



Department of  
**Children's Services**



# Contract Provider Manual

## Section Five (5) Sub-Acute Psychiatric Residential Care

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## **1.General Characteristics**

- a) Sub-Acute Psychiatric residential care is a physician-directed level of care focused on establishing the behavioral and emotional prerequisites for functioning in the most appropriate, non-hospital environments.
- b) Sub-Acute Psychiatric residential care is a transitional level of care that a child may enter as a move towards permanency from an acute admission or as a temporary admission from a lower level of care for the purpose of emotional and/or behavioral stabilization.
- c) The child's treatment team under the leadership of the physician makes decisions regarding which clinical issues are addressed on the plan of care, the sequence in which they are addressed and discharge recommendations.
- d) All needed specialized mental health services will be provided by the agency. This includes necessary assessments such as psychiatric evaluation, psychological evaluation, psychoeducational evaluation, psychosexual evaluation, and alcohol and drug assessment. This also includes treatment, such as individual, group, and family therapy, medication management, alcohol and drug treatment, sexual offender treatment, and mental health/behavioral treatment. Providers addressing problem sexual behavior will be approved by DCS Central Office. The cost of all services is included in the per diem rate paid to the provider by DCS. Appropriate agreements with external providers will ensure that those providers will not also bill TennCare or any other insurance provider for the service as it is covered under the per diem.
- e) The facility will be appropriately licensed according to the population served.

## **2. Admission/Clinical Criteria**

- a) Sub-Acute Psychiatric Hospital programs operated under terms of this agreement will be designed to serve children in the custody of the Department of Children's Services (DCS) who do not meet criteria for involuntary acute psychiatric hospitalization but who continue to require specialized mental health services, which are highly structured, therapeutically intensive, and provided within a psychiatric facility.
- b) The team consults with the Regional Licensed Mental Health Clinician prior to placing a child or youth in a Sub-Acute Psychiatric Hospital.
- c) Child/youth will present with difficult and challenging needs/behaviors and will have an immediate need for initial short-term or intermittent stays in the RTF setting. The following medical necessity criteria will be met for admission to a Sub-Acute Psychiatric Hospital:
  - ◆ The youth has a significantly severe mental health disorder (DSM-IV-TR, DSM-5 or by clinical presentation) and is markedly impaired in social, educational, familial, and occupational functioning. This level of functioning is not due exclusively to mental retardation, organic dysfunction, or developmental disabilities. This disorder is amenable to "active psychiatric treatment" and requires physician-directed care that

cannot be successfully provided at a lower level of care. The youth cannot be psychiatrically stable in a less restrictive setting, requires 24-hour nursing staff on site, minimum of weekly psychiatric face-to-face consultation, and daily supportive guidance toward short-term stabilization status.

- ◆ The youth is unable to adequately care for physical needs without external support that is beyond the capacity/capabilities of the family and/or other non-inpatient community support system representatives to provide. This inability represents harm to self or others (e.g., reckless self-endangerment) and is due to psychiatric disorder *not* developmental, social, cognitive, or specific medical limitations.
  - ◆ The youth's current living environment, family setting, extended community do not provide the support and access to therapeutic services necessary to maintain stability or maximize effective daily functioning and/or the youth has not been successful in lower levels of treatment efforts (i.e., has failed to maintain or sustain adequately).
  - ◆ The youth cannot achieve successful adaptation for the purpose of short-term stabilization at this time without significant structure and supportive inpatient guidance that can only be provided through twenty-four (24) hour per day, seven (7) day per week regimen.
  - ◆ The youth meets the age, cognitive capacity, adaptive functioning level and/or developmental level requirements necessary for minimal acceptance in the specific setting.
  - ◆ The youth does not require medical substance abuse treatment (e.g. detoxification) as the primary need, does not have contraindicated medical conditions that are primary and supersede the psychiatric symptoms.
- d) Child/youth may be of any adjudication type;
  - e) Child/youth may pose a high risk for elopement, instability in behavior and mental health status or occasionally experience acute episodes. These youth also experience persistent maladjustment of peer and other social relationships or other influencing systems which interfere with learning and social environments.
  - f) Children/youth with a primary diagnosis of intellectual disability are evaluated on a case-by-case basis for admission and a special needs contract. Children with an IQ lower than 55 or who have adaptive functioning indicating moderate to severe intellectual disability may not be appropriate unless the agency is able to make appropriate adjustments to the regular programming as needed.

