



# **Texas Resilience and Recovery Utilization Management Guidelines: Child and Adolescent Services**

**Texas Resilience and Recovery  
Utilization Management Guidelines  
Child & Adolescent Services**

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## **I. LEVEL OF CARE 0: Crisis Services**

### **Purpose for Level of Care**

The services in this Level of Care (LOC) are brief interventions provided in the community or a residential setting that will ameliorate the crisis situation and prevent utilization of more intensive services. The desired outcome is resolution of the crisis, avoidance of more intensive and restrictive intervention, and prevention of additional crisis events.

**Note: These services do not require prior authorization. However, Utilization Management (UM) staff must authorize the crisis service within 2 business days of presentation. If further crisis follow-up and relapse prevention services are needed, then the child/youth may be authorized for LOC 5.**

**Any service offered must meet medical necessity criteria.**

### **Special Considerations During and Following Crisis**

Level of Care (LOC) 0 may only be assigned to a child/youth who is not currently assigned to an LOC. Following stabilization of the crisis, the child/youth should be reassessed to determine further eligibility and the most appropriate LOC for continuation of services.

If a child/youth enrolled in another LOC experiences a psychiatric crisis, crisis services should be delivered within the current LOC assignment.

### **Admission Criteria**

For admission into LOC-0 the child/youth must meet criteria on the Child & Adolescent – Texas Recommended Assessment Guidelines (CA-TRAG).

Note: A mental health diagnosis is not required for services in this LOC.

### **Special Considerations**

**The child/youth meets the following definition of a crisis cited in the Community Standards Rule:**

A situation in which:

- Because of a mental health condition:
  - The child/youth presents an immediate danger to self or others; or
  - The child/youth's mental or physical health is at risk of serious deterioration; or
- A child/youth believes that he or she presents an immediate danger to self or others or that his or her mental or physical health is at risk of serious deterioration.

### **Criteria for Level of Care Review**

- **Continued Stay:** Up to 7 additional days may be authorized, as medically necessary.
- **Indication for potential increase in LOC:** If a child/youth cannot be treated safely or effectively within this LOC, evaluation for potential hospitalization is indicated.
- **Following a crisis:** Providers should reassess the child/youth to determine which, if any, LOC is clinically indicated.

### **Discharge Criteria**

**ANY of the following indicators would support discharge from this LOC:**

- Identified crisis is resolved and the child/youth has been transitioned to LOC-1.1, LOC-1.2, LOC-2.2, LOC-2.3, LOC-2.4, LOC-4, or LOC-5; or
- Identified crisis is resolved and the child/youth is placed on a waiting list for an appropriate LOC; or
- The child/youth and family are referred and linked to community resources outside the DSHS system; or
- The child/youth or family terminates services.

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**Expected Outcomes**

- The child/youth decreases risk of placement in a more restrictive environment, such as a psychiatric hospital, residential treatment center, or juvenile detention center.
- The child/youth or family reports a reduction or stabilization in presenting problem severity or improvement or stabilization in functional impairment.
- The child/youth or family is engaged in appropriate follow-up treatment and linked with natural and community support systems.

**LOC-0 Table Overview**

<b>Authorization Period: 7 Days</b>		
<b>Target Utilization in This Level of Care: N/A</b>		
For this LOC overall target hours of utilization are indeterminable. For children/youth authorized this LOC it is expected that the services available in the crisis service array be utilized as medically necessary and available to treat and stabilize the psychiatric crisis.		
Available Services:	Individual Services in LOC – 0 Utilization Per 7 Days	
	Standard Therapeutic	High Need Therapeutic
<b>Crisis Intervention Services</b>	N/A	<b>3.75 hours</b> (15 units)
<b>Psychiatric Diagnostic Interview Examination</b>	N/A	<b>1 Event</b> (1 unit)
<b>Pharmacological Management</b>	N/A	<b>10 Events</b> (10 units)
<b>Safety Monitoring</b>	N/A	<b>2 hours</b> (8 units)
<b>Crisis Transportation (Event)</b>	N/A	<b>1 Event</b> (1 unit)
<b>Crisis Transportation (Dollar)</b>	N/A	<b>As necessary</b> (\$1 units)
<b>Crisis Flexible Benefits (Event)</b>	N/A	<b>As necessary</b> (Event)
<b>Crisis Flexible Benefits (Dollar)</b>	N/A	<b>As necessary</b> (\$1 units)
<b>Respite Services: Community-Based</b>	N/A	<b>6 hours</b> (24 units)
<b>Respite Services: Program-Based (not in home)</b>	N/A	<b>3 bed days</b> (3 units)
<b>Extended Observation</b>	N/A	<b>1 unit</b> (1 bed day)
<b>Children’s Crisis Residential</b>	N/A	<b>4 units</b> (4 bed days)
<b>Family Partner</b>	N/A	<b>6 hours</b> (24 units)
<b>Engagement Activity</b>	N/A	<b>6 hours</b> (24 units)
<b>Inpatient Hospital Services</b>	N/A	<b>As necessary</b> (1 bed day units)
<b>Inpatient Services (Psychiatric)</b>	N/A	<b>As necessary</b> (1 bed day units)
<b>Emergency Room Services (Psychiatric)</b>	N/A	<b>As necessary</b> (Events)
<b>Crisis Follow-up &amp; Relapse Prevention</b>	N/A	<b>8 hours</b> (32 units)

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## **II. LEVEL OF CARE 1.1: Externalizing Disorders**

### **Purpose for Level of Care**

This LOC is targeted to children/youth diagnosed with externalizing disorders (e.g., ADD/ADHD, Conduct or Oppositional Defiant Disorder) and who experience a moderate level of functional impairment. The focus of intervention is on psychosocial skill development in the child/youth and the enhancement of parenting skills, especially in child behavior management. Access to parent support groups is available. Information regarding the diagnosis, medication, monitoring of symptoms and side effects is provided through medication training and support. This LOC is generally considered short-term and time-limited.

The general goal of services at this LOC is to reduce or stabilize symptoms, decrease functional impairment and build resiliency in the child/youth and family. Family support is facilitated through linkage to natural and community resources. Services are provided in the office, school, home, or other community setting.

### **Special Considerations During Crisis**

If the child/youth experiences a psychiatric emergency while receiving services in LOC-1.1, the child/youth has access to all medically necessary crisis services without prior authorization. Medical necessity of crisis services must be documented. These services are intended to stabilize the crisis situation and prevent utilization of more intensive or restrictive interventions. Following a crisis, providers should reassess the child/youth to determine if a more appropriate LOC is indicated.

### **Admission Criteria**

#### **All criteria must be met:**

- An Axis I diagnosis of ADHD, Conduct Disorder, Oppositional Defiant Disorder or other disruptive behavioral Axis I diagnosis, with the exception of a single diagnosis of mental retardation, developmental delay or substance abuse; and
- Meets criteria on CA-TRAG for LOC-1.1; and
- The child/youth and family are willing to participate in treatment.

### **Special Considerations**

**In addition to the above criteria, any of the following may indicate this as the most appropriate LOC:**

- The child/youth is eligible for a higher LOC but the child/youth or caregiver refuses more intensive services; or
- The child/youth is eligible for a higher LOC but due to lack of service capacity is served in this LOC.

Note: Medicaid eligible children/youth must be authorized into a LOC based on medical necessity.

### **Criteria for Level of Care Review**

- **Continued Stay:** This LOC will terminate in 90 days unless additional skill deficits are identified that require the provision of different skills training interventions for the child/youth and/or caregiver, warranting a re-authorization of the LOC.
- **Indication for potential increase in LOC:** CA-TRAG scores indicate a higher LOC. If at any point in time, the child/youth meets admission criteria for a higher LOC, the higher LOC may be authorized.
- **Following a crisis:** Providers should reassess the child/youth to determine if a more appropriate LOC is indicated.

### **Discharge Criteria**

#### **ANY of these indicators would support discharge from this LOC:**

- Authorized treatment has been completed and the child/youth can continue with progress without additional treatment at this LOC. Caregivers may continue to participate in support groups without assignment to a LOC; or
- Authorized treatment has been completed and the child/youth is authorized for LOC-4 Aftercare Service; or.

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- The child/youth's condition has worsened and requires a higher LOC; or
- The child/youth or family terminates services.

**Expected Outcomes**

- Caregiver and/or child/youth self-report reduction or stabilization in presenting problem severity or functional impairment on the CA-TRAG; or
- Family is better able to use natural and community support systems as resources.

