



## BASIC SERVICES: Prevention & Health Maintenance

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Basic Services are designed to prevent the onset of illness and/or to limit the magnitude of morbidity associated with individual family or social risk factors, developmental delays, and existing emotional disorders in various stages of improvement or remission. Services may be developed for individual or community application and are generally offered in a variety of community settings. Prevention and community support involve education and referral services and may be provided through traditional means, as well as through print and broadcast media (e.g., public service announcements and/or targeted mailings). The expectation that individuals utilizing these services may have complex needs requires that these services should be designed to be welcoming to all individuals and provide preventive, holistic care. They should be capable of providing quality care to those who present with complexity.

This level of care should be available to everyone in the community without obtaining a prior authorization from insurers. Professionals providing services should be appropriately licensed and in good standing. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including certified peer and family specialists.

- 1. Clinical Services** - It is imperative that Basic Services in all settings provide screening for mental health and developmental disorders. Comprehensive, multidisciplinary assessments for children and adolescents who, after initial screening, emerge with multi-faceted problems should be readily available. Expert evaluations should also be readily available. Linkage with mental health and substance abuse services (e.g., scheduling intakes) should be provided to families identified in screening assessments. Consultative services by mental health clinicians should be effectively integrated into all prevention and support functions. Medical care from either a pediatrician or family physician should be available in the community.
- 2. Support Services** - Basic Services should be available to children, adolescents, and families through active collaboration with religious and culturally distinct community groups, and in a variety of community settings, including schools and adult education centers, day care and recreational/social facilities, vocational and social services agencies, and medical facilities. Community volunteers and agency staff should be trained to provide prevention services.
- 3. Crisis Stabilization and Prevention Services** - 24-hour crisis services should be publicized, accessible, and fully integrated into Basic Services in all community settings. Crisis services should include emergency evaluation, brief intervention, and disposition. Child and adolescent psychiatrists and/or psychosocial nurses should be available for direct contact and consultation on a 24-hour basis. Additional crisis intervention and stabilization efforts should include outreach to vulnerable populations, such as homeless families, as well as intervention with victims of trauma and disaster.
- 4. Care Environment** - Prevention and community support activities may occur in many settings, from a child or adolescent's home, to Head Start programs, schools, churches, medical and recreational facilities, or traditional mental health settings. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); cultural competence (e.g., ambiance that is welcoming to families of multiple ethnic and socio-economic groups) and specific service needs (e.g., supervised day care so that parents can participate, staff or consultants for non-English speaking and/or hearing-impaired attendees).

### **Placement Criteria**

All children, adolescents, and families should have access to Basic Services.

## LEVEL ONE: Recovery Maintenance & Health Management

Level One services typically provide follow-up care to mobilize family strengths and reinforce linkages to natural supports. Those appropriate for Level One services may either be substantially recovered from an emotional disorder or other problem, or their problems are sufficiently manageable within their families, such that the problems are no longer threatening to expected growth and development. It is a “step down” level of care, designed to prevent or mitigate future episodes of illness or deterioration of function. Treatment and service needs do not require supervision or frequent contact when community support plans are in place. Although this is a low intensity service level, there should be an expectation that individuals utilizing these services may have complex needs. As such these services should be designed to be welcoming to individuals who have multiple conditions, and be able to address complexity capably.

This low intensity level of care should not require prior authorization from insurers, and should be available as long as it is needed in much the same way as periodic visits to primary care providers are provided. Professionals providing services should be appropriately licensed or certified. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including certified family and peer specialists.

- 1. Clinical Services** - Treatment programming (i.e. individual, family and/or group therapy) will be available up to one hour per month, and usually not less than one hour every three months. Psychiatric or physician review and/or contact should take place about once every three to six months. While clinical services at Level One may be non-intensive and/or episodic, they should be readily accessible so that families may use services to avert the need for higher levels of care. Clinical consultation and assessment should be culturally competent and should consider the extent to which families can mobilize natural supports in the community. Time-limited professional interventions, opportunities for check-ins for “graduates” who value continuity of a treatment relationship, as well as ongoing case management and follow-up medication services may be provided as part of Level One clinical services. Medical care from either a pediatrician or family physician should be available in the community.
- 2. Support Services** - Level One support services consist mainly of natural supports in the community, including extended family, friends, and neighbors; parent sponsored support groups, church and recreational programs; 12-step and other self-help programs; school-sponsored programs; and employment. Families appropriate to this level of care have the capacity to access these community resources as needed without professional intervention. Provision of these services should not require more than 1-2 hours per month on the average, though there may be occasional life crises, which would require additional support for short periods of time.
- 3. Crisis Stabilization and Prevention Services** - 24-hour crisis services should be available to children, adolescents, and families at this level of care. Crisis intervention staff should consult with primary clinicians. Crisis services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and/or psychosocial nurses should be available in each community on a 24-hour basis.
- 4. Care Environment** - Recovery maintenance and health management services may be provided in a traditional mental health setting (e.g., office or clinic), or in facilities of other components in the system of care. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.).

