TEXAS
Department of
State Health Services

Texas Resilience and Recovery

Utilization Management Guidelines: Child and Adolescent Services

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Introduction to the Children's Mental Health System

"Hope, Resilience, and Recovery for Everyone" is the vision statement of the Mental Health and Substance Abuse Division (MHSA) of the Department of State Health Services (DSHS). This vision is aligned with the national movement to incorporate resilience and recovery oriented services, supports, practices, and beliefs into publicly funded mental health service delivery systems. In September 2012, to further reflect a commitment to these principles, the name of Texas' mental health system was changed from Resiliency and Disease Management (RDM) to "Texas Resilience and Recovery" (TRR). MHSA acknowledges that children and youth affected by mental illness and severe emotional disturbance (SED) are on a continuum of mental health and have natural supports and strengths which should be built upon to foster resilience and recovery. Through the promotion of mental health, early intervention, and the provision of quality mental health services, providers have the opportunity to support children and youth to achieve not only mental health but also their individual potential.

In 2010 MHSA began its review of the RDM service delivery system, implemented in 2004. This review included feedback/input from frontline staff/providers and a review of research on best practices in serving children and youth with mental health needs. In response to this review, the Children's Mental Health (CMH) System has been re-designed. Resilience and recovery are fundamental principles of the CMH system and have been incorporated throughout the new design and considered in the selection of available services.

The modern framework of the new system design utilizes an intensity-based approach to service delivery. Within this model, the intensity of services responds to where the child/youth is on the continuum of mental health. Levels of Care (LOCs) have been designed to make services available that correspond to the intensity and complexity of the child/youth's identified needs. An expanded array of evidence based and promising practices (EBPs) can be individualized to meet these needs and build upon the unique strengths of each child or youth. Through the use of EBPs, the services and supports provided within the CMH system will result in measurable outcomes and ultimately the resilience, recovery, and achievement of mental health of children/youth.

The Substance Abuse and Mental Health Services Administration (SAMSHA) defines Recovery in the following way:

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

While the concept of recovery is often applied primarily to adults, the term is being used more and more in child-serving systems with the understanding that recovery supports extend to caregivers as well as the child/youth.

Historically, CMH service delivery systems have focused on building resiliency in children and youth. SAMHSA defines Resilience in the following way:

The ability to adapt well over time to life-changing situations and stressful conditions.

In other words, resilience is the ability of a child/youth to achieve positive developmental outcomes in spite of personal and environmental risk factors. Resilience-based systems seek to reduce risk factors and increase protective factors at the individual, family, and environmental levels.

In addition to resilience and recovery, the design of the intensity model of service delivery was heavily influenced by Systems of Care values and principles. Broadly speaking, the system of care approach involves collaboration across child-serving agencies, families, and youth in order to improve access to community-based services and supports for children/youth with SED and their families. Additionally, this approach places emphasis on the use of evidence-based practices to help children/youth and families function better at home in school, in the community, and throughout life. The goal of the new Texas CMH

system is to incorporate systems of care principles to build meaningful partnerships with families, children, and youth. It is through these partnerships that resilience is fostered and recovery is supported.

It is important that clinicians and providers understand the principles and values that provide the foundation for the new system. In order for individuals receiving services to experience and benefit from these principles being put into practice; these values should be reflected in the services, supports, practices, and beliefs of service providers and be evident in the interactions with the children/youth and caregivers that touch the system. The specific values that serve as the foundation of the new service delivery system include the following:

Child Centered, Family Focused: Child/youth centered means that children and youth should be engaged as equal partners in care and should have their voices heard throughout their involvement in the CMH system. Family focused means that caregivers also have a primary decision-making role in the care of their children/youth. Remaining child centered and family focused by involving caregivers and children/youth helps ensure sensitivity to cultural, service, and support needs.

Engagement: Engaging caregivers and youth in the planning and provision of services is one of the most important aspects of care. Engagement emphasizes a respect for child/youth's and caregiver's capabilities and their role(s) as part of the solution to the identified problems.

Evidence-Based Practices: Evidence-Based Practices (EBPs) are programs or practices that effectively integrate the best research evidence with clinical expertise, cultural competence, and the values of the individuals receiving the services. EBPs must be appropriate to the target population(s) and service settings in order to achieve the desired outcomes.

Fidelity: Fidelity is the act of implementing an EBP in a manner that is consistent with the treatment model. Fidelity to evidence-based practices will result in the outcomes intended by the intervention.

The Guidelines outlined in this manual provide a more detailed description of the changes to the system and how these changes will be implemented locally. However, the changes to the CMH system can be broadly summarized as the following:

New Assessment Instrument: Two versions of the Child and Adolescent Needs and Strengths (CANS) assessment will be used to assess the 3-5 and 6-17 year-old populations, respectively;

New Levels of Care: The new service delivery design is based on an intensity model of service delivery where the service array expands based on the child/youth's needs, strengths, and the complexity of need(s);

New Interventions: New evidence-based practices were selected to better equip clinicians in meeting the needs of children, youth, and families receiving services in the CMH system.

It is the hope of the department that the care provided within the Texas CMH system fosters resilience, hope, and recovery in all those participating in care; and that each individual can develop a healthy sense of identity and well-being, and can succeed in school, the family, and in the community. Towards that aim; the dedication and efforts of providers, clinicians, and all staff within the children's mental health system are appreciated as invaluable assets. Your daily commitment to the children, youth, and families within this system of care will help move Texas forward in achieving its vision of Hope, Resilience, and Recovery for Everyone. Thank you for all that you do.

Intensity Driven Service Delivery Model

LOC-R	LOC 0- Crisis Services	LOC 1- Medication Management	LOC 2- Targeted Services	LOC 3- Complex Services	LOC 4- Intensive Family Services	LOC YC- Young Child Services
CANS Scores	**Address the Crisis CANS Completion Not Required**	Severity & Complexity of Symptoms →				**Full Range of Scores**
		← Increased Natural Supports and Strengths				
LOC Indicators	**Crisis**	**Recovery/Low Emotional, Behavioral & Life Domain Needs**	**Emotional Needs** **Behavioral Needs**	**Emotional, Behavioral, and/or Life Domain Needs**	**Multi-System Involvement**	**Sorted by Age 3-5** ***(may include 6 if developmentally appropriate)***
Profile of Child/Youth	▪ Currently in Crisis ▪ Without current authorization into full LOC. ▪ Following stabilization of the crisis episode, the child/youth will be re-assessed and assigned a new LOC-R. ▪ Transition to LOC 1, 2, 3, or 4 will likely require: ▪ Crisis Intervention Services ▪ ANY or ALL services available in the crisis array as clinically indicated.	▪ Stable presentation. ▪ Eligible diagnosis with history of symptoms. ▪ May be transitioning down from LOC 2, LOC 3, or LOC 4. ▪ Needs can be met with Core Services: Routine Case Management and Medication Management ▪ Transition to community provider should be considered.	▪ Stable life domain functioning (low to moderate needs). ▪ Less complex needs (behavioral OR emotional). ▪ May be transitioning from LOC 3 or LOC 4. ▪ Transition to lower LOC and/or recovery will likely require: ▪ Counseling OR ▪ Skills Training AND ▪ Other Core Services ▪ May benefit from Medication Management as clinically indicated.	▪ Complex (behavioral AND emotional) needs; indicating complex array of services. ▪ May have multiple life domain functioning and/or caregiver needs. ▪ May be transitioning down from LOC 4. ▪ Transition to lower LOC and/or recovery will likely require: ▪ Counseling AND ▪ Skills Training AND ▪ Other Core Services ▪ May benefit from Medication Management as clinically indicated.	▪ Multiple severe risk behaviors, threatened community tenure, and risk of juvenile justice involvement; expulsion from school; displacement from home; and/or serious injury to self or others, or death. ▪ Multiple severe life domain functioning symptoms, caregiver needs, behavioral and/or emotional needs. ▪ Transition to lower LOC will likely require: ▪ Counseling AND/OR Skills Training AND ▪ Intensive Case Management / Wraparound with 24/7 accessibility to Wraparound Team AND ▪ Other Core Services ▪ May benefit from Medication Management as clinically indicated.	▪ Child has Emotional and/or behavioral needs. ▪ Child is between 3 and 5 years of age or is developmentally within this age range. ▪ Can benefit from Case Management (Routine or Intensive as clinically indicated) ▪ Recovery will likely require: ▪ Counseling (Parent-Child Psychotherapy) AND/OR ▪ Skills Training AND ▪ Other Core Services
LOC A		← Clinical Judgment/Medical Necessity Consumer Refused OR Resource Limitations *(see Appendix F: Reasons for Deviation)* →				

Level of Care 0: Crisis Services

Purpose for Level of Care

The services in this level of care are brief interventions provided in the community that ameliorate the crisis situation. 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.*

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 beyond the authorization period, the child/youth may be authorized for Level of Care (LOC) 5.

Special Considerations

Level of Care 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.

Level of Care Assignment Criteria

A child/youth may be assigned LOC 0 for the following reasons:

- The Uniform Assessment indicates a Recommended Level of Care (LOC-R) of 0; or
- The Uniform Assessment indicates an LOC-R of 1-4, Young Child (YC), or 9 and it is clinically determined that the child/youth is in crisis; or
- The Uniform Assessment is incomplete but clinical judgment indicates the need for immediate crisis intervention.

Note: A mental health diagnosis is not required.

Criteria for Level of Care Review

Authorization for this LOC will expire in 7 days, unless reauthorized. Additional authorizations may be given if medically necessary.

If the child/youth cannot be treated safely or effectively within this LOC and acuity level increases, hospitalization may be indicated.

Discharge Criteria

The child/youth may be discharged from this LOC for the following reasons:

- The crisis has been resolved and the child/youth has been transitioned to LOC1-5 or LOC-YC; or
- The crisis has been resolved and the child/youth has been placed on a waiting list for the indicated LOC (NOTE: Individuals who are Medicaid Eligible may not be placed on a waiting list or be underserved due to resource limitations); or
- The child/youth and caregiver are referred and linked to community resources outside the DSHS system; or
- The child/youth or caregiver has found services in the community to meet their needs; or
- The child/youth or caregiver terminates services

Expected Outcomes

The following outcomes can be expected as a result of delivering crisis services:

- Reduced risk of placement in a more restrictive environment, such as a psychiatric hospital, residential treatment center, or juvenile detention center; and/or

- Child/youth and/or caregiver reports improved symptom management, behaviors, and/or functioning; and/or
- The child/youth and/or caregiver is engaged in appropriate follow-up treatment and linked with natural and community support systems.

Special Considerations for Certain Adjunct Services

Family Partner Supports:
As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the child/youth's treatment team, and assistance making informed choices regarding the child/youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services;"
- Role-modeling the concepts of hope and resilience through articulation of the Certified Family Partner's successes regarding their child's mental health; and
- Assistance in understanding and advocating for the child/youths mental health needs during the crisis episode.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 0 Table Overview

Authorization Period: 7 Days		
Average Monthly Utilization Standard For This Level of Care: N/A For this LOC overall goal 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.		
Core Services: Identified by the uniform assessment of crisis and must be offered to the child/youth.	**Individual Services in LOC – 0** **Esitmated Utilization Per 7 Days**	
	Standard Therapeutic	**High Need Therapeutic**
Crisis Intervention Services	**N/A**	**3.75 hours** (15 units)
Adjunct Services: Identified by the uniform assessment and addressed in the treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Pharmacological Management	**N/A**	**10 Events** (10 units)
Safety Monitoring	**N/A**	**2 hours** (8 units)
Crisis Transportation (Event)	**N/A**	**1 Event** (1 unit)
Crisis Transportation (Dollar)	**N/A**	**As necessary** ($1 units)
Crisis Flexible Benefits (Event)	**N/A**	**As necessary** (Event)
Crisis Flexible Benefits (Dollar)	**N/A**	**As necessary** ($1 units)
Respite Services: Community-Based	**N/A**	**6 hours** (24 units)
Respite Services: Program-Based (not in home)	**N/A**	**3 bed days** (3 units)
Extended Observation	**N/A**	**1 unit** (1 bed day)
Children's Crisis Residential	**N/A**	**4 units** (4 bed days)
Family Partner Supports	**N/A**	**6 hours** (24 units)
Engagement Activity	**N/A**	**6 hours** (24 units)
Inpatient Hospital Services	**N/A**	**As necessary** (1 bed day units)
Inpatient Services (Psychiatric)	**N/A**	**As necessary** (1 bed day units)
Emergency Room Services (Psychiatric)	**N/A**	**As necessary** (Events)
Crisis Follow-up & Relapse Prevention	**N/A**	**8 hours** (32 units)

Level of Care 1: Medication Management

Purpose for Level of Care

The services in this LOC are intended to meet the needs of the child/youth whose only identified treatment need is for medication management. Children/youth served in this LOC may have an occasional need for routine case management services but do not have ongoing treatment needs outside of medication related services. While services delivered in this LOC are primarily office based, services may also be provided at school, in the community, or via telemedicine.

The purpose of this LOC is to maintain stability and utilize the child/youth's and/or caregiver's natural supports and identified strengths to help transition to community based providers and resources, if available.