**LOC-1.1 Table Overview**

<b>Authorization Period: 90 Days</b>		
<b>Target Monthly Utilization in This Level of Care: 3.5 hours</b>		
Across the population served at this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 3.5 hours/month. Ideally, the average hours of service(s) delivered should include the Core Services and be supplemented by Add-on Services when clinically appropriate.		
<b>Core Services:</b> Identified by the uniform assessment and addressed in the treatment plan.	<b>Individual Services in LOC – 1.1 Utilization Per Month</b>	
	<b>Standard Therapeutic</b>	<b>High Need Therapeutic</b>
<b>Psychiatric Diagnostic Interview Examination</b>	<b>N/A</b>	<b>1 Event</b> (1 unit)
<b>Pharmacological Management</b>	<b>1 Event</b> (1 unit)	<b>4 Events</b> (4 units)
<b>Skills Training (Individual)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Medication Training and Support (Individual)</b>	<b>.5 hours</b> (2 units)	<b>2 hours</b> (8 units)
<b>Routine Case Management</b>	<b>1 hour</b> (4 units)	<b>2 hours</b> (8 units)
<b>Parent Support Group</b>	<b>1 hour</b> (1 unit)	<b>4 hour</b> (4 units)
<b>Engagement Activity</b>	<b>.5 hours</b> (2 units)	<b>2 hours</b> (8 units)
<b>Add-on Services:</b> Identified by the uniform assessment and addressed in the treatment plan.	<b>Standard Therapeutic</b>	<b>High Need Therapeutic</b>
<b>Medication Training and Support (Group)</b>	<b>.5 hours</b> (2 units)	<b>2 hours</b> (8 units)
<b>Skills Training (Group)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Family Training (Individual)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Family Training (Group)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Family Partner</b>	<b>1 hour</b> (4 units)	<b>2 hours</b> (8 units)
<b>Crisis Service Array:</b> Authorized as medically necessary and available during psychiatric crisis	<b>Utilization for IX. Crisis Service Array can be found on page 21</b>	

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### **III. LEVEL OF CARE 1.2: Internalizing Disorders**

#### **Purpose for Level of Care**

This LOC is targeted to children/youth with internalizing disorders (depressive or anxiety disorders) and a moderate level of functional impairment. The focus of intervention is on child/youth and family counseling using Cognitive Behavioral Therapy (CBT) for ages 7 & above and Parent-Child Psychotherapy (Dyadic Therapy), or other therapy approaches for children ages 3 through 6. Access to parent support groups is available. Information regarding the diagnosis, medication, monitoring of symptoms and side effects is provided through medication training and support. This LOC is generally considered short-term and time-limited.

The general goal of services at this LOC is to reduce or stabilize symptoms, decrease functional impairment and build resiliency in the child/youth and family. Family support is facilitated through linkage to natural and community resources and parent support groups. Services are provided in the office, school, home or other community setting.

#### **Special Considerations During Crisis**

If the child/youth experiences a psychiatric emergency while receiving services in LOC-1.2, the child/youth has access to all medically necessary crisis services without prior authorization. Medical necessity of crisis services must be documented. These services are intended to stabilize the crisis situation and prevent utilization of more intensive or restrictive interventions. Following a crisis, providers should reassess the child/youth to determine if a more appropriate LOC is indicated.

#### **Admission Criteria**

##### **All criteria must be met:**

- An Axis I diagnosis of depressive or anxiety disorders, with the exception of a single diagnosis of mental retardation, developmental delay or substance abuse.
- CA-TRAG scores indicate LOC-1.2.
- The child/youth and family are willing to participate in treatment.

#### **Special Considerations**

**In addition to the above criteria, any of the following may indicate this as the most appropriate LOC:**

- The child/youth is eligible for a higher LOC but the child/youth or caregiver refuses more intensive services.
- The child/youth is eligible for a higher LOC but due to lack of service capacity is served in this LOC. Medicaid eligible child/youths must be authorized into a LOC based on medical necessity.

#### **Criteria for Level of Care Review**

- **Continued Stay:** Up to 8 additional units of counseling sessions may be re-authorized if indicated to achieve identified treatment goals. Other services offered in this LOC may be reauthorized at the same level as the initial authorization.
- **Indication for potential increase in LOC:** CA-TRAG scores indicate a higher LOC. If at any point in time, the child/youth meets the admission criteria for a higher LOC, the higher LOC may be authorized.
- **Following a crisis:** Providers should reassess the child/youth to determine if a more appropriate LOC is indicated.

#### **Discharge Criteria**

**ANY of these indicators would support discharge from this LOC:**

- Authorized treatment has been completed and the child/youth can continue with progress without additional treatment at this LOC. Caregivers may continue to participate in support groups without assignment to a LOC.

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- Authorized treatment has been completed and the child/youth is authorized for LOC-4 Aftercare Services.
- The child/youth's condition has worsened and requires a higher LOC.
- The child/youth or family terminates services.

**Expected Outcomes**

- Caregiver and/or child/youth self-report reduction or stabilization in presenting problem severity or functional impairment on the CA-TRAG.
- Family is better able to use natural and community support systems as resources.

**LOC-1.2 Table Overview**

<b>Authorization Period: 90 Days</b>		
<b>Target Monthly Utilization in This Level of Care: 3 hours</b>		
Across the population served at this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 3 hours/month. Ideally, the average hours of service(s) delivered should include the Core Services and be supplemented by Add-on Services when clinically appropriate.		
<b>Core Services:</b> Identified by the uniform assessment and addressed in the treatment plan.	<b>Individual Services in LOC – 1.2 Utilization Per Month</b>	
	<b>Standard Therapeutic</b>	<b>High Need Therapeutic</b>
<b>Psychiatric Diagnostic Interview Examination</b>	<b>N/A</b>	<b>1 Event</b> (1 unit)
<b>Pharmacological Management</b>	<b>1 Event</b> (1 unit)	<b>4 Events</b> (4 units)
<b>Skills Training (Individual)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Counseling (Individual)</b>	<b>2 hours</b> (2 units)	<b>4 hours</b> (4units)
<b>Medication Training and Support (Individual)</b>	<b>.5 hours</b> (2 units)	<b>2 hours</b> (8 units)
<b>Routine Case Management</b>	<b>1 hour</b> (4 units)	<b>2 hours</b> (8 units)
<b>Parent Support Group</b>	<b>1 hour</b> (1 unit)	<b>4 hour</b> (4 units)
<b>Engagement Activity</b>	<b>.5 hours</b> (2 units)	<b>2 hours</b> (8 units)
<b>Add-on Services:</b> Identified by the uniform assessment and addressed in the treatment plan.	<b>Standard Therapeutic</b>	<b>High Need Therapeutic</b>
<b>Medication Training and Support (Group)</b>	<b>.5 hours</b> (2 units)	<b>2 hours</b> (8 units)
<b>Skills Training (Group)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Counseling (Group)</b>	<b>2 hours</b> (2 units)	<b>4 hours</b> (4units)
<b>Counseling (Family)</b>	<b>2 hours</b> (2 units)	<b>4 hours</b> (4units)
<b>Family Partner</b>	<b>1 hour</b> (4 units)	<b>2 hours</b> (8 units)
<b>Crisis Service Array:</b> Authorized as medically necessary and available during psychiatric crisis	<b>Utilization for IX. Crisis Service Array can be found on page 21</b>	

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## **IV.LEVEL OF CARE 2.2: Externalizing Disorders**

### **Purpose for Level of Care**

This LOC is targeted to children/youths with externalizing disorders and moderate to high functional impairment at home, school or in the community. The need for intensive case management and significant caregiver support is indicated. The family service plan is developed using a wraparound planning approach.

The general goal of services at this LOC is to reduce or stabilize symptoms, decrease functional impairment, and build resiliency in the child/youth and family. Family support is facilitated through linkage to natural and community resources. Services are provided in the office, school, home or other community setting.

### **Special Considerations During Crisis**

If the child/youth experiences a psychiatric emergency while receiving services in LOC-2.2, the child/youth has access to all medically necessary crisis services without prior authorization. Medical necessity of crisis services must be documented. These services are intended to stabilize the crisis situation and prevent utilization of more intensive or restrictive interventions. Following a crisis, providers should reassess the child/youth to determine if a more appropriate LOC is indicated.

### **Admission Criteria**

- An Axis I primary diagnosis of ADHD, Conduct Disorder or Oppositional Defiant Disorder. A co-occurring diagnosis of Depression or Bipolar Disorder may also be present. Individuals with a single diagnosis of mental retardation, developmental delay or substance abuse are not eligible.
- CA-TRAG scores indicate a LOC-2.2.
- Because of the nature of this intervention, the child/youth and family must commit to the family service plan and to participation in treatment.

### **Special Considerations**

**In addition to the above criteria, any of the following may indicate this as the most appropriate LOC:**

- The child/youth is eligible for a higher LOC but the child or caregiver refuses more intensive services.
- The child/youth is eligible for a higher LOC but due to lack of service capacity is served in this LOC. Medicaid eligible child/youths must be authorized into a LOC based on medical necessity.

### **Criteria for Level of Care Review**

- **Continued Stay:** Up to 180 additional days may be re-authorized if indicated to achieve identified treatment goals.
- **Indication for potential increase in LOC:** CA-TRAG scores indicate a higher LOC. If at any point in time, the child/youth meets the admission criteria for a higher LOC, the higher LOC may be authorized.
- **Following a crisis:** Providers should reassess the child/youth to determine if a more appropriate LOC is indicated.

### **Discharge Criteria**

**ANY of these indicators would support discharge from this LOC:**

- Authorized treatment has been completed and the child/youth can continue with progress without additional treatment at this LOC.
- Authorized treatment has been completed and the child/youth is authorized for LOC-4 Aftercare Services.
- The child/youth has stabilized but requires treatment at a lower LOC to maintain stability.
- The child/youth or family terminates services.