For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

***Placement Criteria***

Children and adolescents with composite scores in the range of 10-13 generally may be stepped down to or receive Level One services. Placement at Level One usually indicates that the child or adolescent has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past, or does not need services that are more intensive or restrictive than those offered at Level One. Placement determinations should be made by culturally competent staff or with consultation by culturally competent clinical specialists.

## LEVEL TWO: Low Intensity Community Based Services

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This level of care includes mental health services for children, adolescents, and families living in the community. Level Two services frequently are provided in mental health clinics or clinicians' offices. Services also may be provided within a juvenile justice facility, school, social service agency, or other community setting. Children and adolescents appropriate for Level Two services generally do not require the extensive systems coordination and case management of the higher levels of care, since their families are able to use community supports with minimal assistance. The degree of individualization of services at Level Two also may not be as extensive as at higher levels of care; nevertheless, there should be an expectation that individuals utilizing these services will often have complex needs, that these services should be welcoming to individuals who have multiple conditions, and that these services are able to address complexity capably.

Some payers may require that these services be authorized, but close oversight should not be needed, as it would likely incur more expense than savings. Reviews should not be required more often than every four months. Professionals providing services should be appropriately licensed and certified. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including certified family and peer specialists.

- 1. Clinical Services** - Clinical services for outpatient care consist primarily of individual, group, and family therapies with active family participation in treatment planning and implementation. Treatment intensity ranges from one hour every four weeks, to up to two hours per week. Psychiatric and cultural competency consultation to the treatment team should occur regularly. Medication, evaluation and management may be an essential element. Child and adolescent psychiatrists and psycho-social nurses should be part of the primary treatment team for medication services and 24-hour backup. Selected adjunct interventions (e.g., occupational, recreational, vocational, and/or expressive therapies) should be made available as indicated. Medical care from either a pediatrician or family physician should be available in the community.
- 2. Support Services** - Support services for children, adolescents, and families are most often natural supports within the community, including extended family, friends, and neighbors; church and recreational programs; 12 step and other self-help groups; parent organization support groups; youth empowerment programs; school sponsored programs; and employment. These families should have the capacity to access other elements of the system of care without substantial professional help, but may need referral and minimal case management. Families also may need support for financial, housing, or child-care problems, or for accessing vocational and education services. These should be included as part of the child or adolescent's individualized service plan. Provision of professional support services should not average more than 2-3 hours per month at this level.
- 3. Crisis Stabilization and Prevention Services** - 24-hour crisis services should be accessible to children, adolescents, and families at this level of care. Furthermore, crisis services should be provided in collaboration with the family's other service providers. Crisis services should include emergency evaluation, brief intervention, and outreach services. Direct services and/or consultation from child and adolescent psychiatrists and psychosocial nurses should be available on a 24-hour basis.
- 4. Care Environment** - Outpatient services may be provided in a traditional mental health setting (e.g., office or clinic), in facilities of other components of the service system, or in other community settings. Facilities used for treatment should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled

or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

***Placement Criteria***

Children and adolescents with a composite score in the range of 14-16 generally may begin treatment at, or be stepped down to, Level Two services. Placement at Level Two indicates that the child or adolescent either does not need services that are more intensive or restrictive than those offered at Level Two, or has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.

## LEVEL THREE: High Intensity Community Based Services

This level of care generally is appropriate for children and adolescents who need more intensive outpatient treatment and who are living either with their families or in alternative families or group facilities in the community. The family's strengths allow many, but not all, of the child's needs to be met through natural supports. Treatment may be needed several times per week, with daily supervision provided by the family or facility staff. There should be an expectation that individuals utilizing these services will commonly have complex needs, so these services should be welcoming to individuals who have multiple conditions, and should be able to address all of them capably. Service coordination is essential for maintaining the child or adolescent in the community at Level Three. Medical care from either a pediatrician or family physician should be available in the community.