Special Considerations During Crisis

If the child/youth's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered within the current LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the child/youth to determine if a more intensive LOC is indicated.

LOC 0 may only be used for a child or youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A child/youth may be assigned LOC 1 for the following reasons:

- The Uniform Assessment indicates a Recommended Level of Care (LOC-R) of 1; or
- The Uniform Assessment indicates an LOC-R of 2-4, Young Child (YC), or 9 and the child/youth meets deviation reason criteria and is overridden into LOC 1.

Criteria for Level of Care Review

The following indicators require a review of the LOC authorized:

- The Uniform Assessment indicates an LOC-R for the child/youth that is different from the Level of Care Authorized (LOC-A); or
- The clinician determines the child/youth meets criteria for admission into a more intensive LOC; or
- The child/youth experiences a psychiatric crisis and must be reassessed to determine if a more intensive LOC is indicated.

Discharge Criteria

The child/youth may be discharged from this LOC for the following reasons:

- The child/youth has been linked to medication services provided in the community; or
- The child/youth does not meet criteria for admission into a more intensive LOC and medication services are not indicated, have been effectively discontinued or have been declined; or
- The child/youth or caregiver terminates services or moves outside of service area; or
- The child/youth or caregiver is not receptive to treatment after all required engagement efforts have been exhausted.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The child/youth and/or caregiver is linked with—and utilizing—natural and community support systems; and/or
- The child/youth and/or caregiver reports stabilization of symptoms or maintenance of stability; and/or
- The child/youth and/or caregiver is engaged in appropriate follow-up treatment and linked with natural and community support systems.

Special Considerations for Certain Adjunct Services

Family Partner Supports:
As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the child/youth's treatment team and assistance making informed choices regarding the child/youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services;"
- Assistance in understanding and advocating for the child/youth's mental health needs, including provision of expertise in navigating child serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills;
- Facilitation of family support groups;
- Connection to community resources and informal supports in preparation for the child/youth's transition out of the mental health system;
- Identification of the family's natural supports and strengths and guidance; and practical guidance in nurturing those relationships; and
- Celebrating the child/youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 1 Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: .5 hours 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 will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the treatment plan.	**Individual Services in LOC – 1** **Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Pharmacological Management	**1 Event** (1 unit)	**2 Events** (2 units)
Adjunct Services: Identified by the uniform assessment and addressed in the treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Medication Training and Support either/both of the following:		
Medication Training and Support (Individual)	**.5 hours** (2 units)	**3.75 hours** (15 units)
Medication Training and Support (Group)	**.5 hours** (2 units)	**3.75 hours** (15 units)
Routine Case Management	**.5 hours** (2 units)	**1 hour** (4 units)
Parent Support Group	**1 hour** (1unit)	**4 hours** (4 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Family Case Management	**.5 hours** (2 units)	**1 hour** (4 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization for Crisis Service Array can be found on page 30***	

Level of Care 2: Targeted Services

Purpose for Level of Care

The services in this LOC are intended to meet the needs of the child/youth with identified emotional *or* behavioral treatment needs. The child/youth must not have identified needs in both areas. In general, the child/youth will have low or no life domain functioning needs.

The purpose of this LOC is to improve mood symptoms or address behavioral needs while building strengths in the child/youth and caregiver. The services in the LOC target a specific, identified treatment need. Services should be provided in the most convenient location for the child/youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telemedicine, if available.

The targeted service in this LOC is either counseling *or* individual skills training. The only exception occurs when counseling is the primary intervention for the child/youth but individual skills training is also provided as a component of parent skills training.

Note: If the child/youth and/or caregiver chooses not to participate in core services offered at this level of care, engagement services must be provided. Provision of engagement efforts must be documented in the clinical record.

Special Considerations During Crisis

If the child/youth's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered within the current LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the child/youth to determine if a more intensive LOC is indicated.

LOC 0 may only be used for a child or youth who is not currently assigned to an LOC and does not have an active CANS Recommended Level of Care (LOC-R).

Level of Care Assignment Criteria

A child/youth may be assigned to LOC 2 for the following reasons:

- The Uniform Assessment indicates an LOC-R of 2; or
- The Uniform Assessment indicates an LOC-R of 1, 3-4, Young Child (YC), or 9 and the child/youth meets deviation reason criteria and is overridden into LOC 2.

Note: See Appendix F: Reasons for Deviation for clinical guidance on deviation reasons.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The Uniform Assessment indicates an LOC-R for the child/youth that is different from the Level of Care Authorized (LOC-A); or
- The clinician determines the child/youth meets criteria for admission into a more intensive LOC; or
- The clinician determines the child/youth and caregiver has obtained maximum clinical benefit from services and recommends transition to LOC 1 or services in the community; or
- The child/youth experiences a psychiatric crisis and must be reassessed to determine if a more intensive LOC is indicated

Step-Down/Discharge Criteria

The child/youth may be stepped down from this LOC or discharged from services for the following reasons:

- The Uniform Assessment indicates an LOC-R of 1 *and* the child/youth has completed the indicated course of treatment; or

- The child/youth and caregiver report improved mood or behavioral symptoms, have no additional identified goals, and clinical judgment supports transition to LOC 1 or transition to the community; or
- The child/youth or caregiver have found services in the community to meet their needs; or
- The child/youth or caregiver chooses not to participate in services at the indicated intensity, all required engagement efforts have been exhausted, and clinical judgment of risk supports the transition to a lower level of care; or
- The child/youth or caregiver terminates services or moves outside of service area.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The child/youth and/or caregiver reports improved mood symptom management or behaviors; and/or
- The child/youth and/or caregiver is transitioned to a lower level of care; and/or
- The child/youth and/or caregiver is linked with—and utilizing—natural and community support systems; and/or
- The child/youth and/or caregiver reports increased individual and caregiver strengths.

Special Considerations for Certain Adjunct Services

Family Partner Supports:
As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the child/youth's treatment team and assistance making informed choices regarding the child/youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services;"
- Assistance in understanding and advocating for the child/youth's mental health needs, provision of expertise in navigating child serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents through the use of a DSHS approved protocol;
- Facilitation of family support groups;
- Connection to community resources and informal supports that support the child/youth's transition to a less intensive LOC and resilience and recovery; and
- Identification of the family's natural supports and strengths and guidance; and practical guidance in nurturing those relationships.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 2 Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 3 hours 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 will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the recovery plan. NOTE: In this LOC the child/youth should receive counseling *or* skills training as a core service.	**Individual Services in LOC – 2** **Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Routine Case Management	**1 hour** (4 units)	**2 hours** (8 units)
Counseling includes any/all of the following:		
Counseling (Individual)	**2 hours**	**4 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Adjunct Services: Identified by the uniform assessment and addressed in the treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Engagement Activity	**.5 hours** (2 units)	**2 hours** (8 units)
Pharmacological Management*	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support* either/both of the following:		
Medication Training and Support (Individual)	**.5 hours** (2 units)	**3.75 hours** (15 units)
Medication Training and Support (Group)	**.5 hours** (2 units)	**3.75 hours** (15 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training includes either/both of the following:		
Family Training (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Parent Support Group	**1 hour** (1 unit)	**4 hour** (4 units)
Family Case Management	**.5 hours** (2 units)	**1 hour** (4 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization for Crisis Service Array can be found on page 30***	

*When prescribed or indicated by a physician these services must be offered.

Level of Care 3: Complex Services

Purpose for Level of Care

The services in this LOC are intended to meet the needs of the child or youth with identified behavioral *and* emotional treatment needs. The child/youth may also exhibit a moderate degree of risk behaviors and/or life domain functioning impairments that require multiple service interventions. Some children/youth assigned to this level of care may experience a higher degree of functional impairment. This may indicate a need for interventions aimed at preventing juvenile justice involvement, expulsion from school, displacement from home, or further exacerbation of symptoms and/or behaviors.

The purpose of this LOC is to reduce or stabilize symptoms and/or risk behaviors, improve overall functioning, and build strengths and resiliency in the child/youth and caregiver. Services should be provided in the most convenient location for the child/youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telemedicine, if available. Providers may need to consider flexible office hours to support the complex needs of the child/youth and caregiver.

Note: If the child/youth and/or caregiver chooses not to participate in core services offered at this level of care, engagement services must be provided. Provision of engagement efforts must be documented in the clinical record.

Special Considerations During Crisis

If the child/youth's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered within the current LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the child/youth to determine if a more intensive LOC is indicated.

LOC 0 may only be used for a child or youth who is not currently assigned to an LOC and does not have an active CANS Recommended Level of Care (LOC-R).

Level of Care Assignment Criteria

A child/youth may be assigned LOC 3 for the following reasons:

- The Uniform Assessment indicates an LOC-R of 3; or
- The Uniform Assessment indicates an LOC-R of 1-2, 4, Young Child (YC), or 9 and the child/youth meets deviation reason criteria and is overridden into LOC 3.

Note: See Appendix F: Reasons for Deviation for clinical guidance on deviation reasons.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The Uniform Assessment indicates an LOC-R for the child/youth that is different from the Level of Care Authorized (LOC-A); or
- The clinician determines the child/youth meets criteria for admission into LOC 4; or
- The clinician determines the child/youth and caregiver has obtained maximum clinical benefit from services and recommends transition to a less intensive LOC or services in the community; or
- The clinician determines that it is contraindicated to offer counseling and skills training services concurrently and recommends deviation to LOC 2; or
- The child/youth experiences a psychiatric crisis and must be reassessed to determine if a more intensive LOC is indicated.

Step-Down/Discharge Criteria

The child/youth may be stepped down from this LOC or discharged from services for the following reasons:

- The Uniform Assessment indicates an LOC-R of 1-2 *and* the child/youth has completed the indicated course of treatment or can continue a single course of treatment in LOC 2; or

- The child/youth and caregiver report improved mood or behavioral symptoms, have no additional identified goals, and clinical judgment supports transition to a lower level of care or transition to the community; or
- The child/youth or caregiver have found services in the community to meet their needs; or
- The child/youth or caregiver chooses not to participate in services at the indicated intensity, all required engagement efforts have been exhausted, and clinical judgment of risk supports the transition to a lower level of care; or
- The child/youth or caregiver terminates services or moves outside of service area.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The child/youth and/or caregiver reports improved mood symptom management or behaviors, and/or improved life domain functioning; and/or
- The child/youth or caregiver is transitioned to a lower level of care; and/or
- The child/youth and/or caregiver is linked with—and utilizing—natural and community support systems; and/or
- The child/youth and/or caregiver reports increased individual and caregiver strengths

Special Considerations for Certain Adjunct Services

Family Partner Supports:
As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the child/youth's treatment team and assistance making informed choices regarding the child/youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services;"
- Assistance in understanding and advocating for the child/youth's mental health needs, provision of expertise in navigating child serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents and/or caregivers through the use of a DSHS approved protocol;
- Facilitation of family support groups;
- Connection to community resources and informal supports that support the child/youth's transition to a less intensive LOC and resilience and recovery; and
- Identification of the family's natural supports and strengths and guidance; and practical guidance in nurturing those relationships.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 3 Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 5 hours 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 will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the treatment plan. NOTE: In this LOC the child/youth should receive counseling *and* skills training as core services.	**Individual Services in LOC – 3** **Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Routine Case Management	**1 hour** (4 units)	**6 hours** (24 units)
Counseling includes any/all of the following:		
Counseling (Individual)	**2 hours**	**4 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Adjunct Services: Identified by the uniform assessment and addressed in the treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Engagement Activity	**.75 hours** (3 units)	**2 hours** (8 units)
Pharmacological Management*	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support* either/both of the following:		
Medication Training and Support (Individual)	**.5 hours** (2 units)	**4.5 hours** (18 units)
Medication Training and Support (Group)	**.5 hours** (2 units)	**4.5 hours** (18 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training includes either/both of the following:		
Family Training (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Flexible Funds	**N/A**	**$1,500 cap/year** ($1 increments)
Parent Support Group	**1 hour** (1 unit)	**4 hour** (4 units)
Family Case Management	**.5 hours** (2 units)	**1 hour** (4 units)
Respite Services: Community Based	**N/A**	**6 hours** (24 units)
Respite Services: Program Based	**N/A**	**3 Bed days** (3 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization for Crisis Service Array can be found on page 30***	

*When prescribed or indicated by a physician these services must be offered.

Level of Care 4: Intensive Family Services

Purpose for Level of Care

The services in this LOC are intended to meet the needs of the child or youth with identified behavioral and/or emotional treatment needs that has significant involvement with multiple child serving systems. The child or youth is also likely at risk of out of home placement as a result of behavioral and/or emotional needs. These behaviors and/or mood symptoms may have resulted in—or are likely to result in—juvenile justice involvement, expulsion from school, displacement from home, hospitalization, residential treatment, serious injury to self or others, or death.

The purpose of this LOC is to reduce or stabilize symptoms and/or risk behaviors, improve overall functioning, and build strengths and resiliency in the child/youth and caregiver through a team approach. Services should be provided in the most convenient location for the child/youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telemedicine, if available. Providers may need to consider flexible office hours to support the complex needs of the child/youth and caregiver.

Caregiver resilience is fostered through building upon natural supports and strengths that are identified by the caregiver and linkage to community resources through the Wraparound planning process. DSHS has identified the National Wraparound Initiative (NWI) model for Wraparound for the delivery of Intensive Case Management.

