Texas Resilience and Recovery
Utilization Management Guidelines
Child and Adolescent Services (Updated 2016)

Levels of Care and Service Descriptions

Table 1. Texas Resilience and Recovery Levels of Care

LOC	LOC-0 Crisis Services	LOC-1 Medication Management	LOC-2 Targeted Services	LOC-3 Complex Services	LOC-4 Intensive Family Services	LOC-YES Youth Empowerment Services	LOC-RTC Residential Treatment Center	LOC-YC Young Child Services	LOC-5 Transition Services	LOC-8 Waitlist	LOC-9 Ineligible
CANS Scores	**CANS Completion Not Required**	Severity & Complexity of Symptoms →				**Medicaid Waiver**	**RTC Criteria**	**Full Range of Scores**	**Temporary Services**	**Full Range of Scores**	**Not Eligible for Services**
		← Increased Natural Supports & Strengths									
LOC Indicator	**Crisis**	**Low Emotional, Behavioral, Life Domain Needs**	**Emotional Needs *OR* Behavioral Needs**	**Emotional, Behavioral, *and/or* Life Domain Needs**	**Multi-System Involvement**	**Ages 3-18 Meets YES Wavier Eligibility**	**Ages 5-17 Meets RTC Eligibility AND Admitted to RTC**	**Ages 3-5 with Behavioral *and/or* Emotional Needs**	**Ages 3-17 Temporary Services for Transitioning Individuals**	**Wait List**	**Ineligible**
Profile of Youth	Youth currently in crisis situation without current LOC authorization Expected to be a brief intervention to resolve crisis and prevent additional crisis events Following stabilization of the crisis, youth will be reassessed & assigned new LOC	Stable youth whose only identified treatment need is for medication management, with an occasional need for routine case management	Youth with behavioral OR emotional needs, but NOT BOTH	Youth with complex behavioral AND emotional needs May have multiple life domain functioning and/or caregiver needs	Youth with severe risk behaviors, threatened community tenure, risk of juvenile justice involvement, expulsion from school, displacement from home, and/or serious injury to self/others or death, along with significant caregiver needs, and behavioral and/or emotional needs	Youth enrolled in YES Services Includes all Medicaid services which the youth is entitled	Youth referred to DSHS by Child Protective Services due to risk of parental relinquish-ment of custody Referred youth have severe risk behaviors, potential involvement of multiple child-serving systems, and significant caregiver needs	Child between 3 & 5 years of age or is develop-mentally within this age range and has emotional and/or behavioral needs	Assists youth & caregivers in maintaining stability, preventing additional crises, and engaging youth into appropriate LOCs or accessing appropriate community services Highly individualized and length of stay is based on individual need	Youth that has received a full Uniform Assessment, but is currently waiting for services Individuals with Medicaid may not be placed in LOC-8	Youth whose assessment scores or other service eligibility criteria do not qualify the youth to receive services other than Crisis Services (LOC-0) should a psychiatric crisis occur
Core Services	Crisis Intervention Services	Medication Management	Routine Case Management Counseling Skills Training	Routine Case Management Counseling Skills Training	Intensive Case Management (Wraparound) Family Partner Counseling Skills Training	In addition to TRR services, youth has access to additional Medicaid services within YES Waiver	Family Case Management Family Partner	Routine Case Management Counseling Skills Training			

TRR LEVELS OF CARE

Level of Care 0: Crisis Services

Purpose for Level of Care

The services in this LOC are brief interventions provided in the community that ameliorate the crisis situation. Services are intended to resolve the crisis, avoid more intensive and restrictive intervention, and prevent additional crisis events. *Any service offered must meet medical necessity criteria.*

Note: These services do not require prior authorization. However, Utilization Management (UM) staff must authorize the crisis service within two business days of presentation. If further crisis follow-up and relapse prevention services are needed beyond the authorization period, the youth may be authorized for LOC-5.

NOTE: Detailed information about suicide safety planning, the Safety Planning Intervention, and a safety plan template to assist youth in crisis are located in Appendix A: Crisis Services and Planning.

Special considerations for youth presenting in a true or perceived crisis at the time of CANS administration:

If a youth enrolled in another LOC experiences a psychiatric crisis, or reports a personal or subject crisis event, crisis services should be delivered within that current LOC assignment.

LOC-0 may only be assigned to a youth who is ***not currently assigned to an LOC***. Following stabilization of the crisis, the youth should be reassessed to determine further eligibility and the most appropriate LOC for continuation of services.

When a youth not currently assigned to an LOC does not meet the clinical crisis threshold and the youth or family reports that the youth is experiencing a personal or subjective crisis event, the youth can be immediately authorized to LOC-0 in order to receive crisis services. The providers do not have to complete the CANS assessment in its entirety, but have to complete the two CANS domains listed below before they can deviate the LOC Recommended (LOC-R) to LOC-0. This will allow staff to provide crisis services, screen the youth, and determine needs and possible referral resources.

- For the CANS 6-17, the provider has to complete two CANS assessment domains (Child Risk Behaviors and Child Behavioral/Emotional Needs) before deviating to LOC-0. This will help providers to determine needs and make clinical recommendations.
- For the CANS 3-5, the provider has to complete the following two CANS assessment domains (Child Risk Behaviors and Child Risk Factors) before deviating to LOC-0.

Level of Care Assignment Criteria

A youth may be assigned LOC-0 for the following reasons:

- The youth is not currently assigned to an LOC **AND**
  - The Uniform Assessment indicates an LOC-R of 0; or
  - The Uniform Assessment indicates an LOC-R of 1, 2, 3, 4, Young Child (YC), or 9, and it is clinically determined that the youth is in an acute or perceived acute crisis; or
  - The Uniform Assessment is incomplete, but clinical judgment indicates the need for immediate crisis intervention.

Note: A mental health diagnosis is not required.

Criteria for Level of Care Review

Authorization for this LOC will expire in seven days, unless reauthorized. Additional authorizations may be given if medically necessary.

If the youth cannot be treated safely or effectively within this LOC and his/her acuity level increases, hospitalization may be indicated.

Discharge Criteria

The youth may be discharged from this LOC for any of the following reasons:

- The crisis has been resolved and the youth has been transitioned to LOC 1, 2, 3, 4, 5, YES, YC, RTC, or EO.
- The crisis has been resolved and the youth has been placed on a waiting list for the indicated LOC (NOTE: Individuals who are Medicaid Eligible may not be placed on a waiting list or be underserved due to resource limitations).
- The youth and/or caregiver are referred and linked to community resources outside the DSHS system.
- The youth and/or caregiver have found services in the community to meet their needs.
- The youth and/or caregiver terminate services.

Expected Outcomes

The following outcomes can be expected as a result of delivering crisis services:

- Reduced risk of placement in a more restrictive environment, such as a psychiatric hospital, residential treatment center, or juvenile detention center; and/or
- Youth and/or caregiver report improved symptom management, behaviors, and/or functioning; and/or
- The youth and/or caregiver is engaged in appropriate follow-up treatment and linked with natural and community support systems.

Special Considerations for Certain Adjunct Services

Family Partner Supports:
As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the youth's treatment team, and assistance making informed choices regarding the youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/);
- Role-modeling the concepts of hope and resilience through articulation of the Certified Family Partner's successes regarding his/her child's mental health;
- Assistance in understanding and advocating for the youth's mental health needs during the crisis episode; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 0 Table Overview

Authorization Period: 7 Days	
Average Monthly Utilization Standard For This Level of Care: N/A In LOC-0, overall expected hours of utilization are undeterminable. For youth authorized in LOC-0, it is expected that the services in the crisis service array will be utilized as medically necessary and available to treat and stabilize the psychiatric crisis.	
Core Services: Identified by the uniform assessment and must be offered to the youth.	**Individual Services in LOC – 0 Estimated Utilization Per 7 Days**
	High Need Therapeutic
Crisis Intervention Services	**3.75 hours** (15 units)
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**1 Event** (1 unit)
Pharmacological Management	**10 Events** (10 units)
Safety Monitoring	**2 hours** (8 units)
Crisis Transportation (Event)	**1 Event** (1 unit)
Crisis Transportation (Dollar)	**As necessary** ($1 units)
Crisis Flexible Benefits (Event)	**As necessary** (Event)
Crisis Flexible Benefits (Dollar)	**As necessary** ($1 units)
Respite Services: Community-Based	**6 hours** (24 units)
Respite Services: Program-Based (not in home)	**3 bed days** (3 units)
Extended Observation	**1 unit** (1 bed day)
Children's Crisis Residential	**4 units** (4 bed days)
Family Partner Supports	**6 hours** (24 units)
Engagement Activity	**6 hours** (24 units)
Inpatient Hospital Services	**As necessary** (1 bed day units)
Inpatient Services (Psychiatric)	**As necessary** (1 bed day units)
Emergency Room Services (Psychiatric)	**As necessary** (Events)
Crisis Follow-up & Relapse Prevention	**8 hours** (32 units)

Level of Care 1: Medication Management

Purpose for Level of Care

The services in this LOC are intended to meet the needs of youth whose only identified treatment need is medication management. Youth served in this LOC may have an occasional need for routine case management services, but do not have ongoing treatment needs outside of medication-related services. While services delivered in this LOC are primarily office-based, services may also be provided at school, in the community, or via telemedicine.

The purpose of this LOC is to maintain stability and utilize the youth's and/or caregiver's natural supports and identified strengths to help them transition to community-based providers and resources, if available.

Special Considerations During Crisis

If the youth's symptoms or behaviors increase to a crisis level, crisis services should be delivered within this current LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the youth to determine if a more intensive LOC is indicated.

LOC-0 may only be used for a youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A youth may be assigned LOC-1 for the following reasons:

- The Uniform Assessment indicates an LOC-R of 1; or
- The Uniform Assessment indicates an LOC-R of 2, 3, YC, or 9, and the youth meets deviation reason criteria and is overridden into LOC-1.

Criteria for Level of Care Review

The following indicators require a review of the LOC authorized:

- The Uniform Assessment indicates an LOC-R for the youth that is different from the Level of Care Authorized (LOC-A); or
- The clinician determines the youth meets criteria for admission into a more intensive LOC; or
- The youth experiences a psychiatric crisis and must be reassessed to determine if a more intensive LOC is indicated.

Discharge Criteria

The youth may be discharged from this LOC for any of the following reasons:

- The youth has been linked to medication services provided in the community.
- The youth does not meet criteria for admission into a more intensive LOC and medication services are not indicated, have been effectively discontinued, or have been declined.
- The youth and/or caregiver terminates services or moves outside of service area.
- The youth and/or caregiver is not receptive to treatment after all required engagement efforts have been exhausted.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The youth and/or caregiver is linked with—and utilizing—natural and community support systems.
- The youth and/or caregiver reports stabilization of symptoms or maintenance of stability.
- The youth and/or caregiver is engaged in appropriate follow-up treatment and linked with natural and community support systems.

Special Considerations for Certain Adjunct Services

Family Partner Supports:
As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the youth's treatment team and assistance making informed choices regarding the youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/);
- Assistance in understanding and advocating for the youth's mental health needs, including provision of expertise in navigating child-serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills;
- Facilitation of family support groups;
- Connection to community resources and informal supports in preparation for the youth's transition out of the mental health system;
- Identification of the family's natural supports and strengths and guidance, and practical guidance in nurturing those relationships; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 1 Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 0.5 hours Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 0.5 hours/month. Ideally, the average hours will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the recovery plan.	**Individual Services in LOC – 1** **Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Pharmacological Management	**1 Event** (1 unit)	**2 Events** (2 units)
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**Standard Therapeutic**	**High Need Therapeutic**
Medication Training and Support either/both of the following:		
Medication Training and Support (Individual)	**0.5 hours** (2 units)	**3.75 hours** (15 units)
Medication Training and Support (Group)	**0.5 hours** (2 units)	**3.75 hours** (15 units)
Routine Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Parent Support Group	**1 hour** (1unit)	**4 hours** (4 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Family Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization guidelines for the Crisis Service Array are located on page 44.***	
Transition Age Youth: Additional adjunct services for transition age youth may be provided in this LOC.	***Utilization guidelines for the transition age youth population are located on page 62.***	

Level of Care 2: Targeted Services

Purpose for Level of Care

The purpose of this LOC is to improve mood symptoms or address behavioral treatment needs while building strengths in the youth and caregiver.