Minimal oversight should be required for this level of service and reviews should not be required more often than every two weeks for persons with acute conditions and every two months for those with more slowly evolving conditions. Professionals providing services should be appropriately licensed and certified. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including certified family and peer specialists.

- 1. Clinical Services** - Level Three services incorporate individual, group, and family therapy. Level Three services increasingly depend on the use of wraparound teams as service coordination becomes more complex. Service intensity averages approximately three days per week at least two or three hours per day. Psychiatric consultation to the treatment or wraparound team should occur regularly. Medication management may be an essential part of treatment. Child and adolescent psychiatrists and psychosocial nurses are part of the treatment team, providing medication services and 24-hour backup. Selected adjunct interventions (e.g., educational support, recreational, vocational, and/or expressive therapies) may be used as indicated. In addition, referrals for clinical services for other family members may be needed. Transition planning for a lower level of care should be part of the services plan. Close collaboration for medical care with either a pediatrician or family physician should be in place and co-located if possible.
- 2. Support Services** - Case management or outreach service should be provided by a culturally competent primary clinician or case manager, or with cultural competency consultation if needed. Support services for these children, adolescents, and families should emphasize natural and culturally congruent supports within the community, such as extended family, neighborhood, church groups, parents organization sponsored support groups, youth empowerment programs, self-help groups and community employers. Families may have difficulty accessing elements of the system of care without professional help due to the complexity of their child or adolescent's problems. In addition, families may need support for financial, housing, child-care, vocational, or education services. These should be included as part of the child or adolescent's individualized service plan. Although the need for professional support services is variable at this level, an average of two hours per week is commonly required.
- 3. Crisis Stabilization and Prevention Services** - 24-hour crisis services, including child and adolescent psychiatric and nursing consultation and/or direct contact, should be available at this level of care. Crisis services should be accessible and, when provided, crisis team personnel should contact the family's primary service providers. Crisis services should include emergency evaluation, brief intervention, and outreach.

- 1. Care Environment** - Intensive outpatient services may be provided in a traditional mental health setting (e.g., office or clinic), in facilities of other components of the service system, or in other community settings. The site should have the capacity for short-term management of aggressive or other endangering behavior. Facilities should address ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired attendees, etc.). For adolescents, facilities should facilitate a mix of adult supervision with privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families. They should provide easy access to, or be co-located with, parent organization run support groups and teen empowerment programs.

***Placement Criteria***

Children and adolescents with scores in the range of 17-19 generally may begin treatment at, or be stepped down to, Level Three services. Placement at Level Three generally is excluded by a score of 4 or higher on any dimension. Placement at Level Three indicates that the child or adolescent either does not need more intensive or restrictive services, or has successfully completed treatment at a higher level of care and needs assistance in maintaining gains. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or in consultation with cultural competency specialists.

## LEVEL FOUR: Medically Monitored Community-based Services

This level of care refers to services provided to children and adolescents capable of living in the community with support, either in their family, or in placements such as group homes, foster care, homeless or domestic violence shelters, or transitional housing. To be eligible for Level Four services, a child or adolescent's service needs will require the involvement of multiple components within the system of care. These children and adolescents, therefore, need intensive, clinically informed case management to coordinate multi-system and multidisciplinary interventions. Services in this level of care include partial hospitalization, intensive day treatment, treatment foster care, and home-based care determined by a wraparound plan that may involve both support and clinical services brought to the home and various support services for parents/caregivers. Level Four services also may be provided in schools, substance abuse programs, juvenile justice facilities, social services group care facilities, mental health facilities, or in the child or adolescent's home.

Payer oversight may be required for this level of service, but reviews should not be required more often than every four weeks for acute care settings such as partial hospital, and no more than every three months for extended care services such as wraparound. Professionals providing services should be appropriately licensed and certified. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including certified family and peer specialists.