Wraparound team meetings shall take place at least monthly and occur in adherence to the Texas Administrative Code. Due to the high level of symptom severity of the child/youth, the Wraparound team–specifically a member of the treatment team–should be accessible to the child/youth and his/her caregiver 24 hours/day, 7days/week. When a crisis as identified by a member of the Wraparound team occurs, a Wraparound team meeting should occur within 72 hours. The availability of the Wraparound team is meant to reduce the risk of out-of-home placement for the child/youth.

Note: If the child/youth and/or caregiver chooses not to participate in core services offered at this level of care, engagement services must be provided. Provision of engagement efforts must be documented in the clinical record.

Special Considerations During Crisis

If the child/youth's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered within the current LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the child/youth for LOC assignment.

LOC 0 may only be used for a child or youth who is not currently assigned to an LOC and does not have an active CANS Recommended Level of Care (LOC-R)

Level of Care Assignment Criteria

A child/youth may be assigned to LOC 4 for the following reasons:

- The Uniform Assessment indicates an LOC-R of 4; or
- The Uniform Assessment indicates an LOC-R of1-3, Young Child (YC), or 9 and the child/youth meets deviation reason criteria and is overridden into LOC 4.

Note: See Appendix F: Reasons for Deviation for clinical guidance on deviation reasons.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The Uniform Assessment indicates an LOC-R for the child/youth that is different from the Level of Care Authorized (LOC-A); or
- The clinician determines the child/youth's needs can be met in a lower level of care (clinician must document clinical justification for deviation); or

- The clinician determines the child/youth and caregiver has obtained maximum clinical benefit from services and recommends transition to a lower level of care

Step-Down/Discharge Criteria

The child/youth may be stepped down from this LOC or discharged from services for the following reasons:

- The Uniform Assessment indicates an LOC-R of 2-3 *and* the child/youth has completed the indicated course of treatment or can continue an indicated course of treatment in a lower level of care; or
- The child/youth and caregiver report improved mood or behavioral symptoms, have no additional identified goals, and clinical judgment supports transition to a lower level of care; or
- The child/youth or caregiver have found services in the community to meet their needs; or
- The child/youth or caregiver chooses not to participate in services at the indicated intensity, all required engagement efforts have been exhausted, and clinical judgment of risk supports the transition to a lower level of care; or
- The child/youth or caregiver terminates services or moves outside of service area.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The child/youth and/or caregiver reports improved mood symptom management or behaviors; and/or
- The child/youth and/or caregiver is linked with—and utilizing—natural and community support systems; and/or
- The child/youth and caregiver is able to be transitioned to a lower level of care; and/or
- The child/youth and/or caregiver reports increased individual and caregiver strengths; and/or
- Improved stability in areas of life domain functioning, including reduced risk of out of home placement or juvenile justice involvement.

Special Considerations for Family Partner Supports

Family Partner Supports:
As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the child/youth's Wraparound team and assistance making informed choices regarding the child/youth's plan for recovery;
- Assurance that family voice and choice are articulated by the family and heard by professional staff;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services;"
- Assistance in understanding and advocating for the child/youth's mental health needs, provision of expertise in navigating child serving systems as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents and/or caregivers through the use of a DSHS approved protocol;
- Connection to community resources and informal supports that support the child/youth's transition to a less intensive LOC and resilience and recovery; and
- Identification of the family's natural supports and strengths and guidance; and practical guidance in nurturing those relationships.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Special Considerations for Certain Adjunct Services

Routine Case Management:
Routine Case Management may only be provided in this LOC when Intensive Case Management is not available. If Intensive Case Management cannot be provided due to resource limitations, the child/youth may be authorized in LOC 4 and Routine Case Management may be provided until such time that Intensive Case Management is available.

Intensive Case Management is a core service in this LOC. Once the child/youth and family are participating in the Wraparound planning process, per the DSHS approved model for Intensive Case

Management; Intensive Case Management shall be provided and Routine Case Management discontinued.

If despite engagement efforts, the child/youth and family continue to refuse participation in the Wraparound planning process, deviation to a less intensive LOC may be indicated. See Appendix F: Reasons for Deviation for guidance.

Note: Core Services in the LOC-R are determined to be essential to resilience and recovery. The child/youth and/or caregiver/LAR should continue to be engaged to participate in all clinically indicated core services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Level of Care 4 Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 7.5 hours 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 7.5 hours/month. Ideally, the average hours will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the treatment plan. NOTE: In this LOC the individual should receive counseling *and/or* skills training as core services.	**Individual Services in LOC – 4** **Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Intensive Case Management (Wraparound)	**4 hours** (16 units)	**8 hours** (32 units)
Family Partner Supports	**2 hours** (8 units)	**6.25 hours** (25 units)
Counseling includes any/all of the following:		
Counseling (Individual)	**2 hours**	**4 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Adjunct Services: Identified by the uniform assessment and addressed in the treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Engagement Activity	**1.5 hours** (6 units)	**2.5 hours** (10 units)
Pharmacological Management*	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support* either/both of the following:		
Medication Training and Support (Individual)	**.5 hours** (2 units)	**4.5 hours** (18 units)
Medication Training and Support (Group)	**.5 hours** (2 units)	**4.5 hours** (18 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training includes any/both of the following:		
Family Training (Individual)	**3 hours** (24 units)	**6 hours** (12 units)
Family Training (Group)	**3 hours** (24 units)	**6 hours** (12 units)
Parent Support Group	**1 hour** (1 units)	**4 hours** (4 units)
Family Case Management	**.5 hours** (2 units)	**1 hour** (4 units)
Flexible Funds	**N/A**	**$1,500 cap/year** ($1 increments)
Flexible Community Supports	**N/A**	**1.25 hours** (15 units)
Routine Case Management: Routine and Intensive Case Management Services *are not* to be authorized or provided concurrently	**2 hours** (8 units)	**6 hours** (24 units)
Respite Services: Community Based	**6 hours** (24 units)	
Respite Services: Program Based	**N/A**	**3 Bed days** (3 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization for Crisis Service Array can be found on page 30***	

*When prescribed or indicated by a physician these services must be offered.

Level of Care YC: Young Child Services

Purpose for Level of Care

The services in this LOC are intended to meet the needs of the young child (ages 3-5) with identified behavioral *and/or* emotional treatment needs. The young child may also exhibit a moderate degree of life domain functioning impairments that require multiple service interventions.

The purpose of this LOC is to reduce or stabilize symptoms, improve overall functioning, and build strengths and resiliency in the child and caregiver. The focus of services is placed on the dyad relationship as this relationship is the primary context for young children. These primary relationship(s) set the stage for future social-emotional behavior and future relationship behavior. Services should be provided in the most convenient location for the child and caregiver, including the office setting or home. Services may also be provided via telemedicine, if available, and if fidelity can be maintained. Providers may need to consider flexible office/service hours to support the needs of the child and caregiver.

Note: If the child/youth and/or caregiver chooses not to participate in core services offered at this level of care, engagement services must be provided. Provision of engagement efforts must be documented in the clinical record.

Special Considerations During Crisis

If the child's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered within the current LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the child and caregiver to determine if more intensive services are indicated.

LOC 0 may only be used for a child or youth who is not currently assigned to an LOC and does not have an active CANS Recommended Level of Care (LOC-R).

Level of Care Assignment Criteria

A child may be assigned LOC YC for the following reasons:

- The Uniform Assessment indicates an LOC-R of YC; or
- The Uniform Assessment indicates an LOC-R of1-4 or 9 and the child meets deviation reason criteria and is overridden into LOC-YC.

Note: The CANS 3-5 *must* be completed with the child and caregiver before LOC-YC may be authorized.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The Uniform Assessment indicates an LOC-R for the child that is different from the Level of Care Authorized (LOC-A); or
- The child has been served in LOC-YC and after reaching age 6 has an LOC-R of1-4 and the clinician feels that the child should continue to be served in LOC-YC; or
- The child is newly admitted to services and has an LOC-R 1-4 and the clinician feels it is developmentally appropriate for the child to be served in LOC-YC; or
- The clinician determines the child and caregiver has obtained maximum clinical benefit from services and recommends transition to services in the community or LOC-1 (only if medication services are indicated).

Age out/Discharge Criteria

The child may transition from this LOC or be discharged from services for the following reasons:

- The child has completed the indicated course of treatment at this LOC and the Uniform Assessment indicates an LOC-R of 1-4; or
- The child and caregiver report improved mood or behavioral symptoms, have no additional identified goals, and clinical judgment supports transition to the community; or
- The caregiver locates services within the community to meet their needs; or

- The child or caregiver chooses not to participate in services at the indicated intensity, all required engagement efforts have been exhausted, and clinical judgment of risk supports the transition to community-based supports or LOC-1 (only if medication services are indicated) ; or
- The child or caregiver terminates services or moves outside of service area; or
- The child has a birthday and turns 6 years old and has completed the indicated course of treatment. (Note: if the child is age 6 and the course of treatment **has not** been completed, the child should remain in LOC-YC for continuity of care until treatment goals have been reached or the child turns 7 years old).

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The child and/or caregiver reports improved mood symptom management or behaviors; and/or
- The child and/or caregiver is linked with—and utilizing—natural and community support; and/or
- The child and/or caregiver reports increased individual and caregiver strengths.

Special Considerations for Certain Adjunct Services

Family Partner Supports:
As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the child's treatment team and assistance making informed choices regarding the child/youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services;"
- Assistance in understanding and advocating for the child's mental health needs, provision of expertise in navigating child serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents and/or caregivers through the use of a DSHS approved protocol;
- Facilitation of family support groups;
- Connection to community resources and informal supports that support the child's resilience; and
- Identification of the family's natural supports and strengths and guidance; and practical guidance in nurturing those relationships.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Intensive Case Management:
The provision of Wraparound planning process (Intensive Case Management) in this LOC is determined by the clinical needs of the child. One or more of the following scores on the CANS 3-5 represents an intense clinical need and may indicate to the clinician that the child needs Wraparound planning process:

- Child Risks Factors:
  - Abuse/Neglect at a score of 3
- Life Domain Functioning:
  - Living Situation at a score of 3
  - Daycare at a score of 3
  - Relationship Permanence at a score of 3
- Caregiver Strengths/Needs:
  - Involvement at a score of 3

This is not an exhaustive list of indicators and/or scores that may indicate a need for Wraparound planning process. Some CANS 3-5 indicators, such as Residential Stability, may also indicate a need for Wraparound planning process. Services provided must be related to the clinical need of the child and clinicians must use clinical judgment in making this service determination. Justification for services provided must be documented in the clinical record.

Once the child and family are participating in the Wraparound planning process, Intensive Case Management shall be provided. Intensive Case Management and Routine Case Management may not be provided concurrently. Per the DSHS approved model for Intensive Case Management, Wraparound team meetings shall take place at least monthly and occur in adherence to the Texas Administrative Code.

Level of Care YC Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 3.5 hours 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 will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the treatment plan.	**Individual Services in LOC-YC Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Utilization**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Routine Case Management	**1 hour** (4 units)	**2 hours** (8 units)
Counseling includes any/all of the following:		
Counseling (Child-Parent/Dyad)	**3 hours**	**5 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Adjunct Services: Identified by the uniform assessment and addressed in the treatment plan.	**Standard Therapeutic**	**High Need Utilization**
Engagement Activity	**.75 hours** (3 units)	**2 hours** (8 units)
Intensive Case Management (Intensive Case Management can be authorized if clnically necessary; however Routine and Intensive Case Management Services *are not* to be authorized or provided concurrently.)	**3.75 hours** (15 units)	**6.25 hours** (25 units)
Pharmacological Management (when prescribed/ indicated by a physician these services must be offered.)	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support* either/both of the following:		
Medication Training and Support (Individual)	**.5 hours** (2 units)	**3 hour** (12 units)
Medication Training and Support (Group)	**.5 hours** (2 units)	**3 hour** (12 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Family Skills Training includes either/both of the following:		
Family Training (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Parent Support Group	**1 hour** (1 unit)	**4 hour** (4 units)
Family Case Management	**.5 hours** (2 units)	**1 hour** (4 units)
Flexible Funds	**N/A**	**$1,500 cap/year** ($1 increments)
Flexible Community Supports	**N/A**	**1.25 hours** (15 units)
Respite Services: Community Based	**6 hours** (24 units)	
Respite Services: Program Based	**N/A**	**3 Bed days** (3 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization for Crisis Service Array can be found on page 30***	

Level of Care 5: Transitional Services

Purpose for Level of Care

The services in this LOC are intended to assist children/youth and their caregivers in maintaining stability, preventing additional crisis events, and engaging the child/youth and caregiver into the appropriate level of care or assisting in accessing appropriate community-based services. This LOC is highly individualized and the level of service intensity and length of stay is expected to vary based on individual need.

Special Considerations During Crisis

If the child/youth's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered within the current LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the child/youth to determine if a more intensive LOC is indicated.

