of the Child and Adolescent Service System Program (CASSP) principles, and a variously applied understanding of the "Wraparound" philosophy of care. The guidelines and classification system presented in this document and subsequent revisions, provide a basis for admitting children and adolescents to behavioral health services delivered in the home, and school, or elsewhere in the community, under EPSDT, and within the context of multiple child serving systems. For ease of reading in the text which follows "child" will refer to both child and adolescent unless otherwise stated.

CASSP principles and the Wraparound philosophy of care provide the foundation supporting the effort to provide mental and behavioral health services to children in their homes and communities. It is understood here that home/community delivered services are not simply intended to be a replacement for all other clinic and hospital based services. These relatively new services are to address the increasingly complex needs of children receiving services in

multiple child serving systems (i.e.- child welfare, juvenile justice, education, mental retardation, and drug & alcohol) and offer an alternative to some of the functions clinic/hospital based services have previously played, because home/community delivered services are considered more appropriate to specific tasks of directed treatment.

Home/community delivered behavioral health services are specifically appropriate for children and adolescents who require intervention at the sites where their problematic behaviors occur. This eliminates the necessity to understand and treat problems, behaviors, or activities in an abstract form dissociated from their actual occurrence, and allows direct intervention. In this way the clinician observes and learns directly from the child's behavior in the natural context, but it also allows the child and clinician to formulate together the language and symbolic references to the problem and the strategies for resolution. Thus the interaction between the child and clinician is not dependent on first understanding an abstract expression of the problem, and allows the child to firmly establish the practicality of the therapeutic intervention. The clinician is not solely dependent on informants and the child receiving treatment for information, nor does the child need to transfer change which occurs in the clinic or institutional setting to the family or community setting where the problem primarily manifests.

The purpose for any recommended service must be justified and clearly stated whether they are clinic or home based. Also, the recommendation for services must carefully consider not only treatment for an identified problem, but the child's multi-system involvement, willingness to engage in treatment, the confidentiality concerns of both the child and family, and whether safety issues require a certain level of restrictiveness in the treatment planning for a particular child or adolescent. Making the decision for the type and level of service is not always easy, but the rationale for the decision made is necessary. Building the rationale requires the appropriate diagnostic and life domain assessments, treatment and interagency team involvement, and the spirit of building a cooperative effort to enhance the intervention in order to achieve the goals of treatment.

Home/Community Services

The behavioral health system has undergone substantial structural change from an emphasis on community segregation and maintenance of children with emotional disorders, to one of community integration and skill development essential in fostering increasing independence of individuals and families (see Mental Health/Mental Retardation Act of 1966 and the Mental Health Procedures Act of 1976 with subsequent amendments). The change in emphasis from providing service to children exclusively in established sites, such as clinics and hospitals, and residential and day treatment centers, to serving children individually where they live, learn and play in the community is reflective of this overall change. These changes are supportive of the wraparound philosophy of care to the extent that these community delivered services are often identified as "wraparound services." Wraparound is a philosophy which promotes developmentally appropriate behavior, activities, skills, and social skills for the child in his/her natural context through focusing on his/her individualized strengths and needs. More broadly, it

promotes the opportunity for family independence from professional treatment and therapeutic supports. Family autonomy in the care of children with special needs may be fostered through skill development and assisting the family in the development of their informal support network. An understanding of the social contexts of the child or adolescent, including school and community as well as home, is essential to determining the appropriate sites for interventions and the resources available. When professional services provide a necessary treatment, the service(s) must be focused on accomplishing a set of goals, and incorporate into the planning the appropriate tapering of the service or the replacement of the service with informal and other non-behavioral health therapeutic supports.

The Office of Mental Health and Substance Abuse Services (OMHSAS) has promoted the development of expanded behavioral health services in response to the need for services delivered to children in natural community settings. In Pennsylvania these services have multiple references including, "EPSDT mental health services", "expanded mental health services," "psychosocial rehabilitative services" and "'wraparound' mental health services". However, EPSDT refers to more than the services considered in the Level of Care protocols to follow, "enhanced" is a term relative to the services currently offered and therefore not necessarily restricted to community based services, and "wraparound" is a philosophy of care and implementation within which professional services may play a role. For clarity in this paper, the services are called simply by their association with home and community. Other psychosocial rehabilitative services which are offered on provider-site, such as therapeutic summer programs and after-school programs are not incorporated into the protocol for home/community services. It is in the application that home/community services must be medically necessary, adhere to the requirement of EPSDT service provision, and should be consistent with the wraparound process.

Treatment objectives may be characterized in at least three ways, individualized, generalized, and service specific. Individualized objectives for the child and family must be created as part of a treatment process which is strengths-based and developmentally appropriate. The generalized objectives reflected in the admission guidelines for clinic and hospital based services are as follows: ameliorate symptoms such that less restrictive and/or less intrusive services can be planned and introduced; stabilization of medical regimen for children requiring psychotropic medication which helps them to effectively receive the least restrictive/least intrusive services possible; promotion of psychosocial growth and development and prevention of regression/recidivism by improving the child's level of functioning and ability for self maintenance; coordination of the treatment and discharge plan on an ongoing basis with the appropriate agencies to provide the necessary natural community based supports; and increase in age-appropriate interactivity in a variety of settings [see "Community Integration Questionnaire" in Reference Form D (p. 27)]. Some objectives more specific to the home/community services have been mentioned above, such as: development and practice of interpersonal skills as necessary to enhance parent/child, child/adult, and child/peer relations; identification of personal, family and community resources and exploring their usage; and directly relating therapeutic aims with social contexts and laying the groundwork for treatment which references

the problem (a higher level of abstraction) such as occurs in clinic based treatment.

Home and community services are developed and tailored specifically to meet individualized child and family needs (see Table 2). Specialized therapeutic services on the Medical Assistance fee schedule are: Mobile Therapy, Behavioral Specialist Consultant (Doctoral Level), Behavioral Specialist Consultant (Master's Level), Therapeutic Staff Support (TSS), and Summer Therapeutic Activities Program. Each of the first four services is distinct and described in Medical Assistance Bulletin 01-94-01, issued January 11, 1994 on "Outpatient Psychiatric Services for Children Under 21 Years of Age." The last is a new program which is described in Medical Assistance Bulletin 50-96-03, issued April 25, 1996. All of these services are provided for the purpose of improving and developing the capacity of the treated child or adolescent, and the family, thereby contributing toward the independence of the family as a unit. The need for these services will vary according to the severity of the child's problems and the richness of the resources of the child, the family, and the community.