The services in this LOC are intended to meet the needs of the youth with identified emotional ***or*** behavioral treatment needs. The youth must **not have** identified needs in both areas. In general, the youth will have low life domain functioning needs.

The targeted service in this LOC is either counseling ***or*** individual skills training and targets a specific, identified treatment need. The only exception occurs when counseling is the primary intervention for the youth, but individual skills training is also provided as a component of parent skills training. Services should be provided in the most convenient location for the youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telehealth/telemedicine, if available.

Note: If the youth and/or caregiver chooses not to participate in core services offered at this level of care, engagement activities must be provided. Provision of engagement efforts must be documented in the clinical record.

Special Considerations During Crisis

If the youth's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered within this current LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the youth to determine if a more intensive LOC is indicated.

LOC-0 may only be used for a youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A youth may be assigned to LOC-2 for the following reasons:

- The Uniform Assessment indicates an LOC-R of 2; or
- The Uniform Assessment indicates an LOC-R of 1, 3, 4, YC, or 9, and the youth meets deviation reason criteria and is overridden into LOC 2.

Note: See Appendix F: Reasons for Deviation for clinical guidance on deviation reasons.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The Uniform Assessment indicates an LOC-R for the youth that is different from the LOC-A; or
- The clinician determines the youth meets criteria for admission into a more intensive LOC; or
- The clinician determines the youth and caregiver have obtained maximum clinical benefit from services and recommends transition to LOC-1 or services in the community; or
- The youth experiences a psychiatric crisis and must be reassessed to determine if a more intensive LOC is indicated.

Step-Down/Discharge Criteria

The youth may be stepped down from this LOC or discharged from services for any of the following reasons:

- The Uniform Assessment indicates an LOC-R of 1 *and* the youth has completed the indicated course of treatment.
- The youth and/or caregiver report improved mood or behavioral symptoms, have no additional identified goals, and clinical judgment supports transition to LOC-1 or transition to the community.
- The youth and/or caregiver have found services in the community to meet their needs.
- The youth and/or caregiver choose not to participate in services at the indicated intensity, all required engagement efforts have been exhausted, and clinical judgment of risk supports the transition to a lower level of care.
- The youth and/or caregiver terminate services or move outside of service area.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The youth and/or caregiver reports improved mood symptom management or behaviors.
- The youth and/or caregiver is transitioned to a lower level of care.
- The youth and/or caregiver is linked with—and utilizing—natural and community support systems.
- The youth and/or caregiver reports increased individual and caregiver strengths.

Special Considerations for Certain Adjunct Services

Family Partner Supports:

As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the youth's treatment team and assistance making informed choices regarding the youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/);
- Assistance in understanding and advocating for the youth's mental health needs, and provision of expertise in navigating child-serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents through the use of a DSHS-approved protocol;
- Facilitation of family support groups;
- Connection to community resources and informal supports that support the youth's transition to a less intensive LOC and resilience and recovery;
- Identification of the family's natural supports and strengths and guidance, and practical guidance in nurturing those relationships; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 2 Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 3 hours Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 3 hours/month. Ideally, the average hours will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the recovery plan. NOTE: In this LOC, the youth should receive counseling *or* skills training as a core service.	**Individual Services in LOC – 2** **Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Routine Case Management	**1 hour** (4 units)	**2 hours** (8 units)
Counseling includes any/all of the following:		
Counseling (Individual)	**2 hours**	**4 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**Standard Therapeutic**	**High Need Therapeutic**
Engagement Activity	**0.5 hours** (2 units)	**2 hours** (8 units)
Pharmacological Management*	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support* either/both of the following:		
Medication Training and Support (Individual)	**0.5 hours** (2 units)	**3.75 hours** (15 units)
Medication Training and Support (Group)	**0.5 hours** (2 units)	**3.75 hours** (15 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training includes either/both of the following:		
Family Training (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Parent Support Group	**1 hour** (1 unit)	**4 hour** (4 units)
Family Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization guidelines for the Crisis Service Array are located on page 44.***	
Transition Age Youth: Additional adjunct services for transition age youth may be provided in this LOC.	***Utilization guidelines for the transition age youth population are located on page 62.***	

*When prescribed or indicated by a physician these services must be offered.

Level of Care 3: Complex Services

Purpose for Level of Care

The services in this LOC are intended to meet the needs of the youth with identified behavioral *and* emotional treatment needs. The youth may also exhibit a moderate degree of risk behaviors and/or life domain functioning impairments that require multiple service interventions. This may indicate a need for interventions aimed at preventing juvenile justice involvement, expulsion from school, displacement from home, or further exacerbation of symptoms and/or behaviors.

The purpose of this LOC is to reduce or stabilize symptoms and/or risk behaviors, improve overall functioning, and build strengths and resiliency in the youth and caregiver. Services should be provided in the most convenient location for the youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telehealth/telemedicine, if available. Providers may need to consider flexible office hours to support the complex needs of the youth and caregiver.

Note: If the youth and/or caregiver choose not to participate in core services offered at this level of care, engagement activities must be provided and efforts must be documented in the clinical record.

Special Considerations During Crisis

If the youth's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered within this LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be completed with the youth to determine if a more intensive LOC is indicated.

LOC-0 may only be used for a youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A youth may be assigned LOC-3 for the following reasons:

- The Uniform Assessment indicates an LOC-R of 3; or
- The Uniform Assessment indicates an LOC-R of 1, 2, 4, Young Child (YC), or 9, and the youth meets deviation reason criteria and is overridden into LOC 3.

Note: See Appendix F: Reasons for Deviation for clinical guidance on deviation reasons.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The Uniform Assessment indicates an LOC-R for the youth that is different from the LOC-A; or
- The clinician determines the youth meets criteria for admission into LOC-4; or
- The clinician determines that it is contraindicated to offer counseling and skills training services concurrently and recommends deviation to LOC-2; or
- The clinician determines the youth and caregiver has obtained maximum clinical benefit from services and recommends transition to a less intensive LOC or services in the community; or
- The youth experiences a psychiatric crisis and must be reassessed to determine if a more intensive LOC is indicated.

Step Down

The TRR model supports moving youth into less intensive levels of care based on improvement in treatment as informed by clinical impressions, family reports, and the reassessment.

Discharge Criteria

The youth may be discharged from services for any of the following reasons:

- The youth and/or caregiver have found services in the community to meet their needs.
- The youth has completed treatment and is no longer in need of services.
- The youth and/or caregiver terminate services or move outside of service area.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The youth and/or caregiver report improved emotional and/or behavioral functioning.
- The youth and/or caregiver report improvement within the domains of risk behavior or life domain functioning.
- The youth is transitioned to a lower level of care.
- The youth and/or caregiver are linked with and utilizing natural and community support systems.
- The youth and/or caregiver report increased individual and caregiver strengths.

Special Considerations for Certain Adjunct Services

As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the youth's treatment team and assistance making informed choices regarding the youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/).
- Assistance in understanding and advocating for the youth's mental health needs, and provision of expertise in navigating child-serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents and/or caregivers through the use of a DSHS approved protocol;
- Facilitation of family support groups;
- Connection to community resources and informal supports that support the youth's transition to a less intensive LOC and resilience and recovery;
- Identification of the family's natural supports and strengths and guidance, and practical guidance in nurturing those relationships; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 3 Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 5 hours Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 5 hours/month. Ideally, the average hours will be achieved through delivery of core services and supplemented by adjunct services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the recovery plan. NOTE: In this LOC youth should receive counseling *and* skills training as core services.	**Individual Services in LOC-3 Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Routine Case Management	**1 hour** (4 units)	**6 hours** (24 units)
Counseling includes any/all of the following:		
Counseling (Individual)	**2 hours**	**4 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**Standard Therapeutic**	**High Need Therapeutic**
Engagement Activity	**0.75 hours** (3 units)	**2 hours** (8 units)
Pharmacological Management*	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support* either/both of the following:		
Medication Training and Support (Individual)	**0.5 hours** (2 units)	**4.5 hours** (18 units)
Medication Training and Support (Group)	**0.5 hours** (2 units)	**4.5 hours** (18 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training includes either/both of the following:		
Family Training (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Flexible Funds	**N/A**	**$1,500 cap/year** ($1 increments)
Parent Support Group	**1 hour** (1 unit)	**4 hour** (4 units)
Family Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Respite Services: Community Based	**N/A**	**6 hours** (24 units)
Respite Services: Program Based	**N/A**	**3 Bed days** (3 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization guidelines for the Crisis Service Array are located on page 44.***	
Transition Age Youth: Additional adjunct services for transition age youth may be provided in this LOC.	***Utilization guidelines for the transition age youth population are located on page 62.***	

*When prescribed or indicated by a physician these services must be offered.

Level of Care YC: Young Child Services

Purpose for Level of Care

The services in this LOC are intended to meet the needs of the young child (ages 3-5) with identified behavioral *and/or* emotional treatment needs. The young child may also exhibit a moderate degree of life domain functioning impairments that require multiple service interventions.

All services are available in this level of care and the recovery plan should be developed based on the individual needs of the child. The provider may recommend any core service that will help address the developmental, behavioral, and emotional needs of the child. In this level of care, the participation of the caregiver in all services is strongly recommended and most services will require the participation of both the child and caregiver in treatment.

The purpose of this LOC is to reduce or stabilize symptoms, improve overall functioning, and build strengths and resiliency in the child and caregiver. The focus of services is placed on the dyad relationship as this relationship is the primary context for young children. These primary relationship(s) set the stage for future social-emotional behavior and future relationship behavior. Services should be provided in the most convenient location for the child and caregiver, including the office setting or home. Services may also be provided via telemedicine/health, if available. Providers may need to consider flexible office/service hours to support the needs of the child and caregiver.

Note: If the youth and/or caregiver chooses not to participate in core services offered at this level of care, engagement activities must be provided. Provision of engagement efforts must be documented in the clinical record.

Special Considerations During Crisis

If the child's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered in this LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the child and caregiver to determine if more intensive services are indicated.

LOC-0 may only be used for a child or youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A child may be assigned LOC-YC for the following reasons:

- The Uniform Assessment indicates an LOC-R of YC; or
- The Uniform Assessment indicates an LOC-R of 1, 2, 3, 4, or 9, and the child meets deviation reason criteria and is overridden into LOC-YC.

The TX CANS 3-5 is specifically developed for children this age and is administered for assessment and treatment planning purposes. When the TX CANS 3-5 indicates that a young child might meet criteria for the LOC YES Waiver, the TX CANS 6-17 must then be administered to determine if the young child meets criteria for LOC-YES Waiver.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The Uniform Assessment indicates an LOC-R for the child that is different from the LOC-A; or
- The child has been served in LOC-YC and after reaching age 6 has an LOC-R of 1, 2, 3, 4, and the clinician recommends that the child should continue to be served in LOC-YC; or
- The child is newly admitted to services and has an LOC-R 1, 2, 3, 4, and the clinician feels it is developmentally appropriate for the child to be served in LOC-YC; or

- The clinician determines the child and caregiver has obtained maximum clinical benefit from services and recommends transition to services in the community or LOC-1 (if medication services only are indicated).