LOC-0 may only be used for a child or youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A child/youth may be assigned LOC-5 for the following reasons:

- The child/youth has been discharged from LOC-0 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 or released from the hospital and is eligible for ongoing services but ongoing services are not available or the provider has had difficulty engaging the child/youth/caregiver and the child/youth 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 juvenile 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 juvenile justice involvement) and is eligible for ongoing services but ongoing services are not available or the provider has had difficulty engaging the child/youth/caregiver and the child/youth is in need of transitional services; or
- The child/youth has been discharged from LOC-0, released from the hospital, or is identified as part of a high need population and has chosen a community based provider but is in need of transitional services.

The following items may also indicate that LOC-5 is the most appropriate level of care:

- The child/youth has intensive service needs and is underserved or on the wait list for all services (LOC-8). LOC-5 may be authorized for up to 90 days to stabilize or avoid further crisis events until the appropriate level of care can be provided.
- The child/youth has a Medicaid entitlement and may be authorized LOC-5 to ensure access to medically necessary services.

Criteria for Level of Care Review

Authorization for this LOC will expire in 90 days. If eligibility criteria are met, continued services may be provided in LOC 1-4, LOC-YC, or LOC-0.

Transition/Discharge Criteria

The child/youth may be transitioned to a different LOC or discharged from services for the following reasons:

- The crisis is stabilized and no additional services are indicated; or
- The crisis is stabilized and the child/youth has been transitioned to the appropriate level of care for ongoing services; or
- The crisis is stabilized and the child/youth has been in LOC-5 for 90 days and is placed on a waiting list for ongoing services; or
- The child/youth and caregiver have been referred and linked to community based services and supports.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The child/youth and/or caregiver report improved mood symptom management or behaviors, and/or improved life domain functioning; or
- The child/youth and caregiver are engaged in the appropriate level of care; or
- The child/youth and caregiver is linked with—and utilizing—natural and community support systems; or
- The child/youth and caregiver are better able to use natural and community support systems.

Level of Care 5 Table Overview

Authorization Period: 90 Days
Average Monthly Utilization Standard For This Level of Care: N/A 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.

Adjunct Services: Identified by the uniform assessment and addressed in the treatment plan.	**Individual Services in LOC-5**
	Unit
Routine Case Management	15 minutes
Psychiatric Diagnostic Interview Examination	Event
Pharmacological Management	Event
Medication Training and Support (Individual)	15 minutes
Medication Training and Support (Group)	15 minutes
Counseling: includes any/all of the following:	
Counseling (Individual or Child-Parent/Dyad)	Event
Counseling (Group)	Event
Counseling (Family)	Event
Skills Training & Development includes any/all of the following:	
Skills Training & Development (Individual)	15 minutes
Skills Training & Development (Group)	15 minutes
Skills Training & Development (delivered to the caregiver or LAR)	15 minutes
Family Partner Supports	15 minutes
Family Training	
Family Training (Individual)	15 minutes
Family Training (Group)	15 minutes
Parent Support Group	15 minutes
Engagement Activity	15 minutes
Flexible Funds (dollars)	$1 increments
Flexible Community Supports (time)	15 minutes
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization for Crisis Service Array can be found on page 30***

Appendix A: Crisis Services and Planning

Crisis Services Utilization

A child/youth receiving mental health services may require crisis services to help cope with a situation that has escalated to the point of crisis. The need for crisis services may be indicated in a variety of ways. When using the CANS during an assessment, a clinician may observe scores on items in the Child Risk Behaviors domain or other items that indicate the need for crisis services and the development of a safety plan. Additionally, a clinician, along with the child/youth and caregiver may together make the decision that crisis services and a safety plan are necessary to help resolve and cope with a situation that has been identified as a crisis.

Regardless of how the need for crisis services is identified, when a crisis *is* identified it is essential to join with the child/youth and caregiver in the development of a safety plan. The 2012 National Strategy for Suicide Prevention recommends that a safety plan developed with a child/youth should include elements such as warning signs/triggers, coping strategies, natural supports, and safekeeping measures. The following pages provide a list of the crisis services available within the service array as well as a sample safety plan that clinicians may use to help develop safety plans with children/youth and their caregivers.

As indicated in the description of each LOC, crisis services should be delivered within the assigned LOC whenever indicated (Note: children/youth currently enrolled in services must not to be deviated to LOC-0 in order to receive crisis services). Additionally, each crisis service delivered must meet medical necessity criteria.

For more information on suicide prevention, safety planning, and crisis follow-up best practices go to the Action Alliance for Suicide Prevention website: http://actionallianceforsuicideprevention.org/

Crisis Service Array for individuals currently enrolled in services

Authorization Period: N/A
The crisis services below are available for all children/youth who are experiencing a crisis and are enrolled in a level of care. Please see the LOC-0 section of this document to identify the crisis services available to individuals who have not been assigned to a level of care.

Crisis Service Array	Individual Crisis Services Unit/Event
Crisis Intervention Services	15 Minutes
Psychiatric Diagnostic Interview Examination	1 Event (1 unit)
Pharmacological Management	**10 Events** (10 units)
Safety Monitoring	**2 hours** (8 units)
Crisis Transportation (Event)	**1 Event** (1 unit)
Crisis Transportation (Dollar)	**As necessary** ($1 units)
Crisis Flexible Benefits (Event)	**As necessary** (Event)
Crisis Flexible Benefits (Dollar)	**As necessary** ($1 units)
Respite Services: Community-Based	**6 hours** (24 units)
Respite Services: Program-Based (not in home)	**3 bed days** (3 units)
Extended Observation	**1 unit** (1 bed day)
Children's Crisis Residential	**4 units** (4 bed days)
Family Partner Supports	**6 hours** (24 units)
Engagement Activity	**6 hours** (24 units)
Inpatient Hospital Services	**As necessary** (1 bed day units)
Inpatient Services (Psychiatric)	**As necessary** (1 bed day units)
Emergency Room Services (Psychiatric)	**As necessary** (Events)
Crisis Follow-up & Relapse Prevention	**8 hours** (32 units)

Sample Safety Plan

Warning signs that tell me a crisis may be developing (these may include thoughts, situations, behaviors, images, etc.):

1. _____

2. _____

3. _____

Coping strategies that help me feel better (coping strategies may include listening to music, drawing, writing in a journal, going for a walk, etc.):

1. _____

2. _____

3. _____

Supportive people I have permission to contact and places I have permission to go that can provide a distraction or help me feel better (places may include a neighbor's house, library, backyard, etc.):

People/Phone Number:	Places:
1.	1.
2.	2.
3.	3.

Professionals I can contact during a crisis (this may include your counselor/case manager, a crisis hotline, school social worker/counselor, etc.):

Name:	Contact Information:
1.	
2.	
3.	
4. Local Crisis Line	
5. Suicide Prevention Lifeline	1-800-273-TALK (8255)

Steps to keep my environment safe:

4. _____

5. _____

Developed using recommendations from the American Association of Suicidology

Appendix B: Training Requirements

The training requirements for each approved protocol vary per treatment practice; the training requirements for each protocol are outlined below:

a. Cognitive Behavior Therapy (CBT) – There are no training requirements for CBT; however, proof of competency is required. For specific competency requirements, reference the CBT competency requirements outlined in the contract.

b. Trauma-Focused CBT (TF-CBT) – Clinicians must complete the ten hour online TF-CBT webinar (http://tfcbt.musc.edu/) and the online Childhood Traumatic Grief webinar (http://ctg.musc.edu/) from the Medical University of South Carolina. Clinicians must also complete the two day face-to-face TF-CBT training from an approved national trainer. Additional clinical supervision requirements are listed in the contract.

c. Parent-Child Psychotherapy (Dyadic Therapy): Clinicians must meet the national training requirements for Parent-Child Interaction Therapy (PCIT) as outlined on the PCIT website: http://www.pcit.org/training-guidelines/pcit_training_guidelines_2009/ and must be trained by an approved national trainer (http://www.pcit.org/certified-trainers/); *or* clinicians may document Parent-Child Psychotherapy certification from a DSHS approved university-based institute or program. See the contract for trainings approved prior to the implementation of the above requirements.

d. Seeking Safety – Must complete a one-day training by a national, approved trainer, or must complete the four video training series. The completion of the four video training series must be documented by the staff member's clinical supervisor.

e. Nurturing Parenting – Must complete the three-day basic Nurturing Parenting trainer by an approved organizational trainer or by a national, approved trainer of Nurturing Parenting.

    a. Organizational Trainer Requirements: Must complete the basic three days of training to become a Nurturing Parenting facilitator and have provided two cycles of the DSHS approved Nurturing Parenting protocols (the Tertiary Treatments of Nurturing Parenting) for a period of eight to twelve months. Following the practical experience, the individual must complete an approved Nurturing Parenting Training of Trainers (TOT) and be deemed competent by the TOT trainer. The individual must have documentation that he/she has met all these requirements. Note: The "organizational" trainer is not an approved national trainer and only has permission to train within the DSHS contracted organization that employs him/her. DSHS contracted providers may share organizational trainers.

f. Aggression replacement techniques and socials skills (Skillstreaming) – Must complete a DSHS approved training in either Aggression Replacement Training®, *or* Social Skills Training and Aggression Replacement Techniques (START), *or* must complete the Teaching Pro-Social Behavior DVD training *and* complete one fidelity review.

g. Preparing Adolescents for Young Adulthood (PAYA): At this time, there are no specific training requirements for this protocol.

The following sections provide guidance in selecting the most appropriate counseling or skills training protocol(s) for the child/youth based on the needs identified on the CANS.

Appendix C: Selecting an Intervention

Counseling

Cognitive Behavioral Therapy (CBT) – CBT is an empirically supported treatment in which a therapist or LPHA works together with the 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 CBT protocols are approved for competent LPHAs to use to treat children and youth:

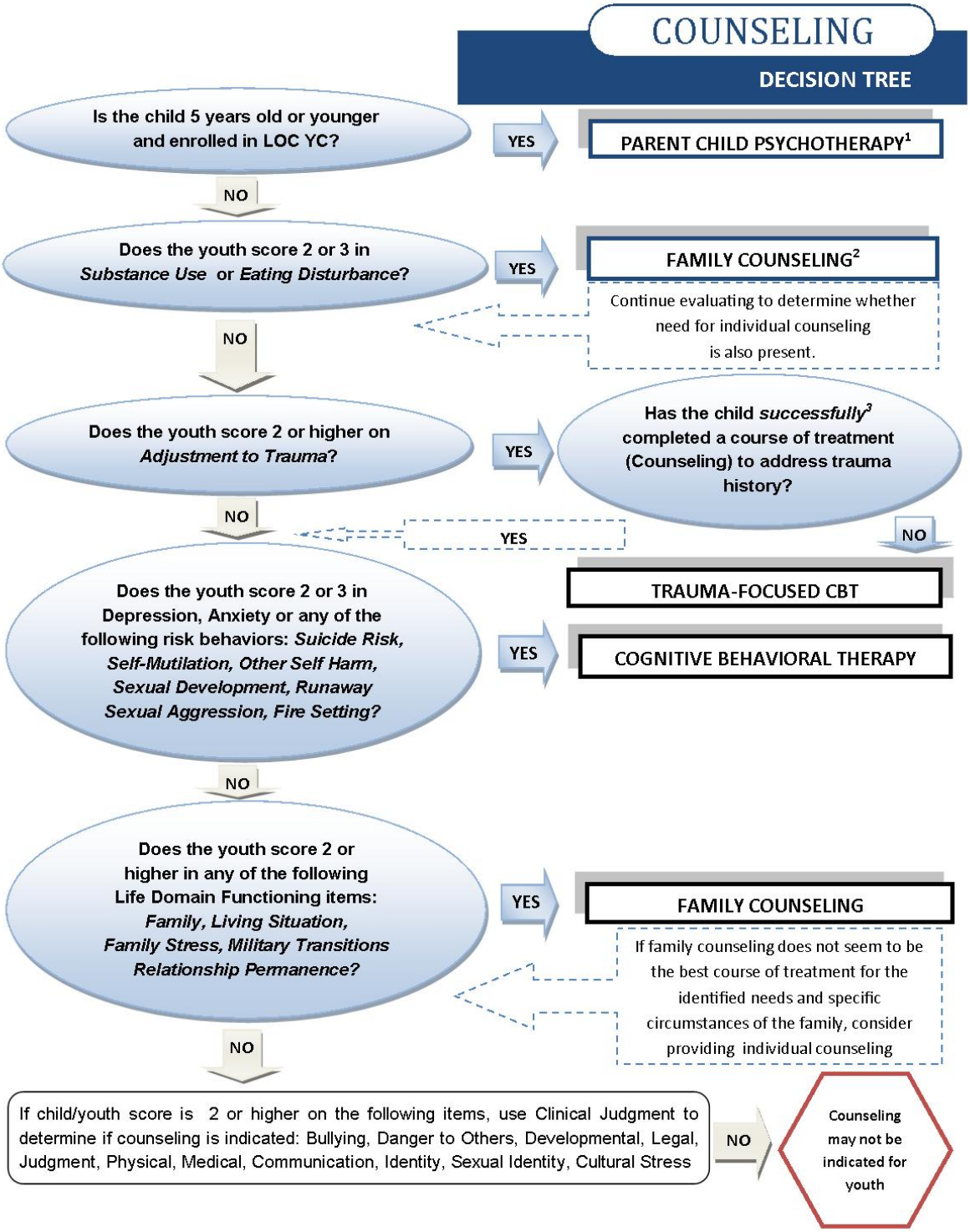
1. *Coping Cat* – This protocol is to be used with children ages 7-13 to treat anxiety related disorders such as: Generalized Anxiety, Anxiety Disorder NOS, Panic Disorder, Social Phobia (Social Anxiety Disorder), etc.
2. *The Cat Project* – This protocol is to be used with youth ages 14-17 to treat anxiety related disorders such as: Generalized Anxiety, Anxiety Disorder NOS, Panic Disorder, Social Phobia (Social Anxiety Disorder), etc.
3. *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.
4. *Adolescent Coping with Depression Course (CWD-A)* – This protocol is to be used with youth ages 13-17 to treat depressive mood disorders such as: Major Depression, Depressive Disorder NOS, Mood Disorder NOS, etc.
5. *General Cognitive Behavioral Therapy* – 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 in children or youth diagnosed with Oppositional Defiant Disorder or Conduct Disorder.