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**Expected Outcomes**

- Caregiver and child/youth report reduction or stabilization in presenting problem severity or functional impairment through the CA-TRAG.
- Risk of out of home placement or juvenile involvement is diminished.
- Family is able to use natural and community support systems as resources.

**LOC-2.2 Table Overview**

<b>Authorization Period: 90 Days</b>		
<b>Target Monthly Utilization in This Level of Care: 5 hours</b>		
Across the population served at this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 5 hours/month. Ideally, the average hours of service(s) delivered should include the Core Services and be supplemented by Add-on Services when clinically appropriate.		
<b>Core Services:</b> Identified by the uniform assessment and addressed in the treatment plan.	<b>Individual Services in LOC-2.2 Utilization Per Month</b>	
	<b>Standard Therapeutic</b>	<b>High Needs Therapeutic</b>
<b>Psychiatric Diagnostic Interview Examination</b>	<b>N/A</b>	<b>1 Event</b> (1 unit)
<b>Pharmacological Management</b>	<b>1 Event</b> (1 unit)	<b>4 Events</b> (4 units)
<b>Intensive Case Management</b>	<b>3.75 hours</b> (15 units)	<b>6.25 hours</b> (25 units)
<b>Skills Training (Individual)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Medication Training and Support (Individual)</b>	<b>.5 hours</b> (2 units)	<b>2 hours</b> (8 units)
<b>Family Partner</b>	<b>1 hour</b> (4 units)	<b>2 hours</b> (8 units)
<b>Parent Support Group</b>	<b>1 hour</b> (1 unit)	<b>4 hour</b> (4 units)
<b>Engagement Activity</b>	<b>.75 hours</b> (3 units)	<b>2 hours</b> (8 units)
<b>Add-on Services:</b> Identified by the uniform assessment and addressed in the treatment plan.	<b>Standard Therapeutic</b>	<b>High Needs Therapeutic</b>
<b>Medication Training and Support (Group)</b>	<b>.5 hours</b> (2 units)	<b>2 hours</b> (8 units)
<b>Skills Training (Group)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Flexible Funds</b>	<b>N/A</b>	<b>1500 cap/year</b> (\$1 increments)
<b>Family Training (Individual)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Family Training (Group)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Family Case Management</b>	<b>.5 hours</b> (2 units)	<b>1 hour</b> (4 units)
<b>Flexible Community Supports</b>	<b>N/A</b>	<b>1.25 hours</b> (15 units)
<b>Crisis Service Array:</b> Authorized as medically necessary and available during psychiatric crisis	<b>Utilization for IX.Crisis Service Array can be found on page 21</b>	

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## **V. LEVEL OF CARE 2.3: Internalizing Disorders**

### **Purpose for Level of Care**

This LOC is targeted to children/youth with depressive or anxiety disorders and a moderate to high level of problem severity or functional impairment. The focus of intervention is on child/youth and family counseling using Cognitive Behavioral Therapy (CBT) for ages 7 & above and Parent-Child Psychotherapy (Dyad Therapy) or other therapy approaches for children ages 3 through 6. Multiple family concerns and significant parental stress indicate the need for intensive case management and the availability of parent-to-parent peer support. The family service plan is developed using a wraparound planning approach.

The general goal of services at this LOC is to reduce or stabilize symptoms, decrease functional impairment and build resiliency in the child/youth and family. Family support is facilitated through linkage to natural and community resources. Services are provided in the office, school, home or other community setting.

### **Special Considerations During Crisis**

If the child/youth experiences a psychiatric emergency while receiving services in LOC-2.3, the child/youth has access to all medically necessary crisis services without prior authorization. Medical necessity of crisis services must be documented. These services are intended to stabilize the crisis situation and prevent utilization of more intensive or restrictive interventions.

Following a crisis, providers should reassess the child/youth to determine if a more intensive LOC is indicated.

### **Admission Criteria**

- An Axis I primary diagnosis of depressive or anxiety disorders. A child with a single diagnosis of mental retardation, developmental delay, autism or substance abuse is not eligible.
- Meets criteria on CA-TRAG for LOC-2.3.
- The child/youth and family are willing to participate in treatment.

### **Criteria for Level of Care Review**

- Up to 8 additional units of child/youth or family counseling may be re-authorized if indicated to achieve identified treatment goals. Other services offered in this LOC may be reauthorized at the same level as the initial authorization.
- If the child/youth's condition worsens, as indicated by the CA-TRAG, placement into a higher LOC may be appropriate.
- Following a crisis, providers should reassess the child/youth to determine if a more intensive LOC is indicated.

### **Discharge Criteria**

#### **ANY of these indicators would support discharge from this LOC:**

- Authorized treatment has been completed and the child/youth can continue with progress without additional treatment at this LOC.
- Authorized treatment has been completed and the child/youth is authorized for LOC-4, Aftercare Services.
- The child/youth has stabilized but requires treatment at a lower LOC to maintain stability.
- The child/youth or family terminates services.

### **Expected Outcomes:**

- Caregiver and child/youth self-report reduction or stabilization in presenting problem severity or functional impairment through the CA-TRAG.
- Family is able to use natural and community support systems as resources.

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**LOC-2.3 Table Overview**

<b>Authorization Period: 90 Days</b>		
<p><b>Target Monthly Utilization in This Level of Care: 5 hours</b>            Across the population served at this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 5 hours/month. Ideally, the average hours of service(s) delivered should include the Core Services and be supplemented by Add-on Services when clinically appropriate.</p>		
<b>Core Services:</b> Identified by the uniform assessment and addressed in the treatment plan.	<b>Individual Services in LOC-2.3 Utilization Per Month</b>	
	<b>Standard Therapeutic</b>	<b>High Needs Therapeutic</b>
<b>Psychiatric Diagnostic Interview Examination</b>	<b>N/A</b>	<b>1 Event</b> (1 unit)
<b>Pharmacological Management</b>	<b>1 Event</b> (1 unit)	<b>4 Events</b> (4 units)
<b>Intensive Case Management</b>	<b>3.75 hours</b> (15 units)	<b>6.25 hours</b> (25 units)
<b>Counseling (Individual)</b>	<b>4 hours</b> (4 units)	<b>6 hours</b> (6 units)
<b>Medication Training and Support (Individual)</b>	<b>.5 hours</b> (2 units)	<b>2 hours</b> (8 units)
<b>Skills Training (Individual)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Family Partner</b>	<b>1 hour</b> (4 units)	<b>2 hours</b> (8 units)
<b>Parent Support Group</b>	<b>1 hour</b> (1 unit)	<b>4 hour</b> (4 units)
<b>Engagement Activity</b>	<b>.75 hours</b> (3 units)	<b>2 hours</b> (8 units)
<b>Add-on Services:</b> Identified by the uniform assessment and addressed in the treatment plan.	<b>Standard Therapeutic</b>	<b>High Needs Therapeutic</b>
<b>Medication Training and Support (Group)</b>	<b>.5 hours</b> (2 units)	<b>2 hours</b> (8 units)
<b>Skills Training (Group)</b>	<b>3 hours</b> (12 units)	<b>6 hours</b> (24 units)
<b>Counseling (Group)</b>	<b>2 hours</b> (2 units)	<b>4 hours</b> (4units)
<b>Counseling (Family)</b>	<b>2 hours</b> (2 units)	<b>4 hours</b> (4units)
<b>Flexible Funds</b>	<b>N/A</b>	<b>1500 cap/year</b> (\$1 increments)
<b>Flexible Community Supports</b>	<b>N/A</b>	<b>1.25 hours</b> (15 units)
<b>Crisis Service Array:</b> Authorized as medically necessary and available during psychiatric crisis	<b>Utilization for IX. Crisis Service Array can be found on page 21</b>	

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## **VI.LEVEL OF CARE 2.4: Major Disorders**

### **Purpose for Level of Care**

This LOC is targeted to children/youth who are diagnosed with Bipolar Disorder, Schizophrenia, Major Depression with Psychosis, or other psychotic disorders and are not yet stable on medication. The general goal of services at this LOC is stabilizing the child/youth and providing information and support to the family. Services are provided in the office, school, home or other community setting.

### **Special Considerations During Crisis**

If the child/youth experiences a psychiatric emergency while receiving services in LOC-2.4, the child/youth has access to all medically necessary crisis services without prior authorization. Medical necessity of crisis services must be documented. These services are intended to stabilize the crisis situation and prevent utilization of more intensive or restrictive interventions.

Following a crisis, providers must reassess the child/youth to determine if a more intensive LOC is indicated.

### **Admission Criteria**

- An Axis I diagnosis of Bipolar Disorder, Schizophrenia, Major Depression with Psychosis or other psychotic disorder.
- A child/youth with a single diagnosis of mental retardation, developmental delay, or substance abuse is not eligible.
- Meets criteria on CA-TRAG for LOC-2.4.
- The child and family are willing to participate in treatment.

