

**CONCERN[®] /
Behavioral Health Management**

Utilization Management
Criteria Manual

2008

INTRODUCTION

CONCERN/Behavioral Health Management initially produced utilization management criteria for mental health and substance abuse from nationally recognized protocols and guidelines in the field. In 1997 CONCERN adopted criteria produced by national organizations which had developed consensus documents to encourage consistent, appropriate decision making for level of care and intensity of service.

For mental health, CONCERN/Behavioral Health Management adopted the Criteria for Short-Term Treatment of Acute Psychiatric Illness, which was published in 1997 jointly by the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association. That document was the result of a process begun in 1991 by the AACAP to establish consensus criteria for level of care placement. The criteria were revised by a workgroup including members from both organizations and formatted to be applicable to patients throughout their development. Particular emphasis was placed throughout the text on patients with special developmental needs, including children, adolescents and individuals who are seriously medically or physically compromised. The revised criteria also included sections on eating disorders and greater specificity on outpatient treatment. The document incorporated aspects of various publicly available criteria, national mental health care standards and the consensus and expertise of the psychiatric profession.

Clinical criteria assist in assessing the medical necessity and appropriateness of treatment plans for level of care, continued stay and discharge. Discharge criteria were added by our clinical staff as the original criteria only addressed admission and continued stay. Other additions to the criteria address family involvement with children and adolescents, especially for residential treatment for adolescents. Additions are noted. These criteria must always be applied using clinical judgement with the consideration of multiple factors as the final determinant for decision making.

The manual is organized according to level of care, with descriptions of the major factors to examine when considering each treatment setting. Admission, continued stay and discharge criteria are presented first and then a section with intensity of service criteria assists in ensuring an appropriate treatment setting and level of service.

Acute, Inpatient Hospitalization: Treatment includes 24-hour nursing and daily active treatment under the direct supervision of a psychiatrist.

Medically Supervised Psychiatric Residential Treatment: A level of care including individualized and intensive treatment on a 24-hour basis in a residential setting.

Acute, Partial Hospitalization: Treatment includes daily nursing and active treatment in a structured treatment program lasting 5-7 days per week and delivering at least 20 hours of active treatment per week, with patients going home each evening and weekend.

Intensive Outpatient Program: Outpatient treatment that provides 2-3 hour per day, 2-3 times per week and may total up to six-nine hours or more per week. Treatment is primarily group with some individual and family therapy.

Outpatient Treatment (General): A level of care in which patients are seen by one or more clinicians as individuals, as part of their families, or as part of a group.

A patient may need admission to a more intensive level of care, even when he/she does not meet the criteria, if the most appropriate setting is not immediately or logistically available. In addition, these criteria may not be sufficient to address the needs of the seriously and persistently mentally ill; who may require social supports, rehabilitation, and intensive care, not reflected in the document.

For substance abuse, CONCERN/Behavioral Health Management has utilized both the ASAM and the ODADAS level of care criteria for adults and youth. The 0.5 level of care described by ASAM was added to the current criteria to allow education and early intervention to families when full treatment criteria are not met, but an at-risk situation is identified and merits intervention. CONCERN recognizes that regulatory standards may vary by state, but utilizes nationally recognized ASAM criteria as the guideline for assessment-based, clinically driven decision-making. More sublevels of care are described by ASAM and ODADAS than are included in CONCERN'S criteria. Simplification of levels was necessary in order to authorize appropriately for reimbursement to available programs. Levels of care include:

Early Intervention: Outpatient treatment with short duration to educate, continue assessment or process resistance.

Outpatient: Outpatient treatment to support recovery and improve coping skills.

Intensive Outpatient: A program meeting 2-3 times per week for a total of 6-9 hours, with group and family treatment.

Day Treatment: A program meeting 5-7 days a week for approximately 20 hours per week with group and family treatment.

Residential: Individualized, intensive treatment in a 24 hour residential setting.

Inpatient: Individualized, intensive treatment in a hospital setting with 24 hour nursing and physician care.

Halfway House: A step-down facility providing room and board and 10 hours of treatment per week.

Court ordered treatment is reimbursable when it meets medical necessity criteria.

Additional criteria for mental health and substance abuse in-home treatment for adolescents and children and halfway house stays have been included as benefits were updated.

Adapted from the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association Criteria for Short-Term Treatment of Acute Psychiatric Illness Introduction to Level of Care Placement Criteria, 1997.

GLOSSARY OF TERMS

Assessment: Systematic collection and review of patient specific data necessary to determine patient care and treatment needs.

Adolescent: Age 13 to 18 or still living at home and completing high school.

Authorization: Process, by which treatment is approved, based on assessment and treatment planning review.

Case Management: A formal process using specific clinical standards and protocols to optimize patient outcomes within appropriate resource management.

Concurrent Review: Review of patient information after admission and before discharge to determine appropriateness of continued care based on the Continued Stay Criteria.

Group Psychotherapy: A group clearly organized for providing psychotherapy services to a designated client/patient population with a DSM-IV diagnosis.

IATP: Individualized Active Treatment Plan.

Intake: Process of patient access of Behavioral Health Management, registration, and recording of demographic data and referral to or scheduling of a service provider.

Medical Necessity: Services or products that a prudent physician (provider) would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury or its symptoms in a manner that is 1) in accordance with generally accepted standards of medical practice 2) clinically appropriate in terms of type, frequency, extent, site and duration 3) not primarily for the convenience of the patient, physician or other health care provider. (2000 APA endorsement of AMA statement on medical necessity)

Network Management: Process of assisting a network of providers: (1) to enhance the quality of care within a benefit structure, (2) to support and enhance utilization of data in sharing, monitoring, and evaluating activities, and (3) provide consultation regarding patient care, (4) function as an advocate and facilitator for patients seeking behavioral health care.

Precertification: Patient or provider notifies reviewer before admission. Reviewer used criteria to give certification.

Psychotherapy: Non-medical psychosocial intervention, which is specifically directed towards the alleviation of symptoms of a diagnosed DSM-IV condition

Treatment Coordination: Process by which we facilitate care over an extended time, in various settings, spanning the continuum of health and functioning, throughout an integrated network of services. This process includes coordinating referrals within and without behavioral health, and providing transition management among various settings and clinicians.

Treatment Planning: Process of matching a patient's assessment to the appropriate level of care and type of treatment.

Utilization Management: “The management of healthcare costs by influencing patient care decision-making through case-by-case assessment of the appropriateness of care throughout its provision.”

Adapted from the Institute of Medicine.

Three main types of Utilization Management

Precertification

Concurrent review (CR)

Case management (CM)

* Retrospective review is not utilization management

MENTAL HEALTH CRITERIA – CHILD, ADOLESCENT AND ADULTS

CLINICAL CRITERIA FOR ADMISSION

ACUTE INPATIENT HOSPITAL ADMISSION

Must satisfy one of the following with a DSM-IV diagnosis being the basis for risk:

1. Imminent risk for self-injury, with an inability to guarantee safety, as manifested by any one of the following:¹
 - 1.1. Recent, serious and dangerous suicide attempt, indicated by the degree of lethal intent, impulsivity, and/or concurrent intoxication, including an inability to reliably contract for safety.
 - 1.2. Current suicidal ideation with intent, realistic plan, or available means that is severe and dangerous.
 - 1.3. Recent self-mutilation that is severe and dangerous.
 - 1.4. Recent verbalization or behavior indicating high risk for severe injury.
2. Imminent risk for injury to others as manifested by any of the following:¹
 - 2.1. Active plan, means, and lethal intent to seriously injure other(s).
 - 2.2. Recent assaultive behaviors that indicate a high risk for recurrent and serious injury to other(s).
 - 2.3. Recent and serious physically destructive acts that indicate a high risk for recurrence and serious injuries to others
3. There is an active psychiatric disorder that can either be more efficiently treated or can more rapidly decrease the patient's suffering.

¹The mental health system traditionally provided respite and/or protection for persons whom, while not meeting the criteria for a high intensity level of psychiatric treatment, may nevertheless represent a threat to themselves or others. Societal pressures largely drive these admissions. While medically oriented third party payors have objected to such utilization, some judicial and other governmental programs, agencies, and families have demanded it. These criteria do not cover such instances. However, these issues are complex and we urge communities to develop and implement strategies to deal with these important social issues. The involvement of juvenile authorities with children or adolescents who present with antisocial behaviors is often quite appropriate. Adults may also require assessment regarding appropriate involvement of the social welfare/justice systems.

4. Acute and serious deterioration from the patient's baseline ability to fulfill age-appropriate responsibilities in one or more of the following areas:

4.1. Educational

4.2. Vocational

4.3. Family; and /or

4.4. Social/peer relations

to the extent that behavior is so disordered, disorganized, or bizarre that it would be unsafe for the patient to be treated at a lesser level of care.

5. Imminent risk for acute medical status deterioration due to the presence and/or treatment of an active psychiatric symptom(s) manifested by either:

5.1. Signs, symptoms, and behaviors that interfere with diagnosis or treatment of a serious and acute medical illness requiring inpatient medical services.²

5.2. A need for acute psychiatric interventions (i.e. drug, ECT, restraint) with a high probability of serious and acute deterioration of physical and/or mental health.

6. Weight loss to a point that the patient is 15% below ideal weight or failure to make expected weight gain during a period of growth, leading to body weight 15% below that expected and any one of the following:

6.1 General medical complications that have resulted from the anorexia, including but not limited to severe malnutrition, arrhythmias, hypotension, impaired renal function, or intestinal atony or obstruction.

6.2 Life threatening complications from bulimia nervosa that may include pancreatitis, gastric dilatation, esophagitis or esophageal tears, severe electrolyte imbalance, colitis, cardiac arrhythmias, impaired renal function, or intestinal atony or obstruction.

6.3 A complicating general medical condition such as cardiac disease, diabetes, or pregnancy present.

6.4 In addition to bulimia or anorexia, a severe concurrent drug or alcohol abuse problem.

²In patients who present with both serious medical and psychiatric illnesses/complications, it is often necessary to co-manage the patient with medical/surgical specialists. The Academy encourages health care professionals, health care organizations, and third party payors to creatively design services that use both medical and mental health resources to optimize care.

MEDICALLY SUPERVISED PSYCHIATRIC RESIDENTIAL TREATMENT ADMISSION

Must satisfy all of the following:

1. Serious and persistent impairment of developmental progression and/or psychosocial functioning (from the patient's baseline) due to a major DSM-IV psychiatric disorder in one or more of the following areas:
 - 1.1. Educational
 - 1.2. Vocational
 - 1.3. Family
 - 1.4. Social/peer relations
2. The patient's behavior, resulting from such a psychiatric disorder, requires a supervised, structured, and 24-hour continuous, therapeutic milieu for effective treatment to occur.
3. Refractory to an adequate trial of, or clearly inappropriate for, active treatment at a lesser level of care.