In this edition of the guidelines for behavioral health home/community services, guidelines for the delivery of home and community behavioral health services to children with mental retardation have been added. The Office of Mental Retardation supports the provision of services in homes and communities. These behavioral health services provide discrete short term, goal oriented rehabilitative interventions to children with mental retardation. The availability of these services helps to ensure that children with mental retardation receiving mental retardation services have access to additional therapeutic interventions when medically necessary and to assist them remain in their communities.

The structural changes in the behavioral health system are reflected in the development of the Child and Adolescent Service System Program (CASSP) and its philosophy. Within the body of this Bulletin is emphasized the importance of consistency in the services with the CASSP principles. The OMHSAS summary representation of the CASSP principles, is provided below.

CASSP Principles

The CASSP philosophy of collaborative service delivery to children, adolescents and their families undergirds all treatment methods. CASSP involves all child-serving systems including mental health, mental retardation, education, special education, children and youth services, drug and alcohol, juvenile justice, health care, and vocational rehabilitation. It should also include informal community supports and organizations. This philosophy is essential to making decisions to provide treatment for children. It is also the foundation that motivates the development of these guidelines. These principles are represented in the following six summary statements:

- (1) Child-centered - Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services should be developmentally appropriate and

child-specific, and should also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

- (2) Family-focused - Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels should include family representation.
- (3) Community-based - Whenever possible, services should be delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.
- (4) Multi-system - Services should be planned in collaboration with all the child- serving systems involved in the child's life. Representatives from all these systems and the family should collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, and provide appropriate support to the child and family.
- (5) Culturally competent - Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

- (6) Least restrictive/least intrusive - Services should take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child.

These principles encompass not only the psychological, but the physical, cognitive, and socio-cultural development of children, which include the child's dependency on family, community, and environmental influences in general. From these principles, the home/ community delivered services for which "Admission Guidelines" are provided below, can be understood as components within a wider network of service options.

CLASSIFICATION SYSTEM:

Because the collective of home/community behavioral health services is appropriate to treat the full range of symptom severity, an organizational system for associating intensity of service with severity of need is essential. This is different from the current clinic and hospital based services which associate the individual service with the severity of need, such that inpatient hospitalization is associated with higher severity of symptoms than that of partial or outpatient. By dividing the community delivered services into four levels of intensity from least to most, these services roughly parallel the four traditional categories of clinic and hospital based services: Outpatient; Partial Hospitalization; Residential Treatment; and Inpatient Hospitalization. Services are further divided into two types: treatment and therapeutic support. With intensity of service defined by the amount of time the service is provided, as related to the type of service provided, the four levels of home/community delivered services may be identified as contiguous segments along a continuum of intensity.

The first of the four levels describes the criteria for the children with the least severe need who are eligible for the service. Each of the successive levels represents an increase in the severity level for which it is designed. Criteria for children with mental retardation are identified in the first two levels only with the recognition that if these children display greater severity in their symptomatology they may receive an axis I diagnosis. Because all of the home/community delivered services are available for each of the levels, the variation in intensity must be ranked by how much service is delivered. Time is selected as a general measure of quantity for each of the levels, because it is already used in this way to determine payment when a rate is assigned to the service. At this writing, the range of hours for each of the levels is not identified, however the levels represent a proportional relationship between both, the identified levels of severity and the range of services within each.

There are a maximum of four components to each of the levels. In order of presentation in the guidelines and the table: the first part identifies the type and extent of the emotional and behavioral disturbance, including the degree of endangerment; the second requires assurance that the child or adolescent and the family is amenable to treatment in community settings; while the third assures that there is the professional opinion that the service necessary is at this level of intensity. The fourth level applies only to the two least intensive levels and tends to serve the purpose of observation based on an initial assessment of need which needs greater clarity. As the two highest levels involve a higher severity of symptoms, "observation" for the purpose of determining the problem does not apply. Differentiation between the levels rests primarily with the severity of the problem, and the ability to treat in the community but it also includes the risk of endangerment allowed. More care is required of the assessment of endangerment, but the other categories solicit the psychiatrist or psychologist to elaborate their justification. The usual process for determining improvement or relapse and identifying service and therapeutic support needs, should guide the use of the services.

Using a continuum of severity expresses schematically the importance of allowing children

to flow from one category to another as indicated by the child's needs (see Table 2, below). However, suggesting discrete categories with fixed ranges may be interpreted in a manner contradictory to the value of a continuum in providing fluidity. The association of fixed ranges of time with each level is complicated by the potential mix in the available array of services such as clinic based services, services from other child serving systems, or the inclusion of informal family and community supports. These issues beg the question of whether the severity levels may be so firmly attached to the hours of service that a child associated with one level must "officially" be reduced to another level, in order to reduce the hours of home/community based services; though the "true" severity level is higher, and the child, in truth continues to receive a high number of hours of service, but from other sources. Ideally, each severity level would have a range of hours for serving a child in each of three categories: clinic/hospital services; home/community services; and the service inherent in the personal support network. However, the usual application of admission guidelines is to structure the use of a specific service or service category, and that is the exercise here. The establishment of a recommended range of hours for the delivery of home/community services is not addressed, except to suggest an adjustable range of times depending on the other services used or functions served by family members, and that there is a proportional increase in the expectation of the maximum amount of service within each category.

For the purpose of establishing a reasonable framework, it will be assumed that the hours assigned do not consider the complicating factors of other services and other therapeutic supports, or temporary reductions of service to assess progress. The next task will be to set up a system of values for any additional services and therapeutic supports which can be used as weights to identify a child with the appropriate level.

GUIDELINE FORMATION:

Working toward furthering consistency between children's treatment needs and the broader philosophy of individualized service delivery in the most appropriate manner, is a complex task. Generalizing work such as, the principles of the Child and Adolescent Service System Program (CASSP), the values presented in a variety of CASSP publications, and the wraparound philosophy of care, provide a theoretical basis, and though this body of work has much room to grow, it is time to develop the tools of implementation. The work of admission guidelines for home/community based services is an important beginning to provide a unified basis for decision-making. It is one of the essential instruments needed for behavioral health providers, case managers, interagency teams, and third party payers (including Managed Care Organizations and their sub-contractors), to coordinate service determinations among themselves and with families (including friends and community services as appropriate). Such coordination is vital to foster confidence in the appropriateness of admissions to any of the recommended treatment modalities, as well as continued stay, and appropriate discharge planning.