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

Parent-Child Psychotherapy (Dyadic Therapy) – The focus of this research-based 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 to improve 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 with children ages 3-7 years old. Providers must use DSHS approved models of Parent-Child Psychotherapy as outlined in the contract.

Appendix C, Cont.: Selecting an Intervention—Counseling

The following flow chart is intended to help guide clinicians in using needs identified on the CANS to select the most appropriate counseling intervention:



1. Parent Child Psychotherapy may also be provided to 6 year olds authorized into LOC-YC if the child has developmental needs that indicate this course of treatment. Clinical Judgment should be used.
2. Although research shows that family counseling is indicated for substance abuse or eating disorders, individual counseling may also be beneficial.
3. "Successfully" indicates that they child/youth and/or LAR agree that the child/youth's functioning is not affected by trauma since completion of treatment.

Appendix C, Cont.: Selecting an Intervention

Skills Training

Aggression Replacement Techniques – 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 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 follow this order: social skills, anger control, and moral reasoning. The order of the components is repeated in the following manner as the child/youth 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-paying, 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 groupings 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 the aggression replacement techniques and social skills training:

a. Aggression Replacement Training® Manual
b. Skillstreaming: The Elementary School Child
c. Skillstreaming: In Early Childhood
d. Skillstreaming: The Adolescent*

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

Nurturing Parenting – This evidence-based skills training 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 functioning of the child and caregiver. 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:

e. Parents and Their Infants, Toddlers & Preschoolers – 16 sessions (Available in English and Spanish)
f. Parents & Their School- Age Children 5-11 years
g. Spanish Speaking Parents and Their Children 4-12 Years (Crianza Con Cariño)
h. Parents & Adolescents (Available in English and Spanish)

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

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

5. 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 both a 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 3rd 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.

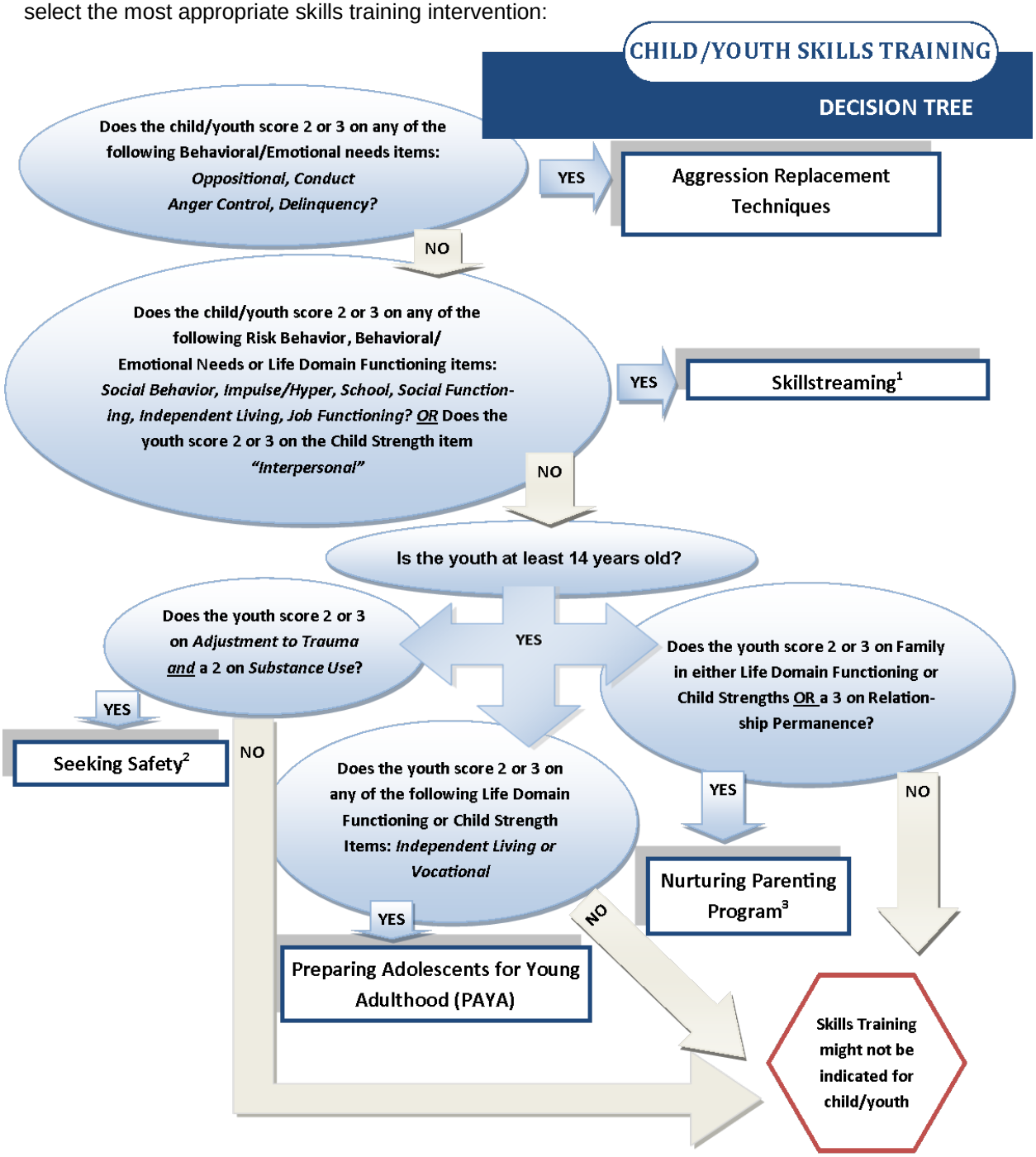
6. Preparing Adolescents for Young Adulthood (PAYA) – This skills training curriculum is to be used with youth ages 14-17 facing issues related to transitioning from adolescence to adulthood. PAYA consists of five modules; each module addresses a group of transitioning-youth skills. PAYA is a promising 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 use the "Gateway to the World: A toolkit and curriculum" to understand the principles that guide the use of the PAYA modules. Each module contains an assessment to identify which transitioning skills the youth needs. Based on the identified needs, sections of the PAYA modules 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 PAYA as a skills training protocol is flexible and does not require a specific sequence of sessions.

   a. The five PAYA modules are listed below:
      i. Module 1: Money, Home and Food Management
      ii. Module 2: Personal Care, Health, Social Skills and Safety
      iii. Module 3: Education, Jobs Seeking Skills and Job Maintenance Skills
      iv. Module 4: Housing, Transportation, Community Resources, Understanding the law and Recreation
      v. Module 5: Young Parents Guide

   For more clinical guidance on services provided to transition-age youth, please reference Appendix E: Transition-Age Youth.

Appendix C, Cont.: Selecting an Intervention—Skills Training

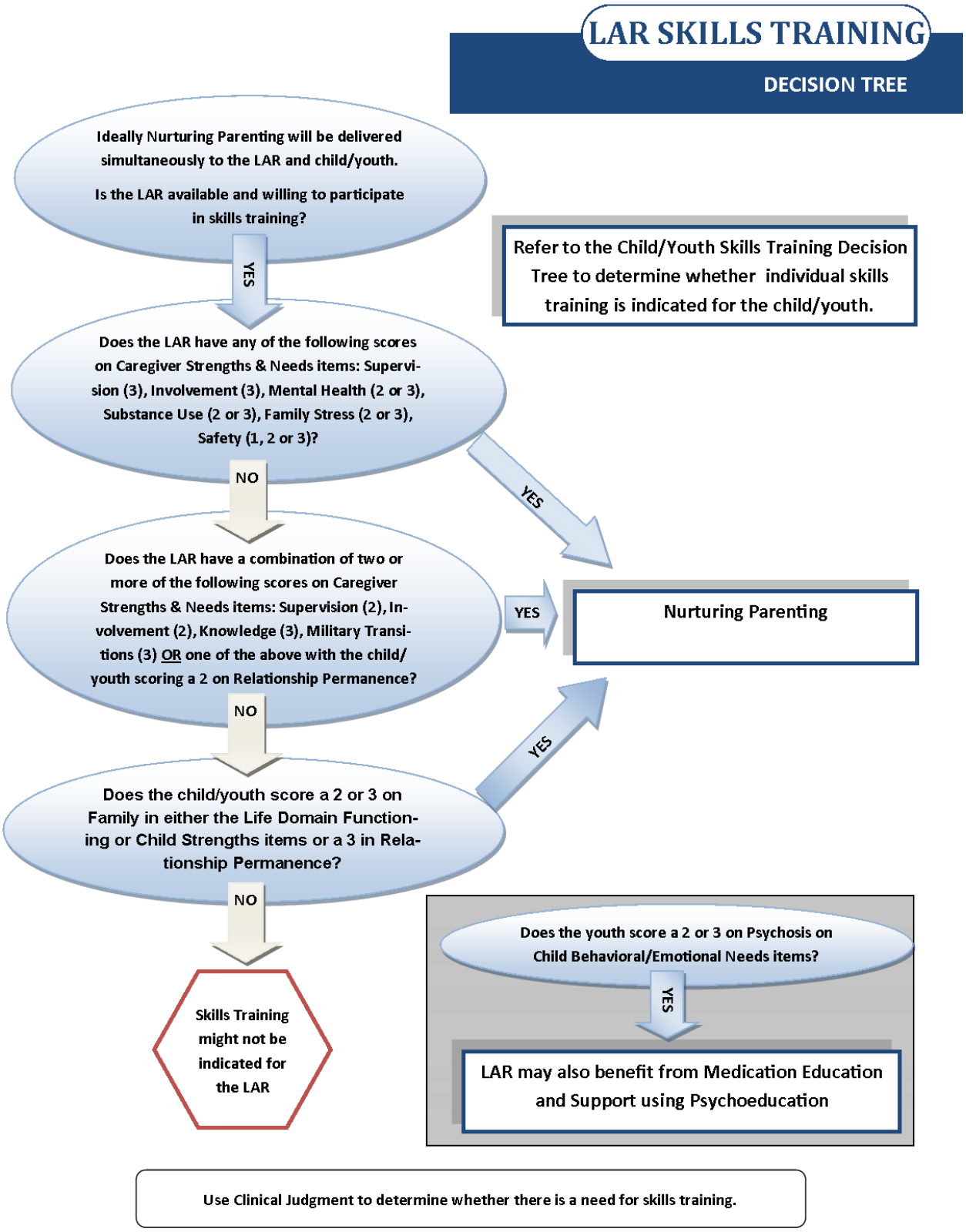
The following flow chart is intended to help guide clinicians in using needs identified on the CANS to select the most appropriate skills training intervention:



Use Clinical Judgment to determine if there is need for skills training, and if so, which protocol(s) to deliver. If more than one protocol is appropriate, use Clinical Judgment to determine if they should be delivered simultaneously or one at a time.

Note:
1. Delivered independently of the other Aggression Replacement Techniques components
2. Youth must **NOT** be receiving TF-CBT in order to receive Seeking Safety.
3. Nurturing Program may be delivered individually to youth if LAR not available, appropriate, or willing to participate. Refer to LAR skills training decision tree.

Appendix C, Cont.: Selecting an Intervention—Skills Training Delivered to the Caregiver(s)/LAR



Appendix D: Family Partner Supports

Certified Family Partners

Certified Family Partners provide supports to the LAR and/or primary caregivers of the child/youth and do not provide services directly to the child/youth. Access to quality family partner supports 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 Certified Family Partner's personal experience is critical to establishing a trusting relationship and earning the respect of families currently within mental health system. Certified 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 primary caregivers, parents and/or LARs, Certified Family Partners directly impact the child or youth's resilience and recovery.

Special Considerations for Family Partner Supports

As formal members of the treatment team, Certified 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 parents/primary caregivers and/or LAR 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 Certified Family Partners' 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 (this may include the provision of Family Skills Training using the DSHS approved protocol for primary caregivers);
- 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;
- Identification of the family's natural supports and strengths and guidance; and practical guidance in nurturing those relationships;
- Stewardship of family voice and choice as a member of the Wraparound team; and
- Support through the facilitation of parent support groups.

Minimum Qualifications

Certified 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 to be a Certified Family Partner (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.