ACUTE PARTIAL HOSPITALIZATION ADMISSION

Must satisfy all of the following:

1. Acute and serious impairment of psychosocial functioning (and/or in the case of children, developmental progression) from the patient's baseline due to a major DSM-IV psychiatric disorder in one or more of the following areas:
 - 1.1. Educational
 - 1.2. Vocational
 - 1.3. Family
 - 1.4. Social/peer relations
2. Refractory to an adequate trial of, or clearly inappropriate for, active treatment at a lesser level of care.
3. The severity of the psychiatric disorder and the impairment of developmental progression and/or psychosocial functioning require a supervised, structured, and supportive milieu. The goals of which are improving adaptive functioning and returning to developmentally and culturally appropriate social roles at school, work, home, etc.
4. Symptoms and history do not meet the criteria for acute inpatient hospitalization and do not require a 24-hour, continuous, structured therapeutic milieu.
5. The patient must have an acceptable and safe living environment when she/he is not at the program. For patients with special dependency needs (e.g., children, adolescents, individuals who are seriously medically or physically compromised, etc.), that environment is provided by families, guardians, and/or other appropriate social support systems.

6. The patient demonstrates intent to form a treatment alliance and comply with treatment.

INTENSIVE OUTPATIENT TREATMENT PROGRAM

Must satisfy all of the following:

1. An acute behavioral and/or emotional crisis due to a major DSM-IV psychiatric disorder, manifested by a mild risk for self-injury, injury to others, destruction of property, or deterioration in ability to fulfill age-appropriate responsibilities.
2. Refractory to an adequate trial of, or clearly inappropriate, for active treatment at a lesser level of care.
3. There is a reasonable expectation that the patient will form a treatment alliance.
4. The patient has sufficient family and/or social resources and is willing to provide support for psychiatric treatment, or failing that, a supportive environment can be identified for that purpose.

OUTPATIENT TREATMENT ADMISSION

Must meet all of the following:

1. Serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a DSM-IV psychiatric disorder in one or more of the following areas:
 - 1.1. Educational
 - 1.2. Vocational
 - 1.3. Family
 - 1.4. Social/peer relations
2. A comprehensive multi-axial diagnostic evaluation is required, as a basis for treatment and the symptoms do not meet the criteria for a more intense level of treatment.
3. Treatment is required to alleviate acute existing symptoms/ or to prevent relapse in those patients with symptoms/behaviors in partial or complete remission.
4. The patient has demonstrated intent to form a treatment alliance and comply with treatment.
5. The patient has sufficient family and/or social resources and is willing to provide support for psychiatric treatment, or failing that, a supportive environment can be identified for that purpose.

CLINICAL CRITERIA FOR CONTINUED CARE

Must meet each of the following:

1. Admission criteria for the given level of care are met due to either continuation of presenting DSM-IV behaviors and/or symptoms or the emergence of new and /or previously unidentified DSM-IV behaviors and /or symptoms.
2. The treatment goals are realistically achievable and directed toward restabilization to allow treatment to continue in a less restrictive environment.
3. Progress toward treatment goals has occurred, as evidenced by measurable reductions in signs, symptoms, and /or behaviors to the degree that indicate continued responsiveness to the treatment.

OR

The patient has failed to improve to a degree that might be expected if the patient is potentially responsive to that treatment, and a modification in the treatment plan and/or discharge goals has been made specifically to address the lack of expected treatment progress.

4. Patient is currently involved in and cooperating with the treatment process.

OR

The patient is not currently involved in and cooperating with the treatment process, but there are measurable indicators that the patient is progressing toward active involvement.

5. When appropriate, the family is involved in and cooperating with the treatment process.

OR

The family is not involved in and cooperating with the treatment process, but there are measurable indicators that they are progressing toward active involvement (except where there are clear indications that involvement of family member(s) would be clinically counterproductive or legally prohibited).

INTENSITY OF SERVICE CRITERIA FOR ADMISSION

ACUTE INPATIENT HOSPITAL ADMISSION

1. Professional Staff: A multi-disciplinary treatment team exists and works closely together to provide integrated care, meets regularly to review each case, and is comprised of at least the following professionals:
 - 1.1. Board eligible/certified psychiatrist (attending physician). In the case of children and adolescents, a board eligible/certified child and adolescent psychiatrist.³
 - 1.2. Registered Nurse (recommend Bachelors-level, Certified Psychiatric nurse)
 - 1.3. Psychologist (consultative)
 - 1.4. Licensed Clinical Social Worker
 - 1.5. Education Specialist (recommend M.Ed. in the case of a child and adolescent program)
 - 1.6. Activities Therapist.
2. A medical director who is a board certified/eligible psychiatrist should direct the inpatient program.
3. Observation and assessments performed daily by a psychiatrist and a psychiatric nurse is available 24 hours per day. Routine assessments are performed to effectively coordinate all treatment, to manage medication trials and/or adjustments, to minimize serious side effects, and to provide medical management of all psychiatric and medical problems.
4. Primary medical consultation is immediately available 24 hours per day, 7 days per week.
5. RN supervision is required 24-hour per day, 7 day per week. The nurse observes, assesses, and documents the assessment at least once each shift.
6. Ability to provide continuous observation and safe control of behavior (i.e. isolation, restraint, and adequate/appropriate suicidal/homicidal precautions) to protect the patient and others from harm, neglect, and/or serious abuse. These measures should be used sparingly and under the direction of a psychiatrist or, in the case of children and adolescents, a child and adolescent psychiatrist. The use of restrictive forms of behavior control must follow JCAHO guidelines and their use for punitive reasons or to compensate for inadequate staffing is unjustifiable.

³The attending psychiatrist should have experience and specialized training consistent with the age group and the needs of the patient.

For the psychiatric treatment of children under 14 years old, the psychiatrist should be a BC/BE child psychiatrist. It is recognized that in some geographic locations, a BC/BE child psychiatrist may not be available (e.g., rural areas). In this case, the attending physician should arrange for consultation with a BC/BE child by direct contact, by teleconference, or by having a patient transferred.

For psychiatric treatment of adolescents, the psychiatrist should be a BC/BE child and adolescent psychiatrist or general psychiatrist with special training, skills, and experience in child and adolescent psychiatry.

7. Initial psychiatric and nursing assessments must be conducted upon admission and include assessments on Axis I-V and an initial treatment plan.
8. Comprehensive multi-disciplinary assessments are performed in a timely fashion and include comprehensive DSM-IV assessments on Axis I-V, assessments of patient, family, community strengths/resources and specific multi-modal treatment recommendations, targeting the specific factors that precipitated the inpatient admission. The assessment also includes comprehensive evaluations of the patient's developmental milestones and course; family dynamics; current and past school, work, or other social roles; the ability to interact socially (including peer relationships); substance use/abuse; and a summary of all prior psychiatric hospitalizations, medication trials, and/or other mental health/psychosocial interventions, including an assessment of their degree of success and/or failure.
9. An Individualized Active Treatment Plan (IATP) is formulated in a timely fashion, lists specific goals and objectives, and is directed toward alleviating the specific symptoms and/or causes of impairment that resulted in admission. The IATP is developed as a result of a multi-disciplinary team meeting in which all of the multi-disciplinary assessments are shared, analyzed, compared, and processed. Patient involvement is actively integrated into formulating the IATP. Restrictions from therapy, meals, or educational services as part of a behavior modification plan are not acceptable components of the treatment plan. For patients with special dependency needs (e.g., children and adolescents, individuals who are seriously medically or physically compromised, etc.), families, guardians, and/or other appropriate social support systems must also be actively involved in the treatment planning process.
10. A highly structured milieu exists that is dedicated to the treatment of psychiatric patients. In the case of adolescents who require more than brief crisis stabilization, treatment takes place in a unit specifically dedicated to their care and is segregated from adult units. In the case of children, treatment takes place in a unit specifically dedicated to their care, including stabilization and treatment, and is segregated from adult units.
11. For children and adolescents, the patient receives an initial educational assessment followed by ongoing educational services while hospitalized. These are coordinated with the patient's existing school system and include an assessment of the appropriateness of his/her current education plan as it relates to the symptoms and/or problems that resulted in admission. In addition, a plan is made for a re-entry to the school system.
12. For patients with special dependency needs (e.g., children, individuals who are seriously medically or physically compromised, etc.), the family and/or caregiver must receive a thorough assessment. Interventions are developed that specifically address stabilization and issues related to re-entry to the home (and/or the least restrictive and most appropriate placement), and the development of a specific disposition plan is initiated.
13. A discharge plan is formulated and directly linked to the behaviors and/or symptoms that resulted in admission. It receives regular review and revision that includes an appropriate and timely evaluation of post-hospitalization needs.
14. The hospital needs to be located as close as possible to the patient's home and family in order to maximize family participation in the patient's treatment.

15. The unit is licensed by the state and is accredited by the JCAHO as a psychiatric hospital program.

MEDICALLY SUPERVISED PSYCHIATRIC RESIDENTIAL TREATMENT ADMISSION

1. Professional Staff: A multi-disciplinary treatment team exists and works closely together to provide integrated care, meets to review each case, and is comprised of at least the following professionals:
 - 1.1. Board eligible/certified psychiatrist. In the case of children and adolescents, a board eligible/certified child and adolescent psychiatrist.⁴
 - 1.2. Registered Nurse (recommend Bachelor's level, Certified Psychiatric nurse)
 - 1.3. Psychologist (consultative)
 - 1.4. Licensed Clinical Social Worker
 - 1.5. Education Specialist (recommend M.Ed. in the case of a child and adolescent program)
 - 1.6. Activities Therapist
2. The director of the residential program is a licensed and/or certified mental health professional with at least three years of clinical/administrative experience in psychiatry. For the child and adolescent residential units, this experience must be in child and adolescent psychiatry.⁵
3. The program had a medical director who is a board certified/ eligible psychiatrist and has overall medical responsibility for the program. In the case of children and adolescents, a board certified/eligible child and adolescent psychiatrist.
4. A psychiatrist performs observations and assessments weekly, at least, and a psychiatrist is available 24 hours per day. In the case of children and adolescents, it is a child and adolescent psychiatrist. Routine assessments are performed to effectively coordinate all treatment, to manage medication trials and/or adjustments, to minimize serious side effects, and to provide medical management of all psychiatric and medical problems.

⁴The attending psychiatrist should have experience and specialized training consistent with the age group and the needs of the patient.

For psychiatric treatment of children under 14 year old, the psychiatrist should be a BC/BE child psychiatrist. It is recognized that in some geographic locations, a BC/BE child psychiatrist may not be available (e.g., rural areas). In this case, the attending physician should arrange for consultation with a BC/BE child psychiatrist by direct contact, by teleconference, or by having the patient transferred. For psychiatric treatment of adolescents, the psychiatrist should be a BC/BE child and adolescent psychiatrist or a general psychiatrist with special training, skills, and experience in child adolescent psychiatry.

⁵The attending psychiatrist should have experience and specialized training consistent with the age group and the need of the patient.

