

3.20 INPATIENT SERVICES

3.201 Acute Inpatient Mental Health (Child/Adolescent)

Acute inpatient mental health treatment represents the most intensive level of psychiatric care. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour secure and protected, medically staffed and psychiatrically supervised treatment environment. Twenty-four hour skilled nursing care, daily medical care (child psychiatrist for children under 12), and a structured treatment milieu are required. The goal of acute inpatient care is to stabilize children/adolescents who display acute psychiatric conditions associated with a relatively sudden onset and a short, severe course, or a marked exacerbation of symptoms associated with a more persistent, recurring disorder. Typically, the child/adolescent poses a significant danger to self or others, or displays severe psychosocial dysfunction. Special treatment may include physical and mechanical restraint, seclusion, and a locked unit. Active family/guardian involvement is important unless contraindicated. Frequency should occur based on individual needs.

Criteria

Admission Criteria

The following criterion is necessary for admission:

1. The child/adolescent has been evaluated by a licensed clinician and demonstrates symptomatology consistent with a DSM-IV-TR Axis I and II diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.

*There is evidence of actual or potential danger to self or others or severe psychosocial dysfunction as evidenced by **at least one** of the following (2-11):*

2. A suicide attempt which is serious by degree of lethality and intentionally or suicidal ideation with a plan and means. Impulsive behavior and/or concurrent intoxication increase the need for consideration of this level of care. However, 23-hour observation may be used initially to rule out presence of acute psychiatric symptomatology and/or as a result of intoxication. Assessment should include an evaluation of:
 - a. the circumstances of the suicide attempt or ideation;
 - b. the method used or contemplated;
 - c. statements made by the individual; and
 - d. the presence of continued feelings of helplessness and/or hopelessness, severely depressed mood, and/or recent significant losses.
 - e. availability of responsible support systems.
3. Current assaultive threats or behavior, resulting from an Axis I disorder, with a clear risk of escalation or future repetition (i.e., has a plan and means).
4. Recent history immediately prior to admission, prompting evaluation or intake of significant self-mutilation (non-chronic), significant risk-taking, or loss of impulse control resulting in danger to self or others.
5. Recent history immediately prior to admission, prompting evaluation or intake of violence, resulting from an Axis I disorder.

	<ol style="list-style-type: none"> 6. Command hallucinations directing harm to self or others. 7. Disordered/bizarre behavior or psychomotor agitation or retardation that interferes with the activities of daily living to such a degree that the child/adolescent cannot function at a less intensive level of care. 8. Disorientation or memory impairment which is due to an Axis I disorder and endangers the welfare of the child/adolescent or others. 9. The child/adolescent manifests severe, sustained, and pervasive inability to attend to age-appropriate responsibilities and/or severe deterioration of family and work/school functioning and no other level of care would be intensive enough to evaluate and treat the disorder. (Note: This does not imply that most evaluations require inpatient admission or that a hospital is the appropriate setting for ongoing treatment. Admissions under this criterion are primarily for the purpose of providing structure, evaluating, and engaging an individual receiving services when all other avenues have been exhausted, i.e., child protective services, legal and/or school system.) 10. Inability in an age appropriate manner to maintain adequate nutrition or self-care due to a psychiatric disorder and family/community support cannot be relied upon to provide essential care. 11. The child/adolescent has experienced severe or life-threatening side effects of atypical complexity from using therapeutic psychotropic drugs. <p><i>In addition the following criteria must be met:</i></p> <ol style="list-style-type: none"> 12. The multi-disciplinary discharge planning process starts from the assessment and tentative plan upon admission, and includes the patient and family unless contraindicated secondary to risk of harm to patient or family/support. 13. The treatment plan needs to clearly state the benefits individual will receive in program, and the goals of treatment cannot be based solely on need for structure and lack of supports.
<p>Psychosocial, Occupational, and Cultural and Linguistic Factors</p>	<p><i>These factors, as detailed in the Introduction, may change the risk assessment and should be considered when making level of care decisions</i></p>
<p>Exclusion Criteria</p>	<p><i>Any of the following criteria is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The child/adolescent can be safely maintained and effectively treated at a less intensive level of care. 2. Symptoms result from a medical condition, which warrants a medical/surgical setting for treatment. 3. The child/adolescent exhibits serious and persistent mental illness consistent through time and is not in an acute exacerbation of the illness. 4. The primary problem is not psychiatric (e.g., social, economic or delinquent behavior)), or one of physical health without a concurrent major psychiatric

	episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.
Continued Stay Criteria	<p><i>All of the following criteria are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. The child/adolescent's condition continues to meet admission criteria for inpatient care, acute treatment interventions (including psychopharmacological) have not been exhausted, and no other less intensive level of care would be adequate. 2. The multi-disciplinary discharge planning process starts from the assessment and tentative plan upon admission, and includes the patient and family/significant other as appropriate unless contraindicated secondary to risk of harm to patient or family/support. 3. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family or other support systems, social, educational and interpersonal assessment with involvement unless contraindicated, within 48 hours of admission. Family sessions need to occur in a timely manner. Treatment planning goals setting should be realistic and attainable Expected benefit from all relevant treatment modalities, including family and group treatment is documented. 4. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice. 5. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress and/or psychiatric/medical complications are evident. 6. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's behavioral and functional outcomes as described in the discharge plan. 7. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated and consistent with prescribing guidelines. 8. Patient is actively participating in plan of care and treatment to the extent possible consistent with his/her condition. 9. Coordination with relevant outpatient providers is implemented.
Discharge Criteria	<p><i>Any of the following criteria are sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. Treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at a lower level of care. Follow-up aftercare appointment is arranged for a timeframe consistent with the member's condition and applicable standards. 2. The child/adolescent no longer meets admission criteria or meets criteria for a less intensive level of care. 3. The child/adolescent, family, legal guardian and/or custodian are competent but non-participatory in treatment or in following program rules and regulations. 4. The non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address

	<p>non-participation issues.</p> <ol style="list-style-type: none">5. Either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment6. Consent for treatment is withdrawn and, either it has been determined that involuntary inpatient treatment is inappropriate, or the court has denied involuntary inpatient treatment.7. Support systems that allow the child/adolescent to be maintained in a less restrictive treatment environment have been thoroughly explored and/or secured.8. The child/adolescent is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care.9. The child/adolescent's physical condition necessitates transfer to a medical or to a child welfare facility.
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