Appendix E: Transition-Age Youth

Definition of Transition Age Youth 14-24

Between the ages of 14-24, individuals undergo tremendous change in all domains of life including physical, cognitive, relationships, educational, vocational and housing. It is important to start conversations about transition early with youth and their caregivers and to provide an environment in which youth can achieve mastery of skills necessary for success in adulthood.

Youth with serious emotional disturbance (SED) or mental illness are at increased risk for dropout from school, arrest, unemployment, and challenges associated with independent living. However, with future-planning and preparation these outcomes can be avoided. Therefore, acknowledging and addressing the needs of transition age youth is imperative to for youth served in the Children's Mental Health System to achieve successful outcomes in adulthood.

Considerations for Working with Transition Age Youth

Youth should be engaged in an individualized process that assesses their strengths and needs in the area of transition to adulthood. Transition goals should be determined and a plan to reach these goals should be created. Youth should be seen as partners in this process and leaders in their own care.

Texas Resilience and Recovery (TRR) providers should consider the following guidelines in their work with transition age youth:

- Services and supports should be accessible, coordinated, strengths based, non-stigmatizing, and developmentally appropriate.
- Youth should be engaged through person-centered planning, focusing on their futures, and developmentally appropriate engagement activities.
- Build on strengths to enable youth to identify and achieve their goals across multiple transition domains including the following:
    - School and Future Educational Opportunities;
    - Job Functioning and Future Career Opportunities;
    - Living Situation and Independent Living;
    - Social Functioning;
    - Recreation and Community and Involvement; and
    - Overall Functioning and Well-Being
- Encourage personal and social responsibility with youth. Specifically leadership opportunities within the organization should be considered such as serving on an advisory board or assisting with special projects.
- Identify a support network by involving a youth's parents, family members, significant others, friends, and other formal and informal supports.
- Assist youth in developing necessary skills toward achieving self-sufficiency and confidence.

Strengths and Needs Assessment for Transition Age Youth

Providers should utilize the Child and Adolescent Needs and Strengths (CANS) assessment to identify the strengths, resources, needs and other formal or informal supports of the youth to develop a Transition Plan. The Transition Plan should be developed in collaboration with the youth, family members, and other supports, and use a strengths-based approach. Other assessments could also be used to supplement the CANS assessment for discovering strengths and needs. For example, the Preparing Adolescents for Young Adulthood (PAYA) module assessments and the National Alliance on Mental Illness's (NAMI) "Preparing to Become an Adult: Youth and Parent/Family Perspective Worksheets" can both be used for this purpose. Assessments in the area of transition to adulthood also allow for the following[1]:

- Identification of the strengths and resources of the youth and his or her family, including resiliency skills.
- Demonstration of interest in the youth and the perspectives of people who are important to him/her.

[1] Deschênes, N., Clark, H. B., Herrygers, J., Blase, K., & Wagner, R., (2009). Strength Discovery and Needs Assessment: A process for working with transition-age youth and young adults. Tampa, FL: National Network on Youth Transition for Behavioral Health.

- Encouraging the youth and those important to them to see him or her in a positive light.

Creating a Plan for the Transition to Adulthood

Transition planning for adulthood should be guided by the youth's vision for the future and utilize his/her strengths, interests, and preferences. The transition plan for adulthood should also be developed in collaboration with people important to the youth, building upon his/her support network and should encourage the development of the youth's self-determination and advocacy skills. The plan should be incorporate a belief in the youth's resiliency and hope for their future.

Individualized transition plans should include the following:

- Needs and Strengths/Resources identified in the transition assessment.
- Measureable and achievable goals, objectives, and tasks.
- Appropriate timelines to achieve goals and complete objectives, which includes reviewing accomplishments and celebrating successes.
- Identification of formal and informal supports that can be helpful to the youth in achieving his/her transition goals.

Transitioning to Adult Mental Health (AMH) Services or a Community Mental Health (MH) Provider

Mental health conditions that begin in childhood or adolescence often continue into adulthood and can develop into severe mental illness (SMI). Once the youth turns eighteen, difficulties in accessing appropriate supports and services in the community often plague youth, their families, and providers. Eligibility criteria, funding mechanisms, and different philosophies across systems may create challenges to obtaining appropriate services for youth upon their eighteenth birthday. Therefore, supporting the transition from CMH to AMH or a community MH provider is crucial.

It is important to begin conversations with the youth and their families early to ensure they understand the transition process and feel supported. In fact, ongoing conversations about the transition process should begin between the ages of 14 and 16 years. The transition process can be a successful and positive experience if youth are offered the following, as appropriate, while they are still enrolled in the children's MH system. Ideally the following should be offered six months to a year before transition to AMH:

- Use of the Adult Needs and Strengths Assessment (ANSA) at the youth's last UA before transfer to AMH.
- Introduction to the future AMH Case Manager who will provide overview of AMH, which should include a comprehensive review of the role, rights, and responsibilities of youth in the AMH.
- A follow up meeting with CMH Case Manager and AMH Case Manager to answer any further questions and to build rapport
- A tour of the AMH facility (if separate or new environment for youth)
- Provision of Supportive Housing, as appropriate in both the CMH and AMH system.
- Provision of Supportive Employment, as appropriate in both the CMH and AMH system.
- When applicable, there should be an explanation of Medicaid and Social Security benefits and the application process with a special emphasis on possible outcomes such as having to apply multiple times before being approved.

Providers must also follow the Texas Administrative Code (TAC) §412.324: Additional Standards of Care Specific to Mental Health Community Services for Children and Adolescents and develop a transition plan for each adolescent who will need adult mental health community services. This transition plan must be developed collaboratively with the youth, LAR and future providers while allowing enough time to avoid a disruption in mental health services. This transition plan may incorporate the guidelines for planning for the transition to adulthood stated above and according to the TAC must include:

- Summary of the mental health community services and treatment the youth has received;
- Current status (e.g., diagnosis, medications, uniform assessment guideline calculation, and unmet needs);
- Information from the youth and the LAR regarding the youth's strengths, preferences for mental health community services, and responsiveness to past interventions;
- Description of the mental health community services the adolescent will receive as an adult;
- List of resources for other recovery supports such as volunteer opportunities, family or peer organizations, 12-step programs, churches, colleges, or community education;

- Documentation that the adolescent's services continued throughout the transition without disruptions; and
- Documentation of the follow up to ensure successful transition to adult services.

Considerations for Youth Peer Support

Youth peer support during adolescence is especially powerful due to the importance of peers during this developmental stage. Peer support within the mental health system can help reduce stigma and help the youth feel understood, supported, and not alone during this time of change and transition. Peer support can happen through an adult-led peer support group or a youth guided group such as Youth Motivating Others through Voices of Experience (Youth M.O.V.E.). Youth M.O.V.E works to raise awareness about youth who have experiences in public systems such as mental illness and juvenile justice. Chapters exist around the country and can be formed in areas that do not currently have a youth peer support network. www.youthmovenational.org Although challenges exist when creating peer support, it is possible.

Additional Tools for Use with Transition Age Youth

- Skills Training: PAYA increases understanding of the fundamentals of independent living and enhances abilities to make successful and smooth transitions to self-sufficient young adulthood:
- The Transition to Independence Process (TIP) model is an evidence-supported practice that demonstrates improvements in outcomes for youth. Resources, including transition planning forms, can be found at their website: www.tipstars.org
- NAMI has learned a tremendous amount through interacting with young adults and has designed a website to better meet the needs of this group: http://strengthofus.org/
- Transition of Youth and Young Adults with Emotional or Behavioral Difficulties: An Evidence Supported Handbook by Hewitt B. Clark and Deanne K. Unruh http://www.tipstars.org/Resources.aspx
- Pathways Research and Training Center with Portland State University consistently publishes online trainings and articles on supporting Transition Age Youth. http://www.pathwaysrtc.pdx.edu/
- Transitions Research and Training Center with the University of Massachusetts is a complimentary entity to Pathways. It also offers online trainings and articles on supporting transition age youth. http://labs.umassmed.edu/transitionsRTC/index.htm

Appendix F: Reasons for Deviation

Purpose

Every effort should be made to authorize children/youth into the Level of Care (LOC) that will best meet his/her needs and support his/her resilience and recovery. The recommended LOC (LOC-R) is based upon the uniform assessment (UA) including the Child and Adolescent Needs and Strengths (CANS) assessment. The CANS is a reliable, dynamic, and comprehensive tool that allows for a significant level of confidence that the recommended LOC (LOC-R) reflects the clinical need and is based on the current presentation of the child/youth. However, because an assessment tool does not have the sensitivity to identify underlying treatment needs, it is imperative that clinicians use clinical judgment when determining the authorized LOC (LOC-A).

When authorizing a LOC that is different from the LOC-R, Utilization Management (UM) staff will make a determination based on the clinician's recommended deviation (LOC-D), the information provided in the uniform assessment, and availability of resources. The rest of this section provides definitions and examples of the reasons for deviation from the LOC-R. UM select may select one reason for deviation.

Using the Provider Requested Deviation– LOC D

The purpose of the Provider Requested Deviation, or LOC-D, is to allow the clinician the option to request a deviation from the LOC-R as calculated by the CANS/Uniform Assessment. The parameters for the use of the LOC-D are as follows:

- The LOC-D shall be completed by the clinician, but is only necessary if the LOC-D is different from the LOC-R
- The clinician justifies the LOC-D and the UM staff shall take this into consideration when determining the LOC-A.
- The clinician may not site resource limitations for the LOC-D.

Definitions of Reasons for Deviation

The LOC-A may deviate from the LOC-R due to the following reasons:

- Clinical Need: To be used when the Licensed Practitioner of the Healing Arts (LPHA)'s judgment identifies the clinical need/medical necessity for a more or less intensive level of care than the level of care recommended.
    - Deviation for Clinical Need must be documented in the clinical record and medical necessity signed by an LPHA, verifying medical necessity.

- Resource Limitations: To be used when the UM staff member identifies that there are not enough resources to offer services at the recommended level of care. Resources are defined as personnel, a slot within a specific level of care, or monetary resources necessary to provide services within the level of care.

NOTE: A child/youth that has Medicaid may not be deviated to the waitlist or to a LOC where a clinically indicated core service is not available.

- Continuity of Care: To be used when there is an identified need to deviate the child/youth to a level of care that is different from the level of care recommended in order to maintain continuity of care. Justification for the deviation must be documented in the clinical record. The following are examples of appropriate utilization of this deviation reason:
    - The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
    - The child/youth is hospitalized and provider communicates with the child/youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
    - The child/youth is living out of the service area for a planned and defined period of time (i.e. summer vacation) and provider plans to leave child/youth open to services; or

- Consumer Refused: To be used when the individual is provided with information necessary to make an informed decision and refuses the recommended level of care. The information discussed with the individual must be documented in the clinical record.

    - All efforts at engagement must be documented in the clinical record

- Other: To be used when none of the reasons listed above accurately describe the reason for deviation.
    - Justification for the deviation must be documented in the “Notes” field of the uniform assessment and retained in the clinical record.

The following pages include guidance for using these reasons for deviation from the LOC-R.

Considerations for Core Services Within an LOC-A

Core Services in the LOC-R are determined to be essential to resilience and recovery. For this reason, all core services in the LOC-A must be offered to the child/youth and should be delivered. If a child/youth is not receiving a core service, justification must be documented in the clinical record.

Deviation to LOC-0: Crisis Services

A child/youth may only be deviated to LOC- 0 if he/she 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 the child/youth does not have an active UA (i.e. is new to services) *and* the following criteria are met, it may indicate a need for deviation to LOC-0:

- The clinician determines the child/youth is in crisis; *and*
- The LOC-R is not LOC-0

NOTE: The UA does not need to be completed before treating a crisis. Address the crisis first.

If a child/youth who is currently enrolled in an LOC other than LOC-0 experiences a psychiatric crisis, crisis services should be delivered within the current LOC assignment.

Deviation from LOC-9: Ineligible

A child/youth may only be deviated from LOC-R 9 if he/she has not received an LOC-R 9 for more than two consecutive authorizations.

Reasons for Deviation to an LOC-A *where services may be provided*

Clinical Need
The following are clinical reasons that may indicate a deviation from the LOC-R 9 and must be documented in the clinical record and medical necessity signed by an LPHA;

- Upon initial assessment, the child/youth has an LOC-R 9 and based on clinical judgment of underlying mental health needs, the clinician determines core mental health services available in full LOC are indicated. This treatment need should be reflected on the UA; or
- Upon reassessment, the child/youth has an LOC- R 9 but has not completed a course of treatment being delivered in an LOC where services have been provided. The clinician may deviate to ensure completion of recommended course of treatment; or
- The child/youth has an LOC-R 9 but in order to ensure that clinical improvements are maintained, should be authorized to an LOC where services may be provided.

Continuity of Care
The following are reasons that may justify deviation to an LOC where services may be provided for continuity of care and must be documented in the clinical record.

- If upon initial assessment the child/youth has an LOC-R 9 but has been recently discharged from a psychiatric hospital or residential treatment setting and requires transitional support in LOC-5.
- If upon reassessment, the child/youth has an LOC-R 9 and continues to have a clinical need for mental health services but has any of the following circumstances
    - The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
    - The child/youth is hospitalized and provider communicates with the child/youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or

Deviation from LOC-R YC (LOC-YC: Young Child Services)

To be authorized into LOC-YC the 3-5 CANS must be completed.