For psychiatric treatment of children under 14 years old, the psychiatrist should be a BC/BE child psychiatrist. It is recognized that in some geographic locations, a BC/BE child psychiatrist may not be available (e.g., rural areas). In this case, the attending physician should arrange for consultation with a BC/BE child psychiatrist by direct contact, by teleconference, or by having the patient transferred. For psychiatric treatment of adolescents, the psychiatrist should be BC/BE child and adolescent psychiatrist or a general psychiatrist with special training, skills, and experience in child and adolescents psychiatry.

5. Primary medical consultation is immediately available 24 hours per day, 7 days per week.
6. An initial psychiatric assessment must be conducted upon admission, including assessments on Axis I-V and an Initial Treatment Plan.
7. Comprehensive multi-disciplinary assessments are performed in a timely fashion and include comprehensive DSM-IV assessments on Axis I-V, assessments of patient, family, community strengths/resources, and specific multi-modal treatment recommendations, targeting the specific factors that precipitated the inpatient admission. The assessment also includes comprehensive evaluations of the patient's development milestones and course; family dynamics; current and past school, work, or other social roles; ability to interact socially (including peer relationships); substance use/abuse; and a summary of all prior psychiatric hospitalizations, residential program admissions, intensive ambulatory mental health services, medication trials, and other mental health/psychosocial interventions, including an assessment of their degree of success and/or failure.
8. An Individualized Active Treatment Plan (IATP) is formulated in a timely fashion, lists specific goals and objectives, and is directed toward the alleviation of the specific symptoms and/or causes of impairment which resulted in the admission. The IATP is developed as a result of a multi-disciplinary team meeting in which all of the multi-disciplinary assessments are shared, analyzed, compared, and processed. Patient involvement is actively integrated into the formulation of the IATP. Restrictions from therapy, meals, or educational services as part of a behavior modification plan are not acceptable components of the treatment plan. For patients with special dependency needs (e.g., children and adolescents, individuals who are seriously medically or physically compromised, etc.), families, guardians, and/or other appropriate social support systems must be actively involved in the treatment planning process also.
9. A highly structured milieu exists that is dedicated to the treatment of psychiatric patients. In the case of children and adolescents, the unit is specifically dedicated to their care and is segregated from the adult units.
10. For children and adolescents, the patient receives an initial educational assessment followed by ongoing educational services. These are coordinated with the patient's existing school system and include an assessment of the appropriateness of his/her current education plan as it relates to the symptoms and/or problem that resulted in admission. In addition, a plan is made for a re-entry to an appropriate educational system.
11. For patients with special dependency needs (e.g., children, individuals who are seriously medically or physically compromised, etc.) the family and/or guardian must receive a thorough assessment. Interventions are developed that specifically address stabilization and issues related to re-entry to the home (and/or the least restrictive and most appropriate placement), and the development of a specific disposition plan in a timely fashion.
12. An initial discharge plan is formulated, is directly linked to the behavior and/or symptoms that resulted in admission, and receives regular review and revision, including an appropriate and timely evaluation of post residential treatment needs. An appropriate and realistic place of post discharge residence is tentatively designated upon admission and the patient is actively involved in making the choice.

13. The residential treatment facility needs to be located as close as possible to the patient's home in order to maximize family participation in the patient's treatment. (Additional criteria: For children, the treatment of the family is integral to the treatment plan and the family therapy should be face to face except in unusual circumstances. The family must commit to intensive involvement in the process and be available to participate in the therapy. An active reintegration plan becomes an immediate part of the therapy process.)
14. For children and adolescents, the family, or if contraindicated, an appropriate relative or legal guardian, should be an integral part of all decisions in the child's treatment process.
15. The residential treatment facility is licensed by the state and is accredited by the JCAHO as a psychiatric residential treatment program.

ACUTE PARTIAL HOSPITALIZATION ADMISSION

1. Professional Staff: A multi-disciplinary treatment team works closely together to provide integrated care, meets regularly to review each case, and is comprised of at least the following professionals:
 - 1.1. Board certified/eligible psychiatrist. In the case of children and adolescents, a board certified/eligible child and adolescent psychiatrist.⁶
 - 1.2. Registered Nurse (recommend Bachelor's-level, Certified Psychiatric nurse)
 - 1.3. Psychologist
 - 1.4. Licensed Clinical Social Worker
 - 1.5. Education Specialist (recommend M.Ed.)
 - 1.6. Activities Therapist
2. The program operates at least 5 days a week and delivers at least 20 hours of active treatment per patient, per week.
3. The acute partial, adolescent psychiatrist hospitalization program has a medical director who is a board certified/eligible psychiatrist. In the case of children of adolescents, a child psychiatrist.⁶

⁶The attending psychiatrist should have experience and specialized training consistent with age group and the need of the patient.

For psychiatric treatment of children under 14 years old, the psychiatrist should be a BC/BE child psychiatrist. It is recognized that in some geographic locations, a BC/BE child psychiatrist may not be available (e.g., rural areas). In this case, the attending physician should arrange for consultation with a BC/BE child psychiatrist by direct contact, by teleconference, or by having the patient transferred. For psychiatric treatment of adolescents, the psychiatrist should be a BC/BE child and adolescent psychiatrist or a general psychiatrist with special training, skills, and experience in child and adolescent psychiatry.

4. A psychiatrist performs regular observations and assessments and a psychiatrist is available 24 hours per day. In the case of children and adolescents, it is a child and adolescent psychiatrist. Routine assessments are performed to effectively coordinate all treatment, to manage medication trials and/or adjustments, to minimize serious side effects, to and provide medical management of all psychiatric and medical problems.
5. Primary medical consultation is immediately available 24 hours per day, 7 days per week.
6. A nurse is present daily to ensure the appropriate administration of medication (if required) and to provide regular nursing observations and assessments on a regular basis when clinically indicated.
7. Initial psychiatric and nursing assessments must be conducted upon admission and include assessments on Axis I-V and an Initial Treatment Plan.
8. Comprehensive multi-disciplinary assessments are performed in a timely fashion and include comprehensive DSM-IV assessments on Axis I-V, assessments of patient, family, community strengths/resources, and specific multi-modal treatment recommendations, targeting the specific factors that precipitated inpatient admission. The assessment also includes comprehensive evaluations of the patient's developmental milestones and course; family dynamics, current and past school, work, or other social roles; ability to interact socially (including peer relationships); substance use/abuse; and a summary of all prior psychiatric hospitalizations, residential program admissions, intensive ambulatory mental health services, medication trials, and other mental health/psychosocial interventions, including an assessment of their degree of success and/or failure.
9. An Individualized Active Treatment Plan (IATP) is formulated in a timely fashion, lists specific goals and objectives, and is directed toward the alleviation of the specific symptoms and/or causes of impairment that resulted in admission. The IATP is developed as a result of a multi-disciplinary team meeting in which all of the multi-disciplinary assessments are shared, analyzed, compared, and processed. Patient involvement is actively integrated into the formulation of the IATP. Restrictions from therapy, meals, or educational services as part of a behavior modification plan are not acceptable components of the treatment plan. For patients with special dependency needs (e.g., children and adolescents, individuals who are seriously medically or physically compromised, etc.), families, guardians, and/or other appropriate social support systems must also be actively involved in the treatment planning process.
10. A highly structured milieu exists that is dedicated to the treatment of psychiatric patients. In the case of children and adolescents, the unit is specifically dedicated to their care and is segregated from the adult units.
11. For children and adolescents, the patient receives an initial education assessment followed by ongoing educational services. These are coordinated with the patient's existing school system and include an assessment of the appropriateness of his/her current education plan as it relates to the symptoms and/or problems that resulted in admission. In addition, a plan is made for full reintegration into the school system.
12. For patients with special dependency needs (e.g., children, individuals who are seriously medically compromised, etc.), the family and/or guardian must receive a thorough assessment. Interventions

are developed that specifically address stabilization and preservation of the patient in the least restrictive environment.

13. A discharge plan is formulated upon admission, is directly linked to the behaviors and/or symptoms that resulted in admission, and receives regular review and revision, including an appropriate and timely evaluation of post partial treatment needs.
14. The partial hospitalization program needs to be located as close as possible to the patient's home (or appropriate placement) and family/guardians in order to minimize barriers to access and to maximize family participation in the patient's treatment.
15. The facility is licensed by the state and is accredited by the JCAHO as a partial hospitalization program.

INTENSIVE OUTPATIENT PROGRAM ADMISSION

1. The program is managed by a licensed mental health professional and it delivers at least 4 hours of a structured outpatient treatment program per patient, per week. The intensive outpatient program has a contractual relationship with a mental health system of care that includes mental health emergency services and had a board certified/eligible psychiatrist on staff. In the case of children and adolescents, a board certified/eligible child and adolescent psychiatrist.
2. Licensed mental health professionals are directly involved in delivering care and have specific experience and/or training in mental health. For children and adolescents, the training is in child and adolescent mental health.
3. Consultation by a board certified/eligible psychiatrist is available 24 hours per day. In the case of children and adolescents, it is a child and adolescent psychiatrist.
4. Primary medical consultation is immediately available 24 hours per day, 7 days per week.
5. Procedures and policies exist and ensure safe control of behavior, protecting the patient and others from harm, neglect, and/or serious abuse.
6. A comprehensive psychiatric assessment must be conducted in a timely fashion including, assessments on Axis I-V and an initial treatment plan. Assessments for patient, family, community strengths/resources, and specific multi-modal treatment recommendations, targeting the specific factors that precipitated the intensive outpatient program and are present in the assessment. The assessment also includes comprehensive evaluations of the patient's developmental milestones and course; family dynamics; current and past school, work, or other social roles; ability to interact socially (including peer relationships); substance use/abuse; and a summary of all prior psychiatric hospitalizations and intensive ambulatory mental health programs, medications trials, and other mental health/psychosocial interventions including an assessment of their degree of success and/or failure.
7. An Individualized Active Treatment Plan (IATP) is formulated in a timely fashion, lists specific goals and objectives, and is directed at alleviating the specific symptoms and/or causes of impairment that resulted in the admission. The IATP is developed as a result of a multi-

disciplinary team meeting where all of the multi-disciplinary assessments are shared, analyzed, compared, and processed. Patient involvement is actively integrated into the formulation of IATP. Restrictions from therapy, meals, or educational services as part of a behavior modification plan are not acceptable components of the treatment plan. For patients with special dependency needs (e.g., children and adolescents, individuals who are seriously medically or physically compromised, etc.), families, guardians, and/or other appropriate social support systems must also be actively involved in the treatment planning process.

8. A highly structured program exists and is dedicated to the treatment of psychiatric patients. In the case of children and adolescents, the unit is specifically dedicated to their care and is segregated from adult programs.
9. For children and adolescents, the patient receives an assessment of the existing educational services, including an assessment of the appropriateness of his/her current educational plan as it relates to symptoms and/or problems that resulted in admission, including specific recommendations made by the treatment plan.
10. For patients with special dependency needs (e.g., children, individuals who are seriously medically or physically compromised, etc.), the family and/or guardian must receive a thorough assessment. Interventions are developed that specifically address stabilization and preservation of the child in the least restrictive placement possible.
11. A discharge plan is initially formulated, is directly linked to the behaviors and/or symptoms that resulted in admission, and receives regular review and revision, including an appropriate and timely evaluation of post intensive outpatient program needs.
12. The program needs to be located as close as possible to the patient's home and family in order to minimize barriers to access and to maximize family participation in the patient's treatment.

