

Comprehensive Behavioral Health Management/College Health IPA Policy and Procedure Manual	
Policy Name: Clinical Pathway: Treatment of Minors	Utilization Management
Date: 2-00 Reviewed by QI Committee: 9-06, 9-07, 9-08, 9-09, 01-10 Revised by QI Committee: 9-06, 9-09, 01-10	Page: 1 of 6 Policy Number: UM-8.5

Purpose: The purpose of this policy is to provide guidance to Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) staff and providers when providing clinical services to minors, particularly children 12 years and under. This policy provides suggestions and recommended practices but does not prescribe treatment. The provider should consider these guidelines in the treatment of a patient but may depart from them when clinically indicated.

Policy:

1.0 Definition of Treatment Issues

Parents/guardians seek treatment for their children for a variety of concerns from academic problems to conduct problems. Typically at the time of initial presentation parents/guardians and minors are in acute crisis. They are experiencing guilt, anxiety, and depression. The family system has been disrupted and both minors and their parents/guardians are hopeful for some immediate resolution.

However, to adequately determine an appropriate course of treatment, a clinician must take time to complete a full psychosocial evaluation. Prior to beginning an evaluation, parents/guardians and minors need to be educated regarding the evaluation and treatment process, as well as expectations for participation. Parents/guardians should also be advised regarding a clinician's responsibility for reporting child abuse.

2.0 Evaluation

Initial evaluation may take up to two sessions to complete. During the first visit, clinicians may meet separately with the parent/guardian prior to meeting with the minor individually or family together. The primary purpose of the initial visit is to develop a therapeutic alliance with minor and parent/guardian and gather historical information. The initial assessment should include the following:

- 2.1 A thorough medical history to rule out symptoms related to a general medical condition. Questions should be asked regarding allergies, hearing or sight problems, and any history of head trauma. If the child has not had a recent medical exam, an immediate referral to the primary care physician should be recommended, and the clinician should obtain a written release from parents to coordinate care with the primary care physician.
- 2.2 Psychosocial evaluation including:
 - 2.2.1 Developmental history, including information regarding prenatal and perinatal problems, developmental milestones, and any academic problems, which may be indicative of an Attention Deficit Disorder or

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- Learning Disability. Clinicians should get written consent to speak with teachers and school personnel as needed. If academic problems are significant, the parents should be instructed to contact the school district to initiate academic testing and an Individualized Education Plan (IEP).
- 2.2.2 History of any suicidal, homicidal, and/or aggressive behaviors and consequences.
 - 2.2.3 History of any childhood abuse and consequences (e.g., past reports or involvement of County Children’s Services).
 - 2.2.4 Family history of mental health issues, including drug or alcohol abuse.
 - 2.2.5 Prior treatment history including school counseling, outpatient therapy, or hospitalization. Special attention should be given to medication history including type, dosage, when taken, for how long, compliance, and response.
 - 2.2.6 Family dynamics in regard to parenting techniques, interaction patterns, and parental stability.
- 2.3 Full Mental Status Exam with particular emphasis on insight, judgment, and impulse control.
- 2.4 Evaluation of current level of functioning including:
- 2.4.1 Sleep
 - 2.4.2 Appetite
 - 2.4.3 School Performance
 - 2.4.4 Peer Relationships
 - 2.4.5 Sibling Relationships
- 2.5 During the evaluation process, an Initial Treatment Plan Form is initiated. If a psychiatric referral is needed to complete the evaluation, the referring clinician, after obtaining Release of Confidentiality, should either fax the preliminary Initial Treatment Plan Form to the psychiatrist or should leave a voice mail for the psychiatrist with pertinent clinical information. If the initial referral is to a psychiatrist, he/she may receive authorization for a second 90801 by calling CBHM/CHIPA.
- 2.6 Following completion of the evaluation and diagnosis, clinicians should educate and engage parents in the treatment process. Education should include:
- 2.6.1 Diagnosis and recommended treatment plan.
 - 2.6.2 Expectations for parental involvement, including completion of homework assignments and follow-through with referrals.
 - 2.6.3 Appropriate referrals (e.g., parenting class, psychiatric consult, hearing or eye exam, etc.)

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3.0 Diagnosis

Clinicians need to be cautious about presenting a diagnosis to the parent/legal guardian and minor until the appropriate evaluation has been completed. A clinician may present a rule out diagnosis while ongoing evaluation is taking place. If after a complete psychosocial evaluation, medical evaluation, and psychiatric evaluation, a diagnosis is still unclear, clinician should seek authorization for psychological testing by completing the CBHM/CHIPA *Psychological Testing Plan Form*.

Besides the DSM-IVR Diagnostic Categories for “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence”, the following diagnoses should be considered when working with minors.

- 3.1 Adjustment Disorder, especially if any recent changes have occurred within the family system (e.g., move to new area and new school; separation of parents; death of grandparent, etc.).
- 3.2 Major Depression. This diagnosis is frequently overlooked in younger children because the symptoms are often attributed to other diagnoses. For example, children usually show more anxiety symptoms, somatic complaints, temper tantrums, and behavioral problems. In middle and late childhood, children may begin to self-report their symptoms as low self-esteem, guilt, and hopelessness.
- 3.3 Bi-Polar Disorder, especially if a strong family history is present.
- 3.4 Anxiety Disorders, especially Post-Traumatic Stress Disorder if a child has been a victim of abuse or trauma or Obsessive Compulsive Disorder if a child is demonstrating ritualistic behaviors.