### **Criteria for Level of Care Review**

- Up to 90 additional days may be authorized if indicated to achieve identified treatment goals.
- If the child/youth's condition worsens, as indicated by CA-TRAG, placement into a higher LOC may be appropriate.
- Following a crisis, providers should reassess the child/youth to determine if a more intensive LOC is indicated.

### **Discharge Criteria**

#### **ANY of these indicators would support discharge from this LOC:**

- Authorized treatment has been completed and the child/youth can continue with progress without additional treatment at this LOC.
- Authorized treatment has been completed and the child/youth is authorized for LOC-4 Aftercare Services.
- The child/youth has stabilized but requires treatment at a lower LOC to maintain stability.
- The child/youth or family terminates services.

### **Expected Outcomes**

- Caregiver and child/youth report reduction or stabilization in presenting problem severity or functional impairment through the CA-TRAG.
- Family is better able to use natural and community support systems as resources.
- Achievement of medical stability allowing the child/youth to transition to less intensive services.

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**LOC-2.4 Table Overview**

Authorization Period: 90 Days		
<b>Target Monthly Utilization in This Level of Care: 5 hours</b> Across the population served at this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 5 hours/month. Ideally, the average hours of service(s) delivered should include the Core Services and be supplemented by Add-on Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the treatment plan.	Individual Services in LOC- 2.4 Utilization Per Month	
	Standard Therapeutic	High Needs Therapeutic
Psychiatric Diagnostic Interview Examination	N/A	1 Event (1 unit)
Pharmacological Management	1 Event (1 unit)	4 Events (4 units)
Intensive Case Management	3.75 hours (15 units)	6.25 hours (25 units)
Medication Training and Support (Individual)	.5 hours (2 units)	2 hours (8 units)
Skills Training (Individual)	3 hours (12 units)	6 hours (24 units)
Family Training (Individual)	3 hours (12 units)	6 hours (24 units)
Family Partner	1 hour (4 units)	2 hours (8 units)
Parent Support Group	1 hour (1 unit)	4 hour (4 units)
Engagement Activity	.75 hours (3 units)	2 hours (8 units)
Add-on Services: Identified by the uniform assessment and addressed in the treatment plan.	Standard Therapeutic	High Needs Therapeutic
Medication Training and Support (Group)	.5 hours (2 units)	2 hours (8 units)
Skills Training (Group)	3 hours (12 units)	6 hours (24 units)
Family Skills Training (Group)	3 hours (12 units)	6 hours (24 units)
Family Case Management	.5 hours (2 units)	1 hour (4 units)
Flexible Funds	N/A	1500 cap/year (\$1 increments)
Flexible Community Supports	N/A	1.25 hours (15 units)
<b>Crisis Service Array:</b> Authorized as medically necessary and available during psychiatric crisis	<b>Utilization for IX.Crisis Service Array can be found on page 21</b>	

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## **VII. LEVEL OF CARE 4: Aftercare Services**

### **Purpose for Level of Care**

This LOC is targeted to children/youth who have stabilized in terms of problem severity and functioning and require only medication and medication management to maintain their stability. If CA-TRAG scores indicate the need for a more intensive LOC, LOC-4 can only be authorized if: 1) the caregiver refuses the recommended LOC, wants medication-only services and medication is clinically indicated; or 2) if the child/youth is NOT Medicaid eligible and the recommended LOC is not available due to limited resources but severe presenting problems that are responsive to medication suggest an authorization for LOC-4 during the waiting period.

The general goal of this LOC is to maintain treatment gains made by the child/youth and family and to provide them with medication monitoring services until the family can be adequately linked to natural and community resources. The majority of services available in this package can be provided in the office, school, home or other community setting, but medication check-up appointments with a psychiatrist are performed in the office or from a satellite office via telemedicine.

### **Special Considerations During and Following Crisis**

If the child/youth experiences a psychiatric emergency while receiving services in LOC-4, the child/youth has access to all medically necessary crisis services without prior authorization. Medical necessity of crisis services must be documented. These services are intended to stabilize the crisis situation and prevent utilization of more intensive or restrictive interventions.

Following a crisis, providers should reassess the child/youth to determine if a more intensive LOC is indicated.

### **Admission Criteria**

- Any Axis I diagnosis except a single diagnosis of mental retardation, developmental delay or substance abuse.
- Meets criteria on CA-TRAG for LOC-4.
- Child/youth and family agree to treatment.

### **Special Considerations**

**In addition to the above criteria, any of the following may indicate this as the most appropriate LOC:**

- The child/youth is stable on psychotropic medication and does not currently require psychosocial treatment, however child/youth lacks access to medication from other resources (e.g., has lost insurance coverage).
- The child/youth is on the waiting list for another LOC but the severity of presenting problems indicates the appropriate utilization of LOC-4 while waiting for other treatment.
- The eligibility assessment indicates eligibility for another LOC but the caregiver refuses the LOC, requests medication-only services, and medication-only services is an appropriate intervention.

**Note: A psychiatric evaluation must provide evidence that a medication-only service is clinically appropriate if the caregiver refuses the initial LOC indicated.**

### **Criteria for Level of Care Review**

- The authorization period is automatically set to 90 days based on the clinical guidelines. An extended review period of 180 days may be requested when the recommended LOC (i.e., LOC-R) = LOC-4 and the authorized LOC (i.e., LOC-A) = LOC-4 for two consecutive authorization periods. (LOC-R = LOC-4 when Section 1: CA-TRAG Dimension 10 and "Successfully Completed Level of Care 1 or 2?" have both been selected).

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- If the child/youth’s condition worsens, as indicated by CA-TRAG, placement into a higher LOC may be appropriate.
- Following a crisis, providers should reassess the child/youth to determine if a more intensive LOC is indicated.

**Discharge Criteria**

**ANY of these indicators would support discharge from this LOC:**

- The child/youth is able to access medication services through another resource (e.g., insurance coverage). Referral to a community provider should be facilitated whenever possible.
- The child/youth’s condition has worsened and CA-TRAG indicates a more intensive LOC is needed.
- The child/youth or family terminates services.
- The child/youth is on the waiting list for another LOC and the LOC becomes available.

**Expected Outcomes**

- Maintenance of stable functioning and/or problem severity as self-reported on the Ohio Scales scores.
- Family is able to use natural and community support systems as resources.
- Engagement in services is reflective of child/youth and family needs if underserved.

**LOC-4 Table Overview**

<b>Authorization Period: 90 Days</b>		
<b>Target Monthly Utilization in This Level of Care: .5 hours</b>		
Across the population served at this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than .5 hours/month. Ideally, the average hours of service(s) delivered should include the Core Services and be supplemented by Add-on Services when clinically appropriate.		
<b>Core Services:</b> Identified by the uniform assessment and addressed in the treatment plan.	<b>Individual Services in LOC – 4 Utilization Per Month</b>	
	<b>Standard Therapeutic</b>	<b>High Need Therapeutic</b>
<b>Psychiatric Diagnostic Interview Examination</b>	<b>N/A</b>	<b>1 Event</b> (1 unit)
<b>Pharmacological Management</b>	<b>1 Event</b> (1 unit)	<b>2 Events</b> (2 units)
<b>Routine Case Management</b>	<b>.5 hours</b> (2 units)	<b>1 hour</b> (4 units)
<b>Medication Training and Support (Individual)</b>	<b>.5 hours</b> (2 units)	<b>1.25 hours</b> (5 units)
<b>Parent Support Group</b>	<b>1 hour</b> (1 unit)	<b>4 hours</b> (4 units)
<b>Add-on:</b> Identified by the uniform assessment and addressed in the treatment plan.	<b>Standard Therapeutic</b>	<b>High Need Therapeutic</b>
<b>Family Partner</b>	<b>1 hour</b> (4 units)	<b>2 hours</b> (8 units)
<b>Engagement Activity</b>	<b>1 hour</b> (4 units)	<b>2 hours</b> (8 units)
<b>Crisis Service Array:</b> Authorized as medically necessary and available during psychiatric crisis	<b>Utilization for IX.Crisis Service Array can be found on page 21</b>	

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**VIII. LEVEL OF CARE 5: Transitional Services**

**Purpose for Level of Care**

The major focus for this LOC is to provide flexible services that assist children/youth in maintaining stability, preventing further crisis, and engaging the child/youth into the appropriate LOC or assisting in obtaining appropriate community-based services. This LOC is highly individualized and the level of service intensity and length of stay is expected to vary dependent on individual need. This LOC is available for up to 90 days.

**Special Considerations During Crisis**

As in other LOCs, if a crisis occurs during the time a child/youth is in LOC-5, crisis services are considered a part of the authorization for LOC-5 and crisis services should be delivered without a change in LOC. LOC-0 may only be used for a child/youth who is newly admitted to services or is being transitioned out of LOC-5 and is experiencing a crisis.

Any service offered must be medically necessary.