OUTPATIENT SERVICES ADMISSION

1. Addition: Outpatient services are provided by independent licensed mental health providers in the community or the outpatient services may have a formal relationship with a mental health system that includes mental health emergency services and has a board certified/eligible psychiatrist on staff. For children and adolescents, there is a board certified/eligible child and adolescent psychiatrist.⁷

⁷The attending psychiatrist should have experience and specialized training consistent with the age group and the needs of the patient.

For psychiatric treatment of children under 14 years old, the psychiatrist should be a BC/BE child psychiatrist. It is recognized that in some geographic locations, a BC/BE child psychiatrist may not be available (e.g., rural areas). Especially for complex cases, the attending physician should arrange for consultation with a BC/BE child psychiatrist by direct contact, by teleconference, or by having the patient transferred.

For psychiatric treatment of adolescents, the psychiatrist should be a BC/BE child and adolescent psychiatrist or a general psychiatrist with special training, skills, and experience in child and adolescent psychiatry.

2. Licensed mental health professionals are directly involved in delivering care and have specific experience and/or training working with age-grouped populations such as child and adolescent mental health.
3. Consultation by a board certified/eligible psychiatrist is available. For children and adolescents, there is a board certified/eligible child and adolescent psychiatrist.
4. Procedures and policies exist and ensure safe control of behavior to protect the patient and others from harm, neglect, and/or serious abuse.
5. A comprehensive assessment must be conducted, including assessments on Axis I-V, an initial treatment plan, assessments of patient, family, community strengths/resources, and specific treatment recommendations, targeting the specific factors that precipitated the admission to outpatient care that are present in the assessment. The assessment also includes comprehensive evaluations of the patient's developmental milestones and course; family dynamics; current and past school, work, or other social roles; ability to interact socially (including peer relationships); substance use/abuse; and a summary of all prior psychiatric hospitalizations, residential program admissions, intensive ambulatory mental health services, medication trials, and other mental health/psychosocial interventions, including an assessment of their degree of success and/or failure.
6. An Individualized Active Treatment Plan (IATP) is formulated upon admission, listing specific goals/objectives and is directed toward alleviating the specific symptoms and/or causes of impairment that resulted in the admission. Patient involvement is actively integrated into the formulation of the IATP. For patients with special dependency needs (e.g., children and adolescents, individuals who are seriously medically or physically compromised, etc.), families, guardians, and/or other appropriate social support systems must also be actively involved in the treatment planning process.
7. The outpatient services are designed to address the impairments, behaviors, and/or symptoms associated with a DSM-IV disorder and include a variety of individual therapy, group therapy, or family therapeutic contacts as clinically indicated.
8. Addition: Frequency of outpatient treatment is generally one time per week, or less and is determined by the provider or therapist (who may take into account the insurance benefit available) and is responsible for coordinating treatment with all providers involved. Under specific circumstances, such as a crisis, more frequent visits may be necessary for a short period of stabilization. A crisis is defined as an event or set of events which rapidly and significantly diminish a person's usual ability to function, and one that without rapid, intense intervention would lead to worsening of symptoms and functional problems to the point of posing a risk to self, others or property. It is expected that outpatient crisis intervention requires no more than a two to three week period to stabilize the worsening of the patient's behavioral, affective or cognitive functioning. During crisis intervention, more than one session per week may be used for this short period. Patients who require more than one visit per week beyond the two or three week intervention should be evaluated for a more intensive level of care, medication evaluation or an alternative method of outpatient therapy.
9. Addition: Limited, brief individual psychotherapy may be utilized to facilitate the patient's involvement in a substance abuse treatment process when an Axis I substance abuse/dependence

diagnosis is present. Ongoing, individual psychotherapy is not recommended as the primary treatment for patients with substance abuse diagnoses.

10. Addition: For patients with both mental health and substance abuse diagnoses on Axis I, a combined, individualized treatment plan should be developed by providers, with case management assistance.
11. For children and adolescents, the patient receives an assessment of the existing educational services. This includes an assessment of the appropriateness of the current education plan as it relates to the symptoms and/or problems that resulted in admission, with specific recommendations made by the treatment plan.
12. For patients with special dependency needs (e.g., children, individuals who are seriously medically or physically compromised, etc.), the family and/or guardian must receive a thorough assessment. Interventions are developed that specifically address stabilization and preservation of the child in the least restrictive placement possible.
13. A discharge plan is formulated, is directly linked to the behaviors and/or symptoms that resulted in admission, and receives regular review and revision, including an appropriate and timely evaluation of post treatment needs.
14. The outpatient services need to be located as close as possible to the patient's home and family in order to minimize barriers to access and to maximize family participation in the patient's treatment.

INTENSITY OF SERVICE CRITERIA FOR CONTINUED CARE

ACUTE INPATIENT HOSPITAL CONTINUED STAY

1. The patient is regularly receiving individualized treatment, implemented by a multi-disciplinary team and based on the IATP. For patients with special dependency needs, there is documented evidence that both the patient and the parents/guardians are involved in the treatment process, unless specifically contraindicated.
2. Assessment and treatment by a board certified/eligible psychiatrist occurs on a daily basis and is individualized to meet the clinical needs of the patient. In the case of children and adolescents, a board eligible or certified child and adolescent psychiatrist.
3. As determined in the IATP, the appropriate clinical staff performs daily interventions.
4. There are regular and timely assessments and documentation of the patient's response to all treatments. Timely and appropriate modifications to the treatment plan are made that are consistent with the patient's clinical status and/or presence of new symptoms/information since admission.
5. A comprehensive discharge plan is formulated and regularly reviewed, revised, and appropriately implemented in a timely manner, with specific target dates for implementation of each procedure involved in the discharge process.
6. Restrictive interventions (e.g., seclusion, restraint, isolation) are used only for clinically appropriate periods of time, consistent with state and national licensing and accreditation standards. They are used only after less restrictive alternatives have failed and/or have been considered and documented as to why they would be inappropriate and/or ineffective. Their use for punitive reasons or to compensate for inadequate staffing is unjustifiable.
7. A minor's rights are protected from unwarranted abridgment by a system of regular administrative and/or clinical review for all patients admitted under involuntary commitment.
8. The active treatment intervention focuses on stabilization and/or alleviation of the symptoms/problems that necessitated admission or symptoms/problems that have emerged and/or been identified since admission that would otherwise meet criteria for inpatient admission.
9. For patients with special dependency needs, the family/guardian are actively and regularly involved in the treatment process. There is documentation of their input into the treatment planning process, as well as their active involvement in the treatment unless specifically contraindicated.
10. Children and adolescents receive appropriate educational services. They are directed toward stabilizing and/or improving the educational functioning of the patient (given the symptoms, behaviors, or problems that necessitated inpatient hospitalization) through the development and implementation of a comprehensive, individualized educational plan. There must be specific recommendations based on the patient's presenting behaviors, symptoms, or impairment related to a DSM-IV disorder.

MEDICALLY SUPERVISED PSYCHIATRIC RESIDENTIAL TREATMENT CONTINUED STAY

1. The patient is regularly receiving individualized treatment, implemented by a multi-disciplinary team and based on the IATP. For patients with special dependency needs, there is documented evidence that both the patient and the parents/guardians are involved in the treatment process unless specifically contraindicated.
2. Assessment and treatment by a board certified/eligible psychiatrist occurs on at least a weekly basis. This is individualized to meet the clinical needs of the patient. In the case of children and adolescents, it is a child and adolescent psychiatrist.
3. As determined in the IATP, the appropriate clinical staff performs daily interventions
4. There are regular and timely assessments and documentation of the patient's response to all treatments. Timely and appropriate modifications to the treatment plan are made that are consistent with the patient's clinical status and/or the presence of new symptoms/information since admission to the facility.
5. A comprehensive discharge plan is formulated, regularly reviewed, revised, and appropriately implemented in a timely manner, including specific target dates for implementation of each procedure involved in the discharge process.
6. A minor's rights are protected from unwarranted abridgment by a system of regular administrative and/or clinical review for all patients admitted under involuntary commitment.
7. Restrictive interventions (e.g., seclusion, restraint, isolation) are used only for clinically appropriate periods of time, consistent with state and national licensing and accreditation standards. They are used only after less restrictive alternatives have failed and/or have been considered and documented as to why they would be inappropriate and/or ineffective. Their use for punitive reasons or to compensate for inadequate staffing is unjustifiable.
8. The active treatment intervention focuses on stabilization and/or alleviation of the symptoms/problems that necessitated admission or symptoms/problems that have emerged and/or been identified since admission that would otherwise meet criteria for residential treatment admission.
9. For patients with special dependency needs, the family/guardians are actively and regularly involved in the treatment process. There is documentation of their input into the treatment planning process, as well as their active involvement in the treatment unless specifically contraindicated.
10. Children and adolescents receive appropriate educational services. These are directed toward stabilizing and/or improving the educational functioning of the patient (given the symptoms, behaviors, or problems that necessitated admission to the residential treatment facility) through the development and implementation of a comprehensive, individualized educational plan with impairment related to a DSM-IV disorder.

ACUTE PARTIAL HOSPITALIZATION CONTINUED STAY

1. The patient is regularly receiving individualized treatment, implemented by a multi-disciplinary team and based on the IATP. For the patients with special dependency needs, there is documented evidence that both the patient/guardians are involved in the treatment process.
2. A psychiatrist performs assessments and treatments, at least twice a week, which are individualized to meet the clinical needs of the patient. In the case of children and adolescents, it is child and adolescent psychiatrist.
3. As determined in the IATP, the appropriate clinical staff performs daily interventions.
4. There are regular and timely assessments and documentation of the patient's response to all treatments. Timely and appropriate modifications to the treatment plan are made that are consistent with the patient's clinical status and/or presence of new symptoms/information since admissions to the facility.
5. The comprehensive discharge plan is formulated and regularly reviewed, revised, and appropriately implemented in a timely manner, including specific target dates for implementation of each procedure involved in the discharge process.
6. Restrictive interventions (e.g., time outs, physical restraint) are used only for clinically appropriate periods of time, consistent with state and national licensing and accreditation standards. They are used only after less restrictive alternatives have failed and/or have been considered and documented as to why they would be inappropriate and/or ineffective. Their use for punitive reasons or to compensate for inadequate staffing is unjustifiable.
7. The active treatment intervention focuses on stabilization and/or alleviation of the symptoms/problems that necessitated admission or symptoms/problems that have emerged and/or been identified since admission that would otherwise meet the criteria for residential treatment admission
8. For patients with special dependency needs, the family/guardians are actively and regularly involved in the treatment process. There is documentation of their input into the treatment planning process, as well as their active involvement in the treatment unless specifically contraindicated.
9. Children and adolescents receive appropriate educational services. They are directed toward stabilizing and/or improving the educational functioning of the patient (given the symptoms, behaviors, or problems that necessitated admission to the residential treatment facility) through the development and implementation of a comprehensive, individualized educational plan with impairment related to a DSM-IV disorder.