4.0 Intervention

- 4.1 Family Therapy
 - 4.1.1 The primary treatment modality for minors should be family therapy in conjunction with medication management (when appropriate) and community referrals.
 - 4.1.2 The treatment plan should have specific time-limited behavioral goals, which can help parents/guardians to anticipate measurable change. Homework assignments practicing behavioral goals should be given at the end of each session. Focus should be building upon strengths while introducing new interventions.
 - 4.1.3 Treatment plans should include interventions, which help younger minors to identify and verbalize emotional states, such as play or art therapy. Involvement of parents in these “play” or “art” sessions can help to not

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only demonstrate and teach techniques, which can be practiced at home, but can also help to establish non-threatening bonds between younger minors and their parents/legal guardians.

4.1.4 As parental involvement is crucial to successful outcomes for treatment of minors, clinicians need to be responsible for ongoing communication with parents/guardians. This may often mean communicating with two sets of parents. All parents/guardians should be advised regarding confidentiality and limits of confidentiality, office hours, policy about returning routine calls, and how to contact clinician in emergency situations.

4.1.5 If during the course of treatment, parents/guardians are resistant to participate or are unable to participate due to their own mental health issues, recommendations should be made for the parents/guardians to seek another therapist for individual or conjoint counseling.

4.2 Medication Management

4.2.1 Medication may be an effective part of the treatment for several psychiatric disorders of childhood and adolescence. The physician who recommends medication should be experienced in using it to treat psychiatric illnesses in children and adolescents as many medications have not been approved by the FDA for use with children and adolescents, however, have been found to be effective. He or she should fully explain the reasons for its use, what benefits it should provide, its unwanted effects or dangers, and treatment alternatives. In particular, a physician prescribing antidepressants should alert parents to the possibility of increased suicidal ideation within the first weeks of use. When any medication is prescribed a follow-up appointment should be scheduled within two weeks.

4.2.2 Parents/Guardians should sign consent indicating understanding of all potential side effects and actions to take if side effects do occur.

4.2.3 Psychiatric medications may be prescribed for a number of problems. From less to more serious, these disorders include:

4.2.3.1 **Bedwetting** - if it persists regularly after age 5 and causes serious problems in low self-esteem and social interaction.

4.2.3.2 **Specific fears (phobias) or general anxiety** - if it keeps the youngster from normal daily activities.

4.2.3.3 **Attention deficit hyperactive disorder** - marked by a short attention span, trouble concentrating and restlessness. The child is easily upset and frustrated, and usually has trouble in school.

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- 4.2.3.4 **School phobia (separation anxiety)** - a fear of leaving home. The child refuses to go to school or repeatedly feels too sick to go.
- 4.2.3.5 **Depression** - lasting feelings of sadness, helplessness, hopelessness, unworthiness and guilt, inability to feel pleasure, a decline in schoolwork and changes in sleeping and eating habits.
- 4.2.3.6 **Eating disorder** - either self-starvation (anorexia nervosa) or binge eating and vomiting (bulimia), or a combination of the two.
- 4.2.3.7 **Manic-depressive condition** - periods of depression alternating with manic periods, which may include irritability, "high" or happy mood, excessive energy, behavior problems, staying up late at night, and grand plans.
- 4.2.3.8 **Psychosis** - symptoms include irrational beliefs, paranoia, hallucinations (e.g., seeing things or hearing sounds that don't exist) social withdrawal, clinging, strange behavior, extreme stubbornness, persistent rituals, and deterioration of personal habits.
- 4.2.4 There are major categories of psychiatric medication:
 - 4.2.4.1 **Stimulant medication** - such as dexedrine or methylphenidate (Ritalin). Useful as part of the treatment for attention deficit hyperactive disorder.
 - 4.2.4.2 **Anti-depressants** - used in the treatment of serious depression, school phobias, some other serious anxiety disorders, bedwetting, some bulimic-type eating disorders and attention deficit hyperactive disorder.
 - 4.2.4.3 **Antipsychotic medication** - such as Risperdol, or Zyprexa. Usually gives more inner control to the psychotic patient; stops or at least takes the panic out of irrational beliefs and hallucinations.
 - 4.2.4.4 **Lithium, Tegretol, and Depakote** - very helpful in treating and preventing mood swings.
 - 4.2.4.5 **Anti-anxiety medications** - short-term use for certain conditions associated with high anxiety. Their usefulness in children has not been well studied, so only a physician should prescribe them with experience in their use.
- 4.3 Coordination of Care
 - 4.3.1 Effective treatment of minors involves coordination with those systems or resources, which impact a minor's welfare (e.g., school, home, church, sports programs, primary care physician, psychiatrist, etc.). A good treatment plan will utilize resources from each of these systems.

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- 4.3.2 Clinicians are encouraged to obtain signed releases of confidentiality within the first two sessions. This allows for prompt phone calls to gather more assessment information and/or develop additional resources for the patient, which can then be incorporated into the treatment plan.
- 4.3.3 Ongoing coordination of care should be discussed with the minor and his/her parents and should be documented in the chart.

5.0 Participating Clinicians

The following clinicians contributed to the development of this policy:

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6.0 Bibliography

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