Overview

Select Level of Care
Residential Treatment Center

Notes

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Overview

Informational Notes

The Child and Adolescent Psychiatry criteria are for the review of patients who are ages 4 thru 17, unless otherwise specified within a specific level of care.

InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender reassignment via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender−specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

InterQual® criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence−based literature and include input from our independent panel of clinical experts. To generate the most appropriate recommendations, a comprehensive literature review of the clinical evidence was conducted. Sources searched included the Agency for Healthcare Research and Quality (AHRQ) Effective Health Care Program, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Psychological Association, American Society of Addiction Medicine, Centers for Medicare and Medicaid Services, Choosing Wisely, Cochrane Library, National Institute of Alcohol Abuse and Alcoholism, National Institute for Health and Care Excellence, National Institute on Drug Abuse, PubMed, Substance Abuse and Mental Health Services Administration, and other key medical societies. The Association of Ambulatory Behavioral Healthcare, Commission on Accreditation of Rehabilitation Facilities, and the Joint Commission were also searched. Other medical literature databases, medical content providers, data sources, regulatory body websites, and specialty society resources may also have been utilized. Relevant studies were assessed for risk of bias following principles described in the Cochrane Handbook. The resulting evidence was assessed for consistency, directness, precision, effect size, and publication bias. Observational trials were also evaluated for the presence of a dose−response gradient and the likely effect of plausible confounders.
RESIDENTIAL TREATMENT CENTER, One: (1)

- **Episode Day 1, ≥ One:**
  - Eating disorder symptom severe and unable to be managed at less intensive level of care, All:
    - Support system, ≥ One: (2)
      - Expected sabotage of treatment (3)
      - Unable to ensure safety (4)
      - Unable to manage intensity of symptoms (5)
      - Unavailable (6)
    - Symptom, ≥ One:
      - Current weight more than 75%(0.75) but less than or equal 80%(0.80) IBW (7, 8)
      - Food refusal or inadequate nutritional intake
      - Purging at least 5 times daily (9)
      - Restricting food intake at most or all meals
      - Self-induced vomiting after most or all meals
      - Status post acute medical treatment for life-threatening complication of eating disorder
    - Treatment not expected to be successful in less intensive level of care and requires intensive structured treatment and medical monitoring to prevent further deterioration in condition, ≥ One:
      - Need for external structure, ≥ One:
        - Needs external limits to prevent over-exercising (10)
        - Needs supervision at all meals or will restrict
        - Needs support from others to refrain from purging (11)
        - Preoccupied with intrusive or repetitive thoughts about eating or weight or body image 4 hours or more daily (12)
        - Supervised Living or Partial Hospital Program or Intensive Outpatient Program attempted and unsuccessful
    - Serious emotional disturbance or autism spectrum disorder or intellectual developmental disability and age 6 thru 17, All: (13, 14)
    - Functional impairment severe, ≥ One:
      - Unable or unwilling to follow instructions or negotiate needs (15)
      - Unable to maintain behavioral control for more than 48 hours (16)
    - Support system, ≥ One: (2)
      - Abusive (17, 18)
      - High-risk environment (19)
      - Intentional sabotage of treatment while engaged in intensive community-based treatment (3)
      - Unable to ensure safety (4)
      - Unable to manage intensity of symptoms
      - Unavailable (6)
    - Symptom, Both:
      - Persistent or repetitive over at least 6 months
    - Unable to be managed safely within the community, ≥ One:
      - Aggression unresponsive to adult de-escalation or direction (20, 21)
      - Angry outbursts causing harm to self or others or property (22)
      - Daredevil behavior (23)
      - Delusions (24)
      - Disorganized thoughts or speech or behavior (25, 26)
      - Fire setting
      - Hallucinations (27)
      - Hypomanic symptoms increased (28)
      - Nonsuicidal self-injury (29)
      - Persistent violation of court orders (30)
      - Poor impulse control with harm to self or others and unresponsive to adult intervention * (31)
      - Repeated arrest or confirmed illegal activity (32)
      - Runaway for more than 24 hours and places self in dangerous situations (33)
      - Sexually inappropriate or abusive (34)
  - **Episode Day 2−15, One:**
    - Symptom improved and discharge expected today, One: (35)
      - Caregiver or patient demonstrates ability to manage condition and condition does not require daily monitoring (see Outpatient criteria)
High risk of hospitalization (see Intensive Outpatient Program criteria), Both:
- Impairment in daily functioning
- Moderate symptoms of disorder

