CHILD Behavioral Health Rehabilitative Services

PROGRAM DESCRIPTION

Behavioral Health Rehabilitative Services (BHRS) are therapeutic interventions provided to children and adolescents up to the age of 21 in the school, home, and/or community setting. BHRS is specifically appropriate for children and adolescents who require intervention at the sites where the problematic behaviors occur. The goal is to provide individualized treatment in the least restrictive, most familiar environment, while maintaining the child/youth within his or her natural setting. Services can be recommended singularly or in combination, with the exception of therapeutic support staff, which must be prescribed along with either behavioral specialist consultant (BSC) or mobile therapist (MT). BHRS must be delivered in the community with the involvement and participation of a parent or caregiver.

Components of BHRS include:

Behavioral Specialist Consultant

Behavioral Specialist Consultant (BSC) is a consultation service delivered by a master’s or Ph.D. level professional with expertise in behavioral management principles. Please refer to the CBH Manual for Review of Provider Personnel Files (MRPPF) regarding additional qualifications for this position.

In some cases, specific expertise in behavioral management protocols is needed that exceeds what the mobile therapist and therapeutic support staff can provide. Under such circumstances, and following agreement by child, family, and mental health professionals on the treatment team, a BSC can be a part of the treatment team if the service is included in the treatment plan. When a BSC is not indicated, the MT will serve as the lead clinician on the case.

The BSC, in collaboration with other members of the treatment team, designs and directs the implementation of an individualized behavior modification intervention plan. The BSC identifies behavioral goals and intervention techniques, and recommends non-aversive behavioral change methods. Members of the treatment team and family provide the service directly to the child and/or family in the home, school, day care, or other community program or setting. The BSC typically serves as consultant to the mobile therapist within the treatment team. While maintaining some direct contact with child and family, the BSC primarily provides assessment, program design, and monitoring rather than direct therapy.

Functional Behavior Assessment

In addition to, or prior to delivering BSC services, BSCs may be authorized hours to complete a Functional Behavioral Assessment (FBA). FBAs must be completed by BSC who has completed FBA
certification at the state level. FBAs are authorized for a set number of hours over a set amount of time, for example 12 hours over 60 days. An FBA should include at least:

- Indirect assessment of the behavior via a structured interview with a parent or caregiver
- An interview with the teacher if the challenging behavior is occurring in the school
- Records review
- Rating scales such as Motivational Assessment Scale (MAS), Questions about Behavioral Function (QABF), or Functional Analysis Screening Tool (FAST), with data summarized in graph or chart (average scores and number/percentage of respondents with their identified potential source of reinforcement)
- Direct observation of the behavior while collecting data regarding the observed setting events, antecedents, and consequences that may be maintaining the behavior
- Direct observation in the location and setting in which the behavior has been reported as likely to occur based on the results of the parent/caregiver interview
- Direct observation across multiple settings
- Graph of behavior (frequency, duration, etc.)
- Summary of all assessment data, in table or graph form, including but not limited to data identifying the percentage of time the behavior occurred during particular activities, percentage of times the behavior occurred after each antecedent, and percentage of time the behavior occurred followed by each identified consequence
- Hypothesis statements based on the results of the assessments and conditions under which the target behavior is more likely to occur

Mobile Therapy
Mobile Therapy is provided by a master’s level professional who provides intensive therapeutic services to a child and family in settings other than a provider agency or office. Please refer to the MRPPF regarding qualifications for this position. This service takes place primarily in the child’s home; however, other potential settings include school, church, community center, the homes of family members or neighbors, and other community settings.

Services provided by a MT vary according to the individualized needs of a child and family. Core services include the following:

- Assessment of strengths and therapeutic needs of child and family
- Inclusion of child as a participant in his/her own treatment
- Inclusion of parents or other caretakers as members of the treatment team and as partners in treatment
- Determination, with the family and the case manager, of any necessary family support services
- Provision of child-centered, family-focused, individual and family psychotherapy, as agreed upon by therapist and family
• Determination, in conjunction with child and family and other involved professionals, of the clinical need for special evaluations and services, such as medication assessment by a psychiatrist, psychological testing, or other
• Collaboration with child and family and other involved professionals to develop daily routines during times of crisis and transition and a 24-hour crisis plan
• Collaboration with other involved professionals and agencies in order to provide unified services and continuity of care to child and family
• When a BSC is not indicated, the MT will serve as the lead clinician on the case, and will develop the treatment plan, oversee TSS intervention (if applicable) and provide mobile therapy.

Therapeutic Staff Support
Therapeutic Staff Support (TSS) services are one-on-one interventions to a child or adolescent at home, school, day care, YMCA, other community-based program or setting when the behavior without this intervention would require a more restrictive treatment setting. Please refer to the MRPPF regarding qualifications for this position. Specific TSS services include crisis intervention techniques, immediate behavioral reinforcements, emotional support, time out strategies, and additional psychosocial rehabilitative activities as prescribed in the treatment plan. TSS provides the following:

• Implementation of specific interventions to stabilize the child or adolescent, as indicated by the treatment plan
• Collection of data about behaviors and responses to planned interventions
• Assistance of a child’s family and other natural supports in learning how to implement interventions and strategies indicated in the treatment plan
• Collaboration with other members of the treatment team and other professionals working in the home or in other community settings and participation in ISPT meetings, when possible.

Therapeutic Staff Support-Aide
The Therapeutic staff support-aide (TSS-A) is similar to a TSS; however, the educational and professional requirements for a TSS-A are less intensive. This service is only utilized by Maternal Child Consortium, Inc. (MCC) for children who are deaf or hard of hearing. Please refer to the MRPPF regarding qualifications for this position.

Group Therapeutic Staff Support
Group TSS works simultaneously with three or four children, typically in a camp or school setting. The assigned group TSS works with a lead clinician who, based on direct observations of the child and information gathered from the child’s family and other sources, develops individualized treatment interventions.
MEDICAL NECESSITY CRITERIA for 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;
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;
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 caregivers (usually parent/guardian) to the therapeutic plan; and
   
   c. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary caregiver develop a safety plan which, at least the caregiver 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.