Inherent in these guidelines is a framework for implementing the wraparound concept in service delivery and developing discrete individualized service programs. Individualized

treatment plans may coordinate a number of services but importantly, the functions of the services must be identified so that they build upon actual strengths, actual needs are addressed by the services. It is also important to help develop family and community resources to meet these needs. Traditional outpatient and partial hospitalization services are examples of other services which may be coordinated with home/community delivered services when medically necessary. Home/community treatment is for children who: may be effectively treated at home; who require comprehensive wraparound planning for transition from a more restrictive setting back to the home and community; who may require a treatment support system while in the community until an effective family and community support network can be activated. These services provide a full range of intensity to the child in his/her natural setting, depending on the evaluated need of the child. In considering the intensity of home/community service, delivery involves three basic elements of consideration: severity of presenting problem, appropriate intensity of service, and the least restrictive and/or intrusive service necessary. These elements are considered separately below.

Severity of Symptoms

Symptom severity is often more apparent to the clinician than it is easy to describe. Levels with identifiable indicators can make the process of assessing severity easier. Additional descriptive information remains important to provide clarifying documentation in the child or adolescent's record. Each of the four levels represented in these guidelines requires an assessment of the child's expression of emotional and behavioral disturbance in any of the following categories for consideration in the design of the individual's treatment: judgement, thought, mood, affect, impulse control, psychosocial, psychomotor retardation/ excitation, physiological functioning and/or cognitive/perceptual abilities. Also important is an assessment of the impact of any disturbance on social skill development and the relationship between them. Gaging the severity of any of these presenting symptoms is ultimately left to the judgement of the clinician in his or her review. If severity is otherwise linked to endangerment or imminent risk of out-of-home or out-of-school placement, descriptors may be crafted to indicate relative severity. Challenging behaviors closely associated with social contexts such as family, school, or other community activities must be considered when determining an appropriate treatment design involving home/community services, or any combination of home/community and the more conventional services. The severity of presentation determines the extent of service need. The severity of expression for a child with mental retardation must be evaluated in relation to the individual child's behavioral norm or "baseline." The design of the treatment plan must also consider the concomitant discharge planning.

Intensity of Treatment

The intensity and range of treatment varies for each of the home/community services available for children (see Table 1). But because different treatment plans call for different combinations of services to treat a variety of children or adolescents who could be assessed at the same level of severity, intensity is associated with a multiplicity of service options and

gauged by the amount of total service time needed. However, one division has been made, establishing two tiers of service based on the professional level of the service. The first is "home/community professional behavioral health services," such as Mobile Therapy and Behavioral Specialist Consultant, and the second is "home/community behavioral health implementation-therapeutic support services," such as Therapeutic Staff Support (TSS) and Therapeutic Staff Support Aid (TSSA). The professional services are those performed by highly credentialed individuals who also play a critical role in the development of the treatment plan. Therapeutic support services require personnel who have specific training and a Bachelor's degree or, for TSSAs, a High School diploma. Their role is to assist the child or adolescent, and the family, in the follow-through of the treatment plan.

Of the four severity levels, the last two listed are intended to divert the child or adolescent from out-of-home services, or serve as a step down following the child's discharge from any in-patient or out-of-home placement. Highly intensive community delivered treatment is often needed to prevent out-of-home placement, and/or to help children to return to their natural home, school, and community from an out-of-home placement. This works by directly associating the therapeutic process of treatment with effective adaptation to the social environment. The first two severity levels allow a lower range of service intensity to assist the child and family. All the levels provide treatment, but they also encourage the family's developmental process in unassisted interaction. The therapeutic function and emphasis of each of the four service levels depends strongly on the cohesiveness of the interagency and treatment teams and the interaction between the behavioral health staff, the parents/custodians, and the child, for the effectiveness of the treatment plan developed.

Least Restrictive/Least Intrusive

Structural differences between the two kinds of services allow each to be scaled differently along the CASSP principle of providing the least restrictive and least intrusive services necessary. The site-based services, clinics and hospitals, may be scaled on a continuum of restrictiveness from more to less. Restrictiveness essentially refers to the degree the child or person is separated from the general community and integrated into a treatment community. For off-site delivery of services, or those delivered to individuals in their homes, schools, or other community settings, scaling restrictiveness does not apply. However, these services may be scaled on a continuum of intrusiveness, if intrusiveness is to be understood as the degree to which service is integrated into the natural setting and the lifestyle of the individual(s) served. It is through this understanding that it may be asserted that mental and behavioral health services in the lives of clients are not "natural," but an intervention intended to be time-limited. Of course, depending on the severity of the problem, the network of inclusion/ support and the other environmental/ecological factors, the time required for individuals' successful treatment will vary. It is these last three elements which are used to formulate the classification system in the guideline.

Home/community services are generally regarded as the least restrictive service options for

children who need intensive behavioral health services. However, by delivering services to children in their homes and communities these services may potentially be the most intrusive. Traditionally, intensive behavioral health services were designed to provide treatment in settings separate from the community, such as inpatient and partial hospitalization settings, residential treatment facilities, and outpatient clinics. This segregation of children from greater community involvement for the period of treatment has become the defining characteristic of restrictiveness and allows consideration of these services on a continuum from least restrictive to more restrictive. Home/community services parallel the intensity available in the traditional services, but because these services engage the child in family and community activities home/community services are not easily characterized as restrictive. However, they may be identified with intrusiveness due to their close involvement with, and presence in the daily activities of the child receiving treatment, and the family.

The four levels for the delivery of the home and community addressed in this bulletin, are presented in ascending order of service intensity and professional intervention. The need for greater or lesser intensity of service must be adjusted to the individual's need for active treatment as reflected in the evaluation and the treatment plan. Increased intensity of service may improve the effectiveness of treatment by providing convenience and opportunity for more responsive intervention. Reducing levels of intervention is a necessary element of therapy directed toward fostering and developing independence in the relationship formations of children with their families, peers, and functioning in normalized settings in the community. Also, care must be taken to avoid the development of a dependency relationship between any family members and behavioral health professionals which result in a non-therapeutic alliance. Each service level provides treatment with the object of helping children with acute behavioral problems or serious emotional disturbance to increase their ability to integrate into the community and culture of their respective families by increasing his or her capacity for self control.

ADMISSION GUIDELINES:

Criteria for each level of Home/community service is based on the individual severity indicators. In the admission guidelines described below is a process for deciding when to treat, continue, or discontinue treatment and refer elsewhere for other services. However, the concept of tapering, or systematically reducing the intensity of the services delivered has been added here. The guideline is divided into five (5) sections: I- Diagnostic Evaluation and Documentation; II- Severity Levels and Service Correlates; III- Therapeutic Support Criteria; IV- Continued Care; and V- Discharge and Service Transition. The first three include the evaluation and documentation criteria for Admission, the fourth and fifth are for determining the appropriateness of continuing, tapering, and discontinuing care.

