



## CHILD Clinical Transition and Stabilization Services

### PROGRAM DESCRIPTION

Clinical Transition and Stabilization Services (CTSS) is a short-term program (maximum of 90 days) that addresses the mental health and stabilization needs of children ages 4 to 21, with a focus on children in foster care. The treatment team consists of a master's level clinician and a bachelor's level mental health worker who provide in-home individual and family therapy; crisis intervention; one-to-one support and modeling in the home, school, and community; evaluation and medication management; psycho-education for caregivers, foster care agency staff, and school personnel; and coordination of needed supports and services. Treatment goals include reducing the number of disruptions in foster care home placements; fostering caregiver acceptance and understanding of children's mental health challenges; reducing the need for higher levels of services, such as hospitalization or a residential treatment facility; and building positive relationships between children and their foster and biological families. Clinical care managers approve this level of care based on medical necessity, and behavioral health liaisons carry out the referral process.

### MEDICAL NECESSITY CRITERIA (same as BHRS, Appendix T)

#### Admission Criteria (Must meet I, II, and III)

#### 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. Intellectual Disabilities

1. Diagnosis on DSM IV Axis II and Axis IV, as part of a complete multi-axial, face-to-face evaluation (ID 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 intellectual disabilities; **and/or**
- b. a notable adverse change in the baseline behavior of a child or adolescent with intellectual disabilities; **and**
- c. a medical condition has been ruled out; **and**
- d. existing intellectual disability 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 intellectual disability 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 intellectual disabilities 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 intellectual disabilities;

AND/OR

3. a notable adverse change in the baseline behavior a child or adolescent with intellectual disabilities 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 intellectual disabilities;

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 intellectual disabilities, 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 reenforce 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. 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;

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 intellectual disabilities 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 intellectual disabilities, 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 intellectual disabilities, 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 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.

#### **Continued Care Criteria**

- 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.

#### **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. Intellectual Disabilities

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.