- 1. Clinical Services** - Clinical services at Level Four should be available at times that meet the needs of the family, including non-traditional periods (e.g., evenings and weekends). The frequency of direct contact and/or consultation by child and adolescent psychiatrists and psychosocial nurses should be determined in consultation with the primary clinician and the wraparound team. Close collaboration with primary medical care should be in place as an integrated part of the comprehensive array of services and should be co-located if possible. Interventions may include individual, group, and family therapy, and may be organized into protocols such as occur in day treatment, or offered as part of a comprehensive wraparound plan. Services may be offered within any of the components of the system of care. Services should be designed for flexibility as part of the wraparound plan which encompasses the mental health individualized treatment plan, and places emphasis on building on the strengths of the child or adolescent and family. Psychiatric services should be accessible on a daily basis and contact would occur as required by initial and ongoing assessment, usually not less than one hour per month, or more than four hours per month. Psychiatric services would also be available by remote communication on a 24-hour basis. Medication will be carefully monitored, but in many cases can be self-administered. Non-psychiatric clinical services generally average 5-16 hours weekly.
- 2. Support Services** - Case management services are provided to coordinate the multi-faceted service needs of the children and adolescents and their families at this level of care. Recreational activities, after-school employment, church programs, and other community activities may be integrated into the wraparound plan to form a graded continuum of natural, clinical, and culturally congruent supports, with emphasis on natural supports from family, advocacy programs, and youth empowerment programs when available. Families are likely to need support for financial, housing, childcare, vocational, and/or education services. These should be included as part of the child or adolescent's wraparound plan. Services should be family-centered, with the goals of either maintaining or reintegrating the child or adolescent in to the home and community. The need for professional supportive services will vary, but will usually require an average 5 to 10 hours per week including indirect service time.



- 3. Crisis Stabilization and Prevention Services** - At Level Four, children, adolescents, and families must have access to 24-hour emergency evaluation and brief intervention services that include direct contact and/or consultation by a child and adolescent psychiatrist or psychosocial nurse. Crisis services must be mobile and integrated into the care plan. Crisis services may be offered by a number of components in the system of care including outreach by family organization members and/or youth peer support specialists. Care should be taken to avoid service duplication. The goal of crisis services is to foster family strengths and prevent the need for admission to higher levels of care.

At Level Four, respite care may be offered to families to provide relief from the demands of caring for the child or adolescent and as a “cooling off” mechanism during crises and while treatment plans are implemented.

A wraparound team’s capacity for managing a child or adolescent at Level Four is partially determined by their age, size, and developmental level, as well as the strengths and size of the team. An inability to manage risk of harm may be reflected in a higher composite score on CALOCUS, and justifies transfer to a more restrictive setting or intensification of the wraparound program to offer active medical monitoring or management.

- 4. Care Environment** - Level Four services may be provided in an outpatient clinic or hospital (e.g., partial or intensive day treatment), any component in the service system (e.g. public or private day school, juvenile detention center, group home), or in the home (e.g., home-based services). The facility must have the capacity for short-term management of aggressive or other endangering behavior. Transportation needs should be accommodated, both for staff to serve children and adolescents in community settings and to help children, adolescents, and families access services. When home-based treatment is provided, staff transportation needs should be addressed as well as flexible hours to assure continuity of supports for as many hours of the day as is deemed necessary. To optimize family participation, Level Four facilities should be located as near as possible to the child or adolescent’s home. Facilities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing impaired people). For adolescents, facilities should allow for a mix of adult supervision and privacy for peer group activities. The facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as their families.

#### ***Placement Criteria***

Children and adolescents with scores in the range of 20-22 generally may begin treatment at, or be stepped down to, Level Four services. Placement at Level Four indicates that the child or adolescent either does not need more intensive services, or has successfully completed treatment at a more intensive level and primarily needs assistance in maintaining gains. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or with consultation by culturally competent specialists.

## LEVEL FIVE: Medically Monitored Residence-based Services

This level of care refers to treatment in which the essential element is the maintenance of a milieu in which the therapeutic needs of the child or adolescent and family can be addressed intensively. This level of care traditionally has been provided in non-hospital settings such as residential treatment facilities or therapeutic foster homes. Equivalent services have been provided in juvenile justice facilities and specialized community based residential schools, hospitals with designated step down program units and could be provided in homeless and/or domestic violence shelters or other community settings. Ideally, the transition plan will provide continuity of care and integrate the child or adolescent's treatment experiences into their return to a more open community setting. Clearly, there is an expectation that individuals utilizing these services will have complex needs. These services should be welcoming to individuals who have multiple conditions, and should be able to address complexity capably.

Payer authorization is often required for this level of service, but reviews should not be more often than every week for sub-acute intensive care settings such as respite or step down facilities, and no more than every three months for extended care services such as residential treatment facilities. Professionals providing services should be appropriately licensed and certified and should include a full array of disciplines including rehabilitation, addiction, and medical specialists. Many support services may be provided by appropriately trained and/or certified paraprofessionals, including family and peer specialists.