### **3. Personnel**

- a) The agency provides a psychiatrist-directed program and has available the services of a licensed physician on a 24-hour basis.
- b) The provider has trained personnel who can meet the developmental, therapeutic, and supervision needs of all children/youth accepted for care and services.
- c) The program will be under the direct clinical supervision of a licensed mental health

- professional with training and experience in mental health treatment of children and youth.
- d) Staff will be appropriately credentialed to provide individual and family counseling/therapy. The agency is responsible for providing the credentials of therapists upon request. If a specialized treatment such as Trauma Focused Cognitive Behavior Therapy (TFCBT), Dialectical Behavior Therapy (DBT), or treatment for problem sexual behavior is being provided, the agency will be able to demonstrate that the therapist is appropriately trained to deliver this treatment.
  - e) Educational staff will meet the employment standards outlined in the state Board of Education Rules, Regulations and Minimum Standards.
  - f) A Registered Nurse will be provided at the facility on a 24-hour per day basis, with at least one (1) nurse per building per shift.
  - g) The agency will provide a direct-care staffing level of at least 2 direct-care staff members on duty per unit per shift. The minimum staffing level will be 1:5 (one direct-care, awake staff for every five on-site youth) during the day and 1:8 (one direct-care, awake staff for every eight on-site youth) overnight staff. Staff persons counted in the staff-to-child/youth ratio may only be persons who are assigned to provide direct program services as described by written job description. Support staff such as clerical, housekeeping, van and bus driver staff or students involved in an onsite practicum for academic credit may not be counted in the staff-to-child/youth ratio.
  - h) All prospective employees whose responsibilities include direct contact with youth will have a risk assessment/screening for tuberculosis within ninety (90) days of employment and annually thereafter.
  - i) The program will provide, at all times, at least one (1) on-duty staff member trained in First Aid and the Heimlich maneuver and certified in cardiopulmonary resuscitation (CPR).

#### **4. Individualized Treatment Plan**

- a) An Initial Treatment Plan will be developed within the first 72 hours for each child/youth. This plan will be based on initial history and current assessment of child/youth's needs and strengths.
- b) A more comprehensive Treatment Plan will be developed after testing and/or assessment has occurred. The Treatment Planning process will include the family and youth per the CFTM model for collaborative planning. This will be completed within 30 days of admission.
- c) The program will ensure that the following assessments are completed prior to development of the child/youth's Comprehensive Treatment Plan:
  - ◆ Assessment of current functioning, and a history in the following areas: Community living skills; living skills appropriate to age; emotional and psychological health; and Educational level (including educational history).
  - ◆ Basic medical history and information;

- ◆ A six (6) month history of prescribed medication, frequently used over-the-counter medication and alcohol or other drug use;
  - ◆ History of prior mental health and alcohol and drug treatment episodes; and,
  - ◆ Assessment of whether child/youth is currently eligible for special education services in accordance with the State Board of Education Rules, Regulations and Minimum Standards.
- d) The Comprehensive Treatment Plan will address referral concerns and identify treatment goals as relate to safety, mental health, medical, and educational well-being. The Treatment Plan will include specific steps to work toward permanency, including visitation plan. This plan may integrate information from tools such as the CANS, historical FAST, and Permanency Plan. For example, actionable items on the CANS (items rated 2 or 3) will be addressed.
- e) The individual Treatment Plan will consider discharge goals and estimated length of stay. Discharge planning will begin at admission and be an ongoing process;
- f) Documentation of the Treatment Plan and of its implementation will be kept in the child/youth record and will include the following, per TCA 0940-5-37-.05:
- ◆ The child/youth's name on the Treatment Plan;
  - ◆ The date of development of the Treatment Plan;
  - ◆ Individual problems specified in the Treatment Plan which are to be addressed within the particular service/program component, including treatment and educational components;
  - ◆ Individual objectives which are related to specified problems identified in the Treatment Plan and which are to be addressed by the particular service/program component;
  - ◆ Interventions and staff responsible for addressing goals and objectives in the Treatment Plan;
  - ◆ Signatures of the staff providing the services;
  - ◆ Documentation of participation of child/youth and parent/guardian/legal custodian or conservator where appropriate in the Treatment Planning process. If any of the parties refuse to participate, reasons for refusal must be documented;
  - ◆ Standardized diagnostic formulation(s), (including, but not limited to, the current Diagnostic and Statistical Manual [DSM] Axis I-V and/or ICD-9 or ICD-10) where appropriate, and assessment documentation on file which is updated as recommended by treatment team;
  - ◆ Planned frequency of treatment contacts; and,
  - ◆ A plan for family involvement in the child/youth's treatment.