Patient with serious emotional disturbance or autism spectrum disorder or intellectual disability, ≥ One:
- Able to live within community with intensive support (see Intensive Community-Based Treatment criteria)

Symptom of psychiatric disorder interferes with ability to function in school setting and imminent risk of school failure (See Day Treatment Program), Both:
- Persistent and severe functional impairment over last 6 months
- Support system agrees to participate in treatment and unsuccessful implementing interventions

Patient requires structured program and clinical assessment at least 5 days per week (see Partial Hospital Program criteria), All:
- High risk of hospitalization
- Support able to provide monitoring or assistance during non-program hours
- Symptoms severe

Symptom improving or expected to improve and not clinically stable for discharge, ≥ One:

Eating Disorder, Both:
- Intervention within last week, All:
  - Clinical assessment at least 1 time per day
  - Individual or group or family therapy at least 3 times per day
  - Individualized treatment plan and supervised activities
  - Nutritional assessment daily
  - Psychiatric or medication evaluation at least 1 time per week
  - School or vocational program
  - Weight measurement at least 1 time per week

Symptom within last week, ≥ One:
- Pronounced body image distortion
- Unable to judge amount of food to eat at all meals
- Unable to make appropriate food choices without assistance or supervision at all meals

Unachieved prescribed weight or behaviors to prevent weight gain, ≥ One:
- Attempting to restrict at meals even when supervised by staff
- Discarding food from most meals
- Excessive or compulsive exercising without external limits
- Persistent decline in oral intake
- Sabotage of weight measurement
- Self-induced vomiting after meals when not supervised
- Restricting at meals when not supervised
- Weight gain less than 2 lb (0.9 kg) per week and consuming prescribed calories for therapeutic weight gain
- Weight loss and weight more than 75%(0.75) but less than or equal 80%(0.80) IBW
- Uncontrolled ritualistic or compulsive eating behavior at all meals

Serious emotional disturbance or autism spectrum disorder or intellectual disability, All:

Functioning within last week, ≥ One:
- Age 6 thru 12 and school refusal or daily resistance to school attendance

Improved independent functioning, Both:
- Discharge planned within next week
- Therapeutic passes planned to transition to alternate level of care

Interpersonal conflict, ≥ One:
- Hostile or intimidating in most interactions
- Persistently argumentative when given direction
- Poor or intrusive boundaries causing anger in others and requiring frequent staff intervention
- Threatening
- Unable to establish positive peer or adult relationships
- Repeated privilege restriction or loss of privileges
- Unable or unwilling to follow instructions or negotiate needs
- Unresponsive to staff direction or limits

- Intervention within last week, **All:**
  - Behavioral contract or symptom management plan (52)
  - Clinical assessment at least 1 time per day (38)
  - Individual or family psychoeducation
  - Individual or group or family therapy at least 3 times per week (53, 54)
  - Psychiatric evaluation at least 1 time per week (55)
  - School or vocational program

- Symptom within last week, ≥ **One:**
  - Aggressive or assaultive behavior (56)
  - Angry outbursts (22)
  - Depersonalization or derealization (57, 58)
  - Destruction of property (59)
  - Easily frustrated and poor impulse control (60)
  - Homicidal ideation without intent
  - Hypervigilance or paranoia (61, 62)
  - Nonsuicidal self-injury (29)
  - Persistent rule violations

- Psychiatric medication refractory or resistant and symptoms increasing or persisting, ≥ **One:** (63)
  - Anxiety and associated symptom (64, 65)
  - Depressive disorder or major depressive episode and associated symptoms (66)
  - Hypomanic symptom (28)
  - Obsessive or compulsive disorder (67, 68)
  - Psychosis and associated symptom (69)
  - Psychomotor agitation or retardation (70, 71)
  - Runaway from facility or while on home pass
  - Sexually inappropriate (72)
  - Suicidal ideation without intent (73)

- Symptom improved and discharge planned within next week, ≥ **One:**
  - Family or guardian requires further intervention and return to family planned
  - Treatment goals not met (74)

- **Symptom worsening** and more intensive level of care indicated, **One:** (75)
  - Acute danger to self and others or gravely disabled (see Inpatient criteria) (76)
  - Age 13 thru 17 with severe withdrawal potential or withdrawal syndrome severe or life threatening (see InterQual® Substance Use Disorders Inpatient Detoxification criteria)