Age out

The child has a birthday and turns 6 years old and has completed the indicated course of treatment. This child will transition into LOC-A of 1, 2, 3, 4 or YES Waiver. (Note: if the child is age 6 and the course of treatment **has not** been completed, the child should remain in LOC-YC for continuity of care until treatment goals have been reached or the child turns 7 years old.)

Discharge Criteria

The child may be discharged from services for any of the following reasons:

- The caregiver locates services within the community to meet their needs.
- The youth has completed treatment and is no longer in need of services.
- The youth and/or caregiver terminates services or moves outside of service area.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The child and/or caregiver report improved emotional and/or behavioral functioning.
- The child and/or caregiver are linked with and are utilizing natural and community supports.
- The child and/or caregiver report increased individual and caregiver strengths.

Special Considerations for Certain Adjunct Services

As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the child's treatment team and assistance making informed choices regarding the youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/);
- Assistance in understanding and advocating for the child's mental health needs, and provision of expertise in navigating child serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents and/or caregivers through the use of a DSHS approved protocol;
- Facilitation of family support groups;
- Connection to community resources and informal supports that support the child's resilience;
- Identification of the family's natural supports and strengths and guidance; and practical guidance in nurturing those relationships; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Intensive Case Management:
The provision of Wraparound planning process (Intensive Case Management) in this LOC is determined by the clinical needs of the child. One or more of the following scores on the TX CANS 3-5 represents an intense clinical need and may indicate that the child needs the Wraparound planning process:

- Child Risks Factors:
  - Abuse/Neglect score of 3
- Life Domain Functioning:
  - Living Situation score of 3

    - Daycare score of 3
    - Relationship Permanence score of 3
- Caregiver Strengths/Needs:
    - Involvement score of 3

This is not an exhaustive list of indicators and/or scores that may indicate a need for Wraparound planning process. Some CANS 3-5 indicators, such as Residential Stability, may also indicate a need for Wraparound planning process. Services provided must be related to the clinical need of the child and clinicians must use clinical judgment in making this service determination. Justification for services provided must be documented in the clinical record.

Once the child and family are participating in the Wraparound planning process, Intensive Case Management shall be provided. Intensive Case Management and Routine Case Management may not be provided concurrently. Wraparound child and family team meetings shall take place at least monthly to achieve Wraparound fidelity and comply with ICM provisions in TAC §412.407.

Level of Care YC Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 3.5 hours Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 3.5 hours/month. Ideally, the average hours will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the recovery plan.	**Individual Services in LOC-YC Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Utilization**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Routine Case Management	**1 hour** (4 units)	**2 hours** (8 units)
Counseling includes any/all of the following:		
Counseling (Child-Parent/Dyad)	**3 hours**	**5 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**Standard Therapeutic**	**High Need Utilization**
Engagement Activity	**0.75 hours** (3 units)	**2 hours** (8 units)
Intensive Case Management (Intensive Case Management can be authorized if clinically necessary; however Routine and Intensive Case Management Services *are not* to be authorized or provided concurrently.)	**3.75 hours** (15 units)	**6.25 hours** (25 units)
Pharmacological Management (when prescribed/ indicated by a physician these services must be offered.)	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support either/both of the following:		
Medication Training and Support (Individual)	**0.5 hours** (2 units)	**3 hour** (12 units)
Medication Training and Support (Group)	**0.5 hours** (2 units)	**3 hour** (12 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Family Skills Training includes either/both of the following:		
Family Training (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Parent Support Group	**1 hour** (1 unit)	**4 hour** (4 units)
Family Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Flexible Funds	**N/A**	**$1,500 cap/year** ($1 increments)
Flexible Community Supports	**N/A**	**1.25 hours** (15 units)
Respite Services: Community Based	**6 hours** (24 units)	
Respite Services: Program Based	**N/A**	**3 Bed days** (3 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization guidelines for the Crisis Service Array are located on page 44.***	

Appendix A: Crisis Services and Planning

Crisis Services Utilization

This appendix describes crisis services for youth currently in an LOC who are experiencing a crisis. Per the Texas Administrative Code, for youth and/or families who report experiencing a crisis, whether or not the clinician agrees, the situation should be treated as an acute crisis for the individual, and crisis services should be immediately provided.

As indicated in the description of each LOC, crisis services should be delivered within the assigned LOC whenever indicated (Note: youth currently enrolled in services must not to be deviated to LOC-0 in order to receive crisis services). Additionally, each crisis service delivered must meet medical necessity criteria.

Regardless of how the need for crisis services is identified, when a crisis *is* identified it is essential to join with the youth and his/her caregiver in the development of a safety plan. The 2012 National Strategy for Suicide Prevention recommends that a safety plan developed with a youth should include elements such as warning signs/triggers, coping strategies, natural supports, and safekeeping measures. The following pages provide a list of the crisis services available within the service array as well as a sample safety plan that clinicians may use to help develop safety plans with youth and their caregivers. For more information on suicide prevention, safety planning, and crisis follow-up best practices, please see the Action Alliance for Suicide Prevention website: http://actionallianceforsuicideprevention.org/

Texas Zero Suicide toolkit for providers is located at HTTPS://Sites.utexas.edu/zest/. The national zero suicide in behavioral health care model that has been adopted as the Texas suicide safe care practice is outlined in detail in the toolkit referenced above. In our public mental health system we have adopted the use of the Columbia Suicide Severity Rating Scale (www.cssrs.columbia.edu/) as the recommended best practice screening tool. There is a free online training with a printable certificate available on this website, which also offers free, downloadable screeners and risk assessments.

There are a variety of factors that can impact the quality of a suicide screener and a risk assessment, including stigma, societal or cultural attitudes, and clinical discomfort. Individuals may be unwilling to disclose information on ideation, intent, plans, or behaviors because they do not want an attempt thwarted or are wary of the potential response. Research on risk assessments conducted over a national crisis hotline has identified some of the core characteristics of helpful interactions as reported by the person at risk (Mishara, Chagnon, Daigle, et. al., 2007b). Approaches that were tied to positive outcomes included the demonstration of empathy and respect, as well as the use of a supportive approach and collaborative problem-solving. The assessor should approach the interaction as a collaboration, focused on working together to determine what to do next. Providers need to be aware of any direct or indirect communication to the individual that they are uncomfortable with a discussion of suicide, prefer negative responses to questions, or are shocked by the information they hear.

Another best practice to consider is the conduct of the professional administering the screening tool. A best practice approach, such as the CASE approach, is recommended. It is preferable to facilitate a collaborative conversation between the youth and the staff person, which uses motivational interviewing techniques to elicit a truer response from the youth within the context of a caring conversation, instead of a rote checklist-driven screening approach.

The CASE Approach, developed by Shawn Shea, provides a strategy for enhancing the quality of the information gathered from an individual during a suicide risk assessment. Dr. Shea posits that: *Real Suicide Intent = Stated Intent + Reflected Intent + Withheld Intent*
Dr. Shea points out that the stronger the individual's actual intent, the more likely he/she is to withhold his/her true intent. The individual's reflected intent may be the most important component for determining real suicide intent. Reflected intent is "the quality and quantity of the patient's suicidal thoughts, desires,

plans, and extent of action taken to complete the plans." (Shea, 2009). Shea states that it is the amount of time spent thinking, planning, preparing and practicing for an attempt that may be the strongest indicator of imminent risk of a suicide attempt.

The CASE Approach is a best practice interviewing strategy designed to maximize the likelihood that the assessor is gathering valid information about the stated and reflected intent and to minimize withheld intent. The CASE Approach draws on research to identify strategies to raise the issue of suicidality in a way that minimizes shame and stigma, as well as ways of formulating questions to maximize validity. Training on the CASE Approach can be obtained through the Training Institute for Suicide Assessment and Clinical Interviewing. Shea, S. C., Green, R., Barney, C., et al. (2007) provide a resource training providers in the CASE Approach.

After a risk assessment is conducted and a positive score indicated elevated risk for suicide, a best practice based risk assessment should be administered. As far as the frequency of screening, the C-SSRS should be used as a screening tool during crisis assessments, clinical assessments, and assessments in which the CANS or ANSA Suicide Risk scale is elevated. In addition, the C-SSRS should be utilized as a brief measure of risk at every consumer contact for those individuals found to be at moderate or high suicide risk (up to once daily). There is no activity more critical than identifying increases in suicide risk for individuals at risk of suicide.

All youth within the public mental health system who are identified as potentially at risk during a suicide screening will receive an evidence-informed suicide risk assessment. This suicide risk assessment should include all of the core components of an effective risk assessment.

A comprehensive risk assessment should include the following information gathered from the individual and his/her natural supports (adapted from SAMHSA's SAFE-T and the Joint Commission's B-SAFE):

- Suicide Inquiry - Current and previous suicidal thoughts, plans, behavior, and intent
- Warning signs – Characteristics that are temporally related to the acute onset of suicidal behaviors (hours to a few days)
- Risk factors – Characteristics that statistically put an individual at increased risk
- Protective factors – Characteristics that statistically indicate lower risk
- Determine risk level – Develop appropriate treatment plan to address risk in least restrictive environment
- Documentation - Document risk level, rationale, treatment plan, and follow-up.

DSHS is recommending the use of the **Columbia Suicide Severity Rating Scale** (C-SSRS) to insure a comprehensive, evidence-based assessment of current and previous suicidal thoughts, behaviors, intent, and plan.

Documentation

Determining Risk Level

Determining and documenting risk level is a critical component of the risk assessment. No study has identified one specific risk factor or set of risk factors that specifically predicts suicide or suicidal behavior; therefore, the determination of risk level will depend on careful consideration of the information gathered in the assessment and the clinical judgment of the assessor. The determination of the best setting of care and course of treatment should consider not only the level of risk, but also the benefits and potential risks to the individual. While a more restrictive care setting may be necessary to safeguard against potential self-harm, there may also be negative effects from this course of treatment that must be weighed in the decision, such as disruption of employment, disruption of therapeutic alliance, and increased family conflict. When possible, the provider should collaborate with the individual in understanding and weighing different treatment options.

Considerations for Each Risk Level

Urgent/ High	Suicidal thoughts with intent to act in past 30 days (C-SSRS Item 4) Ideation with plan and intent in past 30 days (C-SSRS Item 5) Any suicide behavior in past 90 days (C-SSRS Item 6)	One or more risk factors likely to be present; extra concern for psychiatric diagnoses with severe symptoms, including psychosis; recent discharge from psychiatric inpatient unit; lack of family and/or social support; lack of engagement in care; intent with lethal means.
Emergent/ Moderate	Suicidal thoughts with method in past 30 days (but no plan or intent; C-SSRS Item 3) Suicidal thoughts with intent to act (but no plan) at worst ever (C-SSRS Item 4) Suicidal thoughts with specific plan and intent at worst ever (C-SSRS Item 5) Any suicide behavior at worst ever (C-SSRS Item 6)	Absence or presence of risk and protective factors may play stronger role in overall risk.
Low or Chronic Risk	Wish to be dead in past 30 days (C-SSRS Item 1) General thoughts of killing self without thoughts of methods (C-SSRS Item 2)	Modifiable risk factors, strong protective factors; available social support.

Information on the potential interventions and monitoring to be considered at each level of risk can be found in the *Pathways to Care* and *Safety Planning* chapters of the Suicide Safe Care and Zero Suicide Texas Toolkit for providers at https://sites.utexas.edu/zest/.