**Admission Criteria**

- The child/youth has been discharged from LOC-0 services or released from the hospital and is not eligible for ongoing services and is in need of more than crisis services to stabilize; or
- The child/youth has been discharged from LOC-0 services or released from the hospital and is eligible for ongoing services, but ongoing services are not available or the individual is difficult to engage and is in need of transitional services; or
- The child/youth is identified as part of a high need population e.g. homelessness, substance abuse issues, primary healthcare needs or has a history of criminal justice involvement and is not eligible for ongoing services but is in need of more than crisis services to stabilize; or
- The child/youth is identified as part of a high need population e.g. homelessness, substance abuse issues, primary healthcare needs or has a history of criminal justice involvement and is eligible for ongoing services, but ongoing services are not available or the individual is difficult to engage and is in need of transitional services; or
- The child/youth has been discharged from LOC-0 services, released from the hospital or is part of a high need population e.g. homelessness, substance abuse issues, primary healthcare needs or has a history of criminal justice involvement and has chosen an external provider for ongoing services but is in need of transitional services.

**Additional Admission Criteria**

Any of these criteria may be met:

**Reason for Deviation**

Resource Limitations

**Explanation of Deviation**

Not applicable for persons with Medicaid entitlement services.

LOC-R=9

- N/A

LOC-R=levels 1-4 with no ongoing services

- Client is in need of services and capacity does not currently exist in LOC levels 1-4.

LOC-R=levels 1-4 LOC-A=levels 1-4

- Client is being discharged from ongoing services due to resource limitations and short term services are indicated to assist with the transition.

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Consumer Choice	<p>Also for:</p> <ul style="list-style-type: none"> <li>• individuals whose crisis is resolved whose LOC-R=1-4 and capacity does not currently exist for ongoing services</li> <li>• individuals who have been released from psychiatric hospitalization with an LOC-R=1-4 and capacity does not exist for ongoing services.</li> </ul> <p>Consumers cannot “choose” a higher level of services.</p> <p>LOC-R=9</p> <ul style="list-style-type: none"> <li>• N/A</li> </ul> <p>LOC-R=levels 1-4 with no ongoing services</p> <ul style="list-style-type: none"> <li>• Although capacity exists for entrance into LOC levels 1-4, client chooses to begin services with the flexible array available in LOC-5.</li> </ul> <p>LOC-R=levels 1-4 LOC-A=levels 1-4</p> <ul style="list-style-type: none"> <li>• Client currently enrolled in ongoing services requests discharge from ongoing services but allows continued services short term through LOC-5.</li> </ul> <p>Also for clients who have chosen an external provider but agree to LOC-5 services short term to assist their successful transition.</p>
Consumer Need	<p>LOC-R=9</p> <ul style="list-style-type: none"> <li>• Client ineligible for services but short term services are clinically indicated.</li> </ul> <p>LOC-R=levels 1-4 with no ongoing services</p> <ul style="list-style-type: none"> <li>• Although capacity exists for entrance into LOC levels 1-4, client chooses to begin services with the flexible array available in LOC-5.</li> </ul> <p>LOC-R=levels 1-4 LOC-A=levels 1 and 4</p> <ul style="list-style-type: none"> <li>• Client is enrolled in ongoing services but needs the flexible service array available in LOC-5 for a short period for stabilization or engagement.</li> </ul> <p>LOC-R=levels 1-4 LOC-A=levels 2-3</p> <ul style="list-style-type: none"> <li>• N/A</li> </ul> <p>Care should be taken to assure that client access to Medicaid entitlement services is maintained.</p>
Continuity of Care	<ul style="list-style-type: none"> <li>• The client is identified as ineligible for services, but has been discharged from a State or Community Mental Health Hospital and requires transitional support.</li> </ul>
Other	<ul style="list-style-type: none"> <li>• Requires a text note justification.</li> </ul>

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**Criteria for Level of Care Review**

If the child/youth's condition worsens, as indicated by assessment, placement into a higher LOC may be appropriate.

**Discharge Criteria**

**ANY of these indicators would support discharge from this LOC:**

- Client is stabilized and no further service in the DSHS system is needed; or
- Client is stabilized and the child/youth has been transitioned to ongoing services; or
- Client has been in LOC-5 for 90 days and is then placed on a waiting list for ongoing services; or
- Client is not fully stabilized, but has been in LOC-5 for 90 days and an ongoing LOC is not available and the individual is placed on the waiting list; or
- Referred and linked as needed to community resources outside of the DSHS system.

**Expected Outcomes**

- The caregiver and/or the child/youth reports reduction or stabilization in presenting problem severity or functional impairment on CA-TRAG.
- The child/youth and caregiver are better able to use natural and community support systems as resources.
- There is a smooth transition from crisis to ongoing services.

**LOC-5 Table Overview**

<b>Authorization Period: 90 Days</b>	
<b>Target Monthly Utilization in This Level of Care: N/A</b>	
Across the population served at this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate. This LOC is designed to flexibly meet the needs of the individual prior to admission into ongoing services; services should reflect the child/youth's needs.	
<b>Add-On Services: Identified by the uniform assessment and addressed in the treatment plan.</b>	<b>Individual Services in LOC-5</b>
	<b>Unit</b>
<b>Routine Case Management</b>	<b>15 minutes</b>
<b>Psychiatric Diagnostic Interview Examination</b>	<b>Event</b>
<b>Pharmacological Management</b>	<b>Event</b>
<b>Medication Training and Support (Individual)</b>	<b>15 minutes</b>
<b>Medication Training and Support (Group)</b>	<b>15 minutes</b>
<b>Counseling (Individual or Child-Parent/Dyad)</b>	<b>15 minutes</b>
<b>Counseling (Group)</b>	<b>15 minutes</b>
<b>Counseling (Family)</b>	<b>15 minutes</b>
<b>Skills Training (Individual)</b>	<b>15 minutes</b>
<b>Skills Training (Group)</b>	<b>15 minutes</b>
<b>Family Partner</b>	<b>15 minutes</b>
<b>Engagement Activity</b>	<b>15 minutes</b>
<b>Flexible Funds (dollars)</b>	<b>\$1 increments</b>
<b>Flexible Community Supports (time)</b>	<b>15 minutes</b>
<b>Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis</b>	<b>Utilization for IX. Crisis Service Array can be found on page 21</b>

This Level of Care is designed to flexibly meet the needs of the individual prior to admission into ongoing services. Therefore, no average expected units are indicated. Services should reflect the individual's needs.

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**IX. Crisis Service Array**

Crisis services are brief interventions provided in the community that ameliorate the crisis situation. These services are intended to resolve the crisis, avoid more intensive and restrictive intervention, and prevent additional crisis events. *Any service offered must meet medical necessity criteria.*

If a child/youth enrolled in another LOC experiences a psychiatric crisis, crisis services should be delivered within the current LOC assignment.

<b>Crisis Service Array</b>		
For children/youth receiving crisis services it is expected that the services available in the crisis service array be utilized as medically necessary and available to treat and stabilize the psychiatric crisis.		
<b>Available Services:</b>	<b>Standard Therapeutic</b>	<b>High Need Therapeutic</b>
<b>Crisis Intervention Services</b>	<b>N/A</b>	<b>3.75 hours</b> (15 units)
<b>Psychiatric Diagnostic Interview Examination</b>	<b>N/A</b>	<b>1 Event</b> (1 unit)
<b>Pharmacological Management</b>	<b>N/A</b>	<b>10 Events</b> (10 units)
<b>Safety Monitoring</b>	<b>N/A</b>	<b>2 hours</b> (8 units)
<b>Crisis Transportation (Event)</b>	<b>N/A</b>	<b>1 Event</b> (1 unit)
<b>Crisis Transportation (Dollar)</b>	<b>N/A</b>	<b>As necessary</b> (\$1 units)
<b>Crisis Flexible Benefits (Event)</b>	<b>N/A</b>	<b>As necessary</b> (Event)
<b>Crisis Flexible Benefits (Dollar)</b>	<b>N/A</b>	<b>As necessary</b> (\$1 units)
<b>Respite Services: Community-Based</b>	<b>N/A</b>	<b>6 hours</b> (24 units)
<b>Respite Services: Program-Based (not in home)</b>	<b>N/A</b>	<b>3 bed days</b> (3 units)
<b>Extended Observation</b>	<b>N/A</b>	<b>1 unit</b> (1 bed day)
<b>Children's Crisis Residential</b>	<b>N/A</b>	<b>4 units</b> (4 bed days)
<b>Family Partner</b>	<b>N/A</b>	<b>6 hours</b> (24 units)
<b>Engagement Activity</b>	<b>N/A</b>	<b>6 hours</b> (24 units)
<b>Inpatient Hospital Services</b>	<b>N/A</b>	<b>As necessary</b> (1 bed day units)
<b>Inpatient Services (Psychiatric)</b>	<b>N/A</b>	<b>As necessary</b> (1 bed day units)
<b>Emergency Room Services (Psychiatric)</b>	<b>N/A</b>	<b>As necessary</b> (Events)
<b>Crisis Follow-up &amp; Relapse Prevention</b>	<b>N/A</b>	<b>8 hours</b> (32 units)

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## Crisis Service Definitions

**Children's Crisis Residential Services:** Twenty-four hour, usually short-term residential services provided to a child/youth demonstrating a psychiatric crisis that cannot be stabilized in a less restrictive setting. This service may use crisis beds in a residential treatment center or crisis respite beds.