INTENSIVE OUTPATIENT PROGRAM CONTINUED STAY

1. The patient is receiving individualized treatment, implemented by licensed mental health professionals and based on the IATP. For patients with special dependency needs, there is documented evidence that both the patient and the parents/guardians are actively involved in the treatment process.
2. Assessments and treatment by or in consultation with a board certified/eligible psychiatrist occur at least weekly and are individualized to meet the clinical needs of the patient. In the case of children and adolescents, it is a board certified/eligible child and adolescent psychiatrist
3. As determined in the IATP, the appropriate clinical staff performs therapeutic interventions during each session.
4. There are regular and timely assessments and documentation of the patient's response to all treatments. Timely and appropriate modifications to the treatment plan are made that are consistent with the patient's clinical status and/or presence of new symptoms/information since admission.
5. A discharge plan is formulated and regularly reviewed, revised, and appropriately implemented in a timely manner and includes specific target dates for implementation of each procedure involved in the discharge process.
6. Restrictive interventions (e.g., time out, physical restraint, etc.) are only used for clinically appropriate periods of time, for valid clinical reasons, and are used according to written policies and procedures that include documentation of each episode and the subsequent clinical management.
7. The active treatment intervention focuses on stabilization and/or alleviation of the symptoms/problems that necessitated admission or symptoms/problems that have emerged and/or been identified since admission that would otherwise meet criteria for admission
8. For patients with special dependency needs, the family/guardians are actively and regularly involved in the treatment process, as well as their active involvement in the treatment, unless specifically contraindicated and/or impossible to implement.
9. If designated as part of the IATP, a liaison or consultation directed toward stabilizing and/or improving the educational functioning of the patient (given the symptoms, behaviors, or problems that necessitated admission to the program), with specific recommendations based on the patient's behaviors, symptoms, or impairment related to a DSM-IV disorder.

OUTPATIENT SERVICES CONTINUED STAY

1. The patient is regularly receiving individualized treatment, implemented by licensed mental health professionals and based on the IATP.
2. Outpatient services are performed as determined in the IATP.
3. There are regular and timely assessments and documentation of the patient's response to all treatments. Timely and appropriate modifications to the treatment plan are made that are consistent with the patient's clinical status and/or presence of new symptoms/information since admission.
4. A discharge plan is formulated and regularly reviewed, revised, and appropriately implemented in a timely manner. This includes specific target dates for reaching each goal designated in the discharge process and defines the criteria for when outpatient treatment can be brought to a conclusion without significant risk to the patient.
5. The active treatment interventions focuses on stabilization and/or alleviation of the symptoms/problems that necessitated admission to the program or symptoms/problems that have emerged and/or been identified since admission that would otherwise meet criteria for admission to outpatient services.
6. For the patient with special dependency needs, the family/guardians are actively and regularly involved in the treatment process, unless specifically contraindicated and/or impossible to implement.

CLINICAL CRITERIA FOR MENTAL HEALTH DISCHARGE

1. The symptoms/behaviors that precipitated admission and continued stay have sufficiently improved so that the patient can be maintained at a lesser level of care and the patient will not be compromised with treatment being given at a less intensive level of care.

2. Goals on the IATP have been achieved.

3. A comprehensive follow-up plan at the next appropriate level of care had been developed and scheduled and agreed upon by the patient, family or guardian, as appropriate.

OR

4. Patient withdrew from treatment against advice and does not meet criteria for involuntary commitment.

OR

5. Patient transferred to another facility or program.

OR

6. Patient transferred to a higher level of care.

OR

7. Patient has not responded to interventions and there is no evidence that more treatment time or sessions will result in progress toward desired outcomes and there are no imminent risk factors.

OR

8. The patient was administratively discharged based on known requirements not fulfilled by the patient.

CLINICAL CRITERIA FOR ADMISSION, CONTINUED STAY AND INTENSITY OF SERVICE FOR MENTAL HEALTH HALFWAY HOUSE

A halfway house is a non-medical structured living environment providing room, board, supervision and counseling services following discharge from a more intensive level of care. It is intended as a step-down level of care to allow ongoing treatment and consolidation of coping strategies prior to returning to a residence in the community and an outpatient level of care. It is not intended as an alternate or permanent residence.

ADMISSION

1. Must have a serious and persistent impairment of developmental progression and /or psychosocial functioning due to a DSM-IV psychiatric disorder in one or more of the following areas:
 - Education
 - Vocation
 - Family, and/or
 - Social/peer relations
2. Must have successfully completed a higher level of care and no longer a risk to self or others.
3. The patient's symptoms and behaviors resulting from the psychiatric disorder require a supervised, semi-structured therapeutic environment for effective treatment to occur.
4. Ability to function in the home environment is impaired due to patient's limited coping strategies, ongoing need for psychiatric stabilization, continuing family dysfunction or conflicted family relationships.
5. The patient has the ability to engage in treatment and the family, where appropriate, has committed to reintegration and is actively involved in the therapeutic process.

CONTINUED STAY

1. Admission criteria are met for the level of care based on continuing DSM-IV diagnosis or the emergence of new or previously unidentified DSM-IV diagnoses.
2. Treatment goals are realistically achievable and directed toward stabilization to allow treatment to continue in a less restrictive environment.
3. Progress toward treatment goals has occurred, as evidenced by measurable reductions in signs, symptoms and/or behaviors to the degree that indicate continued responsiveness to treatment.

OR

The patient has failed to improve to a degree that might be expected if the patient is potentially responsive to that treatment, and a modification in the treatment plan and /or discharge goals has been made specifically to address the lack of expected treatment progress.

4. Patient is currently involved in and cooperating with the treatment process.

OR

The patient is not currently involved in and cooperating with the treatment process, but there are measurable indicators that the patient is progressing toward active involvement.

5. When appropriate, the family is involved in and cooperating with the treatment process.

OR

The family is not involved in and cooperating with the treatment process, but there are measurable indicators that they are progressing toward active involvement (except where there are clear indications that involvement of family member(s) would be clinically counterproductive or legally prohibited).

INTENSITY OF SERVICE CRITERIA

1. Facility licensed by the state to provide room, board and 24 hour supervision to residents who are obtaining mental health care through the facility or other local mental health providers.
2. Accreditation by JCAHO, AOA(American Osteopathic Association), CARF(Commission on Accreditation of Rehabilitation Facilities) or COA(Council on Accreditation).
3. An individualized active treatment plan is formulated in a timely fashion, lists goals and objectives and is directed toward the alleviation of symptoms and/or behaviors which resulted in admission. Reintegration into the patient's home and community should be a major objective.
4. Mental health and psychosocial interventions, including psychiatric assessment and follow-up, are available on site or arranged by the program.
5. Educational needs for children and adolescents are evaluated and met and coordinated with discharge planning.
6. The facility must be located as close to the patient's home as possible in order to maximize family involvement, where appropriate.

Substance Abuse Admission Criteria

	Education Level .05	OP Level One	IOP Level Two	Day Treatment Level Three	Inpatient Rehab Level Four	Ambulatory Detoxification	Inpatient Detoxification
1 Acute Intoxication and/or Withdrawal Potential	NONE	NONE or minimal risk of withdrawal	NONE or minimal risk of withdrawal	Mild to moderate risk of withdrawal	Mild to moderate risk of withdrawal; may need medical monitoring	Moderate to severe risk of withdrawal	Moderate to severe risk of withdrawal needing monitoring 24 hours daily
2 Biomedical conditions and complications	None or very stable	None or sufficiently stabilized	None or sufficiently stabilized	None or stable and not distracting from treatment	Low to moderate complications/may need medical intervention	Daily contact is needed to monitor medical conditions	24 hour medical and nursing monitoring is needed
3 Emotional/ Behavioral conditions and complications	None or very stable May be receiving concurrent mental health treatment	None or very stable. Client has no adverse emotional, behavioral or cognitive functioning that would interfere with this level of care	Client has mild to moderate adverse emotional, behavioral, cognitive conditions Needs monitoring but can sustain responsibilities	Client has mild to moderate adverse emotional, behavioral, cognitive conditions that require frequent contact	Client has moderate adverse emotional, behavioral, cognitive conditions or require s close supervision in a high intensity setting	Emotional cognitive behavioral stabilized or will not interfere with the detoxification process	Emotional, cognitive, behavioral is stable or evaluation and treatment is needed for severe and unstable symptoms
4 Acceptance/ Resistance	Willing to accept how use may affect personal goals Resistant but can be motivated	Client is motivated or can be sufficiently motivated to comply without more frequent contact	Client requires a structured treatment program to address resistance and motivation	Client needs intense daily motivational interventions or is motivated to follow structured treatment program	Resistance high and impulse control poor. Client needs intense motivational interventions on a 24 hour a day basis	Client accepts the need for medical intervention	Problems in this dimension do not qualify client for this level of service.
5 Relapse Potential	Able to currently maintain abstinence but potential for difficulty with specific relapse risk factors Client needs understanding or skills to change current use pattern	Needs minimal support to maintain abstinence	Moderate risk of relapse without close monitoring	Moderate to high risk of relapse without daily intervention or history of relapse in lower level of care	Moderate to high risk of relapse without 24 hour intervention. History indicates high likelihood of continued use or relapse at lower level of care.	Moderate to high without daily contact	Problems in this dimension do not qualify client for this level of service.
6 Recovery Environmental	Supportive recovery environment and/or client has appropriate coping skills. Social support system increases risk of initiation or progression of use	Client's environment supportive or client has sufficient skills to cope	Client lacks a supportive environment but with structure and support can cope	Client's living environment is not supportive and may interfere with the treatment process but with support client can cope	Living environment is dangerous or does not support recovery and client does not have coping skills	Living environment is stable or client has sufficient coping skills	Problems in this dimension do not qualify client for this level of service.
	Client must meets 4 out of 6 dimensions.	Client must meets 4 out of 6 dimensions.	Client must meets 4 out of 6 dimensions.	Client must meets 4 out of 6 dimensions.	Client must meets 4 out of 6 dimensions.	Client must meets 4 out of 6 dimensions.	Client must meet minimum of dimension 1