- g) A review of the Treatment Plan must occur at least every thirty (30) days or upon completion of the stated goals and objectives and will include the following documentation, per TCA 0940-5-37-.05:
- ◆ Dated signatures of appropriate staff;
  - ◆ An assessment of progress toward each treatment goal and / or objective with revisions as indicated;
  - ◆ A statement of justification for the level of service(s) needed, including suitability for treatment in a less restrictive environment and continued services

## **5. Service Components & Overview**

- a) Twenty-four (24) hour awake staff;
- b) In addition to a comprehensive treatment plan, other assessments may be requested by the following personnel: DCS Regional Licensed Mental Health Clinician, juvenile court personnel, the Local Education Agency (LEA), or the treating mental health provider.
- c) If additional assessments are requested, the assessment will be completed and final report made available within thirty (30) days of the date the request was made.
- d) Each child/youth will have a clinical team comprised of representatives from front line staff, nursing staff, educators, therapeutic staff and a psychiatrist. The clinical team will participate in monthly documented clinical staffing for each child/youth;
- e) The Program will provide an evidenced based model(s) as defined by SAMHSA or California clearing house. The program will be designed for the population served. The program will develop and maintain a manual that details the agency's plan for staff training in the model, maintaining model fidelity, and will define how staff will adhere to components of the manual.
- f) Behavior management system emphasizing positive reinforcements;
- g) Development of Individualized Crisis Management Plan, if warranted by youth behavior;
- h) Utilization of a nationally-recognized crisis intervention program for the use of seclusion, restraint and restrictive interventions.
- i) Provision of recreational activities, social skills training, daily living skills and interdependent living skills. These activities will be appropriate to, and adapted to, the needs, interests and ages of the children/youths. More information about independent living may be found in the IL Core Services portion of this manual.
- j) Group counseling/therapy conducted by an appropriately credentialed staff at least three (3) times per week with each session being at least one (1) hour in length and no longer than one and a half (1.5) hours. Group size is not to exceed ten (10). These are clinically-focused groups and are specific to the specialized needs of the youth such as alcohol and drug, mental health or sexually abusive issues;
- k) One (1) hour of individual counseling/therapy will be provided by an appropriately credentialed staff member at least weekly, with sessions lasting no less than one-half (.5) hour.

- l) Family counseling/therapy:
- ◆ Provided by appropriately credentialed/licensed staff to the family identified as the family of care or the permanency family. This family is identified by the DCS Family Service Worker (FSW) as soon as possible after coming in to custody or upon admission to the facility. The agency therapist will have contact with the family of care or permanency family and the DCS FSW either by phone or in person within the first week of admission;
  - ◆ Provided at a minimum of two (2) times per month unless contraindicated;
  - ◆ Routine contacts with family and youth (visitation, phone calls) are not considered counseling/therapy;
  - ◆ Sessions will be one (1) hour in length;
  - ◆ Family schedules may necessitate minor changes in the length and frequency of counseling /therapy and these changes are to be documented in the case notes;
  - ◆ Contraindications to family involvement and family counseling/therapy will be documented in the Treatment Plan. Provider concerns regarding family involvement will be addressed in writing to the DCS FSW (e-mail notification is allowed);
  - ◆ The provider agency is responsible for working with the family to overcome barriers to involvement such as transportation and schedules;
  - ◆ The DCS FSW will assist with coordination and help to overcome barriers; and,
  - ◆ Family counseling/therapy is not contingent on the youth's behavior.
- m) Psychiatric evaluation by the treating psychiatrist within three (3) days of admission, and at least weekly contact with the psychiatrist on an ongoing basis.

