

GREATER COLUMBIA BEHAVIORAL HEALTH

Policies and Procedures

Category: Clinical
Approved On: 04/25/2004
Approved By: The Board of Directors
Revised: 05/06/10; 04/07/11
Reviewed: 09/28/06
Effective Date: 15 days from the approval date/ the last revision date

No: CL310

<p>Title: Local Application Process for Children's Long-Term Inpatient Treatment (CLIP)</p>

I. Purpose:

The purpose of this policy is to delineate the Greater Columbia Behavioral Health (GCBH) policies and procedures for accessing CLIP facilities and to fulfill the Agreement between GCBH and the State Children's Long-term Inpatient Treatment Committee. In order to implement the agreement, GCBH has formed a GCBH CLIP Screening Committee.

II. Selection of the GCBH CLIP Screening Committee:

- A. Minimum Qualifications: 3 – 5 years clinical experience serving children is preferred.
- B. Applicants are to complete a GCBH Committee Application Form.
- C. Membership is recommended by the GCBH Children's Committee and approved by the GCBH Board of Directors chairperson.
- D. Committee Membership is limited to four individuals, three of which will be approved per above and the 4th member will be from a contracted GCBH Network Provider agency. This position will be rotated every six months and the newly appointed provider member will be approved by the Children's Committee. There will also be an alternate network provider member appointed who will serve in the event the applicant being reviewed is a client at the agency of the network provider member.

III. Objectives:

This Committee's purposes are:

- A. To review applications of children for long-term inpatient services in CLIP facilities.
- B. To approve/disapprove CLIP applications.
- C. To provide feedback to applying counties about other possible services for their applying children.
- D. Establish an on-going priority list for admission of GCBH children into CLIP facilities.

IV. CLIP Application Process:

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- A. When a child's Individual Service Team (IST) decides that CLIP is the most appropriate level of service, that child's local Mental Health Provider will call the Chair of the CLIP Screening Committee to start the GCBH CLIP process.
- B. The child's local Mental Health Provider will send a packet to the three members of the Committee. The packet should include:
 - 1. Psychiatric evaluation completed within the last six months, including all five axes.
 - 2. The Preliminary Application filled out by the IST.
 - 3. A chronology of treatment and placement providers.
 - 4. Any special report or evaluation that the child's local Mental Health Provider thinks important.
- C. The Committee will decide if the child is appropriate for CLIP placement within 30 working days. If the Committee is undecided about the appropriateness of a CLIP placement, it may request input from an independent Child Mental Health Specialist (not involved with the child, the family, or the CLIP Screening Committee).
 - 1. If the application is approved, the Committee Chair will notify the child's local Mental Health Provider and the State CLIP Staff. The CLIP Staff will then start the State process.
 - 2. If the application is not approved, The Committee Chair will notify the child's local Mental Health Provider and advise of the Committee's recommendations for local care.
 - 3. If the application is denied by the GCBH CLIP Screening Committee, and the IST still thinks that CLIP is the appropriate level of service; the child's local Mental Health Provider may resubmit the application, with additional information and/or new perspectives. At this point, the Committee will request input from an independent Child Mental Health Specialist (not involved with the child, the family, or the committee).
 - 4. If the application is denied a second time, and the IST still thinks that CLIP is the appropriate level of service, the next level of grievance is to utilize the GCBH Grievance Process

APPROVAL

/S/ Kenneth Roughton
 Kenneth Roughton, Ph.D
 Director

04/07/11
 Date

Children's Long-term Inpatient Program (CLIP) Administration Voluntary Application

Application Date:	Youth's Name:
US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth date:
State youth was born in:	Age:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity:
Height:	Weight:
Does parent agree with the need for CLIP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Adopted: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, State of Adoption:
School District:	IEP or 504 plan: <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No PIC #:	SSI/SSA Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No Private Insurance Name:
Parent/Guardian Name & Address:	Tel:
Does youth have a DCFS caseworker? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Name and Office Location of Caseworker: Tel:
FOR RSN OFFICIAL USE ONLY	
RSN Referral Source:	Tel:
Date of local RSN Review:	Youth's County of Origin:
RSN designee to follow youth while in CLIP:	Tel:

Current Psychotropic Medications:

Name of Treating Psychiatrist or current prescriber:

Serious/Current/Significant Medical/Health Concerns:

Inappropriate Sexual Behavior: Yes No
If yes, please describe:

Psychosexual Evaluation completed: Yes No

Youth Treatment/Placement History

Psychiatric Hospitalizations:

Facility	Admit (s)	Discharge (s)
Use boxes below to enter information for 'other' or out of state hospitals		

DCFS Services (i.e. group homes, residential care, Family Reconciliation Services, Family Preservation Services, foster care):

Agency	Admit/Intake Date	Discharge/Termination

Outpatient Mental Health Treatment Episodes (i.e. therapy, crisis services, psychiatric care)

Agency	Admit/Intake Date	Discharge/Termination

Chemical Dependency Treatment:

Agency	Admit/Intake Date	Discharge/Termination

Other (ARY, CHINS, CHAP, WRAP, CRC, Juvenile Detention, JRA incarcerations, Day Treatment)

Please describe the family's 3-5 MOST CRITICAL needs to be addressed in treatment. Please be specific/detailed. (i.e. family therapy, behavior management skills, improved communication, coping skills specific to youth's needs, education/knowledge regarding psychiatric disorders, support to cope with youth's challenges, etc.)

1.

2.

3.

4.

5.

Please describe:

Youth's strengths/interests:

Family's strengths/interests:

Barriers **family** may have to participate in treatment?

Please provide a *brief narrative* describing the youth's **developmental, family and cultural history**. Information should describe:

- Pregnancy, birth, developmental milestones
- Current living situation
- Name, occupation, marital status and location of natural and/or step-parents, adoptive parents or guardians
- Names and birth dates of siblings
- History of known psychiatric problems in the family
- Cultural background, including any specific practices of the youth and family

(*or reference the *specific* document(s) which provides this information)

Narrative:

Please provide a *brief narrative* describing the youth's current **medical status** including a description of any health issues or medical conditions and known allergies.

(*or reference the *specific* document(s) which provides this information)

Narrative:

Please provide a *brief narrative* describing the youth's current **legal status** including a description of current probationary or parole status, history of diversion, adjudication and incarceration, a description of pending charges and any changes in legal custody.

(*or reference the *specific* document(s) which provides this information)

Narrative:

Please provide a *brief narrative* describing the youth's **educational history** including most recent school attended, whether currently attending, current performance in school and a brief outline of youth's historical performance, and highest grade completed.

(*or reference the *specific* document(s) which provides this information)

Narrative:

CLIP Application Materials Checklist

In addition to the previous pages additional documentation is required to meet the complete application requirements. Please provide the following information in the form of copies of existing documents which contain the required information. You may also choose to prepare an outline of the required material. Please use this document to check off the documents you have attached.

Current Psychiatric Evaluation

A current psychiatric evaluation is required for all referrals. This can be done either through an inpatient or outpatient treatment provider. This must be:

- Completed and signed by a psychiatrist (Per federal standards ARNP or PhD are *not* acceptable)
- Dated within the last 6 months
- Includes a 5 Axis DSM IV Diagnostic classification
- Includes at a minimum a Mental Status Exam, and Complete Assessment of Treatment needs of the applicant.

Inpatient Psychiatric Treatment

If youth has been hospitalized please provide the following for **each admission**:

- Admission History and Physical
- Discharge Summary
- Any Special Testing or Evaluations completed

Outpatient Mental Health Treatment and Chemical Dependency Treatment

If youth has received outpatient mental health or chemical dependency services please provide documents which describe the services and treatment provided, outcomes/progress and reason for termination.