Substance Abuse Continued Stay

	Education Level .5	OP Level One	IOP Level Two	Day Treatment Level Three	Inpatient Rehab Level Four	Ambulatory Detoxification	Inpatient Detoxification
1 Acute Intoxication and/or Withdrawal Potential	NONE	NONE	NONE or minimal risk of withdrawal	Mild to moderate risk of withdrawal	Mild or moderate risk of withdrawal, does not need medical monitoring on a 24 hr. basis	Moderate to severe risk of withdrawal	Moderate to severe risk of withdrawal needing monitoring 24 hours daily
2 Biomedical conditions and complications	None or stabilized	Biomedical conditions do not interfere with TX	Biomedical conditions do not interfere with TX	Mild to moderate complications/professional medical supervision is needed	NONE OR continues to have conditions that require monitoring in a residential setting	Continued daily contact is needed to monitor medical conditions	24 hour monitoring is needed
3 Emotional/Behavioral conditions and complications	NONE or very stable Emotional/Cognitive functioning does not interfere with treatment	None or very stable. Mild adverse emotional/behavioral/cognitive conditions OR they don't interfere with TX	Client has mild to moderate adverse emotional, behavioral, cognitive conditions but can sustain responsibilities	Client has mild to moderate adverse conditions or condition has deteriorated requiring frequent contact	Moderate emotional, behavioral, cognitive conditions requiring close supervision in a high intensity setting	Emotional, behavioral, cognitive conditions stabilized or will not interfere with the detoxification process	Emotional, behavioral, cognitive condition is stable or evaluation and treatment is needed for severe ongoing symptoms
4 Acceptance/Resistance	Cooperative, if resistant, can be motivated to accept TX	Motivated to cooperate with TX process OR can be motivated to continue TX	Making progress but still requires a structured treatment program to address resistance and motivation	Some progress noted but structured setting needed to develop acceptance of TX goals.	Motivation has improved but 24 hour supervision is still needed. OR Resistance requires intervention.	Client continues to accept the need for medical intervention	Client continues to accept the need for inpatient medical intervention.
5 Relapse Potential	Relapse potential reduced, but continued services are still needed.	Structured contact needed to prevent relapse.	Requires close monitoring and professionally supervised program to prevent relapse	Moderate to high risk of relapse without daily intervention. Additional TX can prevent future risks	Moderate to high risk of relapse without 24 hour supervision.	Moderate to high without daily contact	Acute crisis as result of addiction symptoms requiring continued TX.
6 Recovery Environmental	Supportive environment/coping skills. OR Environment not supportive, continued TX can increase coping skills.	Supportive environment or if not supportive, TX can increase coping skills	Supportive environment OR support can be provided through structured program to increase coping skills	Living environment continues to interfere with TX progress. Structured setting is required to develop coping skills.	Searching for alternative options, OR further stabilization needed before release.	Living environment is stable or client has sufficient coping skills	Clients living environment is not a factor in continued stay at this level of care.
	Client must meet at least 4 of 6 dimensions.	Client must meet at least 4 of 6 dimensions.	Client must meet at least 4 of 6 dimensions.	Client must meet at least 4 of 6 dimensions.	Client must meet at least 4 of 6 dimensions	Client must meet at least 4 of 6 dimensions	Client must meet criteria in dimension 1

Substance Abuse Discharge Criteria

	Education Level .05	OP Level One	IOP Level Two	Day Treatment Level Three	Inpatient Rehab Level Four	Ambulatory Detoxification	Inpatient Detoxification
1 Acute Intoxication and/or Withdrawal Potential	NONE	NONE	NONE	NONE or can benefit from less intensive level of care OR deteriorated and requires different level of care	None or requires higher level of care.	Stabilized or requires higher level of care.	Stabilized
2 Biomedical conditions and complications	None OR stabilized OR needs different level of care.	None OR deteriorated requiring different level of care.	None OR stabilized OR deteriorated requiring a higher level of care	None OR can benefit from less intensive level of care OR deteriorated requiring different level of care	None OR can move to less intensive level of care OR deteriorated needing more medical supervision.	Daily contact is no longer required to monitor medical conditions OR has deteriorated requiring higher level of care	24 hour monitoring is no longer needed
3 Emotional/ Behavioral conditions and complications	None OR stable not requiring services OR deteriorated requiring different level of care.	None OR sufficiently stabilized OR deteriorated requiring different level of care.	None OR stable OR deteriorated requiring different level of care	None OR stable and do not interfere with less intensive services OR deteriorated requiring different level of care	Stable OR deteriorated requiring more intensive TX.	Stabilized OR will not interfere with lower level of care OR deteriorated requiring higher level of care.	Emotional, cognitive, behavioral is stable OR evaluation and treatment is needed but can be accomplished safely at a lower level of care
4 Acceptance/ Resistance	Sufficiently motivated and stabilized OR resistant and refusing TX OR requiring higher level.	Sufficiently motivated and stabilized OR resistant and refusing TX OR requiring a higher level of care	Goals achieved OR condition deteriorated requiring different level of care OR refusing treatment.	Condition improved no longer requiring day TX OR deteriorated requiring different level of care OR refusing treatment	Ready for less intensive level of care OR resistance not improved despite interventions OR refusing treatment.	Accepts lower level of care OR deteriorated requiring higher level of care OR refusing treatment.	Accepts lower level of care OR refuses treatment
5 Relapse Potential	Low risk of relapse OR repeated relapses requiring different level of care	Low risk OR repeated relapses requiring different level of care	Low risk of relapse OR repeated relapses despite TX requiring different level of care	Low risk of relapse OR repeated relapses requiring different level of care	Low risk of relapse OR repeated relapses requiring different level of care or TX plan	Low risk of relapse OR repeated relapses requiring different level of care	Moderate to high risk of relapse without structured treatment.
6 Recovery Environmental	Environment supportive allowing discharge to no Tx OR environment nonsupportive and coping insufficient requiring different level of care	Environment supportive OR environment nonsupportive and coping insufficient requiring different level of care	Environment supportive OR environment nonsupportive but coping adequate OR environment nonsupportive and coping insufficient requiring different level of care	Environment nonsupportive but coping adequate OR environment nonsupportive and coping insufficient requiring different level of care	Environment supportive OR environment nonsupportive but coping adequate OR environment nonsupportive and coping insufficient requiring different level of care or Tx plan	Environment supportive OR environment nonsupportive but coping is adequate	Clients living environment is stable OR environment is unstable.
	Client must meet at least 4 of 6 dimensions.	Client must meet at least 4 of 6 dimensions.	Client must meet at least 4 of 6 dimensions.	Client must meet at least 4 of 6 dimensions.	Client must meet at least 4 of 6 dimensions	Client must meet at least 4 of 6 dimensions	Client must meet criteria at least in dimension 1

CLINICAL CRITERIA FOR SUBSTANCE ABUSE HALFWAY HOUSE

A halfway house (residential transitional living program, non-medical residential treatment) is a non-medical community rehabilitation facility with a planned program of professionally-directed evaluation, care and treatment for the restoration of functioning for patients with substance abuse issues. It is intended to be a step-down placement after completion of a higher level of care until the patient is able to return to their home and continue treatment on an out patient basis. It is not intended to be an alternate or permanent residence. Regulations for these programs vary from state to state. A description of minimum requirements is outlined under intensity of service.

CLINICAL CRITERIA FOR ADMISSION

1. Patient must have a DSM-IV diagnosis of substance abuse and may have a co-morbid mental health diagnosis but no evidence of risk to self or others.
2. Patient must have successfully completed a higher level of care.
3. Patient must require ongoing stabilization due to continuing issues on Dimensions 2, 3, 4, 5 and/or 6, with specific issues in the recovery environment which preclude reintegration into the home or family and a moderate to high level of relapse potential.
4. The family, when appropriate, is actively engaged in the treatment process and reintegration plan but there is a moderate to high level of instability in the family or support system.

CLINICAL CRITERIA FOR CONTINUED STAY

1. Admission criteria are met for the level of care based on continuing DSM-IV diagnosis or the emergence of new or previously unidentified DSM-IV diagnoses.
2. Treatment goals are realistically achievable and directed toward stabilization to allow treatment to continue in a less restrictive environment.
3. Progress toward treatment goals has occurred, as evidenced by measurable reductions in signs, symptoms and/or behaviors to the degree that indicate continued responsiveness to treatment.

OR

The patient has failed to improve to a degree that might be expected if the patient is potentially responsive to that treatment, and a modification in the treatment plan and /or discharge goals has been made specifically to address the lack of expected treatment progress.

4. Patient is currently involved in and cooperating with the treatment process.

OR

The patient is not currently involved in and cooperating with the treatment process, but there are measurable indicators that the patient is progressing toward active involvement.

5. When appropriate, the family is involved in and cooperating with the treatment process.

OR

The family is not involved in and cooperating with the treatment process, but there are measurable indicators that they are progressing toward active involvement(except where there are clear indications that involvement of family member(s) would be clinically counterproductive or legally prohibited).

DISCHARGE CRITERIA

1. There is no withdrawal risk.
2. Biomedical conditions and complications are none or stabilized.
3. Low adverse emotional, behavioral or cognitive conditions.
4. Goals have been achieved or the condition has deteriorated requiring a higher level of care.
5. There is a low risk of relapse or repeated relapses require a higher level of care.
6. The family environment has improved and is supportive or skills have increased to manage the environment or the client cannot cope and requires a higher level of care.

CLINICAL CRITERIA FOR INTENSITY OF SERVICE

1. The halfway house facility must be licensed or certified by the state in which it is located.
2. Room, board and supervision occurs for patients twenty-four hours a day and seven days per week.
3. Treatment with structured substance abuse services and activities occurs for at least ten hours per seven day week at the program site or agency. Individual and/or group counseling services should be available at a certified program site. The program shall provide at a minimum:

Assessment services

Individual and group counseling services

Crisis intervention services

Case management

Patients will have at least three nutritionally balanced meals per day and the opportunity for eight hours of sleep per night.

Interpersonal and group living skills shall be promoted to assist the patient in transitioning to their home environment.

Services provided may include:

Drug and alcohol education

Expressive therapies such as art, drama, poetry and movement

Occupational therapy

Recreational therapy

Nutrition education

Parenting skills training

Anger management techniques

Time management

4. A medical history shall be completed on or before admission by a licensed medical practitioner or may accept a physical examination completed ninety days or less prior to the admission. Communicable disease screenings for tuberculosis and hepatitis should occur when indicated.

DIMENSION

1. Acute intoxication and /or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral conditions and complications
4. Acceptance/
5. resistance
6. Relapse potential
7. Recovery environment

Substance Abuse Halfway House Criteria

ADMISSION

1. No withdrawal risk
2. None or stabilized
3. Low to moderate adverse emotional, behavioral or cognitive conditions
4. Patient requires structured program to address resistance and motivation
5. Moderate to high risk of relapse potential
6. Lacks supportive family/peer environment or sufficient skills to maintain abstinence

CONTINUED STAY

1. No withdrawal risk
2. None or stabilized
3. Low to moderate adverse emotional, behavioral or cognitive conditions

4. Making progress but requires structured program to address resistance and motivation
5. Making progress but still needs to practice skills addressing triggers and lifestyle changes
6. Family environment improving and/or skills improving to allow patient to maintain sobriety in home environment

DISCHARGE

1. No withdrawal risk
2. None or stabilized
3. Low adverse emotional, behavioral or cognitive conditions
4. Goals achieved or condition deteriorated requiring higher level of care
5. Low risk of relapse or repeated relapses requiring higher level of care
6. Family environment has improved and is supportive or skills have increased to manage environment or cannot cope and requires higher level of care

CLINICAL CRITERIA FOR IN-HOME TREATMENT

Must satisfy all of the following:

1. Acute and serious impairment of psychosocial functioning (and/or in the case of children, developmental progression) from the child or adolescent patient's baseline due to a major DSM-IV psychiatric and/or substance use disorder in one or more of the following areas:
 - 1.1. Educational
 - 1.2. Vocational
 - 1.3. Family
 - 1.4. Social/peer relations
2. Intervention is essential to maintain gains accomplished at a higher level of care or to prevent return to a higher level of care. In certain cases where intensive outpatient therapy has not been successful in maintaining the patient and hospitalization could be imminent, in-home care may be appropriate to prevent the hospitalization.
3. Refractory to an adequate trial of, or clearly inappropriate for, active treatment at a lesser level of care.
4. Not responsive to brief or intermittent multiple interventions at higher levels of care due to the nature of the presenting problems or family dynamics.
5. The severity of the psychiatric disorder and the impairment of developmental progression and/or psychosocial functioning from the disorder require an ongoing, supervised, and structured intervention in the home. The goal is to improve adaptive functioning and a return to developmentally and culturally appropriate social roles in school and home.
6. Current symptoms do not meet the criteria for acute inpatient hospitalization and do not require a 24-hour, continuous, structured therapeutic milieu.
7. The patient must have a safe living environment provided by the family/guardians to allow for the therapeutic intervention.
8. The patient/family demonstrates intent/ability to form a treatment alliance and comply with treatment.

