

Intensive Residential Treatment Services -IRTS

Program Description

A highly structured non-hospital based treatment setting that brings comprehensive and specialized diagnostic and treatment services to youth and their families. The youth approved for these programs require exceptional care on a 24/7 basis in a safe environment with continuous line of sight supervision, medication management, and a concentrated individualized treatment protocol.

The majority of those referred for the IRTS programs will be youth who have received inpatient services in one of the nine CCIS's or private psychiatric hospitals and cannot be maintained in lower level community program with a reasonable degree of safety. The IRTS programs are not authorized to use mechanical restraint or any form of locked seclusion.

Criteria

Inclusionary Criteria

The youth must meet criteria A through E.

- A. Child/youth presents symptoms consistent with a DSM IV (Axis I-V) diagnosis and requires therapeutic intervention.
- B. The child/youth meets the age range for the specific IRTS (11-13) or (14-17)
- C. The child/youth is not sufficiently stable to be treated outside a highly structured, 24-hour therapeutic environment.
- D. The child/youth is sufficiently stable to be treated in a community-based setting that is less restrictive than a hospital.
- E. The Strength and Needs Assessment (SNA) and other relevant clinical information indicate that the child/youth needs the IRTS level of care.

The youth meets any ONE of the following:

- F. The child/youth is a potential danger to self as exemplified by suicidal ideation without a plan or by being prone to self-harm.
- G. The child/youth is a potential danger to others but maintains

	some level of impulse control. He/she may manifest any of the following: verbal abuse, overreactions to mild provocation, destruction to property, harms others, intimidates or threatens others by physical and/or verbal aggression, abuses animals, reports violent fantasies and is assessed as “at risk” for acting out. H. The child/youth manifests psychotic symptoms that are disruptive to daily functioning but do not require inpatient hospitalization. Symptoms may include loose associations, or marked suspiciousness, or delusions, or he/she may respond to internal stimuli. I. The child/youth demonstrates a disturbance of mood that interferes with personal, family or school functioning and/or responsibilities. Symptoms may include mood swings, irritability, and diminished interest in pleasurable activities, withdrawal, fatigue, and loss of appetite, trouble sleeping, difficulty concentrating or a general loss of energy. J. The child/youth demonstrates a daily loss of impulse control resulting in unpredictable, inappropriate behavior in multiple settings such as home, school and with peers. His/her behaviors suddenly and significantly changes. K. The child/youth is unable to adequately function in multiple areas and requires constant supervision. He/she consistently manifests bizarre behaviors, may be very isolated or withdrawn, is unable to relate to others and his/her personal hygiene is impaired. L. The child/youth manifests poor judgment and lacks problem-solving skills to the extent that he/she might inadvertently place him/herself in life threatening situations. There is also a total lack of acceptance of problems and responsibility for their solutions.
Psychosocial, Occupational, Cultural and Linguistic Factors	<i>These factors may change the risk assessment and should be considered when making level of care decisions</i>
Exclusion Criteria	Any of the following is sufficient for exclusion from this level of care: A. The child/youth is at imminent risk of causing serious harm to self or others.

	B. The Strengths and Needs Assessment (SNA) and other relevant clinical information indicate that the child/youth needs a more (or less) intensive level of care. C. The child/youth manifests behavioral and/or psychiatric symptoms that require a more intensive level of care. D. The child/youth can be safely maintained and effectively treated in a less intensive level of care. E. The child/youth and/or parent/guardian/custodian do not voluntarily consent to treatment and there is no court order requiring such placement. F. Primary diagnosis is substance abuse or dependence. G. The child/youth has a sole presenting diagnosis of Conduct Disorder. H. The child/youth's sole diagnosis is Developmental Disability that may include one of the following: • The child/youth has a sole diagnosis of Autism and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/ behaviors consistent with a DSM IV Axis I Diagnosis. • The child/ youth has a sole diagnosis of Mental Retardation/ Cognitive Impairment and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/ behaviors consistent with a DSM IV Axis I Diagnosis. • The child/youth has a diagnosis of autism and or mental retardation and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/ behaviors consistent with a DSM IV Axis I Diagnosis.
Continued Stay Criteria	All of the following criteria are necessary for continuing treatment at this level of care: A. The severity of the behavioral/emotional disturbance continues to meet the criteria for this level of care. B. The SNA Assessment and other relevant information indicate that the child/youth continues to need the Intensive Residential Treatment Service level of care. C. The child/youth's treatment does not require a more

	intensive level of care and no less intensive level of care would be appropriate. D. Services at this level of care continue to be required to support reintegration of the child/youth into a less restrictive environment. E. The individualized treatment plan is appropriate to the child/youth's changing condition with realistic and specific goals and objectives that include target dates for accomplishment. F. The child/youth and the parent/guardian/caregiver are participating in treatment to the extent all parties are able. G. Individualized services and treatments are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice. H. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms. However, some goals of treatment have not yet been achieved; and adjustments in treatment plan include strategies for achieving these unmet goals. I. When clinically necessary, appropriate psychopharmacological evaluation has been completed and ongoing treatment is initiated and monitored. J. There is documented evidence of active, individualized discharge planning.
Discharge Criteria	Any of the following criteria are sufficient for discharge from this level of care: A. The child/youth's documented treatment plan goals and objectives for this level of care have been substantially met. B. The child/youth meets the criteria for a more (or less) intensive level of care. C. The SNA Assessment and other relevant information indicate that the child/youth need a more (or less) intensive level of care.

	D. Consent for treatment is withdrawn by the parent/guardian/custodian and/or the child/youth. E. Support systems (which allow the child/youth to be maintained in a less restrictive level of care) have been thoroughly explored and/or secured. F. The child/youth and the parent/guardian/custodian are competent but non-participatory in treatment or in following the program rules and regulations. The non-participation is of such a degree that treatment, at this level of care, is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues. G. The child/youth is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care despite treatment planning changes. H. A discharge plan with follow-up appointments is in place; and the first follow-up appointment will take place within 10 calendar days of discharge.
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