- **Episode Day 16–X, Extended Stay, One:**

- **Symptom improved** and discharge expected today, ≥ **One:** (35)
  - Caregiver or patient demonstrates ability to manage condition and condition does not require daily monitoring (see Outpatient criteria)

- **High risk of hospitalization** (see Intensive Outpatient Program criteria), **Both:**
  - Impairment in daily functioning
  - Moderate symptoms of disorder (36)

- **Patient with serious emotional disturbance or autism spectrum disorder or intellectual disability, One:** (13)
  - Able to live within community with intensive support (see Intensive Community-Based Treatment criteria)

- **Symptom of psychiatric disorder interferes with ability to function in school setting and imminent risk of school failure** (See Day Treatment Program), **Both:**
  - Persistent and severe functional impairment over last 6 months
  - Support system agrees to participate in treatment and unsuccessful implementing interventions (37)

- **Patient requires structured program and clinical assessment at least 5 days per week** (see Partial Hospital Program criteria), **All:**
  - High risk of hospitalization
  - Support able to provide monitoring or assistance during non-program hours
  - Symptoms severe (36)
  - High risk of harm to self or others without intensive supervision within the community (see Supervised Living criteria)

- **Symptom improving or expected to improve** and not clinically stable for discharge, ≥ **One:**
Eating Disorder, Both:
- Intervention within last week, All:
  - Clinical assessment at least 1 time per day (38)
  - Individual or group or family therapy at least 3 times per day (39)
  - Individualized treatment plan and supervised activities (40, 41)
  - Nutritional assessment daily
  - Psychiatric or medication evaluation at least 1 time per week
  - School or vocational program
  - Weight measurement at least 1 time per week

Symptom within last week, ≥ One:
- Pronounced body image distortion (42)
- Unable to judge amount of food to eat at all meals
- Unable to make appropriate food choices without assistance or supervision at all meals

Unachieved prescribed weight or behaviors to prevent weight gain, ≥ One: (43)
- Attempting to restrict at meals even when supervised by staff
- Discarding food from most meals
- Excessive or compulsive exercising without external limits (44)
- Persistent decline in oral intake
- Sabotage of weight measurement
- Self-induced vomiting after meals when not supervised (45, 46)
- Restricting at meals when not supervised
- Weight gain less than 2 lb(0.9 kg) per week and consuming prescribed calories for therapeutic weight gain
- Weight loss and weight more than 75%(0.75) but less than or equal 80%(0.80) IBW (7, 8)
- Uncontrolled ritualistic or compulsive eating behavior at all meals (47, 48)

Serious emotional disturbance or autism spectrum disorder or intellectual disability, All: (13)

Functioning within last week, ≥ One:
- Age 6 thru 12 and school refusal or daily resistance to school attendance (49)

Improved independent functioning, Both:
- Discharge planned within next week
- Therapeutic passes planned to transition to alternate level of care

Interpersonal conflict, ≥ One:
- Hostile or intimidating in most interactions (50)
- Persistently argumentative when given direction
- Poor or intrusive boundaries causing anger in others and requiring frequent staff intervention (51)
- Threatening
- Unable to establish positive peer or adult relationships
- Repeated privilege restriction or loss of privileges (77)
- Unable or unwilling to follow instructions or negotiate needs (15)
- Unresponsive to staff direction or limits

Intervention within last week, All:
- Behavioral contract or symptom management plan (52)
- Clinical assessment at least 1 time per day (38)
- Individual or group or family therapy at least 3 times per week (53, 54)
- Individual or family psychoeducation
- Psychiatric evaluation at least 1 time per week (55)
- School or vocational program

Symptom within last week, ≥ One:
- Aggressive or assualtive behavior (56)
- Angry outbursts (22)
- Depersonalization or derealization (57, 58)
- Destruction of property (59)
- Easily frustrated and poor impulse control (60)
- Homicidal ideation without intent
- Hypervigilance or paranoia (61, 62)
- Nonsuicidal self-injury (29)
- Persistent rule violations
Psychiatric medication refractory or resistant and symptoms increasing or persisting, \( \geq \textbf{One:} \) (63)
- Anxiety and associated symptom (64, 65)
- Depressive disorder or major depressive episode and associated symptoms (66)
- Hypomanic symptom (28)
- Obsessive or compulsive disorder (67, 68)
- Psychosis and associated symptom (69)
- Psychomotor agitation or retardation (70, 71)
- Runaway from facility or while on home pass
- Sexually inappropriate (72)
- Suicidal ideation without intent (73)