**Crisis Flexible Benefits:** Non-clinical supports that reduce the crisis situation, reduce symptomatology, and enhance the ability of the child/youth to remain in the home. Examples in children's/youth's mental health services include home safety modifications, child care to allow the family to participate in treatment activities, and transportation assistance.

**Crisis Follow-up and Relapse Prevention:** Supported services provided to children/youths who are not in imminent danger of harm to self or others but require additional assistance to avoid reoccurrence of the crisis event. The service is provided to ameliorate the situation that gave rise to the crisis event, ensure stability, and prevent future crisis events. This service includes ongoing assessment to determine crisis status and needs, provides time-limited (up to 30 days) brief, solution-focused interventions to children/youths and families, and focuses on providing guidance and developing problem-solving techniques to enable the child/youth to adapt and cope with the situation and stressors that prompted the crisis event.

**Crisis Intervention Services:** Interventions in response to a crisis in order to reduce symptoms of severe and persistent mental illness or emotional disturbance and to prevent admission of a child/youth to a more restrictive environment. Shall be provided in accordance with 25 TAC, Part 1, Chapter 419, Subchapter L, *MH Rehabilitative Services*.

**Crisis Transportation:** Transporting child/youths receiving crisis services or crisis follow-up and relapse prevention services from one location to another. Transportation is provided in accordance with state laws and regulations by law enforcement personnel, or, when appropriate, by ambulance or qualified staff.

**Engagement Activity:** Short term planned activities with the child/youth, caregiver and/or legally authorized representative (LAR) to develop treatment alliance and rapport with the child/youth, caregiver and/or LAR. Activities include but are not limited to: enhancing the child/youth and/or caregiver/LAR's motivation to participate in services; explaining recommended services; and providing education regarding value of services, adherence to the recommended level of care and its importance in recovery. This service shall not be provided in a group and shall be provided in accordance with confidentiality requirements.

**Extended Observation:** Up to 48 hour emergency and crisis stabilization service that provides emergency stabilization in a secure and protected, clinically staffed (including medical and nursing professionals), psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment. Child/youths are provided appropriate and coordinated transfer to a higher LOC when needed.

**Family Partner:** Family Partners are primary caregivers (i.e. birth parent, adoptive parent, foster parent, a family member acting on behalf of an absent parent, or a non-family member who is chosen by the family to act on behalf of the parent) of a child or youth with a serious emotional disturbance. Family Partners have at least one year of experience navigating a child-serving system (e.g. mental health, juvenile justice, social security, special education). They provide peer mentoring and support to the primary caregivers; introduce the family to the treatment process; model self-advocacy skills; provide information, referral and non-clinical skills training; assist in the identification of natural/non-traditional and community support systems; and document the provision of all family partner services, including both face-to-face and non-face-to-face activities. Family Partners are active members of the intensive Case Management/Wraparound team process and are instrumental in engaging families in services.

**Inpatient Hospitalization Services:** Hospital services staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute psychiatric crisis. Staff provides intensive interventions designed

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to relieve acute psychiatric symptomatology and restore child/youth's ability to function in a less restrictive setting. The hospital must be contracting with or operated by Contractor.

**Pharmacological Management:** A service provided by a physician or other prescribing professional who focuses on the use of medication and the in-depth management of psychopharmacological agents to treat an individual's signs and symptoms of mental illness.

**Psychiatric Diagnostic Interview Examination:** An assessment by a licensed professional practicing within the scope of his or her license that includes relevant past and current medical and psychiatric information and documented as described in the most current version of Title 25 TAC, Part I Chapter 412, Subchapter G, Section 412.322(b) *MH Community Services Standards*.

**Respite Services:** Services provided for temporary, short-term, periodic relief for primary caregivers. Program-based respite services are provided at a temporary residential placement outside the child/youth's usual living situation. Community-based respite services are provided by respite staff at the child/youth's usual living situation. Respite includes both planned respite and crisis respite to assist in resolving a crisis situation.

**Safety Monitoring:** Ongoing observation of an individual to ensure the individual's safety. An appropriate staff person shall be continuously present in the individual's immediate vicinity, provide ongoing monitoring of the individual's mental and physical status, and ensure rapid response to indications of a need for assistance or intervention. Safety monitoring includes maintaining continuous visual contact with frequent face-to-face contacts as needed.

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## **X. Special Considerations for Utilizing Family Partners**

Access to quality family partner services can be instrumental in engaging families as active participants in the child or youth's care and equal members of the child/youth's treatment team. A Family Partner's personal experience is critical to establishing a trusting relationship and earning the respect of families currently within the mental health system. Family Partners can be a mediator, facilitator, or a bridge between families and agencies; they ensure each family is heard and their individual needs are being addressed and met. Through their work with parents and caregivers, Family Partners directly impact the child or youth's resilience and recovery.

### Special Considerations for Utilizing Family Partners

As formal members of the treatment team, Family Partners should be utilized in every LOC to engage caregivers as equal members of a child/youth's treatment team and to provide the following to primary caregivers of children/youth:

- Advocacy that encourages the positive choices of the caregiver, promotes self-advocacy for caregivers and their children/youth, and supports the positive vision that the caregiver has for their child/youth's mental health and recovery;
- Mentoring through the transfer of knowledge, insight, experience, and encouragement including the Family Partner's articulation of their own successful experience of navigating a child serving system;
- Role-modeling the concepts of hope and positive parenting, advocacy and self-care skills that will ultimately benefit the resilience, and recovery of the child/youth;
- Expert guidance in navigating the child serving systems, including mental health, special education, juvenile justice, child protective services, etc.;
- Connection to community resources and informal supports;
- Stewardship of family voice and choice as a member of the Wraparound team; and
- Facilitation of parent support groups.

### Minimum Qualifications

Family Partners are the parent or LAR of a child or youth with a serious emotional disturbance and have at least one year of experience navigating a child-serving system. Individuals shall meet minimum qualifications to fill the role of Family Partner. Via Hope, the training and credentialing entity recognized by DSHS, has stated the following minimum requirements (Note: Beginning FY2014 all Family Partners must meet these requirements and become certified within one year of hire or prior to FY2014):

- Must be a parent or legally authorized representative (LAR) with a minimum of one year of lived experience being responsible for making the final decisions for a child/youth (person 17 years or under) who has been diagnosed with a mental, emotional or behavioral disorder.
- Must be at least 18 years or older and must have a high school diploma or GED.
- Have successfully navigated a child serving system for at least one year (i.e. mental health, juvenile justice, social security or special education) and be able to articulate their lived experience as it relates to advocacy for their child/youth and success in navigating these systems.
- Have lived experience that speaks to accomplishments concerning their child/youth's mental health including their child/youth being in a stable place in their recovery and/or resiliency.
- Can meet requirements for a Medicaid background check.

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## **XI. Service Definitions**

**Children's Crisis Residential Services:** Twenty-four hour, usually short-term residential services provided to a child/youth demonstrating a psychiatric crisis that cannot be stabilized in a less restrictive setting. This service may use crisis beds in a residential treatment center or crisis respite beds.

**Counseling:** Individual, family, and group therapy focused on the reduction or elimination of a child/youth's symptoms of emotional disturbance and increasing the individual's ability to perform activities of daily living. Cognitive Behavioral Therapy (CBT) is the selected treatment model for Children's Mental Health (CMH) counseling services. Trauma-Focused Cognitive Behavioral Therapy is the approved counseling treatment model for children/youth with trauma disorders or children/youth whose functioning or behavior is affected by their history of traumatic events. DSHS approved CBT protocols for treating children/youth for depression and anxiety are outlined in the Utilization Management Guidelines.

Additional models of counseling available to children age 3-5 include Parent-Child Psychotherapy (Dyad Therapy) and Play Therapy. These models must be used as outlined in the Utilization Management Guidelines.

Counseling services includes treatment planning to enhance recovery and resiliency.

All counseling services shall be provided by a Licensed Practitioner of the Healing Arts (LPHA) practicing within the scope of his or her license or, if not billed to Medicaid, by an individual with a master's degree in a human services field pursuing licensure under the direct supervision of an LPHA..

**Crisis Flexible Benefits:** Non-clinical supports that reduce the crisis situation, reduce symptomatology, and enhance the ability of the child/youth to remain in the home. Examples in children's/youth's mental health services include home safety modifications, child care to allow the family to participate in treatment activities, and transportation assistance.

**Crisis Follow-up and Relapse Prevention:** A service provided to or on behalf of individuals who are not in imminent danger of harm to self or others but require additional assistance to avoid recurrence of the crisis event. The service is provided to ameliorate the situation that gave rise to the crisis event, ensure stability, and prevent future crisis events.

**Crisis Intervention Services:** Interventions in response to a crisis in order to reduce symptoms of severe and persistent mental illness or emotional disturbance and to prevent admission of a child/youth to a more restrictive environment. Shall be provided in accordance with 25 Texas Administrative Code (TAC), Chapter 419, Subchapter L, *MH Rehabilitative Services*. The provision of Crisis Intervention Services to collaterals is limited to the coordination of emergency care services as defined and outlined in the provision of crisis services within 25 TAC, Part 1, Chapter 412, Subchapter G, *MH Community Standards*.