All youth with moderate or high risk for suicide will work collaboratively with a trained provider to develop an effective, individualized safety plan.

Crisis Service Array for youth currently enrolled in services

Authorization Period: N/A	
The crisis services below are available for all youth who are experiencing a crisis and are enrolled in a level of care. Please see the LOC-0 section of this document to identify the crisis services available to individuals who have not been assigned to a level of care.	
Crisis Service Array	**Individual Crisis Services**
	Unit/Event
Crisis Intervention Services	**3.75 Hours** (15 units)
Psychiatric Diagnostic Interview Examination	**1 Event** (1 unit)
Pharmacological Management	**10 Events** (10 units)
Safety Monitoring	**2 hours** (8 units)
Crisis Transportation (Event)	**1 Event** (1 unit)
Crisis Transportation (Dollar)	**As necessary** ($1 units)
Crisis Flexible Benefits (Event)	**As necessary** (Event)
Crisis Flexible Benefits (Dollar)	**As necessary** ($1 units)
Respite Services: Community-Based	**6 hours** (24 units)
Respite Services: Program-Based (not in home)	**3 bed days** (3 units)
Extended Observation	**1 unit** (1 bed day)
Children's Crisis Residential	**4 units** (4 bed days)
Family Partner Supports	**6 hours** (24 units)
Engagement Activity	**6 hours** (24 units)
Inpatient Hospital Services	**As necessary** (1 bed day units)
Inpatient Services (Psychiatric)	**As necessary** (1 bed day units)
Emergency Room Services (Psychiatric)	**As necessary** (Events)
Crisis Follow-up & Relapse Prevention	**8 hours** (32 units)

Description of the Safety Planning Intervention

The Safety Plan Intervention (SPI; Stanley & Brown, 2011) is a brief 20 to 45 minute intervention that provides an individual with a set of steps that can be used progressively to attempt to reduce risk and maintain safety when suicidal thoughts emerge. SPI should follow a comprehensive risk assessment after strong rapport has been developed. Safety plans should be developed within a collaborative process among a provider (including peer providers), the individual at risk, and his or her close family or friends. Safety planning can be a stand-alone intervention, utilized during crisis contacts (e.g., in emergency departments, mobile crisis contacts) or as a part of an on-going treatment relationship. The Safety Planning Intervention includes the following **core components**, each of which is documented in the individual's plan:

- Recognizing warning signs of an imminent suicidal crisis, i.e., changes in mood, thoughts or behaviors.
- Utilizing internal coping skills that can help reduce distress;
- Using people in the individual's support network as a means of distraction from suicidal thoughts;
- Reaching out to family or friends to help manage the crisis;
- Contacting mental health professionals or emergency contacts (i.e., hotlines); and
- Reducing access to potential lethal means.

Training and Resources for the Safety Planning Intervention

All individuals who will conduct safety planning with individuals at risk should be trained and competent in the intervention. Several resources are available to support staff training. An introductory training on SPI, lasting about 30 minutes, can be found on the Zero Suicide website. The training includes the rationale for the model, the core components, and a video example of Dr. Stanley intervening with a mock individual.

Additional training in safety planning is recommended and information on training resources is available at http://www.suicidesafetyplan.com/Training.html. DSHS has also supported the development of in-state trainers in SPI. A list of regional trainers is available from Jenna Heise at Jenna.Heise@dshs.state.tx.us. The workshop training is four hours in length and consists of both didactic learning and role playing of safety planning steps to provide additional opportunities for practice and feedback. Follow-up coaching is recommended to assist providers learning the model to receive feedback on skills development and to have an opportunity to bring questions and challenges to the trainer or their colleagues.

The following safety planning intervention resources provide further information:

1. A general description can be found at Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19,* 256-264. (http://www.suicidesafetyplan.com/uploads/Safety_Planning_-_Cog___Beh_Practice.pdf)
2. A Safety Planning manual can be accessed through the Safety Planning website at http://www.suicidesafetyplan.com/Page_8.html.
3. Dr. Stanley also developed a smartphone app for safety planning titled, "Safety Net" on the online app store.

A template to support documentation of safety planning is included on the next page or can be accessed from http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf.

SAFETY PLAN

Step 1: Warning signs: (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity)**:**

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____
4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____

Clinician Pager or Emergency Contact #_____

2. Clinician Name_____ Phone_____

Clinician Pager or Emergency Contact #_____

3. ***Suicide Prevention Lifeline: 1-800-273-TALK (8255)***
4. Local Emergency Service _____

Emergency Services Address_____

Emergency Services Phone _____

Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

_____

A critical component of safety planning is counseling individuals at risk and their loved ones to limit access to lethal means. Research has shown that reducing access to lethal means can be an effective prevention strategy because many suicide attempts are impulsive acts undertake as a reaction to a short-term crisis. The best practice Counseling on Access to Lethal Means (CALM) was developed by Elaine Frank and Mark Ciocca. In CALM, the provider learns how to ask individuals and their families about their access to lethal means and to develop a plan to reduce access, particularly around firearms and medication.

A free, web-based training is available from the Suicide Prevention Resource Center at http://training.sprc.org/enrol/index.php?id=3. The training requires approximately two hours to complete and includes didactic information and video-based examples of counseling interventions. All staff responsible for safety planning should complete this online training or a live training from a certified training provider. The developers offer master trainer certification if agencies prefer to provide face-to-face training. Texas offers a version of this training for mobile crisis and first responders titled, "CALM for First Responders."

Appendix B: Training Requirements

The training requirements for each approved protocol vary per treatment practice; the training requirements for each protocol are outlined below:

a. **Cognitive Behavior Therapy (CBT):** There are no training requirements for CBT; however, proof of competency is required. For specific competency requirements, reference the CBT competency requirements outlined in the performance contract notebook. http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml

b. **Trauma-Focused CBT (TF-CBT):** Clinicians must complete the ten hour online TF-CBT webinar and the online Childhood Traumatic Grief webinar from the Medical University of South Carolina. Both are found on their website, http://ctg.musc.edu/. Clinicians must also complete the two-day face-to-face TF-CBT training from an approved national trainer. Additional clinical supervision requirements are listed in the performance contract notebook. (http://tfcbt.musc.edu/)

c. **Parent-Child Psychotherapy (Dyadic Therapy):** Clinicians must meet the national training requirements for Parent-Child Interaction Therapy (PCIT) as outlined on the PCIT website: http://www.pcit.org/training-guidelines/pcit_training_guidelines_2009/ and must be trained by an approved national trainer (http://www.pcit.org/certified-trainers/); *or* clinicians may document Parent-Child Psychotherapy certification from a DSHS approved university-based institute or program. See the performance contract notebook for trainings approved prior to the implementation of the above requirements. (http://www.pcit.org/)

d. **Seeking Safety:** Must complete one-day training by a national, approved trainer, or must complete the four video training series. The completion of the four video training series must be documented by the staff member's clinical supervisor. (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=376)

e. **Nurturing Parenting** – Must complete the three-day basic Nurturing Parenting trainer by an approved organizational trainer or by a national, approved trainer of Nurturing Parenting.

    - Organizational Trainer Requirements: Must complete the basic three days of training to become a Nurturing Parenting facilitator and have provided two cycles of the DSHS approved Nurturing Parenting protocols (the Tertiary Treatments of Nurturing Parenting) for a period of eight to twelve months. Following the practical experience, the individual must complete an approved Nurturing Parenting Training of Trainers (TOT) and be deemed competent by the TOT trainer. The individual must have documentation that he/she has met all these requirements. Note: The "organizational" trainer is not an approved national trainer and only has permission to train within the DSHS contracted organization that employs him/her. DSHS contracted providers may share organizational trainers. (http://www.nurturingparenting.com/)

f. **Aggression replacement techniques and socials skills (Skill streaming):** Must complete a DSHS approved training in either Aggression Replacement Training®, *or* Social Skills Training and Aggression Replacement Techniques (START), *or* must complete the Teaching Pro-Social Behavior DVD training *and* complete one fidelity review. (http://aggressionreplacementtraining.com/)

g. **Preparing Adolescents for Young Adulthood (PAYA):** At this time, there are no specific training requirements for this protocol. (http://www.itsmymove.org/training_resources_lifeskills.php)

h. **Barkley's Defiant Child and Barkley's Defiant Teen:** At this time, there are no specific training requirements for this protocol. (http://www.russellbarkley.org/)

i. **Wraparound Planning Process:** Wraparound care planning process is required for Level of Care (LOC) 4 and YES and the provision of Intensive Case Management (ICM). (http://nwi.pdx.edu/wraparound-basics/)

Facilitators must meet the following training requirements through a DSHS approved entity:

1. Be a QMHP-CS, CSSP, or LPHA; and
2. Have completed, or be in the process of completing, each of the core trainings listed below in the order in which they are listed. These trainings must be provided by a person/entity that has been certified as a training entity by the National Wraparound Implementation (NWIC) standards:
    i. Introduction to Wraparound
    ii. Engagement in the Wraparound Process
    iii. Intermediate Wraparound: Improving Wraparound Practice
3. At least once per month, Wraparound Facilitators must receive ongoing Wraparound supervision from a Wraparound Supervisor who has completed the following training which must be provided by a person/entity that has been certified as a training entity by NWIC:
    i. Advancing Wraparound Practice—Supervision and Managing to Quality

The following sections provide guidance in selecting the most appropriate counseling or skills training protocol(s) for the youth based on the needs identified on the CANS.

Appendix C: Selecting an Intervention

The following interventions are evidence-based or promising practices available in TRR levels of care. Training and/or competency is required for providers to deliver these services. Training and competency requirements are included in Info Item A. Established competency in CBT covers the provision of most CBT protocols. However specific competency must be demonstrated for TF-CBT and PCIT. It is the responsibility of the LMHA to procure and fund the training necessary for each provider to achieve competency. Many of these trainings are provided through the Centralized Training Infrastructure (www.centralizedtraining.com).

Counseling

Counseling can take place in an individual, family, and/or group setting. A therapist will use a therapeutic process through conversations, therapeutic activities, or games to address personal, family, and situational issues. Counseling can improve individual and family relationships or circumstances. It can also address parent-child relationships, depression and/or anxiety, or traumatic events.

Cognitive Behavioral Therapy (CBT): CBT is an empirically supported treatment which helps youth to overcome difficulties by changing thinking, behavior, and emotional responses. Although there is not a specific protocol identified to provide Cognitive Behavioral Therapy, this general treatment modality can be used to treat diverse disorders or specific behavior problems in youth such as: Obsessive Compulsive Disorder, Specific Phobias, Bipolar Disorder, Substance Abuse, and anger issues in youth diagnosed with Oppositional Defiant Disorder or Conduct Disorder. (http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml). CBT may not be indicated for youth with a diagnosis of intellectual developmental disorder, traumatic brain injury or a medical condition that significantly impacts their cognitive functioning.

The following manualized CBT treatments are approved to treat youth:

1. *Coping Cat* – for youth ages 7-13 to treat anxiety related disorders such as: Generalized Anxiety, Anxiety Disorder NOS, Panic Disorder, Social Phobia (Social Anxiety Disorder), etc. (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=91)

2. *The Cat Project* – for youth ages 14-17 to treat anxiety related disorders such as: Generalized Anxiety, Anxiety Disorder NOS, Panic Disorder, Social Phobia (Social Anxiety Disorder), etc. (http://www.promisingpractices.net/program.asp?programid=153).

3. *Taking Action* – for youth ages 9–13 to treat depressive mood disorders, such as: Major Depression, Depressive Disorder NOS, Mood Disorder NOS, etc. (https://www.msu.edu/course/cep/888/Depression/taking.htm).