Symptom improved and discharge planned within next week, \( \geq \textbf{One:} \)
- Family or guardian requires further intervention and return to family planned
- Treatment goals not met (74)

Symptom worsening and more intensive level of care indicated, \( \textbf{One:} \) (75)
- Acute danger to self and others or gravely disabled (see Inpatient criteria) (76)
- Age 13 thru 17 with severe withdrawal potential or withdrawal syndrome severe or life threatening (see InterQual® Substance Use Disorders Inpatient Detoxification criteria)
Notes:

1: Introduction
The residential treatment center criteria is used for a patient who has been admitted or is expected to be admitted to a psychiatric residential treatment center. There is lack of evidence to support the effectiveness of this level of treatment over less restrictive levels of care for individuals with a viable living environment, therefore it is only recommended in cases where an individual cannot be managed safely in the community yet doesn't require the services of an inpatient hospitalization. A psychiatric residential treatment center is a licensed residential facility that provides medical monitoring and 24-hour individualized treatment to a group of individuals. The treatment is provided by paid staff unrelated to the individual.

Evaluation and Treatment
Programming may differ based upon legislative and geographical variances and is subject to organizational policy, however, at a minimum it should include:
- Awake adult supervision 24 hours per day
- Clinical assessment at least 1 time per day
- Individual, group, or family therapy at least 3 times per week
- Medical history and physical examination within 12 months prior to admission or within 30 days after admission, unless otherwise medically indicated (The Joint Commission, Comprehensive Accreditation Manual for Behavioral Health Care, 2017)
- Medication reconciliation initiated within 24 hours
- Individualized goal-directed treatment plan within 1 week (Work Group on Healthcare Access and Economics, 2010)
- Nursing staff on-site or on-call 24 hours per day
- Parent training for patient's parents or guardians if return to family is expected
- Preliminary discharge plan initiated with 24 hours
- Psychiatric evaluation, initial within 1 business day, subsequent at least 1 time per week (Work Group on Healthcare Access and Economics, 2010)
- Psychosocial assessment and substance evaluation within 48 hours
- School or vocational program
- Toxicology screen, quantitative drug analysis, self-help, 12-step, or education group as needed

2: Support system includes social, emotional, caregiving, or environmental resources that can provide empathy, structure, oversight, or tangible aids such as goods, services, and housing:
- Formal supports consist of social welfare, social service, and health care providers or agencies.
- Informal supports include family, friends, educators, clergy, sponsors, church groups, neighborhood organizations, clubs, and self-help groups.

3: Intentional sabotage of treatment by a support person is purposeful and may include the following:
- Canceling therapy sessions or withdrawing transportation for the patient to the therapy sessions
- Failing to fill prescriptions, not dispensing or administering medications when needed, or not supervising medication ingestion to ensure adherence
- Intentionally undermining the therapeutic relationship between the patient and the treatment provider(s)
- Violating restraining orders

4: A support system's inability to ensure safety refers to the safety of the individual or the safety or others.

5: A support system that is unable to manage the intensity of symptoms may be unable to provide the required supervision needed due to the severity of the symptoms. This is an indicator of the patient's severity of illness, and unless grossly negligent or enabling, may not positively correlate to the support system's level of concern, or attempts to support the individual.

6:
Unavailable support refers to the patient who lacks the support needed to ensure safety or facilitate recovery so the patient can be therapeutically managed in a less intensive level of care.

7: Ideal body weight (IBW) is a weight that is believed to be the maximum healthy weight for a person. It is based primarily on height, but can be modified by factors such as gender, age, body build, and degree of muscular development. No single formula for calculating IBW is universally employed. Multiple calculators of IBW can be found online which calculate IBW based on just height, or based on height, age, and gender. Utilizing the same calculation for all cases will ensure consistent application of the criteria. Organizational policy determines which calculation should be used to determine IBW.

8: Evidence in the medical literature to support the effectiveness of this intervention or service is mixed or unclear. The criteria point reflects current best evidence and practice. It is the product of a peer review process involving multiple clinicians with diverse expertise in varied practice and geographic settings.