CLINICAL CRITERIA EMPLOYEE ASSISTANCE PROGRAM (EAP)

ADMISSION CRITERIA

1. Issue is not DSM-IV related
 - 1.1. Issues related to stress management, financial problems, etc.
 - 1.2. The focal issue can be resolved with a brief therapy model (average sessions 4-5) within the EAP benefit
2. Issue DSM-IV related
 - 2.1. Diagnosis of an Axis I V code or Adjustment Disorder
 - 2.1.1. Level of Stability
 - 2.1.1.1. Risk to self, others, or property is minimal to none
 - 2.1.1.2. Adequate support system available
 - 2.1.1.3. Client requires no medical supervision
 - 2.1.1.4. Client shows the capacity for active participation in treatment
 - 2.1.1.5. Solution to one focal conflict is the main therapeutic issue
 - 2.1.2. Intensity of Service
 - 2.1.2.1. Focal issue can be resolved with sessions defined by the benefit; otherwise assess and refer should occur.
 - 2.1.2.2. More than one episode of EAP treatment can occur during a 12 month period for separate focal issues, but repeat EAP treatment episodes should not address the same, chronic ongoing therapeutic issues.
 - 2.1.2.3. Assessment of children and adolescents usually requires a referral into the benefit if significant behavioral issues are identified with phone assessment.
 - 2.1.2.4. Substance abuse assessment is recommended when any concern of chemical use is identified for clients of all ages.
 - 2.1.2.5. Marital treatment is an episode of EAP treatment and utilizes one EAP benefit (up to 5 or 10 sessions). If a couple is in marital therapy and individual treatment is recommended for one or both members of the couple, referral into the panel is most likely necessary due to the complexity of the case. Exceptions may be approved by the clinical supervisor.
 - 2.1.2.6. Care usually can be completed in less than 6 months.
 - 2.1.2.7. Client can assume therapeutic contract responsibility.
 - 2.1.3. Mild to moderate symptoms (e.g., depressed mood and mild insomnia) or some difficulty in social, occupational, or school functioning (e.g., new job or graduation anxiety), but generally functioning is adequate, with some meaningful interpersonal relationships.

CONTINUED STAY CRITERIA

1. Client continues to meet admission criteria.
2. Client is engaged in process and working toward problem resolution within EAP benefit visit limit.

DISCHARGE CRITERIA

1. Client has completed course of treatment.
2. Client did not engage in treatment process and alternate plan was arranged.
3. Client decompensated or one or more moderate to serious problems were identified. Client was referred to a different level of care or type of care.

CRITERIA FOR COACHING

Coaching is a service designed to improve professional/personal effectiveness through assessment of strengths and weaknesses, goal focused action planning, feedback on systematic implementation of improvement activities and evaluation of results.

Clients access services through telephone or on-line. Assessment identifies area of concern or focus.

If clinical or health issues are identified which raise a question regarding the appropriateness of coaching as a resource for the client, further assessment is performed.

Parent Coaching

1. Appropriate for mild to moderate behavioral issues with no level of risk to parent or child.
2. Appropriate for a specific situation or behavior expected to resolve within 3 months.
3. Appropriate for general parenting instruction regarding discipline strategies.

Health/Wellness Coaching

1. Appropriate for general health improvement in areas such as healthy eating, motivation to engage in fitness activities, stress management and expected to last 3-6 months.
2. If significant health/medical issues are identified by assessment, a physician certificate is required to allow the client to engage in coaching. Clients with health conditions not under treatment and/or not stable will not be accepted into coaching but will be referred to other more intensive resources including their primary care physician.

APPENDIX I

General Guidelines for Psychological Testing and Assessment

DEFINITIONS

1. A psychological test is “an objective and standardized measure of sample behavior” (Anastasi, 1982). The diagnostic and predictive value of a psychological test is largely dependent on the psychometric properties of the test, the scientifically derived indicators of validity and reliability, and the user’s clinical judgment and skill. Users should be thoroughly familiar with the psychometric properties of the psychological tests, as well as the appropriate uses and limitations of any instrument.
2. Psychological testing is a specialized procedure used to assess personal characteristics of individuals, which may include, but is not limited to: cognitive and intellectual functioning, special aptitudes and achievement, personality, emotional and motivational traits, interests, values, and other personal characteristics (Anastasi, 1982).

QUALIFICATIONS OF TEST ADMINISTRATORS/ASSESSORS

1. Minimum requirements for the evaluation of tests, testing practices, and the effects of test use are described in “Standards for Educational and Psychological Testing.” The American Psychological Association (1999).
2. Minimum requirements for test administrators/assessors are usually a doctoral degree in psychology, or its equivalency, plus licensing as an independent and autonomous practitioner in the field of psychology. Licensure laws govern the practice of psychology, use of the title, and description of the words “psychology”, “psychological”, “psychologist”. Such laws also govern supervision and regulate supervisory requirements of non-licensed personnel assisting the licensed psychologist in rendering psychological services (including psychological testing and assessment). Appropriate titles should reflect the non-licensed person’s status as a “psychology assistant”, “psychology trainee”, “psychology intern”, or similar term (as determined by state law).

ESTABLISHING MEDICAL NECESSITY FOR PSYCHOLOGICAL TESTING

In order to qualify for reimbursement/coverage under a health care insurance benefit, psychological testing needs to guide the diagnosis and treatment of a mental disorder included in the benefit plan. Testing for excluded conditions and diagnoses will not be criteria for medical necessity. Likewise, testing for conditions or personal characteristics which are not considered mental disorders according to the Diagnostic and Statistics Manual IV, shall not meet criteria for medical necessity. Specifically, psychological testing is considered medically necessary only when the following conditions are met:

1. The establishment of a diagnosis of a mental disorder or condition can only be made with assistance of information derived from psychological testing. This may include ruling out all other mental disorders or conditions, establishing the presence of two or more coexisting conditions, and/or establishing sufficient diagnostic criteria for diagnosis of a mental disorder or condition.
2. Psychological testing establishes diagnostic formulation and functional status in a more timely and cost effective manner than would be possible through other means (review of prior testing, continued observation and interview, history or other currently available clinical data). Psychological testing has not been conducted to assess the same questions of diagnostic formulation and functional status within the last year.
3. The results of psychological testing specifically guide focused treatment and/or case management.

4. The proposed psychological tests are chosen to assess specific referral questions concerning diagnostic formulation and/or functional status and are considered reasonable, professionally accepted measures of the personal characteristics in question.
5. The selection, administration, interpretation, and reporting of psychological tests results requires the specific expertise of a qualified psychologist (as described by the “Standards for Educational and Psychological Testing”, American Psychological Association, 1990). The qualified psychologist is ultimately responsible for selection, modification, interpretation, and reporting of psychological testing and shall review all results and sign all reports. Psychological procedures rendered by anyone other than the licensed/qualified psychologist must meet supervisory and regulatory requirements of state law.

GUIDELINES FOR ASSESSMENT AND DIAGNOSIS OF ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD) IN CHILDREN AND ADOLESCENTS

The process and procedures for assessment and diagnosis of ADHD shall conform to the general guidelines described above. Specific psychological testing may not always be necessary to establish the ADHD diagnosis. However, when testing is appropriate, tests must meet the criteria for medical necessity described above. A definitive diagnosis of ADHD should only be made by a physician, psychiatrist, or psychologist qualified by training and/or experience. CONCERN has followed the “Practice Parameter for the Assessment and Treatment of Children and Adolescents With Attention-Deficit/Hyperactivity Disorder” adopted by the AACAP in 2000 and updated in 2007.

DESCRIPTION OF ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Research and clinical conceptualization on ADHD has grown dramatically in the past decade. Recent diagnostic formulations suggest that ADHD is characterized by developmentally inappropriate degrees of inattention, impulsivity (behavioral disinhibition) and hyperactivity (over-activity) (see DSM-IV, 1994 and R. Barkley, 1991). The diagnostic formulation further suggests that symptoms and functional deficits are not accounted for and do not occur exclusively by existence of gross neurological, sensory, language, or motor impairment, mental retardation, or severe emotional disturbance (diagnoses such as, Pervasive Developmental Disorder, Schizophrenia, other Psychiatric Disorders, Mood Disorders, Anxiety Disorder, Dissociative Disorder or Personality Disorder). The ADHD disorder is considered both chronic and pervasive, with symptoms that have been present longer than 6-12 months and arise in early childhood (were evident prior to age 6 or 7). Individuals with ADHD display some pattern of deficit in response to rules or instructions, do not respond well to behavioral consequences, and have difficulty inhibiting, initiating or sustaining attention and/or task directed behavior (particularly in less structured situations in which consequences or external direction are delayed, weak, or absent). Throughout the life-span development of an individual with ADHD, the deficits persist in comparison to normal same-age individuals.

ETIOLOGY AND CAUSES OF ADHD

While etiological and causal mechanisms of ADHD are not fully understood, research has implicated a combination of genetic, biologic, and environmental factors. History of ADHD, mood disorders, and/or alcohol/drug abuse sometimes exists in the family history of ADHD individuals. Various prenatal, perinatal, and other developmental health factors and socioeconomic factors are also implicated (though this correlation may be considered weaker).

COMORBIDITY/COEXISTING DISORDERS

ADHD has been found to sometimes coexist with Conduct Disorders, Oppositional Defiant Disorder, Thought or Mood Disturbances, and various Learning Disabilities. While the coexistence of another disorder does not preclude diagnosis of ADHD, the assessment process should attend to the possibility of another disorder, to more effectively guide intervention, recommendations, and/or treatment.