**Crisis Transportation:** Transporting children/youths receiving crisis services or crisis follow-up and relapse prevention services from one location to another. Transportation is provided in accordance with state laws and regulations by law enforcement personnel, or, when appropriate, by ambulance or qualified staff.

**Engagement Activity:** Short term planned activities with the child/youth, caregiver and/or legally authorized representative (LAR) to develop treatment alliance and rapport with the child/youth, caregiver and/or LAR. Activities include but are not limited to: enhancing the child/youth and/or caregiver/LAR's motivation to participate in services; explaining recommended services; and providing education regarding value of services, adherence to the recommended level of care and its importance in recovery. This service shall not be provided in a group and shall be provided in accordance with confidentiality requirements.

**Extended Observation:** Up to 48 hour emergency and crisis stabilization service that provides emergency stabilization in a secure and protected, clinically staffed (including medical and nursing professionals), psychiatrically supervised treatment environment with immediate access to urgent or

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emergent medical evaluation and treatment. Child/youths are provided appropriate and coordinated transfer to a higher LOC when needed.

**Family Case Management:** Activities to assist the child/youth's family members in accessing and coordinating necessary care and services appropriate to the family members' needs. The need for Family Case Management must be documented in the child/youth's Case Management Plan.

**Family Partner:** Family Partners are primary caregivers (i.e. birth parent, adoptive parent, foster parent, a family member acting on behalf of an absent parent, or a non-family member who is chosen by the family to act on behalf of the parent) of a child or youth with a serious emotional disturbance. Family Partners have at least one year of experience navigating a child-serving system (e.g. mental health, juvenile justice, social security, special education). They provide peer mentoring and support to the primary caregivers; introduce the family to the treatment process; model self-advocacy skills; provide information, referral and non-clinical skills training; assist in the identification of natural/non-traditional and community support systems; and document the provision of all family partner services, including both face-to-face and non-face-to-face activities. Family Partners are active members of the intensive Case Management/Wraparound team process and are instrumental in engaging families in services.

**Family Training:** Training provided to the child/youth's primary caregivers to assist the caregivers in coping with and managing the child/youth's mental health needs. This includes instruction on basic parenting skills and other forms of guidance that cannot be considered rehabilitative skills training. Concurrent rehabilitative training should be identified as a separate encounter with the appropriate rehabilitative service code.

**Flexible Funds:** Funds utilized for non-clinical supports that augment the service plan to reduce symptomatology and maintain quality of life and family integration. Non-clinical supports shall be:

1. Included as strategies in the individual's Case Management Plan;
2. Based on the preference of the child/youth and caregiver and focus on the outcomes they choose;
3. Monitored for effectiveness by the Case Manager and adjusted based on effectiveness;
4. Available through General Revenue (GR) funding; and
5. Not readily available through other sources (e.g., other agencies, volunteers)

Community supports that may be purchased through Flexible Funds include but are not limited to: tutors, family aides, specialized camps, therapeutic child-oriented activities, temporary child care, temporary kinship care, initial job development and placement activities, initial independent living support, transportation services, short-term counseling for family members who do not meet the child or adult priority population definitions. Authorization of flexible funds should be provided in a timely manner. In cases of emergencies, Flexible Funds should be available within 24 hours of a request by the family. If respite services are provided with Flexible Funds, they should be identified with Procedure Codes H0045ETHA, H0045HA, T1005ETHA, or T1005HA.

**Flexible Community Supports:** Non-clinical supports that assist the child/youth with community integration, reducing symptomatology, and maintaining quality of life. Flexible community supports include but are not limited to: transportation services, educational training, (e.g. computer skills, budgeting, etc.) temporary child care, job development and placement activities, and independent living support.

**Inpatient Hospitalization Services:** Hospital services staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute psychiatric crisis. Staff provides intensive interventions designed to relieve acute psychiatric symptomatology and restore child/youth's ability to function in a less restrictive setting. The hospital must be contracting with or operated by Contractor.

**Intensive Case Management:** Activities to assist a child/youth and caregiver/LAR in obtaining and coordinating access to necessary care and services appropriate to the individual's needs. Wraparound Planning is used to develop the Case Management Plan. Intensive Case Management activities shall be

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provided in accordance with 25 TAC, Part 1, Chapter 412, Subchapter I, *MH Case Management Services*. Contractor shall not subcontract for the delivery of these services.

**Medication Training and Support:** Education and guidance about medications and their possible side effects as described in 25 TAC, Part 1, Chapter 419, Subchapter L, *MH Rehabilitative Services*, provided to children, youth, and caregivers and/or LAR. The department has reviewed and approves the use of the materials that are available on the department's internet site at <http://www.dshs.state.tx.us/mhsa/patient-family-ed/>

**Psychiatric Diagnostic Interview Examination:** An assessment by a licensed professional practicing within the scope of his or her license that includes relevant past and current medical and psychiatric information and documented as described in the most current version of Title 25 TAC, Part I Chapter 412, Subchapter G, Section 412.322(b) *MH Community Services Standards*.

**Pharmacological Management:** A service provided by a physician or other prescribing professional which focuses on the use of medication and the in-depth management of psychopharmacological agents to treat an individual's signs and symptoms of mental illness.

**Parent Support Group:** Routinely scheduled support and informational meetings for the child/youth's primary caregiver(s).

**Respite Services:** Services provided for temporary, short-term, periodic relief for primary caregivers. Program-based respite services are provided at a temporary residential placement outside the child/youth's usual living situation. Community-based respite services are provided by respite staff at the child/youth's usual living situation. Respite includes both planned respite and crisis respite to assist in resolving a crisis situation.

**Routine Case Management:** Primarily site-based services that assist a child/youth or caregiver/LAR in obtaining and coordinating access to necessary care and services appropriate to the individual's needs. Routine Case Management activities shall be provided in accordance with 25 TAC, Part 1, Chapter 412, Subchapter I, *MH Case Management Services*. Contractor shall not subcontract for the delivery of these services.

**Safety Monitoring:** Ongoing observation of an individual to ensure the individual's safety. An appropriate staff person shall be continuously present in the individual's immediate vicinity, provide ongoing monitoring of the individual's mental and physical status, and ensure rapid response to indications of a need for assistance or intervention. Safety monitoring includes maintaining continuous visual contact with frequent face-to-face contacts as needed.

**Skills Training and Development Services:** Training provided to a child/youth and the primary caregiver or Legally Authorized Representative (LAR) that addresses the serious emotional disturbance and symptom-related problems that interfere with the child/youth's functioning, provides opportunities for the child/youth to acquire and improve skills needed to function as appropriately and independently as possible in the community, and facilitates the child/youth's community integration and increases his or her community tenure. For 17-year-old youth, skills training and development may also include supported employment and supported housing services delivered as defined for Adult Mental Health Services. Must be provided in accordance with 25 TAC, Chapter 419, Subchapter L, *MH Rehabilitative Services*.

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**XII. Standard Requirements for All Levels of Care**

**Provider Qualifications**

In accordance with 25 TAC, Chapter 412, Subchapter G, *MH Community Services Standards*:  
*“All staff must demonstrate required competencies before contact with consumers and periodically throughout the staff’s tenure of employment or association with the LMHA, MMCO, or provider.”*

Crisis Intervention Services: QMHP-CS

Psychiatric Diagnostic Interview Examination: LPHA

Pharmacological Management: MD, RN, PA, Pharmacy D, APN, LVN

Safety Monitoring: QMHP-CS, trained and competent paraprofessional

Family Partners: Experienced parents/primary caregivers/LARs of a child/youth with a serious emotional disturbance.

Skills Training and Development: QMHP-CS, CSSP

Medication Training and Support: QMHP-CS, CSSP

Parent Support Group: Trained and competent paraprofessional, QMHP-CS

Family Training: QMHP-CS, CSSP

Family Case Management: QMHP-CS, CSSP

Intensive Case Management: QMHP-CS, CSSP

Counseling: LPHA or LPHA Intern

Routine Case Management: QMHP-CS, CSSP

Crisis Follow-up and Relapse Prevention: QMHP-CS

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### **XIII. Clinical Guidance: Selecting an Intervention**

#### **Allowable Protocols: Skills Training and Development**

The implementation of new protocols for skills training and development means there are several choices available when selecting an intervention to use with children, youth, and their families. The information below is intended to provide guidance for the clinician in selecting the most appropriate skills training intervention to meet the needs of the children and youth served in the CMH service delivery system.

**Aggression Replacement Techniques utilizing the Aggression Replacement Training® curriculum:**

Aggression replacement techniques are intended to help children and youth ages 7-17 improve social skills and moral reasoning, better manage anger, and reduce aggressive behaviors. This skills training protocol is divided into the following two groups, which can be provided individually or in a group format:

1. *Aggression Replacement Techniques* – These techniques can be used to treat children and youth with anger issues, oppositional defiant behavior, conduct disorder, and delinquent behavior. The techniques, created by Dr. Arnold Goldstein, consist of three components: social skills (skillstreaming), anger control, and moral reasoning.