- Last 6-months of medication management notes
- Current treatment plan
- Psychiatric assessments
- Intake assessment from current treatment provider
- Medication history

Foster Care, In-home Services and Residential Care

If youth has received in or out of home services please provide the following documents from **each provider**.

- Intake Assessments
- Quarterly/Monthly Treatment Reviews
- Discharge Summaries
- Specialized evaluations done within those settings

Children's Administration (DCFS)

If a youth has an open case with Children's Administration (DCFS) please provide:

- Legal and Placement History
- Most recent ISSP
- Group Care Social Summary
- Dependency Order

- Foster care Health Assessment or Passport
- CPS history

School

Please provide information regarding the youth’s educational history to include

- Current IEP/504 plan
- Most recent Summary Assessment Review or Reevaluation (this document qualifies youth for Special Education Services, is done every 3 years)

Other Specialized Evaluations

If the youth has received any specialized evaluations please provide these documents. Such evaluations may include:

- Neuropsychological Evaluations
- Psychosexual Evaluations
- IQ Testing
- Fetal Alcohol Evaluations
- Autism Evaluation
- Developmental Disability Evaluations
- Any medical evaluation specific to the youth’s individual issues.

Documentation of Intellectual Functioning (if the youth has received psychological testing)

Please provide a current psychological evaluation in which an IQ test (WISC-IV, Stanford Binet V, Kaufman Brief Intelligence Test) was administered. If IQ scores are not available send other documentation of the applicant’s intellectual capabilities. This may be in the form of results from academic achievements tests (such as the WRAT) or a transcript.

You may also include any other pertinent information to overall treatment

Youth Agreement to CLIP Treatment (*final page, filled out by hand, required for youth ages 13+, optional for youth ages 5-12years*)

If you have any questions regarding the application process please call your local RSN or the CLIP Coordinator at the CLIP Administration at (206) 298-9654.

Application Completed by:	
Name:	Affiliation/Relationship:
Phone Number:	Email:

Please print and include all pages of this application, sign and date below, and include with the above attached materials.

Signature of RSN representative: _____ **Date:** _____

Youth Agreement to CLIP Treatment

Required for youth 13-17, optional for youth 5-12

Read:

Your family and community treatment team have recommended you for inpatient treatment at the Children's Long Term Inpatient Program (CLIP).

CLIP is a voluntary residential treatment program for youth ages 5-17 years old. Any youth over the age of 13 years old must agree with the need for treatment and sign in as a voluntary client upon admission.

CLIP treatment is provided in a secure environment that is supervised 24 hours a day, 7 days a week. CLIP program staff includes doctorate-level clinical staff, psychiatrics, nurses, social workers and direct care staff. Each CLIP program has a school on campus as well as recreational therapy, family therapy, skills groups, and individual therapy. The facility runs on a structured schedule. Treatment focuses on addressing the clinical needs you and your family and community team have identified prior to admission. Treatment is geared towards assisting you in becoming safe and to gain the skills necessary to transition back to your community. The average length of stay is from 6-12 months. A plan for your return to your community starts to be developed as soon as you begin treatment. It is called a discharge plan. Your discharge plan will be made with your input; as well as input from your treatment team and family. You can request discharge from the program at any time. Each program will explain the process for requesting discharge during your admission.

By agreeing to residential treatment you accept the need for inpatient treatment, have identified what you would like to work on while in treatment are willing to sign in to the program when an admission date is confirmed. Your family and community team will continue to be involved in your treatment through visitations, treatment planning meetings and ongoing contact and should be able to assist in answering any of the questions you may have about CLIP application and treatment process. Please feel free to look at our website which may provide you with more information about CLIP as well as pictures of the various CLIP programs,

www.clipadministration.org

Please list or describe what you would like to achieve while in treatment:

Please sign below indicating you understand and are willing to accept treatment in a CLIP facility.

Signature of Youth requesting CLIP Treatment