4. *Adolescent Coping with Depression Course (CWD-A)* – for youth ages 13-17 to treat depressive mood disorders such as: Major Depression, Depressive Disorder NOS, Mood Disorder NOS, etc. (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=11).

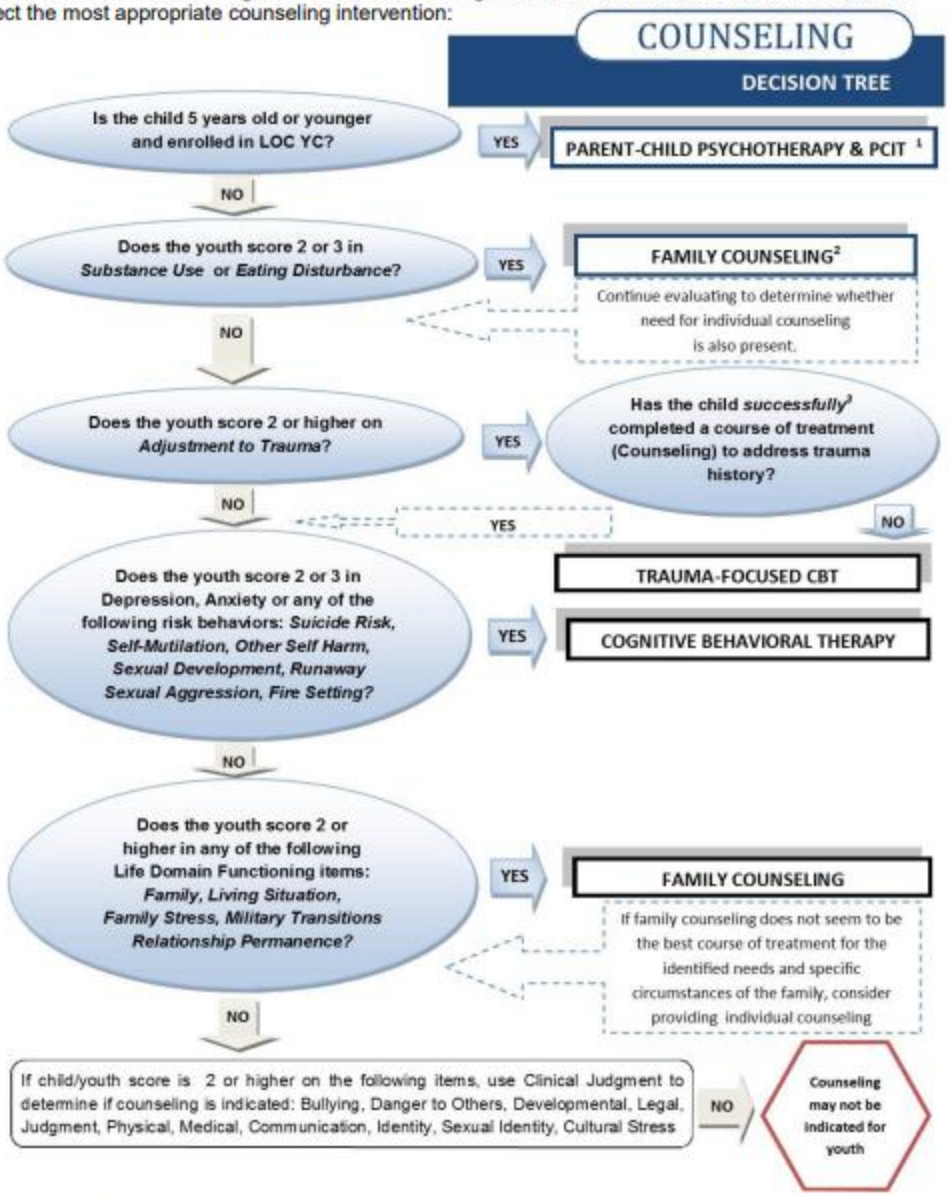
Trauma-Focused CBT (TF-CBT): TF-CBT is a recognized evidence-based treatment that can be used with youth ages 3-18. This treatment is a components-based model of psychotherapy that addresses the unique needs of youth with PTSD symptoms, depression, behavior problems, or any other difficulties related to exposure to traumatic life events, including childhood traumatic grief. The average length of treatment ranges between 12 to 16 sessions; however, if compounding complex trauma is present, the length of treatment could be significantly longer. This counseling modality requires both individual sessions for the youth and caregivers/parents, as well as joint sessions. (http://tfcbt.musc.edu/)

Parent-Child Psychotherapy and Parent Child Interaction Therapy (PCIT): The focus of this research-based therapeutic intervention is to support and strengthen the relationship between the child and caregiver as a vehicle for restoring the child's sense of safety, attachment, appropriate affect, and to improve the child's cognitive, behavioral, and social functioning. This treatment modality is to be used with children ages 3-6 years old. If the specific evidence-based intervention Parent Child Interaction Therapy (PCIT) is provided, it can be used with children ages 3-7 years old. Providers must use DSHS approved models of Parent-Child Psychotherapy as outlined in the contract. (http://www.pcit.org/)

Family Therapy (Family Counseling): Family therapy or family counseling is a type of psychological counseling in which family members are treated together to solve relational conflicts or address specific psycho-social needs of the youth within the context of the family. Certain modalities of family therapy have been found effective (or designated as evidenced-based practices) for youth with conduct disorder, substance abuse issues and/or eating disorders. Providers should use the modality that will be most effective for the specific youth and family. Family therapy is allowed for ages 3 to 17 based on the youth's needs. Couple's counseling is not an approved family therapy modality by DSHS. (https://store.samhsa.gov/shin/content/SMA13-4784/SMA13-4784.pdf)

Appendix C, Cont.: *Selecting an Intervention Counseling*

This flow chart is intended to guide clinicians in utilizing needs identified on the CANS assessment to select the most appropriate counseling intervention:



1. Parent-Child Psychotherapy and Parent Child Interaction Therapy (PCIT) may also be provided to children six years old authorized into LOC-YC if the children have developmental needs that indicate this course of treatment. Clinical judgment should be used.
2. Although research shows that family counseling is indicated for substance abuse or eating disorders, individual counseling may also be beneficial.
3. "Successfully" indicates that the youth and/or LAR agree that the youth's functioning is not affected by trauma since completion of treatment.

Appendix C, Cont.: *Selecting an Intervention*
Skills Training and Development

Skills Training

Skills training is used to address negative behaviors that are symptoms of emotional disturbance. A skills trainer works with youth to build skills that improve their ability to cope with their unique symptoms. These skills will help youth function independently in school, at home, and in the community. Skills training is also available for parents. This goes beyond basic parenting techniques and is specifically designed to help parent address their youth's mental health needs.

Aggression Replacement Techniques: Aggression replacement techniques are intended to help youth ages 7-17 improve social skills and moral reasoning, better manage anger, and reduce aggressive behaviors. This skills training protocol is divided into the following two groups, which can be provided individually or in a group format:

1. *Aggression replacement techniques* – These techniques can be used to treat youth with anger issues, oppositional defiant behavior, conduct disorder, and delinquent behavior. The techniques, created by Dr. Arnold Goldstein, consist of three components: social skills (skill streaming), anger control, and moral reasoning.

   The components of the aggression replacement techniques were originally developed to be provided in sets of three components in one week, creating a weekly set of skills. However, the protocol has been adapted for outpatient community mental health settings and it is expected that this skills training intervention will be provided at least once per week. The three components of the aggression replacement techniques must be provided in a sequenced order and each session must address at least one component. It should be noted, however, that a maximum of two components can be provided in one session following the established sequence. The sequence of the components must follow this order: social skills, anger control, and moral reasoning. The order of the components is repeated in the following manner as the youth progresses in treatment: social skills #1, anger control #1, moral reasoning #1, social skills #2, anger control #2, moral reasoning #2, social skills #3, and so on. Thus, one session may cover both social skills #1 *and* anger control #1 components, if clinically appropriate.

   For youth in elementary school the social and anger control skills to be used are from the book *Skillstreaming: The Elementary School*. For youth that need aggression replacement techniques all treatment components are inside the aggression replacement techniques manual.

2. *Social skills training* – This component will be provided using the series of manuals called *Skillstreaming*. Skillstreaming is a pro-social skills training treatment created by Dr. Arnold Goldstein. It employs a systematic four-part training approach that includes modeling, role-playing, performance feedback, and generalization to teach essential pro-social skills to youth. Skillstreaming is integrated in the components of aggression replacement techniques, but it can be used as a single skills training protocol for youth in need of social skills training. Skillstreaming has a series of grouped and sequenced skills training curriculum. The groupings are used as skills training modules based on the needs of the youth and the age group (e.g., "Group III: Skills for dealing with feelings" is targeted toward youth with difficulties expressing and coping with their feelings).

The following books should be used as manuals for delivering the aggression replacement techniques and social skills training:

a. Aggression Replacement Training® Manual (https://www.researchpress.com/books/409/aggression-replacement-training)
b. Skillstreaming: The Elementary School Child (https://www.researchpress.com/books/727/skillstreaming-elementary-school-child)

c. Skillstreaming: In Early Childhood (https://www.researchpress.com/books/716/skillstreaming-early-childhood)
d. Skillstreaming: The Adolescent* (https://www.researchpress.com/books/719/skillstreaming-adolescent)

*Note: The A.R.T. ® manual contains "Skillstreaming: The Adolescent" in the section "Social Skills/Skillstreaming".

Nurturing Parenting: This evidence-based skills training is a Tertiary Prevention-Treatment for caregivers of youth receiving mental health services. It treats abusive or neglecting parent-child dysfunctional interactions and develops caregiver's pro-social skills that will help the functioning of the youth and caregiver. Nurturing Parenting can be provided individually or in a group format. There is a sequence to be followed according to each protocol. Nurturing Parenting combines meeting with the youth and caregiver separately and then jointly depending on the age group. The typical length of treatment is 16 sessions. The following are the DSHS approved Nurturing Parenting skills training protocols:

a. Parents and Their Infants, Toddlers & Preschoolers – 16 sessions (Available in English and Spanish)
b. Parents & Their School- Age Children 5-11 years
c. Spanish Speaking Parents and Their Children 4-12 Years (Crianza Con Cariño)
d. Parents & Adolescents (Available in English and Spanish)
e. It's All About Being a Teen (http://nurturingparenting.com/ecommerce/category/1:3/)

Barkley's Defiant Child: This is a research-based skills training protocol for children ages 3–12 with disruptive behavior disorders. DSHS allows the use of Barkley's Defiant Child only for children with a single diagnosis of Attention Deficit/Hyperactivity Disorder or Disruptive Behavior Disorder, Unspecified. If anger issues are present, aggression replacement techniques should be provided instead of Defiant Child. (http://www.russellbarkley.org/)

Barkley's Defiant Teen: This is a research based skills training protocol for youth ages 13-17 with disruptive behavior disorders. DSHS allows the use of Barkley's Defiant Teen only for youth with a single diagnosis of Attention Deficit/Hyperactivity Disorder or Disruptive Behavior Disorder, Unspecified. If anger issues are present, aggression replacement techniques should be provided instead of Defiant Child. (http://www.russellbarkley.org/)

Seeking Safety: This is a present-focused therapy (skills training) to help individuals attain safety from trauma/PTSD and substance abuse. The treatment was designed for flexible use and can be conducted in both a group and individual format. Seeking Safety can be used with youth (ages 13 and older) that have *both* substance abuse issues *and* a history of trauma. However, note that a diagnosis of PTSD is *not* required in order for an individual to receive the Seeking Safety intervention. The first three sessions of this protocol must be provided in sequence; after the 3rd session, all subsequent sessions are provided based on the identified needs of the youth. Providers may follow the suggested sequence but, as previously stated, should base treatment on the youth's identified needs. A minimum of 10 sessions have been found to be most effective in achieving desired outcomes. (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=376)

Preparing Adolescents for Young Adulthood (PAYA): This skills training curriculum is to be used with youth ages 14-17 facing issues related to transitioning from adolescence to adulthood. PAYA consists of five modules; each module addresses a group of transitioning-youth skills. PAYA is a promising practice created by the Casey Life Skills Foundation and was envisioned to be self-directed by youth to support and facilitate the development of self-determination. It can be delivered by a Qualified Mental Health Professional (QMHP) with the direction of the youth. It is recommended that the QMHP use the "Gateway to the World: A toolkit and curriculum" to understand the principles that guide the use of the PAYA modules. Each module contains an assessment to identify which transitioning skills the youth needs. Based on the identified needs, sections of the PAYA modules that address those needs are selected to

provide skills training. It is not required that the entire module is used with a single youth nor is it required that all modules be provided to a single youth. The use of PAYA as a skills training protocol is flexible and does not require a specific sequence of sessions.