All developmentally appropriate services for children ages 3-5 are available in LOC-YC.

Reasons for Deviation to a *Less Intensive* LOC-A
NOTE: Because the services available in LOC- YC are imperative to resilience and recovery for this population, it is *not* advised that children be deviated to a LOC where counseling and skills training are not available. Providers must make every reasonable effort to authorize children with an LOC-R YC into this LOC.

Clinical Need
The following are clinical reasons that may indicate a deviation from LOC-R YC to LOC-1 and must be documented in the clinical record and medical necessity signed by an LPHA;

- A core service is required in LOC-YC, but the child is receiving that service from another mental health provider in the community and the child otherwise only has a clinical need for medication management.
- Due to developmental needs associated with a Pervasive Developmental Disorder (PDD) and/or Intellectual Disability (ID), the child is not able to benefit from a core service required in LOC-YC at this time; or

NOTE: Because the services available in this LOC will likely be developmentally appropriate, regardless of the child's diagnosis of PDD and/or ID, this reason must be justified by the clinician based on clinical presentation and not solely based on the child's diagnosis. This reason for deviation should *not* be commonly used.

Continuity of Care
The following are reasons that may justify deviation to LOC-1 for continuity of care and must be documented in the clinical record.

- The child is hospitalized and provider communicates with the child and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The child is living out of the service area for a planned and defined period of time (i.e. summer vacation) and provider plans to leave the child open to services

Consumer Refused
The following are reasons that may indicate a deviation from the LOC-R YC and must be documented in the clinical record:

- The caregiver/LAR refuses counseling, skills training *and* Wraparound (if clinically indicated), but does not refuse services at LOC-1. If after attempts at engagement in the LOC-R YC, caregiver/LAR continues to refuse counseling, skills training *and* Wraparound (if clinically indicated), deviation to LOC-A 1 may occur.
- If the child is *new* to services and has an LOC-R YC and caregiver/LAR refuse all services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services, the child should be deviated to LOC-A 6 (Refused All Services); or
- If the child is *currently enrolled* in services and upon reassessment has an LOC-R YC and the child and/or caregiver/LAR refuse all services, the UA should be been reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the child should be discharged from services.

NOTE: Core Services in the LOC- YC are determined to be essential to resilience and recovery. The caregiver/LAR should continue to be engaged to participate in all clinically indicated core services, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations
A child may only be deviated to LOC-A 1 or LOC-A 8 (Waitlist) with a reason of resource limitations if *all* core services cannot be provided because of those resource limitations and the child does not have Medicaid.

When deviating to LOC-A 1 for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the child was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible)
- The date the referral was made
- The disposition (i.e. whether the child and/or caregiver/LAR attended the initial appointment)

NOTE: If *all* core services within LOC-YC cannot be provided due to resource limitations, the child may remain in the LOC and also be placed on a waitlist for the core service until the service becomes available.

Deviation from LOC-R 1 (LOC-1: Medication Management)

Reasons for Deviation to *a Less Intensive* LOC-A (Waitlist or Refused All Services)

Consumer Refused
The following are reasons that may indicate a deviation from the LOC-R 1 and must be documented in the clinical record:

- If the child/youth is *new* to services and has an LOC-R 1 and the child/youth and/or caregiver/LAR refuse medication services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the child/youth does not have a clinical need for services available in a more intensive LOC, he/she should be deviated to LOC-A 6 (Refused All Services); or
- If the child/youth is *currently enrolled* in services and upon reassessment has an LOC-R 1 and the child/youth and/or caregiver/LAR refuse medication services, the UA should be been reviewed with the caregiver/LAR and engagement should be provided. If the child/youth does not have a clinical need for services available in a more intensive LOC, discharge from services should be considered.

NOTE: All attempts at engagement must be documented in the clinical record.

Resource Limitations
Deviation to LOC-A 8 may not occur if the child has Medicaid. A child/youth may only be deviated to LOC-A 8 with a reason of resource limitations if medication management cannot be provided because of those resource limitations and the child/youth does not have Medicaid.

When deviating to LOC-A 8 for resource limitations, the clinician must provide a referral for the medication management and document the following information in the clinical record:

- Name and contact information of the person or agency to which the child/youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible)
- The date the referral was made
- The disposition (i.e. whether the child/youth attended the initial appointment)

Reasons for Deviation to a *More Intensive* LOC-A

Clinical Need
The following are clinical reasons that may indicate a deviation from the LOC-R and must be documented in the clinical record and medical necessity signed by an LPHA;

- Upon initial assessment, the child/youth has an LOC-R 1 and based on clinical judgment of underlying treatment needs, the clinician determines core services available in a more intensive LOC are indicated (i.e. identified need for transition age youth skills training). This treatment need should be reflected on the UA; or
- Upon reassessment, the child/youth has an LOC- R 1 but has not completed a course of treatment being delivered in a more intensive LOC. The clinician may deviate to ensure completion of recommended course of treatment; or
- The child/youth has an LOC-R 1 but in order to ensure that clinical improvements from services in a higher LOC –including hospitalization or residential placement– are maintained, the child/youth should be authorized to a more intensive LOC.
- The child/youth has an LOC- R 1 where a core service that the caregiver has identified as a treatment need is not available. If after reviewing the UA with the caregiver, the clinician determines that the service is clinically indicated, the child/youth may be deviated to a more intensive LOC. The clinician must ensure that the UA reflects this treatment need.

Deviation from LOC-R 2 (LOC-2: Targeted Services)

Reasons for Deviation to a *Less Intensive* LOC-A

The following are clinical reasons that may indicate a deviation from LOC-R 2 to LOC-A 1

Clinical Need
The following reasons justify clinical need for deviation and must be documented in the clinical record and medical necessity signed by an LPHA:

- A core service is required in this LOC, but is contra-indicated for this child/youth based on the clinician's assessment of underlying treatment needs; or
- A core service is required in this LOC, but the service is not appropriate for the child/youth at this time due to cognitive deficits; or
- A core service is required in this LOC, but the child/youth is receiving that service from another mental health provider in the community; or
- A core service is required in this LOC; but the child/youth has already completed this course of treatment, the treatment was provided to fidelity, *and* no positive clinical outcomes were observed. (This indicates a review of the treatment plan with participation of the child/youth and caregiver/LAR); or
- A core service is required in this LOC; but the child/youth has completed this course of treatment, the treatment was provided to fidelity, *and* negative clinical outcome were observed and attributed to the treatment. (This indicates a review of the treatment plan with participation of the child/youth and caregiver/LAR)

NOTE: The clinician may consider authorizing a different course of treatment (skills training or counseling) that can meet the clinical needs of the child/youth without deviating to different LOC.

Continuity of Care
The following are reasons justify deviation to LOC-1 for continuity of care and must be documented in the clinical record:

- The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
- The child/youth is hospitalized and provider communicates with the child/youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The child/youth is living out of the service area for a planned and defined period of time (i.e. summer vacation) and provider plans to leave the child/youth open to services.

Consumer Refused
The following are reasons that may indicate a deviation from the LOC-R 2 and must be documented in the clinical record:

- The child/youth and/or caregiver/LAR refuse a core service (counseling or skills training) but do not refuse services at LOC-1. If after attempts at engagement in the LOC-R, the child/youth and/or caregiver/LAR continue to refuse the core service in the LOC-R, deviation from the LOC-R may occur. The remaining clinically indicated core services must be available in the LOC-A; or
- If the child/youth is *new* to services and the child/youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services, the child should be deviated to LOC-A 6 (Refused All Services); or
- If the child/youth is *currently enrolled* in services and upon reassessment the child/youth and/or caregiver/LAR refuse *all* services, the UA should be been reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the child should be discharged from services.

NOTE: Core Services in the LOC-R are determined to be essential to resilience and recovery. The child/youth and/or caregiver/LAR should continue to be engaged to participate in all clinically indicated core services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations
If a child/youth has Medicaid he/she may not be deviated from LOC-R 2 to LOC-A 1 for resource limitations, because the core services of Counseling and Skills Training are not available in LOC-1. A child/youth without Medicaid may only be deviated to LOC-A 1 with a reason of resource limitations if counseling and skills training cannot be provided because of those resource limitations.

When deviating to LOC-A 1 for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the child/youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible)
- The date the referral was made
- The disposition (i.e. whether the child/youth attended the initial appointment)

NOTE: If a core service cannot be provided due to resource limitations, the child/youth may remain in LOC 2 and be placed on a waitlist for the core service until the service becomes available.

Reasons for Deviation to a *More Intensive* LOC-A

The following are clinical reasons that may indicate a deviation from LOC-R 2 to LOC-A 3 or 4:

Clinical Need
The following reasons justify clinical need for deviation and must be documented in the clinical record and medical necessity signed by an LPHA:

- Child/youth has an LOC-R 2 where counseling and skills training are not available concurrently and the clinician determines that both services are indicated based on the assessment of underlying treatment needs. (Note: This may include an identified need for transition age youth skills training while the individual is receiving counseling services.); or
- Upon reassessment, the child/youth has an LOC- R 2 but has not completed a course of treatment that should continue to be provided concurrently; or
- The child/youth has an LOC-R 2 but in order to ensure that clinical improvements from services in a higher LOC –including hospitalization or residential placement– are maintained, the child/youth should be authorized to a more intensive LOC.
- The child/youth has an LOC- R 2 where a core service that the caregiver/LAR has identified as a treatment need is not able to be provided concurrently. If after reviewing the UA with the caregiver/LAR, the clinician determines that delivery of both services is clinically indicated, the child/youth may be deviated to a more intensive and LOC. The clinician must ensure that the UA reflects this treatment need; or
- The child/youth has a clinical need for Wraparound process planning (i.e. child/youth has several severe needs in areas of life domain functioning that place him/her at risk for displacement from his/her community).

Reason for Deviation to LOC- A *Young Child*

Note: To be authorized into LOC-YC the 3-5 CANS must be completed.

Clinical Need
A child's developmental needs may indicate deviation to the LOC-YC in order to ensure the child receives developmentally appropriate services. This deviation must be documented in the clinical record and medical necessity signed by an LPHA.

NOTE: If a child is age 7 years or older he/she may not be deviated into LOC-YC.

Deviation from LOC-R 3 (LOC-3: Complex Services)

Reasons for Deviation to a *Less Intensive* LOC-A

Clinical Need

The following are clinical reasons that may indicate a deviation from LOC-R 3 and must be documented in the clinical record and medical necessity signed by an LPHA:

- The clinician determines that counseling and skills training services should not be provided to the child/youth concurrently. The child/youth may be deviated down from LOC-R 3 to LOC-A 2; or
- A core service is required in LOC-3, but is contra-indicated for this child/youth based on the clinician's assessment of underlying treatment needs. The remaining recommended services must be available in the LOC-A; or
- A core service is required in this LOC, but the service is not appropriate for the child/youth at this time due to cognitive deficits. The remaining recommended services must be available in the LOC-A; or
- A core service is required in LOC-3; but the child/youth has already completed this course of treatment, the treatment was provided to fidelity, *and* no positive clinical outcomes were observed. (This indicates a review of the treatment plan with participation of the child/youth and caregiver/LAR).The remaining recommended services must be available in the LOC-A; or
- A core service is required in LOC-3; but the child/youth has completed this course of treatment, the treatment was provided to fidelity, *and* negative clinical outcome were observed and attributed to the treatment. (This indicates a review of the treatment plan with participation of the child/youth and caregiver/LAR).The remaining recommended services must be available in the LOC-A; or
- A core service is required in LOC-3, but the child/youth is receiving that service from another mental health provider in the community. The remaining recommended services must be available in the LOC-A

Continuity of Care

The following are reasons that may justify deviation to a less intensive LOC for continuity of care and must be documented in the clinical record:

- The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
- The child/youth is hospitalized and provider communicates with the child/youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The child/youth is living out of the service area for a planned and defined period of time (i.e. summer vacation) and provider plans to leave the child/youth open to services.

Consumer Refused

The following are reasons that may indicate a deviation from the LOC-R 3 and must be documented in the clinical record:

- The child/youth and/or caregiver/LAR refuse a core service (counseling and/or skills training). If after attempts at engagement in the LOC-R, the child/youth and/or caregiver/LAR continue to refuse the LOC-R, deviation from the LOC-R may occur. The remaining clinically indicated core services must be available in the LOC-A; or
- If the child/youth is *new* to services and the child/youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services, the child/youth should be deviated to LOC-A 6 (Refused All Services); or
- If the child is *currently enrolled* in services and upon reassessment the child/youth and/or caregiver/LAR refuse *all* services, the UA should be been reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the child/youth should be discharged from services.

NOTE: Core Services in the LOC-R are determined to be essential to resilience and recovery. The child/youth and/or caregiver/LAR should continue to be engaged to participate in all clinically indicated core services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations
If a child/youth has Medicaid he/she may not be deviated from LOC-R 3 to LOC-A 1 for resource limitations, because the core services of Counseling and Skills Training are not available in LOC-1. A child/youth without Medicaid may only be deviated to LOC-A 1 with a reason of resource limitations if counseling and skills training cannot be provided because of those resource limitations.