As these guidelines are written, it is assumed that any child or adolescent receiving services has a case manager, that children with mental retardation have a county MH/MR case manager, and that all children with multiple systems involvement have incorporated into the planning

process an interagency team. Concerning the structure of Section II which associates the severity of the presenting problem with four contiguous levels, each level proposes corresponding ranges of hours for both professional behavioral health services and behavioral health therapeutic support services. For the purpose of clarity in the structure, the hours proposed assume there are no other services provided to the individual in treatment. Nor do they carry any presumption of the richness of the home/community therapeutic supports available to the child or adolescent in treatment. However, both the system and community therapeutic supports are critical to the appropriate determination of service hours to be delivered. It is for this reason that Table 2 has been included. This table provides two matrices, one for reviewing the problems of the child and the other for the strengths of the child, family and community. Each lists the possible domains and settings affected. The matrices are designed to help in the decision-making process when determining the appropriate mix of services, and the appropriate adjustment for the amount of the services in each severity level in Section II below. Such determinations should be used and documented as an adjustment of time within the severity level selected, and it is expected that this is a natural part of any interagency or treatment team process.

Home/Community Services
Admission Guidelines
(Must meet I, II, and III)

Admission of a child for Home/Community Behavioral Health Treatment is most appropriately based on a face-to-face assessment and diagnosis by the prescribing Board Certified or Board eligible child and adolescent psychiatrist, developmental pediatrician, or licensed psychologist specializing in children or adolescents. In the absence of these prescribers, a diagnosis may be appropriately provided by any Board Certified or Board eligible psychiatrist or a licensed psychologist. Any time a child or adolescent specialist is unavailable to perform the necessary diagnostic services, this should be documented and explained. As part of the assessment process and the development of treatment recommendations, the prescriber addresses the concerns and recommendations of the case manager and the interagency team.

Diagnostic references for the purpose of the documentation below must be from the most current edition of the Diagnostic and Statistical Manual (DSM). The most current edition in use at this writing is the DSM IV; for ease of reading, the text following will reflect this edition. For further convenience in reading, "child and adolescent" will follow the form of "child", unless otherwise indicated.

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Mental Health

1. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multi-axial, face-to-face evaluation (MR or D&A cannot stand alone);

AND

2. Evaluation indicates:

- a. child has, or is at serious risk of developing, an emotional or behavioral disturbance, or mental illness; *and*
- b. clinic based treatment is not sufficient or appropriate to effectively serve the child/family; *and*
- c. behaviors indicate manageable risk for safety to self/others while in the community, and child must not require inpatient treatment or a psychiatric residential treatment facility; *and/or*
- d. the child needs home/community mental health treatment as a result of documented emotional and behavioral disturbance of functioning:
 - 1) within the family or other community-based residential setting, *or*
 - 2) in the school setting, *or*
 - 3) resulting in limitations in social and community interactions;*or*
- e. a combination of mental health needs that cannot be met without treatment delivered to the child in the community by mental/behavioral health professionals.

OR

B. Mental Retardation

1. Diagnosis on DSM IV Axis II and Axis IV, as part of a complete multi-axial, face-to-face evaluation (MR cannot stand alone), without a diagnosis on Axis I;

AND

2. Evaluation indicates:

- a. an onset of remarkable or crisis behavior(s) in a child or adolescent with mental retardation; *and/or*
- b. a notable adverse change in the baseline behavior of a child or adolescent with mental retardation; *and*
- c. a medical condition has been ruled out; *and*
- d. existing mental retardation services are no longer sufficient or appropriate to effectively serve the child/family; *and*
- e. behaviors indicate manageable risk for safety to self/others while in the community, and child must not require inpatient treatment or a residential treatment facility; *and/or*
- f. the child needs home/community behavioral health treatment as a result of a

documented behavioral disturbance functioning:

- 1) within the family, foster care, family living or other community-based setting,
or
 - 2) due to behavior which results in limitations in social and community interactions; *or*
- g. a combination of behavioral health needs that cannot be met by existing mental retardation services without treatment delivered to the child in the community by additional behavioral health professionals.

AND

C. Parent(s)/guardian(s), and/or care giver as appropriate, a lead case manager and the child to his/her fullest ability must be involved in the planning process. Where a parent (or legal guardian) or the child are not or cannot be involved, the attempts to involve either or both and the reasons for non-involvement must be documented. The interagency team should otherwise recommend the most appropriate alternatives should home/community service alone be insufficient to serve the child's needs;

AND

D. There is:

1. serious and/or persistent impairment of developmental progression not attributable to mental retardation and/or psychosocial functioning due to a serious emotional disturbance or psychiatric disorder;

OR

2. an onset of remarkable or crisis behavior(s) in a child or adolescent with mental retardation;

AND/OR

3. a notable adverse change in the baseline behavior a child or adolescent with mental retardation resulting in significant measurable reduction in psychosocial functioning with respect to the existing developmental disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or complete remission;

OR

E. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level when developmental level is unrelated to mental retardation;

OR

F. Behaviors or symptoms improve in response to comprehensive treatment at a higher level of care, but child needs home/community treatment to sustain and reinforce stability;

OR

G. Requires medication, and time limited monitoring of the medications is needed to mitigate the effects of the child's symptoms until the child and/or family can assume this role.

II. SEVERITY LEVELS and SERVICE CORRELATES

(See also Table 1)

Service volume and intensity must be recommended as the most clinically appropriate and least intrusive necessary for the child, by the prescriber, as informed by the interagency team.

(Must meet A or B or C or D)

A. MH - Level 1 (Least) - DSM IV Axis I/ II diagnosis

(MR or D&A cannot stand alone)

Home/Community Professional Mental Health Services

Home/Community Mental Health Therapeutic Support Services

(Must meet 1, 2, and 3; **OR** 4)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the case manager and interagency team, *and*
 - a. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder other than mental retardation, 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; *or*
 - 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 and/or to promote effective adaptation; *or*
 - 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*
 - 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;
AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:
 - a. the delivery of the professional care required to serve the child's specific treatment occurring on site; *and*
 - b. documented commitment by the primary care givers(usually parent/guardian) to the treatment plan;

AND

3. The severity and expression of the child's symptoms are such that:
 - a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; *and*
 - b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

OR

4. OBSERVATION

The child's problematic behavior and/or severe functional impairment discussed in the presenting history *and* psychiatric examination requires further observation for clarification under Section II. Allowable for up to fifteen (15) days within which time the examining psychiatrist must clarify the child's eligibility for admission under Section II *AND/OR* recommend development of a transition plan. Should it be found that the child does not fit the guidelines for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

- a. Troubling symptoms of the child which have been described by members of the family, persist (and/or representatives of the community or school) but,
 - they are 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 an ideal opportunity to observe and treat the child; *or*
- b. Child's symptoms have not sufficiently improved despite well-planned comprehensive treatment in site-based levels of care, which has involved the participation of an interagency team.