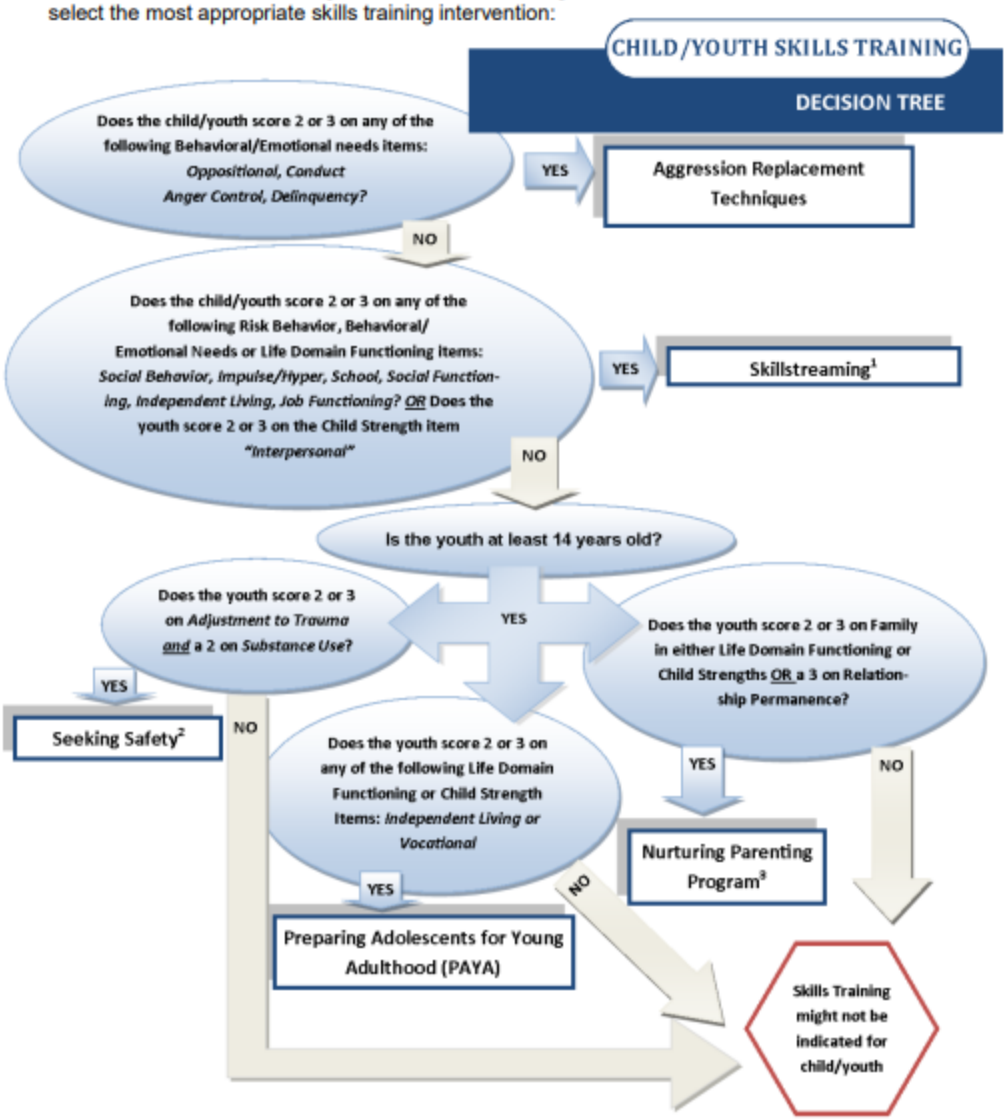
The six PAYA modules are listed below:

i. Module 1: Money, Home and Food Management
ii. Module 2: Personal Care, Health, Social Skills and Safety
iii. Module 3: Education, Jobs Seeking Skills and Job Maintenance Skills
iv. Module 4: Housing, Transportation, Community Resources, Understanding the law and Recreation
v. Module 5: Young Parents Guide
vi. Module 6: Household Management Activities

For more clinical guidance on services provided to transition-age youth, please reference Appendix E: Transition-Age Youth.
(http://www.itsmymove.org/training_resources_lifeskills.php)

Appendix C, Cont.: *Selecting an Intervention*
Skills Training

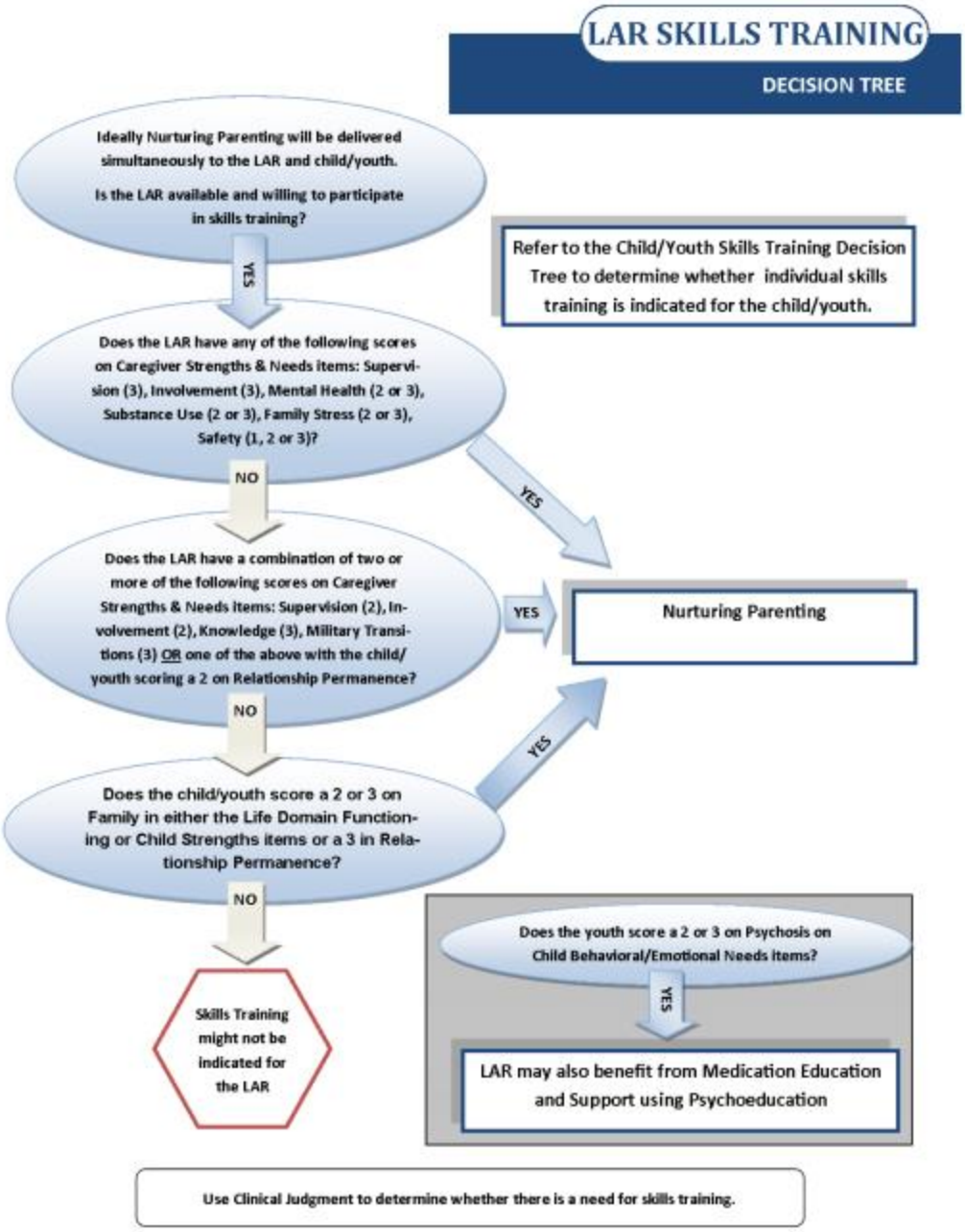
This flow chart is intended to guide clinicians in utilizing needs identified on the CANS assessment to select the most appropriate skills training intervention:



Use Clinical Judgment to determine if there is need for skills training, and if so, which protocol(s) to deliver. If more than one protocol is appropriate, use Clinical Judgment to determine if they should be delivered simultaneously or one at a time.

Note:
1. Delivered independently of the other Aggression Replacement Techniques components
2. Youth must **NOT** be receiving TF-CBT in order to receive Seeking Safety.
3. Nurturing Program may be delivered individually to youth if LAR not available, appropriate, or willing to participate. Refer to LAR skills training decision tree.

Appendix C, Cont.: *Selecting an Intervention*
Skills Training Delivered to the Caregiver(s)/LAR



Appendix D: Family Partner Supports

Certified Family Partners

Certified Family Partners are members of the recovery team. They provide support and advocate for families to assist in engagement, empowerment, self-advocacy, and wellness as they actively participate in the recovery of their child. Family Partners assist families in making informed decisions that drive families toward wellness and recovery. As a supportive partner, the Family Partner has a strong connection to the community and is knowledgeable about resources, services and supports for families. Certified Family Partners provide supports to the LAR and/or primary caregivers of the youth and do not provide services directly to the youth. Access to quality family partner supports can be instrumental in engaging families as active participants in the youth's care. The Family Partner's lived experience is critical to earning respect and establishing trust as they mentor and coach families to find and develop their voice and learn how to use it effectively in their child's treatment, wellness and recovery. The Family Partner assists families in making informed decisions on a routine basis, in crisis and during the wraparound process. The Family Partner provides general consultation to staff. A Certified Family Partner can be a mediator, facilitator, and a bridge between families and agencies; and ensure each family is heard and their individual needs are being addressed and met. Through their work with primary caregivers, parents, and/or LARs, Certified Family Partners directly impact the youth's resilience and recovery.

Special Considerations for Family Partner Supports

As formal members of the treatment team, Certified Family Partners should be utilized in every LOC to engage caregivers as equal members of a youth's treatment team and to provide the following to parents/primary caregivers and/or LAR of youth:

- Advocacy that encourages the positive choices of the caregiver, promotes self-advocacy for caregivers and their youth, and supports the positive vision that the caregiver has for their youth's mental health and recovery;
- Mentoring through the transfer of knowledge, insight, experience and encouragement including the Certified Family Partners' articulation of their own successful experience of navigating a child-serving system;
- Role-modeling the concepts of hope and positive parenting, advocacy and self-care skills that will ultimately benefit the resilience and recovery of the youth (this may include the provision of Family Skills Training using the DSHS approved protocol for primary caregivers);
- Experienced guidance in navigating the child-serving systems, including mental health, special education, juvenile justice, child protective services, etc.;
- Connection to community resources and informal supports;
- Identification of the family's natural supports and strengths and guidance; and practical guidance in nurturing those relationships;
- Stewardship of family voice and choice as a member of all recovery teams including the Wraparound team; and
- Support through the facilitation of parent support groups.