9: Purging refers to the methods patients with eating disorders use to rid themselves of food that has been ingested. Such methods include, but are not limited to, use of diuretics, laxatives, and enemas or self-induced vomiting.

10: External limits consist of restrictions placed on exercising, and interventions to limit or prevent exercising, by program staff.

11: Support from others consists of supportive discussions with and/or interventions by program staff and/or peers at times when the patient is experiencing urges to purge or is demonstrating behavior that suggests urges to purge, e.g. heading to a bathroom immediately after a meal.

12: The American Psychiatric Association guidelines for the treatment of eating disorders indicate that preoccupation with repetitive thoughts about eating, weight, or body image for 4 to 6 hours daily or more is an indication for residential treatment (American Psychiatric Association, Practice guideline for the treatment of patients with eating disorders, third edition, 2006, p. 1097–222).

13: Serious emotional disturbance refers to an individual who is under the age of 18 and has a diagnosed psychiatric disorder within the last 12 months that substantially limits or interferes with the ability to achieve or maintain developmentally appropriate adaptive, behavioral, cognitive, communication, or social skills. The federal definition excludes developmental disorders and substance use disorders. Some states have extended the age to 22 but that is dependent on the state (Substance Abuse and Mental Health Services Administration, Definition of children with a serious emotional disturbance. 1993).

14: The criteria does not address individuals under the age of 6 due to the lack of consensus, evidence, or guidelines recommending this level of care.

15: Patients unable or unwilling to follow instructions or negotiate needs require constant redirection or intervention. Patients may be unable or unwilling to follow the simplest of directions (e.g., go to their room, take their medications, and take a shower), request assistance when needed, or negotiate for themselves. The behavior may or may not be volitional, but is due to the symptoms of the psychiatric illness (e.g., hallucinations, delusions, euphoria, anxiety, hyperactivity, or disruptive behavior).

16:
Impulsivity, angry outbursts, self-destructiveness, and/or aggressive actions are the result of a patient's inability to maintain behavioral control.

17: An abusive support system is one in which the patient is a witness to or a target of abuse. Abuse is a severe form of mistreatment that can be physical, sexual, or emotional. If abuse of a child or adolescent is suspected or identified, a report may need to be filed with the appropriate child protective agency.

18: Health care workers and mental health professionals may be mandated to report suspected abuse or neglect of a child or adolescent to child protective services or law enforcement officials.

19: A high-risk environment refers to a living situation that poses a significantly increased risk for the patient due to the caregiver's uncontrolled psychiatric or substance use disorder or dangerous or illegal behaviors (e.g., drug dealing, prostitution). These may result in misuse of family income or other resources, unsanitary living conditions, and/or exposing the patient to dangerous individuals.

20: Aggression is hostile, injurious, or destructive behavior. This can include behaviors such as biting, kicking, pinching, bullying, cruelty to animals, or threatening behavior.

21: De-escalation refers to techniques used for distraction, calming, or to encourage relaxation in an agitated individual (National Institute for Health and Care Excellence, Transition between inpatient mental health settings and community or care home settings. Clinical guideline 53. 2016).

22: Angry outbursts can include, but are not limited to, punching a fist into the wall, throwing or smashing items, or tantrums of yelling and screaming.

23: Daredevil behavior involves risk-taking or sensation-seeking and involves participating in potentially dangerous behaviors without taking the proper safety precautions or examining the risks. Children and adolescents often minimize or deny the risks involved in their behavior. Daredevil behaviors can include, but are not limited to:
- Body planking – the individual attempts to balance his/her body on ledges of high buildings or other dangerous areas
- Choking game – the individual attempts to choke themselves until directly before losing consciousness to get a high; this can also be done by a peer choking another peer for the same purpose
- Kiki challenge – the individual driving a vehicle gets out while the vehicle is moving and sings and dances with the door open while being videoed
- Laying, walking, or staying in a vehicle parked on train tracks when a train is coming
- Riding a bicycle or skateboard into ongoing traffic
Daredevil behavior combined with substance use may present an increased risk for serious harm to self or others.

24: Delusions are false beliefs that do not conform to reality and are not affected by clear evidence to the contrary.