A. MR- Level 1 - DSM IV Axis II/IV diagnosis

(MR cannot stand alone)

Home/Community Professional Behavioral Health Services
Home/Community Behavioral Health Therapeutic Support Services

(Must meet 1, 2, and 3)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the lead case manager and interagency team, ***and***
 - a. There is significant change or amplification in exhibited behaviors as indicated by an increase in frequency (average number of events per day), duration (after first day, the increase in number of consecutive days), and/or locations; ***and***
 - b. Behavior presents serious risk of self injury, or injury to others, or destruction of environment; ***and***
 - c. Significant psychosocial stressors are present affecting a decrease in the child's functioning; ***and/or***
 - 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;

AND
2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:
 - a. the delivery of the professional care required to serve the child's specific treatment occurring on site; ***and***
 - b. there is documented commitment by the primary care givers(usually parent/guardian) to the treatment plan;

AND
3. The severity and expression of the child's behaviors are such that:
 - a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; ***and***
 - b. on-site intervention in the home or community offers a more effective preventive approach to longer term consequences.

B. MH - Level 2 - DSM IV Axis I/ II diagnosis

(MR or D&A cannot stand alone)

Home/Community Professional Mental Health Services
Home/Community Mental Health Therapeutic Support Services
(Must meet 1, 2, and 3; or 4)

1. Risk of child harming him/herself or others, or causing destruction to property, is assessed low in the child's current problematic behavioral or functional impairment; presenting history and psychiatric examination, ***and***
 - a. Must include at least one (1) of the criterion below:
 - 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 (i.e.- psychosis)
 - 8) Cognitive Impairment; ***and/or***
 - b. Presence of very impaired judgement or functional capacity and capability, for the child's developmental level which is not attributable to mental retardation such that interpersonal skills, and/or self-maintenance in home/school/community is/are highly compromised;
AND
2. 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 treatment plan in the professional judgment of the advising physician or mental health professional , as a result of:
 - a. the delivery of the professional care required to serve the child's specific treatment occurring on site; ***and***
 - b. documented commitment by the primary care givers usually parent/guardian to the therapeutic plan;
AND
3. The severity and expression of the child's symptoms are such that:
 - a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; ***and***
 - b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

OR

4. OBSERVATION:

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history and psychiatric examination requires further observation for clarification under Section II. Allowable for up to fifteen (15) days within which time the examining psychiatrist must clarify the child's eligibility for admission under Section II *AND/OR* recommend development of a transition plan. Should it be found that the child does not meet the guidelines for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

- a. Troubling symptoms of the child which have been described by members of the family, persist (and/or representatives of the community or school) but,
 - they are 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 an ideal opportunity to observe and treat the child; *or*
- b. Child's symptoms have not sufficiently improved despite well planned comprehensive treatment in site-based levels of care, which has involved the participation of an interagency team.

MR - Level 2 - DSM IV Axis II/IV diagnosis

(MR cannot stand alone)

Home/Community Professional Behavioral Health Services
Home/Community Behavioral Health Therapeutic Support Services
(Must meet 1, 2, and 3)

- 1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the lead case manager and interagency team, *and*
 - a. There is significant change or amplification in exhibited behaviors as indicated by an increase in frequency (average number of events per day), duration (after first day, the increase in number of consecutive days), and/or locations; *and*
 - b. Behavior has resulted in self-injury, or injury to others, or destruction to environment; *and*
 - c. Significant psychosocial stressors are present affecting a decrease in the child's functioning or an escalation of the child's symptoms; *and/or*
 - 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;

AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:

- a. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; *and*
- b. there is documented commitment by the primary care givers(usually parent/guardian) to the treatment plan;

AND

3. The severity and expression of the child's behaviors are such that:

- a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; *and*
- b. on-site intervention in the home or community offers a more effective preventive approach to longer term consequences.

C. MH - Level 3 (Intensive)

Home/Community Professional Mental Health Services
Home/Community Mental Health Therapeutic Support Services
(Must meet 1, 2, and 3)

1. Severe functional impairment discussed in the presenting history and psychiatric examination, is assessed in the child's problematic behavior in home, school or community, and there is risk of an out-of-home or out-of-school placement. In addition, there may be risk of danger in child harming him/herself, harming others, and/or demonstrated destruction to property; *and*

- a. Must include at least one (1) of the criterion below:
 - 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 (i.e.- psychosis)
 - 8) Cognitive Impairment; *and/or*,
- b. There is an exacerbation of severely impaired judgement or functional capacity and capability for the child's developmental level, which is not attributable to mental retardation, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;
- AND
- 2. 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 treatment plan in the professional judgment of the advising physician or mental health professional, as a result of:
 - a. the delivery of the professional care required to serve the child's specific treatment occurring on site; *and*
 - b. documented commitment by the primary care givers (usually parent/guardian) to the treatment plan; *and*
 - c. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which at least the care giver signs;
- AND
- 3. The severity and expression of the child's symptoms are such that:
 - a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; *and*
 - b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

D. MH - Level 4 (Highly Intensive)

Home/Community Professional Mental Health Services
 Home/Community Mental Health Therapeutic Support Services
 (Must meet 1, 2, & 3)

- 1) The severe functional impairment discussed in the presenting history and psychiatric examination is assessed in the child's problematic behavior in home, school or community and there is a high risk of an out-of-home or out-of-school placement, or a resumption of out-of-home/school placement for a child transitioning back to home or school. In addition, there may be demonstrated risk of endangerment involving child harming self or others, or destruction to property, due to emotional or behavioral problems, or mental illness;

- a. Must include at least one (1) of the criterion below:
 - 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 (i.e.- psychosis)
 - 8) Cognitive Impairment; *and*

- b. There is an exacerbation of severely impaired judgement or functional capacity and capability for the child's developmental level, which is not attributable to mental retardation, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

AND

2. 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 treatment plan in the professional judgment of the advising physician or mental health professional , as a result of:
 - a. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; *and*
 - b. there is documented commitment by the primary care givers (usually parent/guardian) to the therapeutic plan; *and*
 - c. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which, at least the care giver signs;

AND

3. The severity and expression of the child's symptoms are such that:
 - a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; *and*
 - b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY

Commonwealth of Pennsylvania Page 21
 HealthChoices Behavioral Health Appendix T (Part B(2))
 Program Standards and Requirements – Primary Contractor - County

OF SYMPTOMS or BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE

- A. Child must be reevaluated *and* continue to meet criteria for admission (Section I);
AND
- B. Child shows:
 - 1. measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation);
or
 - 2. increased *or* continued behavioral disturbance with continued expectation for improvement (show rationale in the treatment plan);
AND
- C. Treatment plan is addressing the behavior within the context of the psychosocial stressor(s)/event(s);
AND
- D. Interagency service plan recommends continuation of care.