The components of the aggression replacement techniques were originally developed to be provided in sets of three components in one week, creating a weekly set of skills. However, the protocol has been adapted for outpatient community mental health settings and it is expected that this skills training intervention will be provided at least once per week. The three components of the aggression replacement techniques must be provided in a sequenced order and each session must address at least one skill component. It should be noted, however, that a maximum of two components can be provided in one session following the established sequence. The sequence of the components must be followed in this order: social skills, anger control, and moral reasoning. The order of the components is repeated in the following manner as the child progresses in treatment: social skills #1, anger control #1, moral reasoning #1, social skills #2, anger control #2, moral reasoning #2, social skills #3, and so on. Thus, one session may cover both social skills #1 and anger control #1 components, if clinically appropriate.

For children in elementary school, the social and anger control skills to be used are from the book *Skillstreaming: The Elementary School*. For youth that need aggression replacement techniques, all treatment components are inside the aggression replacement techniques manual.

2. *Social Skills Training* – This component will be provided using the series of manuals called *Skillstreaming*. Skillstreaming is a pro-social skills training treatment created by Dr. Arnold Goldstein. It employs a systematical four-part training approach that includes modeling, role-playing, performance feedback, and generalization to teach essential pro-social skills to children and youth. Skillstreaming is integrated in the components of aggression replacement techniques, but it can be used as a single skills training protocol for children and youth in need of social skills training. Skillstreaming has a series of grouped and sequenced skills training curriculum. The groups are used as skills training modules based on the needs of the child/youth and the age group (e.g. “Group III: Skills for dealing with feelings” is targeted towards children with difficulties expressing and coping with their feelings).

The following books should be used as the manuals for delivering aggression replacement techniques:

- i. Aggression Replacement Training® Manual
- ii. Skillstreaming: The Elementary School Child
- iii. Skillstreaming: in Early Childhood
- iv. Skillstreaming: the Adolescent\*

\*Note: The A.R.T.® manual contains “Skillstreaming: the Adolescent” in the section “Social Skills/Skillstreaming”.

**Barkley’s Defiant Child:** Barkley’s Defiant Child: This is a research based skills training protocol for children ages 3–12 with disruptive behavior disorders. DSHS allows the use of Barkley’s Defiant Child only for children with a single diagnosis of Attention Deficit/Hyperactivity Disorder or Disruptive Behavior

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Disorder Unspecified. If anger issues are present, aggression replacement techniques should be provided instead of Defiant Child.

**Barkley's Defiant Teen:** This is a research based skills training protocol for youth ages 13-17 with disruptive behavior disorders. DSHS allows the use of Barkley's Defiant Teen only for youth with a single diagnosis of Attention Deficit/Hyperactivity Disorder or Disruptive Behavior Disorder Unspecified.

**Bloomquist's "Skills Training for Children with Behavior Problems: A Parent and Practitioner Guidebook":** This skills training curriculum is to be used as outlined in the text's instructions which recommend the selection of skills based on the child's developmental age (i.e. how the child functions developmentally). It targets children with behavior and adjustment problems who are younger than 13 years of age. It can be used with the child and/or the parent or caregiver. The skills are not required to be provided in sequence.

**Nurturing Parenting:** This evidence-based skills training protocol is a Tertiary Prevention-Treatment for parents or caregivers of children and youth receiving mental health services. It treats abusive or neglecting parent-child dysfunctional interactions and develops caregiver's pro-social skills that will help the child and caregiver function. Nurturing Parenting can be provided individually or in a group format. There is a sequence to be followed according to each protocol. Nurturing Parenting combines meeting with the child/youth and caregiver separately and then jointly depending on the age group. The typical length of treatment is 16 sessions. The following are the DSHS approved Nurturing Parenting skills training protocols:

- a. *Parents and Their Infants, Toddlers & Preschoolers – 16 sessions*
- b. *Parents & Their School-Age Children 5-11 years*
- c. *Parents & Adolescents*

**Seeking Safety:** This is a present-focused therapy (skills training) to help individuals attain safety from trauma/PTSD and substance abuse. The treatment was designed for flexible use and can be conducted in group and individual format. Seeking Safety can be used with youth (ages 13 and older) that have *both* substance abuse issues *and* a history of trauma. However, note that a diagnosis of PTSD is *not* required in order for an individual to receive the Seeking Safety intervention. The first three sessions of this protocol must be provided in sequence; after the 3<sup>rd</sup> session, all subsequent sessions are provided based on the identified needs of the youth. Providers may follow the suggested sequence but, as previously stated, should base treatment on the youth's identified needs. A minimum of 10 sessions have been found to be most effective in achieving desired outcomes.

**Preparing Adolescents for Young Adulthood (PAYA):** This skills training curriculum is to be used with youth ages 14-17 facing issues related to transitioning from adolescence to adulthood. PAYA consists of five modules; each module addresses a group of transitioning-youth skills. PAYA is a promising practice created by the Casey Life Skills Foundation and was envisioned to be self-directed by youth to support and facilitate the development of self-determination. It can be delivered by a Qualified Mental Health Professional (QMHP) with the direction of the youth. It is recommended that the QMHP uses the "Gateway to the World: A toolkit and curriculum" to understand the principles that guide the use of the PAYA modules. Each module has an assessment in the beginning to identify which transitioning skills the youth needs. Based on the identified needs, sections of the PAYA module that address those needs are selected to provide skills training. It is not required that the entire module is used with a single youth nor is it required that all modules be provided to a single youth. The use of the PAYA as a skills training protocol is flexible and does not require a specific sequence of sessions.

The following is the list of the five PAYA modules:

- Module 1: Money, Home and Food Management
- Module 2: Personal Care, Health, Social Skills and Safety
- Module 3: Education, Jobs Seeking Skills and Job Maintenance Skills
- Module 4: Housing, Transportation, Community Resources, Understanding the Law and Recreation
- Module 5: Young Parents Guide

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**Allowable Protocols: Counseling**

In the CMH service delivery system there are several Cognitive Behavioral Therapy (CBT) modalities available to help meet the needs of children and youth. For the young child population (ages 3-5) there are non-CBT counseling modalities available to meet the specific developmental needs of that age group. The information below is intended to provide guidance for the clinician in selecting the most appropriate counseling intervention to meet the needs of children and youth served in the CMH service delivery system.

**Cognitive Behavioral Therapy (CBT):** CBT is an empirically supported treatment in which a therapist or Licensed Professional of the Healing Arts (LPHA) works together with an individual to identify and solve problems using a Cognitive Model that helps the individual overcome difficulties by changing thinking, behavior and emotional responses. The following are CBT protocols approved for the use of LPHAs to treat children and youth:

- a) **Coping Cat:** This protocol is to be used with children ages 7-13 to treat anxiety related disorders such as: Generalized Anxiety, Anxiety Disorder NOS, Panic Disorder, Social Phobia (Social Anxiety Disorder), etc.
- b) **The Cat Project:** This protocol is to be used with youth ages 14-17 to treat anxiety related disorders such as: Generalized Anxiety, Anxiety Disorder NOS, Panic Disorder, Social Phobia (Social Anxiety Disorder), etc.
- c) **Taking Action:** This protocol is to be used with children ages 9–13 to treat depressive mood disorders, such as: Major Depression, Depressive Disorder NOS, Mood Disorder NOS, etc.
- d) **Adolescent Coping with Depression Course (CWD-A):** This protocol is to be used with youth ages 14-17 to treat depressive mood disorders such as: Major Depression, Depressive Disorder NOS, Mood Disorder NOS, etc.
- e) **Cognitive Behavioral Therapy (General):** Although there is not a specific protocol identified to provide Cognitive Behavioral Therapy, this general treatment modality can be used to treat diverse disorders or specific behavior problems in children and youth such as: Obsessive Compulsive Disorder, Specific Phobias, Bipolar Disorder, Substance Abuse, and anger issues of children or youth diagnosed with Oppositional Defiant Disorder or Conduct Disorder.

**Parent-Child Psychotherapy (Dyadic Therapy):** The focus of this therapeutic intervention is to support and strengthen the relationship between the child and caregiver as a vehicle for restoring the child's sense of safety, attachment, appropriate affect and improving the child's cognitive, behavioral, and social functioning. This treatment modality is to be used with children ages 3-6 years old. If the specific evidence-based intervention Parent Child Interaction Therapy (PCIT) is provided, it can be used in children ages 3-7 years old. Providers must use DSHS approved models of Parent-Child Psychotherapy as outlined in the performance contract.

**Trauma-Focused CBT (TF-CBT):** TF-CBT is a recognized evidence-based practice and is a components-based model of psychotherapy. It addresses the unique needs of children with symptoms of Post-Traumatic Stress Disorder, depression, behavior problems, and other difficulties related to traumatic life experiences. TF-CBT can be used with children and youth ages 3 – 18 years old. The average length of treatment ranges between 12 – 16 sessions; however, if compounding complex trauma is present the length of treatment may be significantly longer. This counseling modality requires individual sessions for both the child/youth and for the caregivers/parents, in addition to joint sessions.