## **6. Education of the Child/Youth**

- a) Youth will attend an in-house, non-public school that is approved by the Tennessee State Department of Education and recognized to educate students in custody by the DCS Education Division.
- b) Please refer to [Section Thirteen \(13\)-Education Standards](#) section of this manual for specific information related to the education of students in state custody.

## **7. Records Management**

The individual record for each child/youth will contain the following information:

- a) Documentation of the initial Treatment Plan (within 72 hours), formalized Treatment Plan (within 30 days) and the Individualized Education Program (if required) and of their implementation;
- b) Progress notes will be recorded daily and will include written documentation of child/youth progress and changes which have occurred within the implementation of the Treatment Plan.
- c) These progress notes will be dated and include the signature, title or degree of the person providing the service;



- d) Psychological Evaluations and Psychiatric progress notes. These notes will be dated and include the signature, title or degree of the person providing the service;
- e) Documentation of all drugs prescribed and/or administered by the facility which indicates date prescribed, type, dosage, frequency, amount and reason for prescription;
- f) Documentation of significant behavior and actions taken by staff;
- g) A list of each article of the child/youth's personal property valued at one hundred dollars (\$100.00) or more and its disposition if no longer in the youth's possession.
- h) Documentation of abuse, medical problems, accidents, seizures and illnesses. This documentation will include the treatment for such abuse, accidents, seizures, and illnesses and any reports generated as a result. Results of assessments are required by this rule;
- i) Discharge summary which details the child/youth's condition at the time of discharge and the signature of person preparing the summary;
- j) Documentation of an education plan developed for each child/youth that conforms to the Rules, Regulations and Minimum Standards of the State Board of Education and confirms the Individualized Education Program (IEP) test being developed by an appropriately constituted IEP Team for all "qualified students with disabilities";
- k) The education plan may include education services provided either by the facility or by the Local Education Agency; and,
- l) Appropriate consents and authorizations for the release and obtaining of information about the child/youth will be maintained and current.

## **8. Discharge Planning and Discharge Criteria**

- a) A preliminary discharge plan with discharge goals, projected length of stay, tentative discharge date, and tentative aftercare plan will be formulated and shared with the DCS Regional Licensed Mental Health Clinician, educational specialist, family services worker, and placement specialist.
- b) A youth is ready for discharge when he/she no longer meets the admission criteria (outlined above) and sufficient aftercare services (e.g., mental health, education, family, medical/physical) have been arranged to allow for a smooth transition.

## **9. Special Needs Sub-Acute Psychiatric Hospitalization**

- a) A special needs admission may be negotiated on a case-by-case basis when the special needs of the child exceed the care that is given in the standard sub-acute hospitalization. The following groups of children may be considered:
  - ◆ Children who are dually diagnosed with a clinical disorder and moderate or severe intellectual disability;
  - ◆ Children who require additional care due to an autism spectrum disorder diagnosis;
  - ◆ Children who are dually diagnosed with a clinical disorder and complex associated

- medical problems that require ongoing treatment and care;
  - ◆ Children who exhibit extreme and chronic self-harm, make frequent suicidal threats or gestures, or exhibit chronic and severe assaultive behaviors;
  - ◆ Children with other unique needs may be considered on a case-by-case basis.
- b) Service components provided within the per diem:
- ◆ All items noted under “Service Overview and Components” will be provided for the special needs population as well.
  - ◆ The provider will provide individualized services in addition, to address the special treatment needs of the child/youth. For example, one-to-one staffing or medical supports. The provider will document in writing any additional services they are providing.
  - ◆ Will the child/youth no longer be in need of additional special services, yet remain in need of continued sub-acute hospital services, he/she will be reassigned to the sub-acute hospital level of service. This decision will occur through the CFT process.