

## 3.40 STRUCTURED DAY TREATMENT SERVICES

### 3.403 Intensive Outpatient Programs (Child/Adolescent)

Description of Services: Intensive Outpatient Programs (IOPs) for children/adolescents provide time limited, multidisciplinary, multimodal structured treatment in an outpatient setting. Such programs are less intensive than a partial hospital program (e.g., may not always include medical oversight and medication evaluation and management as a PHP would) but significantly more intensive than outpatient psychotherapy and medication management. This level of care is used to intervene in a complex or refractory clinical situation and should be differentiated from longer term structured day programs intended to achieve or maintain stability for individuals with severe and persistent mental illness. Clinical interventions available should include modalities typically delivered in office-based settings such as individual, couple and family psychotherapy, group therapies, medication management, and psychoeducational services. Family involvement from the beginning of treatment is extremely important unless contraindicated, and should occur based on individual needs. Adjunctive therapies such as life planning skills (assistance with vocational, educational, financial issues) and special issue or expressive therapies may be provided, but must be standardized in content or duration; that is, they must have a specific function within a given patient's treatment plan. Assessment of school performance is an important component of treatment planning, as is involvement with school personnel to monitor the ongoing impact of treatment and facilitate constructive ways of working with children/adolescents.

As functioning improves, the child/adolescent will receive a diminishing number of treatment hours. All treatment plans must be individualized and should focus on acute stabilization and transition to community outpatient treatment and support groups as needed. Although individuals may present as sub-acute, the environment must be sufficiently staffed to allow rapid professional assessment of a change in mental status which warrants a shift to a more intensive level of care or a change in medication. Family involvement from the beginning of treatment is important and, unless contraindicated, ideally occurring at least three times for every 10 days in the program.

#### Criteria

<p><b>Admission Criteria</b></p>	<p><i>All of the following criteria are necessary for admission:</i></p> <ol style="list-style-type: none"> <li>1. The child/adolescent demonstrates symptomatology consistent with a DSM-IV-TR (Axes I-V) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention. Evaluation needs to include an assessment of substance abuse issues.</li> <li>2. The child/adolescent's GAF score should be within the range of 31-60.</li> <li><del>3.</del> There is an expectation that the child/adolescent will show significant progress toward treatment goals within the specified timeframes as dictated by the individual treatment plan.</li> <li>4. There are significant symptoms that interfere with the child/adolescent's ability to function in at least one life area (e.g., school, social, self care).</li> <li>5. The child/adolescent's condition requires a coordinated, office-based treatment plan of services, which may require different modalities and/or clinical disciplines for progress to occur.</li> <li>6. Alternative outpatient services have been explored and exhausted.</li> </ol>
<p><b>Psychosocial, Occupational, and Cultural and Linguistic Factors</b></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>

<b>Exclusion Criteria</b>	<p><i>Any of the following criteria is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> <li>1. The child/adolescent is a danger to self and others or sufficient impairment exists that a more intensive level of service is required.</li> <li>2. The child/adolescent has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications.</li> <li>3. The child/adolescent requires a level of structure and supervision beyond the scope of the program.</li> <li>4. The child/adolescent can be safely maintained and effectively treated at a less intensive level of care (i.e. all alternative outpatient services have been explored and exhausted).</li> <li>5. The primary problem is social, economic (i.e. housing, family, conflict, etc.), 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 or school suspension.</li> </ol>
<b>Continued Stay Criteria</b>	<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"> <li>1. The child/adolescent's condition continues to meet admission criteria at this level of care.</li> <li>2. The child/adolescent's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate</li> <li>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, occupational and interpersonal assessment with involvement unless contraindicated. Family sessions as appropriate need to occur in a timely manner. Expected benefit from all relevant treatment modalities is documented.</li> <li>4. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.</li> <li>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 are evident.</li> <li>6. Care is rendered in a clinically appropriate manner and focused on child/adolescent's behavioral and functional outcomes as described in the discharge plan.</li> <li>7. The child/adolescent is motivated for continued treatment as evidenced by compliance with program rules and procedures and is actively participating in treatment.</li> <li>8. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.</li> <li>9. An active discharge planning process begins with the initial assessment; and includes the patient, family and/or significant other as appropriate.</li> <li>10. Coordination with relevant providers should be implemented.</li> <li>11. Unless contraindicated, family, guardian, and/or custodian is actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.</li> </ol>

<b>Discharge Criteria</b>	<p><i>Any of the following criteria are sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"><li>1. The child/adolescent's documented treatment plan goals and objectives have been substantially met, and/or a continuing care plan can be set up to safely meet the patient needs at a lower level of care.</li><li>2. The child/adolescent no longer meets admission criteria, or meets criteria for less or more intensive level of care.</li><li>3. The child/adolescent, family, guardian and/or custodian are competent but non-participatory in treatment or in following the program rules and regulations. 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 non-participation issues</li><li>4. Consent for treatment is withdrawn, and it is determined that the individual has the capacity to make an informed decision and does not meet criteria for an inpatient level of care.</li><li>5. Support systems, which allow the individual to be maintained in a less restrictive treatment environment, have been thoroughly explored and/or secured.</li><li>6. The child/adolescent is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care despite treatment planning changes.</li></ol>
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