- 1. Clinical Services** - Programs for children or adolescents in residential settings comprise the core treatment at this level of care. The primary clinician should review the child or adolescent's progress daily and debrief back-up staff as needed. Child and adolescent psychiatrists are integral members of the treatment team and, if not the primary mental health clinician, serve an important consultative or supervisory function, maintaining daily contact with the team and providing 24-hour psychiatric consultation. Psychiatric care should be available on site at least weekly, but client contact may be required as often as daily. Facilities serving the most acute populations will require 0.5 - 1.0 hours of psychiatric time per client per week. Treatment modalities may include individual, group, and family therapy, with substance abuse services. Primary medical care should be an accessible, integrated part of the comprehensive array of services. Close collaboration with either a pediatrician or family physician should be in place, and preferably co-located. Non-credentialed child-care staff are an important part of the clinical team, and so will participate in treatment planning, and will be actively supervised and trained. Similarly, parent and youth peer support specialist should be supervised actively and integrated into the treatment plan. Non-psychiatric clinical services generally average 8-20 hours per client weekly. Staff and programs should be culturally competent, with access to cultural competency consultation as needed. Treatment should be family-centered. The goal of treatment for children or adolescents in out-of-home placements should be a timely return to the family and community. Thus, transition planning should be considered in daily clinical review.
- 2. Support Services** - Active case management is integral to care at this level regardless of which component of the system of care is the lead service provider. Children and adolescents in Level Five programs should receive adequate supervision for activities of daily living. Supervised off-campus passes or excursions into the community from a home-based wraparound program should be provided. Facility or program staff, supportive family members, and/or family friends identified by the "child and family" team may provide basic support services, including recreational, social, or educational activities, and, as needed, escort to substance abuse or self-help groups. Families may need help for problems

with housing, child-care, finances, and job or school problems. These services should be integrated into the child or adolescent's individual service plan.

- 3. Crisis Stabilization and Prevention Services** - Children and adolescents at Level Five may require higher levels of care for brief periods to manage crises. All staff must be trained in de-escalation and safe restraint techniques should they be required until a secure placement can be obtained. These interventions should be used in accordance with the legal requirements of the jurisdiction and ethical professional practices.

More restrictive care may be needed temporarily because the team cannot safely manage acute exacerbations in the child or adolescent's risk of harm status or sudden deteriorations in functioning. Reevaluation using the dimension scales of CALOCUS may yield a composite score supporting admission to level six. When more restrictive or intensive services are provided outside of the residential unit or wraparound plan, the staff of all involved service components should collaborate with the family to plan a timely return to lower levels of care. In addition, the treatment plan should be reviewed for adequacy in meeting the child or adolescent's fluctuating needs.

- 4. Care Environment** - When care at Level Five is provided institutionally, living space must be provided that offers reasonable protection and safety given the developmental status of the child or adolescent. Physical barriers preventing easy egress from or entry to the facility may be used, but doors at Level Five facilities are not locked. Staffing and engagement are the primary methods of providing security both in facilities and in home-based plans. Staffing patterns should be adequate to accommodate episodes of aggressive and/or endangering behavior of moderate duration (e.g., sufficient staff should be available to both monitor a safe room for unlocked seclusion and maintain supervision of the other children or adolescents). Capacity for transporting residents off-campus for educational or recreational activities is a critical element of Level Five services.

Level Five facilities should be located as near as possible to the child or adolescent's home. In addition, facilities for Level Five activities should incorporate ease of access (e.g., proximity to public transportation, schools, social services agencies, etc.); adequate design (e.g., accommodation for families with disabled or special needs members, play areas for children); and specific service needs (e.g., supervised day care so that parents can participate, resources for non-English speaking and/or hearing-impaired people, etc.). Facilities should be safe and comfortable for children and adolescents at all developmental levels, as well as for their families.

### ***Placement Criteria***

Children and adolescents with scores in the range of 23-27 generally may begin treatment at, or may be transitioned into, Level Five services. Placement at Level Five indicates that the child or adolescent either does not need more intensive services, or has successfully completed treatment at a more intensive level and primarily needs assistance in maintaining gains. Consideration for Level Five services should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff or in consultation with culturally competent specialists.

