

3.40 STRUCTURED DAY TREATMENT SERVICES

3.401 Partial Hospitalization Program (Child/Adolescent)

Description of Services: Partial hospitalization is a nonresidential treatment program that may or may not be hospital-based. The program provides clinical diagnostic and treatment services on a level of intensity equal to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu, nursing, psychiatric evaluation (by a child psychiatrist if the child is under 12) and medication management, group and individual/family therapy, psychological testing, vocational counseling, substance abuse evaluation and counseling, and behavioral plans. The environment at this level of treatment is highly structured, and there should be a staff-to-patient ratio sufficient to ensure necessary therapeutic services, professional monitoring, control and protection. Psychiatric partial hospital treatment may be appropriate when a child or adolescent does not require the more restrictive and intensive environment of a 24-hour inpatient setting, but does need up to eight hours of clinical services. This level of care provides stabilization of children/adolescents with serious emotional disturbances, therapeutically supported diversion from inpatient care, and restoration to a level of functioning that enables a child/adolescent's return to the community. Partial hospitalization may also provide supportive transitional services to children/adolescents who 1) are no longer acutely ill; 2) require minimal supervision to avoid risk; and 3) are not fully able to re-enter the community and work or school arena. Children/adolescents admitted to treatment may spend part of the day at the treatment site, with other structured time devoted to activities which are part of an integrated therapeutic service plan (e.g., school). Treatment efforts need to focus on the child/adolescent's response during treatment program hours, as well as the continuity and transfer of treatment gains during the child/adolescent's non-program hours in the home/community. Family involvement from the beginning of treatment is important and, unless contraindicated, should occur at least three times for every 10 days in the program.

Criteria

<p>Admission Criteria</p>	<p><i>All of the following criteria are necessary for admission:</i></p> <ol style="list-style-type: none"> 1. The child/adolescent demonstrates symptoms consistent with a DSM-IV (Axes I-V) diagnosis that requires and can reasonably be expected to respond to therapeutic intervention. Evaluation needs to include a complete substance abuse evaluation. 2. There is evidence of child/adolescent's capacity and support for reliable attendance at the partial hospital program. 3. There is an adequate social support system available to provide the stability necessary for maintenance in the program OR the individual demonstrates willingness to assume responsibility for his/her own safety outside program hours. 4. There is a risk to self, others, or property (e.g., inability to undertake self-care; mood, thought or behavioral disorder interfering significantly with activities of daily living; suicidal ideation or non-intentional threats or gestures; risk-taking or other self-endangering behavior) which is not so serious as to require 24-hour medical/nursing supervision, but does require structure and supervision for a significant portion of the day and family/community support when away from the partial hospital program. 5. The child/adolescent's condition requires a comprehensive, multi-disciplinary, multi-modal course of treatment, including routine medical observation/supervision to effect significant regulation of medication and/or routine nursing observation and behavioral intervention to maximize functioning and minimize risks to self, others and property. 6. Multi-disciplinary discharge planning begins with the patient, family and support system from the initial assessment.
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	<p>7. The treatment plan needs to clearly state the benefits member will receive in program; the goals of treatment can not be based solely on need for structure and lack of supports.</p>
<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 are sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The child/adolescent is a danger to self or others or sufficient impairment exists that a more intense level of service is required. 2. The child/adolescent does not voluntarily consent to admission or treatment. 3. The child/adolescent has medical conditions or impairments that would prevent beneficial utilization of services. 4. The child/adolescent requires a level of structure and supervision beyond the scope of the program (e.g., considered a high risk for noncompliant behavior and/or elopement). The individual exhibits a serious and persistent mental illness consistent throughout time and is not in an acute exacerbation of the mental illness; 5. The child/adolescent can be safely maintained and effectively treated at a less intensive level of care 6. 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. 7. Family or support system refuses to be involved in the child/adolescent’s treatment.
<p>Continued Stay Criteria</p>	<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 at this level of care. 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. 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 when indicated. . . Family sessions need to occur in a timely manner. Treatment planning needs to document benefit from group treatment. 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 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 goals. 7. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.

	<ol style="list-style-type: none"> 8. There is documented active discharge planning. 9. Patient , family and/.or significant supports remain actively involved in the treatment and discharge planning 10. Coordination with relevant outpatient providers is implemented. 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.
<p>Discharge Criteria</p>	<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. The child/adolescent’s documented treatment plan, goals and objectives have been substantially met; or a plan for safe, continuing care can be set up and deployed at a lower level of care 2. The child/adolescent no longer meets admission criteria, or meets criteria for a less or more intensive level of care. 3. The individual, family, guardian and/or custodian is competent but non-participatory in treatment or in following the program rules and regulations. 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. In addition, 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 treatment. 4. Consent for treatment is withdrawn and the child/adolescent does not meet criteria for an inpatient level of care. 5. Support systems, which allow the child/adolescent to be maintained in a less restrictive treatment environment, have been thoroughly explored and/or secured. 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. 7. There is a discharge plan with follow-up appointments in place.