The child/adolescent must meet Admission Criteria for Section II, Level 3 or lesser levels of severity. Whenever service is provided for a term greater than three (3) months, there must be 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 rather than another service appropriate to the child's needs or discharge from behavioral health services altogether. The Interagency Service Plan must be updated and attached to the Treatment Plan.

V. DISCHARGE AND SERVICE TRANSITION GUIDELINES

- A. Mental Health
Prescriber, with the participation of the interagency team, determines that home/community service:
 - 1. results in an expected level of stability and treatment goal attainment such that no additional home/community services are necessary and discharge occurs;
OR

2. should be maintained as follows:
 - a. continued at the current level; *or*
 - b. continued with a reduced number of hours as a result of the child's improvement, and/or the child's network of family and friends, and/or the activity of community members and services; *or*
 - c. increased due to changes in the context and/or adjustments in the treatment plan;

OR
3. ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further home/community mental health services;

OR
4. interferes with the development of a service-independent lifestyle, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

OR
5. A child admitted under Section IIB only, of the ADMISSION Guidelines must be discharged within fifteen (15) days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section IIA;

OR

B. Mental Retardation

Prescriber, with the participation of the interagency team, determines that home/community service:

1. results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
 - a. baseline behavior, *or*
 - b. expected positive behavioral response, *and/or*
 - c. that no additional home/community services are necessary;

OR
2. should be:
 - a. discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further home/community behavioral health services; *or*
 - b. continued with a reduced number of hours as a result of the child's improvement, and/or the child's network of family and friends, and/or the activity of community members and services; *or*
 - c. increased due to changes in the context and/or adjustments in the treatment plan;

OR
3. the services provided create a service dependency interfering with the development of the child's progress toward his/her highest functional level, requiring reassessment of the treatment plan and careful analysis of the benefits

derived in light of the potential for problems created;
OR

C. The parent/guardian (or other legally responsible care giver if applicable) or adolescent, 14 years old or older, requests reduction in service or termination of the service.

TABLE 1

BEHAVIORAL HEALTH REHABILITATION SERVICES UNDER EPSDT:
Home/Community Services

**TABLE OF SECTION II 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)

<u>Level 1 (Least)</u>	<u>Level 2 (Moderate)</u>	<u>Level 3 (Intensive)</u>	<u>Level 4 (Highly Intensive)</u>
(Must meet A, B, & C; OR D)	(Must meet A, B, & C; OR D)	(Must meet A, B, and C)	(Must meet A, B, and C)
I. & II. [Combined] DIAGNOSTIC INDICATORS BY LEVEL			
A. Service must be recommended as the most clinically appropriate for the child, by the <i>prescriber</i> , as informed by the <i>interagency team</i> , and	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:	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	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
1. Children with a Diagnostic Indicator on AXIS I			
a. There is serious <u>and/or</u> persistent impairment of developmental progression <u>and/or</u> psychosocial functioning due to a	a. Assessment of at least one (1) of the following: 1. Suicidal/homicidal ideation	a. Assessment of at least one (1) of the following: 1. Suicidal/homicidal threats or intensive ideation	a. Assessment of at least one (1) of the following: 1. Suicidal/homicidal threatening behavior or intensive ideation

TABLE 1

<u>Level 1 (Least)</u>	<u>Level 2 (Moderate)</u>	<u>Level 3 (Intensive)</u>	<u>Level 4 (Highly Intensive)</u>
serious emotional disturbance or psychiatric disorder, requiring treatment to alleviate acute existing symptoms <u>and/or</u> behaviors;	2. Impulsivity and/or aggression 3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation	2. Impulsivity and/or aggression 3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation.	2. Impulsivity and/or aggression 3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation.
or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms <u>and/or</u> behaviors which are in partial or complete remission;	5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment	5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment	5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment
<i>or</i>	<i>and/or</i>	<i>and/or</i>	<i>and</i>
b. Significant psychosocial stressors <u>and/or</u> 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; <i>or</i>	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;	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;	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;
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			

TABLE 1

<u>Level 1 (Least)</u>	<u>Level 2 (Moderate)</u>	<u>Level 3 (Intensive)</u>	<u>Level 4 (Highly Intensive)</u>
to reenforce stability; <i>or</i>			
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;			
AND/OR	AND/OR		
2.Children with a Diagnostic Indicator on AXIS II (without a diagnosis on Axis I)			
a. There is an onset of remarkable behaviors which could escalate to a crisis	a. There is an onset of remarkable or crisis behaviors.		
b. Behavior presents serious risk of self injury, or in jury to others, or destruction of environment; <i>and</i>	b. Behavior has resulted in self-injury, or injury to others, or destruction to environment; <i>and</i>		
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); <i>and/or</i>			
d. Requires medication and home/community based monitoring of medications to help the family, and the child, consistent with the child's age and			

TABLE 1

<u>Level 1 (Least)</u>	<u>Level 2 (Moderate)</u>	<u>Level 3 (Intensive)</u>	<u>Level 4 (Highly Intensive)</u>
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;			
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:			
1. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; <i>and</i>			
2. there is documented commitment by the primary care givers (usually parent/guardian) to the therapeutic plan.			
		<i>and</i>	
		3. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which, at least the care giver signs.	3. if endangerment/destruction is a relevant feature of the presenting problem, both child or adolescent and primary care giver develop a safety plan which, at least the care giver signs.
AND			
C. The severity and expression of the child's symptoms are such that:: 1. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; <i>and</i> 2. on-site intervention in the home or community offers a more effective preventive to longer term consequences.			
D. OBSERVATION- 15 days 1. Troubling symptoms of the child (described by family/ school/ others) persist though - not observed on a psychiatric inpatient unit, <i>or</i> - they are denied by the child in outpatient or partial hos-			