25: Disorganized thinking is evident when the listener cannot understand how or why the patient has moved from one topic to the next. There is little or no meaningful relationship between ideas, topics, or themes. This can range from being "derailed" or "off-track" to tangential or incoherent speech. Speech is not only evaluated for coherence but for rate, volume, and pressure.
Disorganized behavior refers to non-goal-directed or purposeless behavior including, but not limited to, aimlessness, inability to start or complete a task, or sequencing problems.

A hallucination is a sensory perception that occurs without external stimulation of the sensory organ (e.g., vision, hearing, touch, taste, smell). Patients may or may not be able to distinguish between the hallucination and reality. Types of hallucinations are:
- Auditory: a false perception of sound, typically voices that are experienced as coming from either inside or outside of one's head and are different from one's own thoughts. Command hallucinations consist of a false perception of a voice telling the patient to do something, typically destructive to oneself or others
- Gustatory: a false perception of taste, usually unpleasant
- Olfactory: a false perception of smell, usually unpleasant
- Somatic: a false perception of a physical experience within the body
- Tactile: a false perception of being touched or of something on or under the skin (e.g., bugs crawling)
- Visual: falsely perceived images, either formed (e.g., people) or unformed (e.g., flashes of light)

Hypomania is marked by an abnormally elevated, expansive, or irritable mood with increased energy or activity, but symptoms do not include psychosis or marked impairment in social or occupational functioning. Associated symptoms can include:
- Decreased need for sleep
- Distractibility
- Excessive involvement in activities with the potential for painful consequences
- Flight of ideas
- Grandiosity
- Increased goal-directed activity
- Increased talkativeness
- Inflated self-esteem
- Pressured speech
- Psychomotor agitation
- Racing thoughts


Nonsuicidal self-injury refers to the intentional damaging of any part of one's body (e.g., cutting or burning the skin) without suicidal intent. In young children, it may also be exhibited as persistent head-banging.

Violations of court orders can include, but are not limited to, probation violations, curfew violations, violations of foster care service plans, or violations of restraining orders.

Poor impulse control refers to the inability of an individual to resist an urge or an impulse to engage in behavior that may be potentially dangerous to the patient or others (American Psychiatric Association, Diagnostic and statistical manual of mental disorders, fifth edition. 2013).

Illegal activity can include, but is not limited to, theft, destruction of property, assault, possession or dealing of illegal substances, driving while intoxicated, prostitution, and disorderly conduct.

Examples of dangerous situations a runaway may place themselves in can include, but are not limited to:
- Engaging in risky behavior such as substance use and/or unsafe sexual activity
• Involving self in situations where he or she can be exploited or victimized by predatory adults or in situations where there is lack of responsible adult supervision
• Living on the street
This criteria does not apply to a child or adolescent who runs away to a friend’s or relative’s house.

34:
Sexually inappropriate or abusive behaviors refer to the child’s or adolescent’s sexual behavior toward not only another child or adolescent, especially when the patient is older, but also towards family members, adult treaters, or caregivers. This behavior can include noncontact acts (e.g., sexually inappropriate play with inanimate objects, sexual comments, exhibitionism, masturbating in front of another); sexual contact (e.g., inappropriate rubbing or touching of others, inducing another to touch offender’s intimate parts); or penetration (e.g., digital, penile, or object).

35:
Selection of this criteria point indicates that the patient is responding to treatment and is clinically stable for discharge to an alternate level of care. To determine the most appropriate level of care go to the recommended level of care.

36:

37:
A support system refers to the person(s) or agency that has primary responsibility for the child and with whom the child resides most of the time. These individuals provide the child with social, emotional, and environmental resources and can be aided by case managers, case-workers, support-group sponsors, and friends.

38:
The clinical assessment must be completed by a licensed clinician.

39:

40:
Each patient should have an individualized goal-directed treatment plan. The plan should clearly articulate the primary problems for which the patient presents and interventions specific to the reduction or resolution of those problems.

41:
Activities that may need to be supervised include:
• Bathroom use
• Exercise
• Meal planning and selection
• Meals and snacks
Supervision may be necessary to intervene with or prevent restricting at meals or with snacks, to prevent self-induced vomiting after meals or snacks (including preventing bathroom or shower access for a period of time after meals or snacks if necessary), or to intervene with or prevent excessive or compulsive exercising.