Minimum Qualifications

Certified Family Partners are the parent or LAR of a youth with a serious emotional disturbance and have at least one year of experience navigating a child-serving system. Individuals shall meet minimum qualifications to fill the role of Family Partner. Via Hope, the training and credentialing entity recognized by DSHS, has stated the following minimum requirements to be a Certified Family Partner. All Family Partners must meet these requirements and become certified within one year of hire.

- Must be a parent or legally authorized representative (LAR) with a minimum of one year of lived experience being responsible for making the final decisions for a youth (person 17 years or under) who has been diagnosed with a mental, emotional or behavioral disorder.

- Must be at least 18 years or older and must have a high school diploma or GED.
- Have successfully navigated a child-serving system for at least one year (i.e., mental health, juvenile justice, social security or special education) and be able to articulate their lived experience as it relates to advocacy for their youth and success in navigating these systems.
- Have lived experience that speaks to accomplishments concerning their youth's mental health including their youth being in a stable place in their recovery and/or resiliency.
- Can meet requirements for a Medicaid background check.

Appendix G: Reasons for Deviation

Every effort should be made to authorize a youth into the LOC that will best meet his/her needs and support his/her resilience and recovery. The term "every effort" refers to the need for the clinician to thoroughly and completely explain to the family why the services in the recommended LOC are appropriate to help the youth and caregivers achieve agreed upon treatment goals. It also refers to the need to explain why the services in the recommended LOC may not be adequate to reach the desired outcomes. The LOC-R is based upon the uniform assessment (UA) including the CANS assessment. The CANS is a reliable, dynamic, and comprehensive tool that allows for a significant level of confidence that the LOC-R reflects the clinical need and is based on the current presentation of the youth. However, because an assessment tool does not have the sensitivity to identify underlying treatment needs, it is imperative that clinicians use clinical judgment when determining the LOC-A.

A recommended LOC is deviated to a higher or lower service intensity when it is determined that the LOC-R will not meet the youth's recovery goals. When authorizing an LOC that is different from the LOC-R, UM staff will make a determination based on the clinician's recommended deviation (LOC-D), the information provided in the uniform assessment, and availability of resources. This section describes the allowed reasons for deviating from LOC-R.

Using the Provider Requested Deviation– LOC-D

The purpose of the LOC-D is to allow the clinician the option to request a deviation from the LOC-R as calculated by the CANS/Uniform Assessment. The parameters for the use of the LOC-D are as follows:

- The LOC-D shall be completed by the clinician, but is only necessary if the LOC-D is different from the LOC-R.
- The clinician justifies the LOC-D and the UM staff shall take this into consideration when determining the LOC-A.
- The clinician may not site resource limitations for the LOC-D.

Definitions of Reasons for Deviation

The LOC-A may deviate from the LOC-R due to the following reasons:

- *Clinical Need:* To be used when the Licensed Practitioner of the Healing Arts (LPHA) identifies the clinical need/medical necessity for a more or less intensive level of care than the level of care recommended.
    - Deviation for Clinical Need must be documented in the clinical record and medical necessity signed by an LPHA, verifying medical necessity.

- *Resource Limitations:* To be used when the UM staff member identifies that there are not enough resources to offer services at the recommended level of care. Resources are defined as personnel, a slot within a specific level of care, or monetary resources necessary to provide services within the level of care.

NOTE: A youth who has Medicaid may not be deviated to the waitlist or to an LOC where a clinically indicated core service is not available.

- *Continuity of Care:* To be used when there is an identified need to deviate the youth to a level of care that is different from the level of care recommended in order to maintain continuity of care. Justification for the deviation must be documented in the clinical record. The following are examples of appropriate utilization of this deviation reason:
    - The youth is incarcerated or placed in juvenile detention center, but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or

- The youth is hospitalized and provider communicates with the youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The youth is living out of the service area for a planned and defined period of time (e.g., summer vacation) and provider plans to leave youth open to services; or

- *Consumer Refused:* To be used when the individual is provided with information necessary to make an informed decision and refuses the recommended level of care. The information discussed with the individual must be documented in the clinical record.
  - All efforts at engagement must be documented in the clinical record

- *Other:* To be used when none of the reasons listed above accurately describe the reason for deviation.
  - Justification for the deviation must be documented in the "Notes" field of the uniform assessment and retained in the clinical record.

Considerations for Core Services Within an LOC-A

Core Services in the LOC-R are determined to be essential to resilience and recovery. For this reason, all core services in the LOC-A must be offered to the youth and should be delivered. If a youth is not receiving a core service, justification must be documented in the clinical record.

LOC-0: Crisis Services

A youth may only be deviated to LOC-0 if he/she is not currently assigned to an LOC. Following stabilization of the crisis, the youth should be reassessed to determine further eligibility and the most appropriate LOC for continuation of services.

If the youth does not have an active UA (i.e., is new to services) *and* the following criteria are met, it may indicate a need for deviation to LOC-0:

- The clinician determines the youth is in crisis (this includes a perceived subjective crisis on the part of the individual); *and*
- The LOC-R is not LOC-0

NOTE: The UA does not need to be completed before treating a crisis. Address the crisis first. If a youth who is currently enrolled in an LOC other than LOC-0 experiences a psychiatric crisis, crisis services should be delivered within the current LOC assignment.

LOC-R YC (LOC-YC: Young Child Services)

To be authorized into LOC-YC, the 3-5 CANS must be completed.
All developmentally appropriate services for children ages 3-5 are available in LOC-YC.

Reasons for Deviation to a Less Intensive LOC-A

NOTE: Because the services available in LOC-YC are imperative to resilience and recovery for this population, it is *not* advised that children be deviated to an LOC where counseling and skills training are not available. Providers must make every reasonable effort to authorize children with an LOC-R YC into this LOC.

Clinical Need
The following are clinical reasons that may indicate a deviation from LOC-R YC to LOC-1 and must be documented in the clinical record and medical necessity signed by an LPHA;

- A core service is required in LOC-YC, but the child is receiving that service from another mental health provider in the community and the child otherwise only has a clinical need for medication management.
- Due to developmental needs associated with a Pervasive Developmental Disorder (PDD) and/or Intellectual Disability (ID), the child is not able to benefit from a core service required in LOC-YC at this time; or

NOTE: Because the services available in this LOC will likely be developmentally appropriate, regardless of the child's diagnosis of PDD and/or IDD, this reason must be justified by the clinician based on clinical presentation and not solely based on the child's diagnosis. This reason for deviation should *not* be commonly used.

Continuity of Care
The following are reasons that may justify deviation to LOC-1 for continuity of care and must be documented in the clinical record.

- The child is hospitalized and provider communicates with the child and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The child is living out of the service area for a planned and defined period of time (i.e., summer vacation) and provider plans to leave the child open to services.

Consumer Refused
The following are reasons that may indicate a deviation from the LOC-R YC and must be documented in the clinical record:

- The caregiver/LAR refuses counseling, skills training *and* Wraparound (if clinically indicated), but does not refuse services available in LOC-1. If after attempts at engagement in the LOC-R YC, caregiver/LAR continues to refuse counseling, skills training *and* Wraparound (if clinically indicated), deviation to LOC-A 1 may occur.
- If the child is *new* to services and has an LOC-R YC and caregiver/LAR refuse all services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services, the child should be deviated to LOC-A 6 (Refused All Services); or
- If the child is *currently enrolled* in services and upon reassessment has an LOC-R YC and the child and/or caregiver/LAR refuse all services, the UA should be been reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the child should be discharged from services.

NOTE: Core Services in the LOC-YC are determined to be essential to resilience and recovery. The caregiver/LAR should continue to be engaged and participate in all clinically indicated core services, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations
A child may only be deviated to LOC-A 1 or LOC-A 8 (Waitlist) with a reason of resource limitations if *all* core services cannot be provided because of those resource limitations and the child does not have Medicaid.

When deviating to LOC-A 1 for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the child was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible).
- The date the referral was made.
- The disposition (i.e., whether the child and/or caregiver/LAR attended the initial appointment).

NOTE: If *all* core services within LOC-YC cannot be provided due to resource limitations, the child may remain in the LOC and also be placed on a waitlist for the core service until the service becomes available.

LOC-R 1 (LOC-1: Medication Management)

Reasons for Deviation to a Less Intensive LOC-A (Waitlist or Refused All Services)

Consumer Refused
The following are reasons that may indicate a deviation from the LOC-R 1 and must be documented in the clinical record:

- If the youth is *new* to services and has an LOC-R 1 and the youth and/or caregiver/LAR refuse medication services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the youth does not have a clinical need for services available in a more intensive LOC, he/she should be deviated to LOC-A 6 (Refused All Services); or
- If the youth is *currently enrolled* in services and upon reassessment has an LOC-R 1 and the youth and/or caregiver/LAR refuse medication services, the UA should be been reviewed with the caregiver/LAR and engagement should be provided. If the youth does not have a clinical need for services available in a more intensive LOC, discharge from services should be considered.

NOTE: All attempts at engagement must be documented in the clinical record.

Resource Limitations
Deviation to LOC-A 8 may not occur if the child has Medicaid. A youth may only be deviated to LOC-A 8 with a reason of resource limitations if medication management cannot be provided because of those resource limitations and the youth does not have Medicaid.

When deviating to LOC-A 8 for resource limitations, the clinician must provide a referral for the medication management and document the following information in the clinical record:

- Name and contact information of the person or agency to which the youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible).
- The date the referral was made.
- The disposition (i.e., whether the youth attended the initial appointment).

Reasons for Deviation to a More Intensive LOC-A

Clinical Need
The following are clinical reasons that may indicate a deviation from the LOC-R and must be documented in the clinical record and medical necessity signed by an LPHA:

- Upon initial assessment, the youth has an LOC-R 1 and based on clinical judgment of underlying treatment needs, the clinician determines core services available in a more intensive LOC are indicated (e.g., identified need for transition age youth skills training). This treatment need should be reflected on the UA; or
- Upon reassessment, the youth has an LOC-R 1 but has not completed a course of treatment being delivered in a more intensive LOC. The clinician may deviate to ensure completion of recommended course of treatment; or
- The youth has an LOC-R 1 but in order to ensure that clinical improvements from services in a higher LOC –including hospitalization or residential placement– are maintained, the youth should be authorized to a more intensive LOC.
- The youth has an LOC-R 1 where a core service that the caregiver has identified as a treatment need is not available. If after reviewing the UA with the caregiver, the clinician determines that the service is clinically indicated, the youth may be deviated to a more intensive LOC. The clinician must ensure that the UA reflects this treatment need.

LOC-R 2 (LOC-2: Targeted Services)

Reasons for Deviation to a Less Intensive LOC-A

The following are clinical reasons that may indicate a deviation from LOC-R 2 to LOC-A 1

Clinical Need

The following reasons justify clinical need for deviation and must be documented in the clinical record and medical necessity signed by an LPHA:

- A core service is required in this LOC, but is contra-indicated for this youth based on the clinician's assessment of underlying treatment needs; or
- A core service is required in this LOC, but the service is not appropriate for the youth at this time due to cognitive deficits; or
- A core service is required in this LOC, but the youth is receiving that service from another mental health provider in the community; or
- A core service is required in this LOC; but the youth has already completed this course of treatment, the treatment was provided to fidelity, *and* no positive clinical outcomes were observed. (This indicates a review of the treatment plan with participation of the youth and caregiver/LAR); or
- A core service is required in this LOC; but the youth has completed this course of treatment, the treatment was provided to fidelity, *and* negative clinical outcome were observed and attributed to the treatment. (This indicates a review of the treatment plan with participation of the youth and caregiver/LAR)

NOTE: The clinician may consider authorizing a different course of treatment (skills training or counseling) that can meet the clinical needs of the youth without deviating to different LOC.

