Mental Health Outpatient Treatment for Reactive Attachment Disorder

Date of Origin: 05/21/2009 **Last Review Date: 09/23/2020** **Effective Date: 10/01/2020**

Dates Reviewed: 05/13, 05/14, 05/15, 07/16, 07/17, 07/18, 07/19, 09/20

Developed By: Medical Necessity Criteria Committee

I. Description

Reactive Attachment Disorder of Infancy or Early Childhood (RAD) is characterized by markedly disturbed and developmentally inappropriate ways of relating socially in most contexts. It can take the form of a persistent failure to initiate or respond to most social interactions in a developmentally appropriate way (known as the "inhibited" form), or it can present itself as indiscriminate sociability, such as excessive familiarity with relative strangers (known as the "disinhibited form"). Children with reactive attachment disorder are presumed to have grossly disturbed internal models for relating to others, based largely on pathogenic care provided in infancy and early childhood. Consequently, they display markedly inappropriate behaviors in their attempts to gain warmth, approval, and social connectedness with others.

The following criteria are intended as a guide for establishing medical necessity for the requested level of care. They are not a substitute for clinical judgment and should be applied by appropriately trained clinicians giving consideration to the unique circumstances of each patient, including co-morbidities, safety and supportiveness of the patient's environment, and the unique needs and vulnerabilities of children and adolescents.

Diagnosis: Appropriate diagnosis is made according to diagnostic criteria in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.*

Assessment & Treatment Notes:

- Assessment for RAD requires evidence directly obtained from serial observations of the child interacting with his/her primary caregivers and with unfamiliar adults, as well as careful review of history (if available). Typically, a full assessment takes 2-3 sessions.
- After assessment, any suspicion of previously unreported or current maltreatment requires reporting to the appropriate protective services agency.
- Assessment of the caregiver's attitudes toward and perceptions about the child should be addressed in the child's treatment plan.

- The diagnosis of RAD should be ruled out in any case where there is no evidence of parental neglect, abuse, or repeated changes in primary caregiving.

- Children that are so aggressive as to be unmanageable in the family setting may require referral for a higher level of care.

- Dyadic therapy with caregiver and child is the preferred intervention strategy, in order to strengthen parenting skills and shape the child's social processing and interactive behavior. Individual therapy should only be considered as a limited, adjunctive service for dealing with behaviors that interfere with dyadic therapy.

- Co-occurring disruptive behavior disorders (Conduct Disorder, ODD) should be addressed separately in the treatment plan with appropriate treatment interventions.

Exclusions:

The following modalities have no empirical support, have been associated with serious harm including death, and are specifically excluded:

1. Interventions that promote regression for "reattachment. "
2. Interventions designed to enhance attachment which involve physical restraint or coercion, including (but not limited to):
    a. therapeutic holding
    b. compression holding
    c. "reworking" of trauma
    d. rebirthing therapy

II. Criteria: CWQI BHC-0010

A. **Continued authorization:**

Continued authorization is indicated by **ALL** of the following:

1. The treatment plan establishes achievable recovery goals appropriate to the patient's symptoms, resources, and functioning.
2. Treatment is provided at the lowest level of intensity (including frequency and duration of outpatient sessions and duration of the treatment episode) necessary to maintain the patient's stability and achieve progress toward appropriate treatment goals.
3. The treatment plan includes a realistic plan for termination and promotes the patient's ability to independently manage symptoms and resolve problems.

Plus **1 or more** of the following:

4. Continued measurable improvement in symptoms and/or functioning as evidenced by improvement in behavioral outcome measures.
5. Continued progress toward development of skills to prevent relapse.

6. Treatment plan revision to address lack of progress. If no improvement is noted, the treatment plan should be modified to include the consideration of
    a. Need for medication evaluation
    b. Need for psychosocial interventions (e.g., support groups)
    c. Possibility of co-occurring conditions that need attention (e.g., medical conditions, substance abuse)
7. If there is a demonstrated risk of deterioration with no further treatment, appropriate maintenance treatment is covered. If continued treatment is intended primarily to prevent deterioration, and significant improvement in symptoms is not expected, treatment should be provided at the least intensive level required to prevent deterioration.

***Note**: Authorization for treatment will be based upon reasonable goals and expectations, and with the **explicit inclusion of caregiver participation in treatment**. Prognosis for optimal functioning, which should be continually assessed, varies depending on a number of factors; however, access to an emotionally available attachment figure is critical for treatment to proceed.*

B. **Termination criteria:**

Termination of continued authorization is indicated by **1 or more** of the following:

1. Caregiver is able to consistently provide an environment for socially appropriate interactions without the need for ongoing psychotherapy support.
2. Patient is not improving, despite amendments to the treatment plan (consider referral to another therapist or another form of treatment).
3. Patient has achieved a stable level of functioning and further treatment is not expected to produce significant improvement.

III. Information Submitted with the Prior Authorization Request:

1. Diagnosis and presenting symptoms
2. Relevant psycho-social and treatment history
3. Assessment of both substance abuse and mental health concerns
4. Measurable treatment goals
5. Scope and duration of planned treatment interventions
6. Response to treatment, including measurable change in symptom presentation, outcomes measures used, and results of outcomes measures
7. Medical conditions affecting treatment and coordination with medical providers

IV. Annual Review History

Review Date	Revisions	Effective Date
05/2013	Annual Review. Added table with review date, revisions, and effective date. Minor wording changes, removed reference to the DSM-IV and changed to current edition.	05/2013
05/2014	Annual Review.	05/2014

05/2015	Annual Review. Clarification in Subject line.	05/2015
07/2016	Annual Review.	07/2016
07/2017	Annual Review.	08/2017
07/2018	Annual Review.	08/2018
07/2019	Added clarification re: role of and application of criteria; removed statement that appeared to limit scope of treatment; additional minor clarifications.	09/2019
09/2020	Annual Review: No changes	10/2020

V. References

1. American Academy of Child & Adolescent Psychiatry (2003). Policy statement: Coercive interventions for reactive attachment disorder. Child Abuse and neglect Committee.
2. American Psychiatric Association (2002). Position statement: Reactive attachment disorder. Washington, DC: American Psychiatric Association.
3. Boris NW, Zeanah CH (2005). Practice parameters for the assessment and treatment of children and adolescents with reactive attachment disorder of infancy and early childhood. *Journal of American Academy of Child & Adolescent Psychiatry*; 44(11): 1206-19.
4. Schuengel Carlo, Oosterman Mirjam and Sterkenburgh Paula. (2009). Children with disrupted attachment histories: Interventions and psychophysiological indices of effects. *Child and Adolescent Psychiatry and Mental Health,* 3(26). Available online at http://www.biomedcentral.com/.
5. Speltz, ML. (2002). Description, history, and critique of corrective attachment therapy. The APSAC Advisor, 14(3): 4-8.