42:
Many patients with eating disorders become preoccupied with a distorted perception of their body weight and shape, often considering themselves overweight or “fat” when in fact they are emaciated. Other patients may realize they are thin but experience a distorted perception of particular body areas such as the abdomen, buttocks, or thighs. This distorted body image can reach delusional status in patients with severe eating disorders.
Prescribed weight refers to the minimum weight threshold determined by a multidisciplinary treatment team that ensures a level of medical stability and cognitive functioning that allows a patient to be managed in an eating disorder program outside of an inpatient hospital or residential treatment setting.

External limits consist of interventions and limitations placed on physical activity or exercise by program staff.

A type of self-induced vomiting is known as "automatic vomiting." This refers to the ability to vomit at will without manual inducement.

Support from others consists of supportive discussions with and/or interventions by program staff and/or peers at times when the patient is experiencing urges to purge or is demonstrating behavior that suggests urges to purge, e.g. heading to a bathroom immediately after a meal.

Symptoms are considered to be uncontrolled when they persist despite therapeutic and/or pharmacologic interventions.

Rituals formed around food and eating are common in individuals with eating disorders and examples include, but are not limited to, excessive chewing but refusal to swallow food, cutting food into excessively small pieces, hoarding of food, excessive food preparation for others, and food ingestion in a particular manner or pattern.

Resistance refers to behavior that interferes with or seriously delays the child's preparation each day (e.g., repeatedly ignoring prompts to get out of bed, protracted dressing or hygiene activities, bargaining to avoid going, or attempts to use somatic complaints to avoid going). It also includes leaving school during the day.

Hostile interactions demonstrate significant animosity toward another person or group and involve behavior that is destructive in nature and purpose. Intimidating interactions threaten and terrorize others. These also include bullying, an attempt to assert interpersonal power through teasing, taunting, and fighting, and attempting to damage a victim's relationship with others. Intimidating interactions can be conducted not only when in close physical proximity to the victim, but also through less direct means, such as electronic communications (i.e., "cyberbullying"), notes, and threatening innuendo.

A patient who displays poor or intrusive boundaries has difficulty maintaining personal physical space, frequently interrupts and asks inappropriate questions, or exhibits interactions or behaviors that are inappropriate for the situation. These patients frequently require staff redirection and reminders regarding appropriate interactions.

A behavioral contract refers to a written or verbal agreement between the patient and provider or program. The behavioral contract should target problem behaviors, identify short-term measurable goals, and provide appropriate interventions.

Family therapy is essential in the treatment of a child or adolescent (American Psychiatric Association, Practice guideline for the treatment of patients with eating disorders, third edition, 2006, p. 1097–222). When a child or adolescent is in the custody of child protective services or involved in child welfare services, it is recommended that family therapy involve biological and foster family members unless reasons exist to not include them (Lee et al.,
Journal of the American Academy of Child and Adolescent Psychiatry 2015, 54: 502−17). Family therapy may be increased as the child or adolescent transitions to the home environment. Parent training may also be considered if a child or adolescent is expected to return home.

54: The residential treatment program should encourage family contact and should engage and support the family of a child or adolescent (Work Group on Healthcare Access and Economics, 2010).

55: It is recommended that a psychiatrist meet with the patient in a residential treatment center a minimum of once per week (Work Group on Healthcare Access and Economics, 2010).

56: Assaultive behavior is an attack on another individual that may result in bodily harm and also includes acts of physical, sexual, and domestic abuse.

57: Depersonalization is a change in a person’s perception or experience of personal identity. Patients often describe feeling detached or disconnected from themselves as if they are outside observers of their thoughts or bodies.

58: Derealization refers to the perception or experience of the external world as "unreal."

59: Destruction of property includes, but is not limited to, punching holes in walls and breaking chairs or other pieces of furniture.

60: Poor impulse control refers to the inability of an individual to resist an urge or an impulse to engage in behavior that may be excessive or potentially dangerous to themselves or others (American Psychiatric Association, Diagnostic and statistical manual of mental disorders, fifth edition. 2013).

61: Hypervigilance describes a heightened awareness and an increased level of sensitivity to external stimuli (e.g., other persons in a room, a faucet dripping, a clock ticking).

62: Paranoia refers to extreme suspiciousness or the false belief that one is being harassed, harmed, persecuted, or unfairly treated. Paranoid individuals may interpret the environment as being hostile when it is not. Examples of paranoia are fear of poisoning, concerns that one is being followed by or investigated by the police, and concerns that staff members may be agents of the devil. If these thoughts evolve into beliefs that are fixed and the patient does not respond to rational explanations, these thoughts qualify as delusions.