TABLE 1

<u>Level 1 (Least)</u>	<u>Level 2 (Moderate)</u>	<u>Level 3 (Intensive)</u>	<u>Level 4 (Highly Intensive)</u>
<p><i>pitalization treatment, such that</i> observation of the child in natural settings provides the opportunity to assess and treat the child; OR</p>			
<p>2. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment in other levels of care, involving the interagency team.</p>			
<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.</p>			
<p>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.</p>			
<p>1. Child must be reevaluated <i>and</i> continue to meet criteria for admission (I); <i>and</i> 2. Child shows: a) measured improvement <i>and/or</i> begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation); <i>or</i> b) increased <i>or</i> continued behavioral or emotional disturbance with continued expectation for improvement (show rationale in the treatment plan); <i>and</i> 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, <i>and/or</i> activity of community members and services, and/or the child's network of family and friends; <i>or</i> b) increased due to changes in the context and/or adjustments in the treatment plan; <i>and</i> 5. Interagency service plan must be updated to reflect the recommendation to continue care and be attached to the treatment plan</p>			

TABLE 1

V. DISCHARGE CRITERIA
<p>A. Prescriber, with the participation of the interagency team, determines that home/community service:</p> <ol style="list-style-type: none">1. results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:<ol style="list-style-type: none">a. baseline behavior, <i>or</i>b. expected positive behavioral response, <i>and/or</i>c. that no additional home/community services are necessary; <p style="text-align: center;">OR</p>
<ol style="list-style-type: none">2. should be discontinued because it <i>ceases to be effective</i>, requiring reassessment of services and alternative planning prior to authorization of any further home/community behavioral health services; <p style="text-align: center;">OR</p>
<ol style="list-style-type: none">3. the services provided <i>create a service dependency interfering with the development of the child's progress toward his/her highest functional level</i>, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created; <p style="text-align: center;">OR</p>
<p>B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent, 14 years old or older, requests reduction in service or termination of the service.</p>

**MATRICES OF
CURRENT PROBLEMS AND CURRENT STRENGTHS
BY DOMAIN AND SETTING**

Matrix of Current Problems

Domain	Setting		
	Home	School	Community
Medical			
Behavioral			
Emotional			
Cognitive/Learning			
Interpersonal			
Leisure			
Unique/Other			

Matrix of Current Strengths

Domain	Setting		
	Home	School	Community
Medical			
Behavioral			
Emotional			
Cognitive/Learning			
Interpersonal			
Leisure			
Unique/Other			

REFERENCE FORM A

Expectations for All Individualized Community Based Enhanced Mental Health Services:

Individualized community based enhanced mental health services can be used in the home, community, or school, separately or in combination, as medically necessary. The child's emotional or behavioral disturbance should be carefully evaluated along the following parameters: thought, mood, affect, judgement, insight, impulse control, psychomotor retardation /excitation, physiological functioning, cognitive/perceptual abilities, psychosocial functioning as manifested in interpersonal and social skills, and motivation. Social contexts, such as home, school, and neighborhood/community must be understood in order to determine the appropriate sites of services as well as the resources within each context. Service planning determines the unique combination of individualized community based enhanced mental health services, other child serving systems and/or traditional mental health services.

The following represent specific expectations regarding the utilization of all individualized, community based enhanced mental health services subject to this document. Treatment and its documentation should be consistent with the following:

- Nature of emotional or behavioral disturbance, mental illness, or serious at-risk status is clear and is clearly demonstrated.
- Each proposed or utilized mental health service has a clearly documented rationale, with a specific role in addressing the child's medically necessary needs. Services, separately and in combination, constitute the least restrictive and least intrusive services which are medically necessary.
- Service decisions are substantially determined by an interagency process based on child-driven needs.
- Proposed treatment is demonstrated to meet identified, individualized needs and strengths, addressing child's development in multiple life domains.
- Ongoing efforts are being made to utilize community resources, whenever possible.
- Parents and guardians have requested or otherwise support the use of proposed services.
- Proposed treatment involves a plan, and subsequent demonstrated efforts to implement plan with active participation by parents, guardians, and other responsible adults.
- Treatment involves teaching and support of efforts by parents, guardians, and other responsible adults, and those activities specifically identified within the treatment plan as appropriate for involved mental health staff, rather than substitute care.
- Treatment involves ongoing integrated and supervised efforts by all service providers, which includes a lead case manager.

- Potential medication needs are being addressed or considered.
- Lack of improvement within a level of care is subject to careful clinical and systemic analysis by the team prior to either an increase or decrease of services or change in level of services.
- Exceptions to any of the above are clearly identified with explanation or rationale, and discussed with the interagency team.

REFERENCE FORM B

Function of Home/Community Services

- Provision of services which are less restrictive, more flexible yet effectively provides therapeutic supports for patients discharged from in-patient, residential treatment facilities, or partial hospitalization. In this way home/community services provide for the delivery of transitional care from a more restrictive setting.

 - Prevent the need for more restrictive or higher level of services. To help the child develop the necessary self-control, *and/or* capacity for constructive expression, including cultivating more adaptive interpersonal skills for effective participation in the child's natural setting.

 - Provision of service for children with mental and/or psychosocial disorders who require treatment directly in the setting where symptoms typically manifest, to remain stable and ensure the effectiveness of a treatment plan.

 - Provision of after-school service for children with mental and/or psychosocial disorders, so that :
 - parents/guardians can develop the behavioral patterns necessary to provide the additional support necessary to maintain a therapeutic environment for the child;
 - parents/guardians can receive family therapy consistent with the treatment of their child.
- Should service involve a child removed from school during regular school hours, this service, and any subsequent plan to continue service during this time, must be documented with an explanation of the child's condition which necessitates such intervention.
- Treatment components include: major diagnostic evaluations, medical and psychiatric treatment, and psychosocial rehabilitation. Recognizing the responsibility of the Department of Education to provide an educational program for all children, the therapist must collaborate with the school or school district, but only when appropriate and as necessary to assist in the child's Individualized Education Plan when one has been or should be developed. Where such collaboration is desired but not possible the reasons must be clearly documented.

