

Child and Adolescent Residential Treatment Center (RTC) Level of Care Guidelines

Preamble:

According to “Mental Health: A Report of the Surgeon General” (1999, David Satcher, MD, PhD) Residential Treatment finds that data supporting the effectiveness of Residential-based services to be scant. Residential treatment is not without liabilities. It results in separation of the child from the family for extended periods of time, creates problems around the reintegration of the child into the family, exposes the child to pathologic and bizarre behavior, the potential for abuse by Residential treatment staff or peers, and is expensive, amongst other concerns. In lieu of Residential treatment, the Report recommends a child be treated in the community in which they live, remain with their family, and attend school and community events. By increasing levels of service coordination and team collaboration, community-based services can be individualized and provided with the right intensity, resulting in more enduring and sustainable outcomes, as opposed to placement in a “bricks and mortar” Residential program.

UnitedHealthcare Community Plan supports the report findings about Residential Treatment, and offers a rich network of well-established, community-based resources such as Comprehensive Child and Family Treatment (CCFT) interventions. These service providers work directly with the member; assist parents/guardians in developing enhanced parenting skills, and work with teachers and the juvenile justice system to address a child’s treatment needs where they live, instead of placing the child in a contrived milieu such as a Residential Treatment venue. Readers are referred to view the Report at <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.

Description: A residential treatment center (RTC) is a licensed, 24-hour facility (although not licensed as a hospital) which offers mental health treatment. The types of treatment vary widely; the major categories are psychoanalytic, psychoeducational, behavioral management, group therapies, medication management, and peer-cultural.

While formerly for long-term treatment (e.g., a year or more), RTCs under managed care are now serving more seriously disturbed youth for as briefly as 1 month for intensive evaluation and stabilization.

While the above is based on research looking at Mental Health RTC services, many of the findings and statements apply equally to treatment of Substance Use Disorders (SUD) in Children and Adolescents. There has been a more recent push to develop SUD programs that concurrently treat both SUD and MH presentations. For these reasons, this Level of Care Guideline has been modified so that it can be utilized as the resource for RTC determinations of medical necessity, regardless of whether the RTC is MH, SO, and/or SUD focused.

Admission Criteria:

ALL MUST BE MET:

1. All available community-based treatments that might otherwise augment ambulatory mental health or substance abuse services and avoid the need for Residential Treatment have been adequately tried in appropriate duration and intensity (e.g. 4-6 months of CCFT, one month of SA IOP/PHP, or an Outpatient treatment trial of 10-12 months duration), yet the member has not shown improvement in referral behaviors.
2. Deterioration of the member's behavioral health condition, with the likelihood of requiring inpatient care if the member is not in a residential treatment program. (This criterion is not intended for use as a long-term solution to maintain the stabilization acquired during treatment in a residential facility/program.)
3. If a residential treatment service has been utilized in the past, it has resulted in sustained benefits for the member lasting at least 6 months or more.
4. Presenting signs and symptoms of a behavioral health condition that clearly demonstrate a clinical need for 24-hour structure, supervision, and active treatment. (This criterion is not intended for use solely as a long-term solution to maintain the stabilization acquired during treatment in a residential facility/program.)
5. Acute Inpatient treatment is not required, due to lack of imminent risk for serious harm to self or others not manageable in a residential unit, is inappropriate for acute inpatient, or the member is unlikely to benefit from it, based on a history of recent failures of treatment.
6. There is an active behavioral health condition that can be more efficiently treated (by more rapidly decreasing the member's symptoms) in a Residential treatment setting than an outpatient or inpatient treatment setting.
7. The member is sufficiently stable from a medical standpoint, and does not require 24-hour nursing care and monitoring.
8. Residential treatment is not being used primarily to address a placement issue, lack of appropriate primary caregiver, parent-child conflict, or as an alternative to legal placements. The goal of treatment is to reunite the member with their family/caretaker system.
9. **In case of substance abuse residential treatment requests:**
 - a. There is clear evidence that use patterns are resulting in severe impairment in biopsychosocial functioning, and/or may present significant safety concerns for the member.
 - b. Severe problems are noted in the recovery environment (i.e. peer group and/or primary caregiver relationships) such that the member would not likely participate and benefit from a lower level of care.

For authorization of continued stay, all of the following criteria must be met:

10. Admission criteria must continue to be met.
11. For children and adolescents, the family or caregiver have consistently evidenced active participation in the treatment process (e.g. family therapy sessions) on a weekly basis. When primary caregiver is not participating in the member's treatment, the provider is actively engaging the Department of Children Services (DCS) to address lack of family engagement, and to collaborate around appropriate service and/or placement planning.
12. Passes with guardian are occurring on a routine basis, unless ongoing clinical assessment indicates that a clear and current safety risk (i.e. severe aggression requiring staff intervention, suicidal/homicidal ideation, self-harm, ongoing sexual offending behaviors) is presented by the member, or there is a significant safety risk identified in the home setting. When a significant risk is identified in the home setting, the provider is appropriately notifying and engaging DCS to address concerns. Passes are not being determined by programmatic considerations (i.e. a level system), but are

instead incorporated into treatment planning and are utilized for the purposes of therapeutic intervention and assessment to determine additional areas of need for therapeutic intervention and/or appropriateness for discharge.

13. Treatment goals that are behavioral in nature and measurable must be in place, and consistent progress towards the goals must be demonstrated. When evidence of meaningful progress towards measurable treatment goals is not present, a plan that is likely to result in renewal of meaningful progress must be in place.

Special considerations:

For Psychosexual Residential Treatment, in addition to the above, all of the following must be met:

14. A complete and independent psychosexual assessment should ideally be available prior to the request for admission to a sex offender residential treatment program, in order to clinically support the admission; this assessment must be completed and submitted no later than 30 days after admission. A psychosexual assessment, conducted in accordance with available best practice guidelines (i.e. as defined by the TDMHSAS and Tennessee Sex Offender Treatment Board) is required to not only understand the relative risk of re-offense, but also to guide sex offender specific treatment interventions. Re-assessments will occur on a periodic basis in order to monitor the member's progress, as well as to guide treatment interventions and discharge planning.
15. For members receiving sex offender residential treatment services, the provider will, on an ongoing basis, communicate and collaborate with provider(s) of identified victim(s) to facilitate the reunification process. In coordination with these providers, the sex offender residential treatment provider will identify timelines for completion of this process, in addition to any barriers to timely completion (if present), and will develop treatment interventions and goals to specifically address these barriers when indicated.
16. Members with intellectual and/or other developmental disabilities who are referred to sex offender residential treatment may present with unique treatment needs, and will be evaluated on a case by case basis to determine appropriate placement and services.



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