63: Medication refractory or resistant refers to a patient’s symptoms that fail to respond to medications when the literature−supported therapeutic drug level or dose is achieved.

64: Anxiety is an emotion that can become clinically significant when nervousness, dread, apprehension, or fear produces significant pain or impairment, or cannot be managed effectively.

65: In addition to subjective feelings of nervousness or anxiousness, other somatic, behavioral, and psychological symptoms can be associated with anxiety:
Behavioral symptoms include disturbed sleep, nightmares, acting "keyed up" or "on edge," and avoiding feared situations or objects.
- Psychological symptoms include depersonalization (feeling unreal); derealization (feeling that the world is unreal); fear of "going crazy," losing control, or dying; and difficulty concentrating.
- Somatic symptoms include palpitations (a pounding or accelerated heart rate); sweating, trembling, shaking, chills, or hot flashes; the sensation of shortness of breath, smothering, or choking; chest pain or discomfort; headache; nausea, vomiting, stomach aches, or other abdominal distress; diarrhea; urinary frequency; dizziness; paresthesia; or muscle tension.


Associated symptoms may include:
- Anhedonia
- Excessive or inappropriate guilt
- Excessive preoccupation with death or violence
- Fatigue
- Feelings of worthlessness
- Hopelessness
- Impaired ability to make decisions
- Loss of energy
- Loss of interest
- Loss of or excessive appetite
- Overeating
- Psychomotor agitation or retardation
- Sleep disturbance
- Unable to think clearly or concentrate
- Weight loss or lack of consistent weight gain

Obsessions are persistent, recurrent urges, thoughts, or images which the individual attempts to ignore or defuse by doing some other action such as counting, repetitive handwashing, or pacing (American Psychiatric Association, Diagnostic and statistical manual of mental disorders, fifth edition. 2013).

Compulsions are repetitive physical acts (e.g., hand washing, ordering, checking under bed, checking locks on door) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform to prevent or reduce distress or to prevent some dreaded event or situation.

Psychotic symptoms include:
- Delusions
- Disorganized behavior
- Disorganized thoughts or speech
- Hallucinations
- Negative symptoms: decreased range and intensity of emotional expression; alogia, or lack of thoughts or words (often referred to as poverty of speech); anhedonia, a lack of enjoyment in activities previously found pleasurable; apathy, a lack of motivation, restricted emotional and cognitive engagement, and diminished purposeful behavior; avolition, the inability to initiate or sustain goal-directed activity; and a lack of interest in social interactions.

Psychomotor agitation is excessive motor activity in association with an inner feeling of tension. The activity is usually repetitive and nonproductive (e.g., pacing, fidgeting, wringing of hands, inability to sit still).

Psychomotor retardation is reflected by slowness in thinking, body movement, and speech patterns (e.g., changes in
speed, volume, inflection, or content), as observed by the provider.

72: Sexually inappropriate behaviors can include predatory behavior, sexually inappropriate play with inanimate objects, public masturbation, inappropriate rubbing or touching of others, or requests to have others touch them or perform sexual acts on them.

73: Suicidal ideation includes not only active ideation that entails serious thoughts and/or plans to commit suicide but also passive ideation without an active plan, intent, or means. Passive ideation can present as a recurrent wish to die, or thoughts of dying in one's sleep.

74: Treatment goals must be specific to the patient and must be realistically attainable.

75: Selection of this criteria point indicates that the patient's symptom is worsening and may require a more intensive level of care. To determine the most appropriate level of care go to the recommended level of care.

76: Gravely disabled is a term that generally refers to an individual who, as a result of a psychiatric or substance use disorder, is in acute danger of serious physical harm due to an inability or failure to provide the essential human needs of food, clothing, shelter, and essential medical care. The individual lacks the capacity to make an informed decision concerning his/her need for treatment and lacks the support to provide needed care. Gravely disabled is a term most often used for the emergency involuntary commitment of an individual to an inpatient unit and the definition of gravely disabled may differ based on legislative and geographical variances.

77: A privilege restriction is the act of taking away a student's privileges for a designated length of time. Disruptive behavior or disciplinary problems can lead to restrictions in participation for recess, lunchroom, and field trips.