Continuity of Care

The following are reasons that justify deviation to LOC-1 for continuity of care and must be documented in the clinical record:

- The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
- The youth is hospitalized and provider communicates with the youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The youth is living out of the service area for a planned and defined period of time (i.e. summer vacation) and provider plans to leave the youth open to services.

Consumer Refused

The following are reasons that may indicate a deviation from the LOC-R 2 and must be documented in the clinical record:

- The youth and/or caregiver refuse a core service (counseling or skills training), but do not refuse services available in LOC-1. If after attempts at engagement in the LOC-R, the youth and/or caregiver/LAR continue to refuse the core service in the LOC-R, deviation from the LOC-R may occur. The remaining clinically indicated core services must be available in the LOC-A; or
- If the youth is *new* to services and the youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services, the child should be deviated to LOC-A 6 (Refused All Services); or
- If the youth is *currently enrolled* in services and upon reassessment the youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the child should be discharged from services.

NOTE: Core Services in the LOC-R are determined to be essential to resilience and recovery. The youth and/or caregiver/LAR should continue to be engaged and participate in all clinically indicated core

services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations

If a youth has Medicaid he/she may not be deviated from LOC-R 2 to LOC-A 1 for resource limitations, because the core services of Counseling and Skills Training are not available in LOC-1. A youth without Medicaid may only be deviated to LOC-A 1 with a reason of resource limitations if counseling and skills training cannot be provided because of those resource limitations.

When deviating to LOC-A 1 for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible).
- The date the referral was made.
- The disposition (i.e., whether the youth attended the initial appointment).

NOTE: If a core service cannot be provided due to resource limitations, the youth may remain in LOC-2 and be placed on a waitlist for the core service until the service becomes available.

Reasons for Deviation to a More Intensive LOC-A

The following are clinical reasons that may indicate a deviation from LOC-R 2 to LOC-A 3 or 4:

Clinical Need

The following reasons justify clinical need for deviation and must be documented in the clinical record and medical necessity signed by an LPHA:

- Youth has an LOC-R 2 where counseling and skills training are not available concurrently and the clinician determines that both services are indicated based on the assessment of underlying treatment needs (Note: This may include an identified need for transition age youth skills training while the individual is receiving counseling services); or
- Upon reassessment, the youth has an LOC-R 2 but has not completed a course of treatment that should continue to be provided concurrently; or
- The youth has an LOC-R 2, but in order to ensure that clinical improvements from services in a higher LOC –including hospitalization or residential placement– are maintained, the youth should be authorized to a more intensive LOC;
- The youth has an LOC-R 2 where a core service that the caregiver/LAR has identified as a treatment need is not able to be provided concurrently. If after reviewing the UA with the caregiver/LAR, the clinician determines that delivery of both services is clinically indicated, the youth may be deviated to a more intensive LOC. The clinician must ensure that the UA reflects this treatment need; or
- The youth has a clinical need for Wraparound process planning (e.g., youth has several severe needs in areas of life domain functioning that place him/her at risk for displacement from his/her community).

Reason for Deviation to LOC-A Young Child

Note: To be authorized into LOC-YC the 3-5 CANS must be completed.

Clinical Need

A child's developmental needs may indicate deviation to the LOC-YC in order to ensure the child receives developmentally appropriate services. This deviation must be documented in the clinical record and medical necessity signed by an LPHA.

NOTE: If a child is age 7 years or older, he/she may not be deviated into LOC-YC.

LOC-R 3 (LOC-3: Complex Services)

Reasons for Deviation to a Less Intensive LOC-A

Clinical Need

The following are clinical reasons that may indicate a deviation from LOC-R 3 and must be documented in the clinical record and medical necessity signed by an LPHA:

- The clinician determines that counseling and skills training services should not be provided to the youth concurrently. The youth may be deviated down from LOC-R 3 to LOC-A 2; or
- A core service is required in LOC-3, but is contra-indicated for this youth based on the clinician's assessment of underlying treatment needs. The remaining recommended services must be available in the LOC-A; or
- A core service is required in this LOC, but the service is not appropriate for the youth at this time due to cognitive deficits. The remaining recommended services must be available in the LOC-A; or
- A core service is required in LOC-3, but the youth has already completed this course of treatment, the treatment was provided to fidelity, *and* no positive clinical outcomes were observed. (This indicates a review of the treatment plan with participation of the youth and caregiver/LAR). The remaining recommended services must be available in the LOC-A; or
- A core service is required in LOC-3 but the youth has completed this course of treatment, the treatment was provided to fidelity, *and* negative clinical outcome were observed and attributed to the treatment. (This indicates a review of the treatment plan with participation of the youth and caregiver/LAR.) The remaining recommended services must be available in the LOC-A; or
- A core service is required in LOC-3, but the youth is receiving that service from another mental health provider in the community. The remaining recommended services must be available in the LOC-A

Continuity of Care

The following are reasons that may justify deviation to a less intensive LOC for continuity of care and must be documented in the clinical record:

- The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
- The youth is hospitalized and provider communicates with the youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The youth is living out of the service area for a planned and defined period of time (e.g., summer vacation) and provider plans to leave the youth open to services.

Consumer Refused

The following are reasons that may indicate a deviation from the LOC-R 3 and must be documented in the clinical record:

- The youth and/or caregiver/LAR refuse a core service (counseling and/or skills training). If after attempts at engagement in the LOC-R, the youth and/or caregiver/LAR continue to refuse the LOC-R, deviation from the LOC-R may occur. The remaining clinically indicated core services must be available in the LOC-A; or
- If the youth is *new* to services and the youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. the LAR continues to refuse *all* services, the youth should be deviated to LOC-A 6 (Refused All Services); or
- If the youth is *currently enrolled* in services and upon reassessment the youth and/or caregiver/LAR refuse *all* services, the UA should be been reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the youth should be discharged from services.

NOTE: Core Services in the LOC-R are determined to be essential to resilience and recovery. The youth and/or caregiver/LAR should continue to be engaged to participate in all clinically indicated core services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations

If a youth has Medicaid, he/she may not be deviated from LOC-R 3 to LOC-A 1 for resource limitations, because the core services of Counseling and Skills Training are not available in LOC-1. A youth without Medicaid may only be deviated to LOC-A 1 with a reason of resource limitations if counseling and skills training cannot be provided because of those resource limitations.

When deviating to a less intensive LOC-A for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible).
- The date the referral was made.
- The disposition (i.e., whether the youth attended the initial appointment).

NOTE: If a core service cannot be provided due to resource limitations, the youth may remain in LOC-3 and be placed on a waitlist for the core service until the service becomes available.

Reasons for Deviation to a More Intensive LOC-A (4: Intensive Family Services)

Clinical Need

The following are clinical reasons that may indicate a deviation from LOC-R 3 and must be documented in the clinical record and medical necessity signed by an LPHA:

- Youth has a clinical need for Wraparound process planning. Clinical need may be indicated by the following (Note: This is not an exhaustive list):
  - The youth has several severe needs in areas of life domain functioning that place him/her at risk for displacement from his/her community; or
  - The youth is currently participating in the Wraparound process and for completion of the Wraparound process, should remain in LOC-4; or
  - The youth has an LOC-R 3 but in order to ensure that clinical improvements from services in a higher LOC –including hospitalization or residential placement– are maintained, the youth should be authorized to LOC-4 where he/she can receive Wraparound.

Reason for Deviation to LOC-A Young Child

Note: To be authorized into LOC-YC the 3-5 CANS must be completed.

Clinical Need

A child's developmental needs may indicate deviation to the young child level of care (LOC-YC) in order to ensure the child receives developmentally appropriate services. This deviation must be documented in the clinical record and medical necessity signed by an LPHA.

NOTE: If a child is age 7 years or older, he/she may not be deviated into LOC-YC.

LOC-R 4 (LOC-4: Intensive Family Services)

Reasons for Deviation to a Less Intensive LOC-A

Clinical Need

The following are clinical reasons that may indicate a deviation from LOC-R 4 and must be documented in the clinical record and medical necessity signed by an LPHA:

- The youth has an LOC-R 4, but the clinician determines that Wraparound process planning is not clinically indicated; or
- The youth is receiving Wraparound process planning from another child-serving agency in the community and the Wraparound facilitator is under the supervision of the other child-serving agency. (Note: Clinicians should be prepared to participate as a Wraparound team member if requested by the family); or
- Wraparound process planning is required in LOC-4, but the youth and caregiver has completed the Wraparound process, it was provided to fidelity, *and* no positive clinical outcomes were observed. (This indicates a review of the treatment plan and Wraparound process plan with participation of the youth and caregiver);or
- Wraparound process planning is required in LOC-4, but the youth has completed the Wraparound process, it was provided to fidelity, *and* negative clinical outcomes were observed and attributed to participation in the Wraparound process. (This indicates a review of the treatment plan and Wraparound process plan with participation of the youth and caregiver).

Continuity of Care

The following are reasons that may justify deviation to a less intensive LOC for continuity of care and must be documented in the clinical record.

- The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
- The youth is hospitalized and provider communicates with the youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The youth is living out of the service area for a planned and defined period of time (e.g., summer vacation) and provider plans to leave the youth open to services.

Consumer Refused

The following are reasons that may indicate a deviation from LOC-R 4 and must be documented in the clinical record:

- The youth and/or caregiver/LAR refuse Wraparound process planning. If after attempts at engagement in the LOC-R, the youth and/or caregiver/LAR continue to refuse the LOC-R, deviation from the LOC-R may occur. The remaining clinically indicated core services must be available in the LOC-A; or
- If the youth is *new* to services and the youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the youth and caregiver/LAR and engagement should be provided. If the caregiver/LAR continues to refuse *all* services, the youth should be deviated to LOC-A 6 (Refused All Services); or
- If the youth is *currently enrolled* in services and upon reassessment the youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the youth and caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the youth should be discharged from services.

NOTE: Core Services in the LOC-R are determined to be essential to resilience and recovery. The youth and/or caregiver/LAR should continue to be engaged to participate in all clinically indicated core services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations
If a youth has Medicaid, he/she may *not* be deviated from LOC-R 4 for resource limitations, because the core service of Wraparound process planning is not available in a less intensive LOC. A youth without Medicaid should be deviated to the next most appropriate LOC where resources are available. All efforts should be made to provide an LOC higher than LOC-A 1 when a youth has an LOC-R 4.

When deviating to a less intensive LOC-A for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible).
- The date the referral was made.
- The disposition (i.e., whether the youth attended the initial appointment).

NOTE: If a core service (i.e. counseling, skills training, or Wraparound) cannot be provided due to resource limitations, the youth may remain in LOC-4 and be placed on a waitlist for the core service until the service becomes available.

Reason for Deviation to LOC-A Young Child

Note: To be authorized into LOC-YC the 3-5 CANS must be completed.

Clinical Need
A child's developmental needs may indicate deviation to the LOC-YC in order to ensure the child receives developmentally appropriate services. This deviation must be documented in the clinical record and medical necessity signed by an LPHA.

NOTE: If a child is age 7 years or older, he/she may not be deviated into LOC-YC.