When deviating to a less intensive LOC-A for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the child/youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible)
- The date the referral was made
- The disposition (i.e. whether the child/youth attended the initial appointment)

NOTE: If a core service cannot be provided due to resource limitations, the child/youth may remain in LOC 3 and be placed on a waitlist for the core service until the service becomes available.

Reasons for Deviation to a *More Intensive* LOC-A (4: Intensive Family Services)

Clinical Need
The following are clinical reasons that may indicate a deviation from LOC-R 3 and must be documented in the clinical record and medical necessity signed by an LPHA:

- Child/youth has a clinical need for Wraparound process planning. Clinical need may be indicated by the following (Note: This is not an exhaustive list):
    - The child/youth has several severe needs in areas of life domain functioning that place him/her at risk for displacement from his/her community; or
    - The child/youth is currently participating in the Wraparound process and for completion of the Wraparound process, should remain in LOC-4; or
    - The child/youth has an LOC-R 3 but in order to ensure that clinical improvements from services in a higher LOC –including hospitalization or residential placement– are maintained, the child/youth should be authorized to LOC 4 where he/she can receive Wraparound.

Reason for Deviation to *LOC-A Young Child*

Note: To be authorized into LOC-YC the 3-5 CANS must be completed.

Clinical Need
A child's developmental needs may indicate deviation to the young child level of care (LOC-YC) in order to ensure the child receives developmentally appropriate services. This deviation must be documented in the clinical record and medical necessity signed by an LPHA.

NOTE: If a child is age 7 years or older he/she may not be deviated into LOC-YC.

Deviation from LOC-R 4 (LOC-4: Intensive Family Services)

Reasons for Deviation to a *Less Intensive* LOC-A

Clinical Need

The following are clinical reasons that may indicate a deviation from LOC-R 4 and must be documented in the clinical record and medical necessity signed by an LPHA:

- The child/youth has an LOC-R 4 but the clinician determines that Wraparound process planning is not clinically indicated; or
- The child/youth is receiving Wraparound process planning from another child serving agency in the community and the Wraparound facilitator is under the supervision of the other child serving agency. (Note: Clinicians should be prepared to participate as a Wraparound team member if requested by the family); or
- Wraparound process planning is required in LOC-4; but the child/youth and caregiver has completed the Wraparound process, it was provided to fidelity, *and* no positive clinical outcomes were observed. (This indicates a review of the treatment plan and Wraparound process plan with participation of the child/youth and caregiver);or
- Wraparound process planning is required in LOC-4; but the child/youth has completed the Wraparound process, it was provided to fidelity, *and* negative clinical outcomes were observed and attributed to participation in the Wraparound process. (This indicates a review of the treatment plan and Wraparound process plan with participation of the child/youth and caregiver).

Continuity of Care

The following are reasons that may justify deviation to a less intensive LOC for continuity of care and must be documented in the clinical record.

- The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
- The child/youth is hospitalized and provider communicates with the child/youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The child/youth is living out of the service area for a planned and defined period of time (i.e. summer vacation) and provider plans to leave the child/youth open to services.

Consumer Refused

The following are reasons that may indicate a deviation from LOC-R 4 and must be documented in the clinical record:

- The child/youth and/or caregiver/LAR refuse Wraparound process planning. If after attempts at engagement in the LOC-R, the child/youth and/or caregiver/LAR continue to refuse the LOC-R, deviation from the LOC-R may occur. The remaining clinically indicated core services must be available in the LOC-A; or
- If the child/youth is *new* to services and the child/youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the child/youth and caregiver/LAR and engagement should be provided. If the caregiver/LAR continues to refuse *all* services, the child/youth should be deviated to LOC-A 6 (Refused All Services); or
- If the child/youth is *currently enrolled* in services and upon reassessment the child/youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the child/youth and caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the child/youth should be discharged from services.

NOTE: Core Services in the LOC-R are determined to be essential to resilience and recovery. The child/youth and/or caregiver/LAR should continue to be engaged to participate in all clinically indicated core services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations

If a child/youth has Medicaid, he/she may *not* be deviated from LOC-R 4 for resource limitations, because the core service of Wraparound process planning is not available in a less intensive LOC. A child/youth without Medicaid should be deviated to the next most appropriate LOC where resources are available. All efforts should be made to provide an LOC higher than LOC-A 1 when a child/youth has an LOC-R 4.

When deviating to a less intensive LOC-A for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the child/youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible)
- The date the referral was made
- The disposition (i.e. whether the child/youth attended the initial appointment)

NOTE: If a core service (i.e. counseling, skills training, or Wraparound) cannot be provided due to resource limitations, the child/youth may remain in LOC-4 and be placed on a waitlist for the core service until the service becomes available.

Reason for Deviation to *LOC-A Young Child*

Note: To be authorized into LOC-YC the 3-5 CANS must be completed.

Clinical Need

A child's developmental needs may indicate deviation to the young child level of care (LOC-YC) in order to ensure the child receives developmentally appropriate services. This deviation must be documented in the clinical record and medical necessity signed by an LPHA.

NOTE: If a child is age 7 years or older he/she may not be deviated into LOC-YC.

Deviation to LOC-5: Transition Services

A child/youth may only be authorized to LOC-5 following authorization into LOC- 0, a crisis episode, discharge from psychiatric hospitalization stabilization or residential treatment setting. After the end of the authorization period for LOC-5, the child/youth should be reassessed to determine further eligibility and the most appropriate LOC for continuation of services.

If a child/youth who is currently enrolled in an LOC other than LOC-0 experiences a psychiatric crisis, crisis services may be delivered within the current LOC assignment.

Clinical Need
The following are clinical reasons that may indicate a deviation to LOC-A 5 and must be documented in the clinical record and medical necessity signed by an LPHA:

- If the child/youth has an LOC-R 9 but the clinician determines that short term services are clinically indicated; or
- If the child/youth has an LOC-R 1-4 or YC but he/she and/or their LAR has elected another provider in the community but needs short term transitional services LOC 5.

Continuity of Care
The following are reasons that may justify deviation to a less intensive LOC for continuity of care and must be documented in the clinical record.

- If the child/youth has an LOC-R 9 but has been discharged from a psychiatric hospital or residential treatment setting and requires transitional support.

Consumer Refused
The following are reasons that may indicate a deviation to LOC-A 5 and must be documented in the clinical record:

- If the child/youth has an LOC 1-4 or YC and he/she and/or LAR refuses the LOC-R but agrees to begin short term services in LOC 5.
- If the child/youth is enrolled in LOC 1-4 or YC but he/she or their LAR has refused to continue enrollment in the LOC R but agrees to continue short term services in LOC 5. LOC 5 may be authorized for purposes of engagement in continuing services.

NOTE: Core Services in the LOC-R are determined to be essential to resilience and recovery. The child/youth and/or caregiver/LAR should continue to be engaged to participate in all clinically indicated core services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations
The following are reasons that may indicate a deviation to LOC- 5 for resource limitations and must be documented in the clinical record:

- If the child/youth has an LOC-R 1-4 or YC but there is not capacity in the LOC-R; or
- If the child/youth is being discharged from ongoing services due to resource limitations and short term services are indicated to assist with the transition.

NOTE: If a child/youth has Medicaid, he/she may *not* be deviated to LOC- 5 from LOC-R 4 for resource limitations as Wraparound process planning is not available in LOC 5.
When deviating to a less intensive LOC-A 5 for resource limitations, the clinician must provide a referral for core services that are indicated in the LOC-R that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the child/youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible)
- The date the referral was made
- The disposition (i.e. whether the child/youth attended the initial appointment)

Deviation Reasons and Deviation Grid Table

	Allowable Deviation to LOC-A and Reasons for Deviation (provided the parameters outlined above have been met)				
LOC R	Clinical Need	Continuity of Care	Consumer Refused	Resource Limitations	Other
0	Not allowable	Not allowable	Not allowable	Not allowable	Not allowable
1	0, 2, 3, 4, or YC (must complete 3-5 CANS)	Child/youth should be engaged in LOC-A 1	5 or 6	5 or 8 (unless Medicaid eligible, then reason not allowable)	Requires justification in notes section of UA.
2	0, 1 (requires justification in notes section of UA), 3, 4, YC (must complete 3-5 CANS) or 5	1 (requires justification) or 5	1, 5, or 6	1, 5, or 8 (unless Medicaid eligible, then only 5 if after crisis)	Requires justification in notes section of UA.
3	0, 1 & 2 (requires justification in notes section of UA), 4, YC (must complete 3-5 CANS) or 5	1 (requires justification), or 5	1, 2, 5 or 6	1, 2, 5, or 8 (unless Medicaid eligible, then only 2 or 5 if after crisis)	Requires justification in notes section of UA.
4	0, 2 & 3 (requires justification in notes section of UA), YC(must complete 3-5 CANS), or 5	1 (requires justification) or 5	1, 2, 3, 5, or 6	1, 2, 3, 5, or 8 (unless Medicaid eligible, then reason is not allowable)	Requires justification in notes section of UA.
YC	1 (requires justification in notes section of UA) or 5	1 (requires justification)	1 or 6	1 or 5 (unless Medicaid eligible then only 5 if after crisis)	Requires justification in notes section of UA.
9	0, 1, 2, 3, 4, YC, or 5 (deviation not allowable for more than two consecutive authorizations)	0, 1, 2, 3, 4, YC, or 5 (deviation not allowable for more than two consecutive authorizations)	Not applicable	Not applicable	Not applicable

Appendix G: Provider Qualifications: Standard Requirements for All Levels of Care

The following list details the minimum qualifications required to deliver each service:

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 Partner Supports: Certified Family Partner (or Family Partner pursuing certification)
Skills Training and Development: CSSP, QMHP-CS
Medication Training and Support: CSSP, QMHP-CS
Parent Support Group: Certified Family Partner (or Family Partner pursuing certification), QMHP-CS
Family Training: Certified Family Partner (or Family Partner Pursuing certification), CSSP, QMHP-CS
Family Case Management: Certified Family Partner (or Family Partner pursuing certification), 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

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.*"

Appendix H: Definitions

Adjunct Services: Clinically indicated services that are customized and may be delivered to support the recovery of the individual.

Children's Crisis Residential: Twenty-four hour, usually short-term residential services provided to an individual 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.

Core Services: The services in a level of care that are essential and are expected to be delivered to all persons to support recovery.

Counseling: Individual, family, and group therapy focused on the reduction or elimination of a client's symptoms of emotional disturbance and increasing the individual's ability to perform activities of daily living. Cognitive behavioral therapies are the selected treatment model for CMH counseling services for LOC 2-4. Parent-Child Psychotherapy (Dyadic Therapy) is the selected therapy for LOC-YC.

Crisis Flexible Benefits: Non-clinical supports that reduce the crisis situation, reduce symptomatology, and enhance the ability of the child to remain in the home. Examples in children'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 & 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 an individual or client to a more restrictive environment. The provision of Crisis Intervention Services to collaterals is limited to the coordination of emergency care services.

Crisis Transportation: Transporting individuals 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.

Emergency Room Services (Psychiatric): Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

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 LOC 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. Individuals are provided appropriate and coordinated transfer to a higher level of care when needed.

Family Case Management: Activities to assist the client's family members in accessing and coordinating necessary care and services appropriate to the family members' needs.

Family Partner Supports: Peer mentoring and support provided by Certified Family Partners to the primary caregivers of a child who is receiving mental health community services. This may include introducing the family to the treatment process; modeling self-advocacy skills; providing information, making referrals; providing non-clinical skills training; assisting in the identification of natural/non-traditional and community supports. 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 (e.g. mental health, juvenile justice, social security, special education) as the LAR to that child or youth.Family Partner document the provision of all family partner supports, including both face-to-face and non-face-to-face activities.

Family Training: Provided to the client's primary caregivers to assist the caregivers in coping and managing with the client's emotional disturbance. 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 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.

Flexible Funds: Funds utilized for non-clinical supports that augment the service plan to reduce symptomatology and maintain quality of life and family integration. Community supports that may be purchased through flexible funds (FF) 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.

Inpatient Hospital 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 the individual's ability to function in a less restrictive setting.

Intensive Case Management: Activities to assist a client and their caregiver obtain and coordinate access to necessary care and services appropriate to the individual's needs. Wraparound Planning is used to develop the Case Management Plan.

Medication Training and Support: Instruction and guidance based on curricula promulgated by DSHS. The curricula include the Patient/Family Education Program Guidelines as referenced in TAC and other materials that have been formally reviewed and approved by DSHS.

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

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 a client's signs and symptoms of mental illness.

Psychiatric Diagnostic Interview Examination: A face-to-face interview with the child/youth and family to evaluate the child/youth's psychiatric diagnosis and treatment needs provided by a licensed professional practicing within the scope of his/her license.

Respite Services: Services provided for temporary, short-term, periodic relief for primary caregivers. Program-based respite services are provided at temporary residential placement outside the client's usual living situation. Community-based respite services are provided by respite staff at the client'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 in gaining and coordinating access to necessary care and services appropriate to the child/youth's needs.

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: 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 individual's functioning, provides opportunities for the individual to acquire and improve skills needed to function as appropriately and independently as possible in the community, and facilitates the individual's community integration and increases his or her community tenure. This service includes treatment planning to facilitate resiliency.