

**PM ATTACHMENT 3.14.3  
ADHS/DBHS LEVEL ONE  
PSYCHIATRIC RESIDENTIAL TREATMENT CENTER  
ADMISSION AUTHORIZATION CRITERIA  
White Mountain Apache Tribal Regional Behavioral Health Authority**

**A. PURPOSE**

Level One psychiatric residential treatment facility (RTC) services provide treatment for children and adolescents who demonstrate severe and persistent psychiatric disorders, when outpatient services (ambulatory care) in the community do not meet their treatment needs and they require services at a psychiatric residential treatment facility under the direction of a psychiatrist. These services are designed for children and adolescents who have significant deficits in social, behavioral, psychiatric, and psychological functioning and who require active treatment in a controlled environment with a high degree of psychiatric oversight, 24 hour nursing presence, effective program and treatment availability, and continuous supervision provided by professional behavioral health staff.

Admissions to a RTC are not emergent or urgent and are always prior authorized. As per ADHS/DBHS Policy Manual Section 3.14 Securing Services and Prior Authorization, "prior authorization seeks to ensure that persons are treated in the most appropriate, most cost effective, and least restrictive setting, with sufficient intensity of service, treatment and supervision to safely and adequately treat the person's behavioral health condition."

Such admissions are only appropriate where outpatient care has failed or where the child's/adolescent's psychiatric treatment needs are so severe they can only be met by the degree of specialized professional treatment available in a RTC. Active treatment focuses on specific targeted goals identified by the Child and Family Team, and are designed to enable the child/adolescent to be discharged from the psychiatric residential treatment facility at the earliest possible time. A lack of available outpatient services is not in and of itself the sole criterion for admission to a RTC.

Determination of the need for services is based on the federal regulations in 42 CFR:

**§ 441.152 Certification of need for services.**

*(a) A team specified in § 441.154 must certify that—*

- (1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;*
- (2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and*
- (3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.*

**§ 441.154 Active treatment.**

*Inpatient psychiatric services must involve “active treatment”, which means implementation of a professionally developed and supervised individual plan of care, described in § 441.155 that is—*

- (a) Developed and implemented no later than 14 days after admission; and*
- (b) Designed to achieve the recipient’s discharge from inpatient status at the earliest possible time.*

## B. BEHAVIOR AND FUNCTIONING **REQUIRED** FOR ADMISSION

- 1) Symptoms or functional impairments of the individual's psychiatric condition are of a severe and persistent nature, are consistent with a DSM IV-TR diagnosis (within the range of 290 through 316.99), and require residential 24-hour psychiatric treatment under the direction of a psychiatrist.
  - a) Psychiatric conditions best described as 314.xx (Attention Deficit/Hyperactivity Disorder) and 312.8 (Conduct Disorder), without another DSM IV-TR co-morbid diagnosis, are not properly treated at a psychiatric residential treatment facility as per *Mental Health: A Report of the Surgeon General* and therefore should be closely reviewed for appropriateness of treatment in this level of care.<sup>1</sup>
- 2) In addition, **all** of the following must be met to ensure appropriate, cost-effective and least restrictive care in this setting:
  - a) Ambulatory care resources (outpatient medically necessary behavioral health services) in the community do not meet the treatment needs of the child/adolescent;
  - b) The child/adolescent does not require a level of medical or professional supervision that surpasses that which is available at a Level I Residential Treatment Center. For example, children/adolescents actively showing signs of danger to self or danger to others may require inpatient psychiatric treatment at an acute psychiatric hospital;
  - c) The admission is **not** used primarily, and in a clinically inappropriate manner, as:
    - i) an alternative to incarceration, preventative detention, or as a means to ensure community safety in a child/adolescent exhibiting primarily delinquent/antisocial behavior; or
    - ii) the equivalent of safe housing, permanency placement, or
    - iii) an alternative to parents’/guardian’s or other agency’s capacity to provide for the child or adolescent; or
    - iv) an intervention when other less restrictive alternatives are available and not being utilized.

## C. EXPECTED IMPROVEMENT DUE TO ACTIVE TREATMENT

Active treatment with the services available at this level of care can reasonably be expected to improve the child/adolescent’s psychiatric condition in order to

achieve discharge from the psychiatric residential treatment facility at the earliest possible time and facilitate his/her return to outpatient care and/or family living.

#### D. DISCHARGE PLAN

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that includes involvement of the Child and Family Team and complies with current standards for medically necessary covered behavioral health services, cost effectiveness, and least restrictive environment and is in conformance with 42 CFR.<sup>2</sup>

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##### <sup>1</sup> **Mental Health: A Report of the Surgeon General - Chapter 3**

In the past, admission to an RTC has been justified on the basis of community protection, child protection, and benefits of residential treatment per se (Barker, 1982). However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings, according to limited evidence (Joshi & Rosenberg, 1997). One possible reason is that association with delinquent or deviant peers is a major risk factor for later behavior problems (Loeber & Farrington, 1998). Moreover, community interventions that target change in peer associations have been found to be highly effective at breaking contact with violent peers and reducing aggressive behaviors (Henggeler et al., 1998). Although removal from the community for a time may be necessary for some, there is evidence that highly targeted behavioral interventions provided on an outpatient basis can ameliorate such behaviors (Brestan & Eyberg, 1998). For children in the second category (i.e., those needing protection from themselves because of suicide attempts, severe substance use, abuse, or persistent running away), it is possible that a brief hospitalization for an acute crisis or intensive community-based services may be more appropriate than an RTC. An intensive long-term program such as an RTC with a high staff to child ratio may be of benefit to some children, especially when sufficient supportive services are not available in their communities. In short, there is a compelling need to clarify criteria for admission to RTCs (Wells, 1991).

##### <sup>2</sup> **§ 441.155 Individual plan of care**

(a) "Individual plan of care" means a written plan developed for each recipient in accordance with §§ 456.180 and 456.181 of this chapter, to improve his condition to the extent that inpatient care is no longer necessary. (b) The plan of care must— (1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care; (2) Be developed by a team of professionals specified under § 441.156 in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge; (3) State treatment objectives; (4) Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and (5) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge. (c) The plan must be reviewed every 30 days by the team specified in § 441.156 to— (1) Determine that services being provided are or were required on an inpatient basis, and (2) Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. (d) The development and review of the plan of care as specified in this section satisfies the utilization control requirements for— (1) Recertification under §§ 456.60(b), 456.160(b), and 456.360(b) of this subchapter; and (2) Establishment and periodic review of the plan of care under §§ 456.80, 456.180, and 456.380 of this subchapter.