Treatment Range- Home/community treatment varies in intensity, duration and purpose. Intensity may be reflected in the number and length of visits as well as the professional level of the service. The duration and types of service offered will vary according to the severity of the child's symptomatology and the complexity of the intervention required as described in the treatment plan. The range of service includes therapeutic support identified in four levels corresponding with the levels of severity established for Severe (but Inpatient Treatment not required), Residential Treatment Facility, Partial Hospitalization, and Outpatient Treatment, where clinical judgement suggests that outpatient treatment is therapeutically necessary to return the child to, or maintain the child in a stable condition. Home/community treatment may serve as a step-down from inpatient treatment, a residential treatment facility, and partial hospitalization, and to prevent the need for a more restrictive treatment setting. It also serves children, and their families, experiencing distress who may need the therapeutic support of short term services to ameliorate the presiding condition or stress.

REFERENCE FORM C

Continued Stay Service Documentation **For Mental Health Services**

The following list of information should be documented for the four service levels.

1. Routine evaluations and treatment updates chart child's progress.
2. The establishment and documentation of active treatment must include, the implementation of the treatment plan, the therapy provided, documentation of the family's participation and interagency collaboration, cultural competency, and active discharge planning.
3. Current active treatment is focused upon stabilizing or reversing symptoms necessitating admission.
4. Current active treatment is focused on ameliorating symptoms and increasing the child's level of functioning.
5. The level of professional expertise and intervention are appropriate to address the child's current condition(s).
6. The initial discharge guidelines formulated for the child have been reviewed and revised, as necessary in the course of developing the discharge plan.
7. The treatment plan and strengths-based evaluation has been updated to reflect the child's progress, medication status, continuing needs and the provider's efforts to meet the identified needs. The treatment plan addresses any necessary therapeutic supports for the child's successful transition into the community, including mental health, substance abuse, mental retardation and other community-based services, and the natural resources of the family. It incorporates a plan to form appropriate transitional linkages in preparation for discharge to less intrusive and non-restrictive services.
8. The treatment team programmatically reduces intensity of treatment as the child progresses toward the expected date of discharge, and through working with an interagency team forms linkages with community and family supports.
9. Type, duration and frequency of services provided to the child, and the outcome of each service must be well documented, i.e.- individual, group and family therapy; education, training and community involvement; family participation in treatment; any special activities; and medication administration and monitoring.
10. As the child improves clinically, active treatment facilitates and increases contact of the child with the community (including home and school) to which the child will return.

11. The provision of services supports the child's involvement in age appropriate activities and interests as outlined in the treatment plan.
12. In special programs where the child does not attend the local school, there must be a current Individualized Education Plan *and/or* plan to provide the child an educational program in collaboration with the local school or school district on record at the PRTF.
13. Family (parent, guardian or custodian) is actively involved in the treatment planning and/or process. Should conditions prevent the possibility of such involvement, attempts to involve parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team.
14. Continued inpatient hospitalization **must** be recommended by the treatment team (to also include child, parent/guardian, case manager [when one is assigned], current treating or evaluating therapist).
15. All appropriate documentation follows the child as the child makes the transition to other therapeutic services, be they more or less intense.

REFERENCE FORM D

Community Integration Questionnaire

1. Are the **child's interest areas**? and **strengths**? documented, with a plan to **explore new interests and strength's** for the child?

2. Have the **child's community and family support network, and cultural resources** been explored for the purpose of involving the child in his/her own community, and recorded?

3. Has there been **recruitment of family members, or other significant individuals**, to participate as designated support persons

4. Do you have a list of the **available services, events and activities** in the community? [Both the child's home community and the community surrounding the therapeutic center, if different].

5. What activities has the child been **involved in** over the past two months? Is there a plan to **continue** this involvement?

6. Does the **treatment plan** include community integrative activities, such as:

- planned parental supervised activities?
- age appropriate, child independent participation in planned community activities [such as: Traditional events/celebrations; school sponsored clubs and gatherings; extra-curricular classes (i.e. dance, music, martial arts, etc); church/community center/playground activities, etc.]?
- opportunity for child-peer interaction in the community [such as: visits to neighborhood friends (including overnight visits); participation in peer group activities (such as: neighborhood "hoops", stick ball, parties and informal gatherings).
- [other activities- specify in treatment plan].

OR, for children who may be more severely impaired:

- staff oversight of planned parental supervised activities?
- staff supervised activities for parent/child interaction?
for child/community peer interaction?
- staff supervised activities in the community?
- planned reentry into the regular classroom (independently, or with a therapeutic staff support

7. Do you have a **plan of reenforcement** for a child's successful participation outside of the treatment setting? and a **crisis intervention plan** for the child while outside of the treatment setting?

8. Do the **progress notes** detail the outcome of the home/community integrative activity?

9. Do you have a data gathering form or instrument to **measure the outcome** of a child's participation in a home/community activity?

10. Do you have a **plan to expand** the child's home/community/cultural participation?

Bibliography:

American Psychiatric Association

- 1994 Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association.

Commonwealth of Pennsylvania

- 1996 "Summer Therapeutic Activities Program." Medical Assistance Bulletin 50-96-03, 25 April 1996, Commonwealth of Pennsylvania, Office of Medical Assistance.
- 1995 "Educational Portions of 'Non-Educational' Residential Placements." Mental Health Bulletin OMH-95-07, 3 April 1995, Commonwealth of Pennsylvania, Office of Mental Health.
- 1993 "Interdistrict Placements-New School Code Provisions." Basic Education Circular, BEC 19-93. Harrisburg, Commonwealth of Pennsylvania, Department of Education.
- 1993 "Mental Health Procedures." Title 55 PA Code, Chapter 5100. Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health.
- 1993 "Psychiatric Outpatient Clinics." Title 55 PA Code, Chapter 5200, Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health.
- 1993 "Partial Hospitalization." Title 55 PA Code, Chapter 5210, Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health.
- 1992 "Private Psychiatric Hospitals." Title 55 PA Code, Chapter 5300, Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health.
- 1992 "Community Residential Rehabilitation Services for the Mentally Ill." Title 55 PA Code, Chapter 5310, Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health.
- 1985 "Description of Services and Service Areas." Title 55 PA Code, Chapter 4210, Harrisburg, Commonwealth of Pennsylvania, Office of Medical Assistance Programs. Title 55 PA Code, Chapters 1151 and 1153. Commonwealth of Pennsylvania.
- 1976 Mental Health Procedures Act of 1976. P. L. 817, No. 143.
- 1966 Mental Health/Mental Retardation Act of 1966. P. L. 96, No.6 . PA School Code, Sections 1306-1309 and 2561.

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Contact: Michael J. Tickner, Ph.D.
Office of Mental Health
PO Box 2675
Harrisburg, PA 17105-2675