## LEVEL SIX: Medically Managed Residence-based Services

Level Six services are the most restrictive and often, but not necessarily, the most intensive in the level of care continuum. Traditionally, Level Six services have been provided in a secure facility such as a hospital or locked residential program. This level of care also may be provided through intensive application of mental health and medical services in a juvenile detention and/or educational facility, provided that these facilities are able to adhere to medical and psychiatric care standards needed at Level Six. Although high levels of restrictiveness are typically required for effective intervention at Level Six, every effort to reduce, as feasible, the duration and pervasiveness of restrictiveness is desirable to minimize its negative effects. With the expectation that individuals utilizing these services will almost always have complex needs, these services should be welcoming to individuals who have multiple conditions, and should be able to address all of these conditions expertly.

Payer authorization is usually required for this level of service. Reviews of revised CALOCUS assessments should not be more often than every three days for acute intensive care settings such as inpatient psychiatric hospitals, and no more than every month for long term secure care services such as state hospitals or community based locked facilities. Professionals providing services should be appropriately licensed and certified and should include a full array of disciplines including rehabilitation, addiction, and medical specialists. Some support services may be provided by paraprofessionals, including family and peer specialists, who have been trained and/or certified.

- 1. Clinical Services** - Clinical services must be comprehensive and relevant to safety issues that may arise. Children and adolescents at Level Six require monitoring and observation on a 24-hour basis. Treatment modalities may include individual, group, and intensive family therapy as well as medication management, and are aimed at managing the crisis, restoring previous levels of functioning, and decreasing risk of harm. The treatment plan must be family-centered and must address management of aggressive and/or suicidal or self-endangering behavior. Access to pediatric or family physician should be available within the hospital community as consultants as needed for management of medical issues.

The team's child and adolescent psychiatrist should consult regularly with the hospital and the family and the wraparound team to assure integration of Level Six services with the care provided at previous levels of care. Uncomplicated or specialized transition plans may be necessary, depending on the child or adolescent's or family's needs during step-down. All children and adolescents leaving Level Six services must have a well-defined crisis plan that anticipates and accommodates complications during transition to lower levels of care.

- 2. Support Services** - All necessities of living and well being must be provided for children and adolescents treated at Level Six. Children's legal, educational, recreational, vocational, and spiritual needs should be assessed according to individual needs and culture. Social and cultural factors must be considered in discharge planning. A wraparound team should be created, if not already in place, mobilizing the strengths of the child or adolescent and family to provide support during the crisis and in aftercare. When capable, children and adolescents should be encouraged to participate in treatment planning, both with the hospital team and with the wraparound process. Families are likely to need support for financial, housing, child-care, vocational, and/or educational services. Case management for coordination of services provided after transition to lower care levels should begin while the child or adolescent receives Level Six services. Transition planning should include integration of the child or adolescent into the home and community, and linkage with social services, education, juvenile justice, and recreational resources as needed and in coordination with the hospital discharge planner. All support services should be described in the wraparound plan.

- 3. Crisis Stabilization and Prevention Services** - At Level Six, crisis services involve rapid response to fluctuations in psychiatric and/or medical status. Crisis stabilization may include seclusion and/or restraint interventions as well as crisis medication, under the supervision of a child and adolescent psychiatrist or other professional within their scope of practice. All efforts must be made to avoid the trauma of seclusion and restraint, and de-escalation techniques must be employed whenever possible, prior to consideration of more extreme measures. Emergency medical services should be available on-site or in close proximity and all staff should have training in emergency protocols.
- 4. Care Environment** - In most cases, Level Six care is provided in a closed and locked facility. Alternative settings must have an equivalent capacity for providing a secure environment. Facilities should have space that is quiet and free of potentially harmful items, with adequate staffing to monitor child or adolescent using such a space (e.g., seclusion, restraint, and/or holding). Facilities and staff also should provide protection from potential abuse from others. Level Six facilities should be capable of providing involuntary care.

Level Six facilities, or their alternatives, should be located as near as possible to the child or adolescent's home. In addition, these facilities should incorporate ease of access (e.g., proximity to public transportation; adequate design (e.g., accommodation for families with disabled or special needs members and specific service needs (e.g., supervised day care so that parents can visit, resources for non-English speaking and/or hearing-impaired people, etc.)). The facilities should be safe and comfortable for all children and adolescents admitted to the facility at all developmental levels, as well as for their families.

#### ***Placement Criteria***

Children and adolescents with scores of 28 or higher are appropriate for treatment at Level Six. Consideration for this level of care should include the age, size, and manageability of the child or adolescent, and the family and community resources available. Placement determinations should be made by culturally competent staff and/or with consultation by cultural competency specialists.