ASSESSMENT OF ADHD

Given that symptom patterns of ADHD may show variability within an individual, or across the population, and that various etiological and predictive factors may also not be entirely consistent from one individual to another, a comprehensive approach to assessment from a biopsychosocial perspective is considered the best approach. Assessment should proceed in a step-wise fashion. Information should be gathered objectively, using standardized measures whenever possible, to establish the individual's functioning in a variety of domains, including behavioral status, and interpersonal and social functioning. The step-wise assessment should consider appropriate genetic, biologic, and environmental influences and it should be directed toward most efficiently documenting the existence of the diagnostic criteria described above. Furthermore, assessment should establish specific areas of functional deficit and guide focused intervention, case management, and/or treatment.

The following procedures should be part of any comprehensive assessment of ADHD:

1. Complete development history (by interview and/or parent/guardian questionnaire)
2. Family history
3. Review of presenting symptoms/problems with parent/guardian
4. Assessment of behavioral status (particularly degrees of inattention, impulsivity, and hyperactivity), using standardized behavior checklists completed by parent/guardian, teacher(s), and (when deemed appropriate with adolescents or older children) the individual patient/client. The evaluator should be aware of the psychometric properties, reliability, and validity of these standardized measures.
5. Observation and interview of individual patient/client
6. Review of available standardized psychological and educational test results, school progress reports/report cards, and any other professional evaluations (such as medical reports, speech/language reports, occupational therapy reports, etc.)
7. If diagnostic criteria have not been met; or if sufficient evidence does not exist to rule out other possible conditions or disorders; other assessment procedures should be considered:
 - 7.1. Tests of intellectual/cognitive functioning may be necessary if:
 - 7.1.1 Available test results are older than one year;
-OR-
 - 7.1.2 There are clear indications that the individual's school will not or cannot conduct such testing within 60 days;
-OR-

- 7.1.3 Such information is necessary to answer diagnostic questions related to diagnostic criteria and/or is vital in planning of treatment, intervention, or case management.
- 7.2 Medical and/or neurological evaluation of the patient/client is considered if other data clearly suggest possible questions about the health status or neurological integrity of the individual.
- 7.3 Tests of continuous performance, vigilance, and sustained attention, laboratory based measures of impulsivity and neuropsychological functioning, and/or direct observational procedures may be necessary if the above measures do not fully establish existence of diagnostic criteria. A number of computerized and examiner-administered measures are available. The evaluator should be aware of the psychometric properties and limitations of such measures in terms of reliability, validity, sensitivity, and specificity.
- 7.4 As stated above, any assessment procedure should meet the general guidelines for Psychological Testing, the criteria for establishment of “medical necessity”, and not be specifically excluded by any other provision of the benefit.

APPENDIX II

Criteria for Electroconvulsive Therapy (ECT)

DEFINITIONS

Attending Physician: The physician responsible for the overall treatment of the condition for which ECT is recommended.

Treating Psychiatrist: The physician administering ECT. This physician has continuing education in the administration of ECTs.

Anesthetist: The individual(s) responsible for administering anesthesia for ECT.

Consentor: The individual providing informed consent for ECT.

Facility: The organization responsible for the development and implementation of policies and procedures for both clinical practice of ECT and privileging of individuals in its administration.

ECT Course: A series of ECT treatments administered to induce a clinical remission in a defined episode of a mental disorder.

Continuation/Maintenance ECT: The use of ECT to maintain an induced clinical remission and/or minimize likelihood of relapse. The onset of a period of continuation or maintenance ECT is defined as the point at which therapeutic intent shifts from inducing a remission to maintaining it.

INDICATIONS

1. Years ago, Electroconvulsive Therapy (ECT) was an extensively used treatment modality when fewer and more problematic medications were available for the treatment of serious psychiatric illnesses. Fear became attached to the use of ECT when, in the past, the treatment was significantly less sophisticated. There were concerns that the treatment was overused or, in some cases, used inappropriately. The memory loss that occurred in some patients has been touted by some mental health advocates as outweighing the positive benefits of the treatment. Current techniques, however, are outweighing the negative effects of the treatment. Current techniques are associated with a very low side effect profile and a significant efficacy for the indicated diagnoses/conditions. It is therefore, probably an underused treatment currently and should be recommended or discussed when appropriate indicators are present.
2. Referrals for ECT are based upon a combination of factors, including the patient's diagnosis, nature, severity of symptomatology, treatment history, consideration of anticipated risks and benefits of viable treatment options, and patient preference.

PRIMARY USE OF ECT

Situations where ECT may be used prior to a trial of psychotropic agents include, but are not limited to, the following:

1. Where a need for rapid, definitive response exists on either medical or psychiatric grounds;
 - 1.1. Severe Bipolar, not responding to medication(s) in 3 days, etc.
 - 1.2. Severe Depression which is life threatening, either from severe medical problems such as dehydration, malnutrition, or lack of sleep, severe agitation or overt suicidality; or
2. When the risks of other treatments outweigh the risks of ECT;
3. When a history of poor drug response and/or good ECT response exists for previous episodes of the illness;
4. Patient preference.

SECONDARY USE OF ECT

In other situations, a trial of an alternative therapy should be considered before referral for ECT.

Subsequent referral for ECT should be based on one of the following:

1. Treatment failure (taking into account issues such as choice of agent, dosage, and duration of trial);
2. Adverse effects which are unavoidable and which are deemed less likely and/or less severe with ECT;
3. Deterioration of the patient's condition such that (where a need for rapid, definitive response exists on either medical or psychiatric grounds) is met;
4. Significant medical problems develop, such as dehydration, malnutrition, and severe inability to sleep, or the patient develops intractable agitation depression or other evidence of severe psychological distress.

MAJOR DIAGNOSTIC INDICATIONS

Diagnoses for which either compelling data are present for efficacy of ECT or a strong consensus exists in the field supporting such use:

Major Depression Single Episode	296.2x
Major Depression Recurrent	296.3x
Bipolar Depression	296.5x
Bipolar Depression/Mania Mixed	296.6x
Bipolar Depression/Mania NOS	296.70
Bipolar Mania	296.4x

Schizophrenia/Other Functional Psychoses	
Catatonia	296.2x
Affective symptomatology is prominent	
History of favorable response to ECT	
Schizophreniform Disorder	
Schizoaffective Disorder	295.70
Atypical Psychosis	298.90

OTHER DIAGNOSTIC INDICATORS

There are diagnoses in mental health, medical, and organic mental syndromes for which the efficacy of ECT is only suggestive or where only a partial consensus exists in the field supporting its use. It is recommended only after standard treatment alternatives have been utilized. Such usage is not adequately substantiated and should be carefully justified in the clinical record on a case-by-case basis. Such conditions include, but are not limited to:

1. Catatonia secondary medical conditions
2. Hypopituitarism
3. Intractable Seizure Disorder
4. Neuroleptic Malignant Syndrome
5. Parkinson's Disease (particularly with the "on-off" phenomenon)

In these situations, Behavioral Health Management will coordinate care and authorization of services with the patient's PCP.

CONTRAINDICATIONS

There are no absolute contraindications to ECT. There are, however, situations associated with substantial risks.

Situations exist in which ECT is associated with an appreciable likelihood of serious morbidity or mortality. In those cases, the decision for ECT should be based upon the premise that the patient's condition is too grave (life threatening) to leave untreated and that ECT is the safest treatment available.

1. Careful medical evaluation of risk factors should be carried out before ECT, with specific attention to treatment modifications that may diminish the level of risk.
2. Specific conditions associated with substantially increased risk include the following:
 - 2.1. Space-occupying cerebral lesion or other conditions with increased intracranial pressure;
 - 2.2. Recent myocardial infarction with unstable cardiac function;
 - 2.3. Recent intracerebral hemorrhage;
 - 2.4. Bleeding, or otherwise unstable, vascular aneurysm or malformation;
 - 2.5. Retinal detachment;

- 2.6. Pheochromocytoma;
- 2.7. Anesthetic risk rated at American Society of Anesthesiologists (ASA) Level 4 or 5
 - 2.7.1. ASA Level 4: Severe systemic illness, which limits the activity of the patient such as, unstable angina.
 - 2.7.2. ASA Level 5: Patient not expected to live more than 24 hours.

INPATIENT

In general, ECT is performed when patients are in licensed facilities. These facilities provide anesthesiologists, post-anesthesia nurses, and all appropriate life support equipment needed for emergencies.

OUTPATIENT

An ECT course may be administered on an outpatient basis for a carefully selected population of patients at a properly equipped facility. The facility must provide the space, staff, and equipment to provide the same services that are available at an inpatient unit.

Criteria for selection of patients for outpatient ECT (the ability of the patient to meet these criteria should be reevaluated on an ongoing basis):

1. The same indications, contraindications, consent requirements, and pre-ECT evaluations as described previously apply to outpatient ECT.
2. The nature and seriousness of the patient's mental illness at the time of the ECT does not present a contraindication to management on an outpatient basis.
3. Anticipated risks associated with the ECT course are detectable and manageable either during the ECT session itself or on an outpatient basis.
4. The patient is willing and able, either individually or with the assistance of specified significant others, to comply with the behavioral limitations that are expected over this time interval.
5. The patient is willing and able to avoid activities that are likely to be substantially impaired by anticipated adverse cognitive effects of ECT, particularly on the day of each treatment.
6. The patient is willing and able to report any adverse effects of ECT and/or apparent changes in medical condition to the attending physician and/or ECT treatment team before any successive treatment.
7. The patient is willing and able to follow prescribed dietary, bowel, bladder, and grooming instructions before each ECT treatment.
8. The patient is willing and able to abide by a specified medication regime, including any medication adjustments to be made on the day of each treatment.
9. An attending physician is designated to maintain overall responsibility for the case during the treatment period.

APPENDIX III

CLINICAL CRITERIA FOR EATING DISORDERS

The American Academy of Child & Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA) published an update of the *Level of Care Placement Criteria for Psychiatric Illness* in August of 1997. The Associations renamed the document *Criteria for Short-Term Treatment of Acute Psychiatric Illness*. In the updated version, the APA and AACAP have adopted the following criteria for an eating disorder patient's admission to inpatient mental health units:

1. Weight loss to a point that the patient is 15% below ideal weight or failure to make expected weight gain during a period of growth, leading to body weight 15% below that expected and any one of the following:
 - 1.1. General medical complications resulting from the anorexia, including, but not limited to, severe malnutrition, emaciation, significant electrolyte or fluid imbalance, cardiac arrhythmia, hypotension, impaired renal function, or intestinal atony or obstruction;
 - 1.2. Life threatening complications from Bulimia Nervosa that may include pancreatitis, gastric dilatation, esophagitis or esophageal tears, severe electrolyte disturbance, colitis, cardiac arrhythmia, impaired renal function, or intestinal atony or obstruction;
 - 1.3. A complicating general medical condition such as cardiac disease, diabetes, or pregnancy;
 - 1.4. In addition to Bulimia or Anorexia, a severe concurrent drug/alcohol abuse problem.

The Utilization Management Criteria Manual Committee recommends that BHM use these criteria for reference, understanding that admission to a medical unit for stabilization may be the appropriate first step and should be advocated with the medical plans. The Academy and the APA encourage health care professionals, health care organizations, and third party payors to creatively design services that use both medical and mental health resources to optimize care.

The following scenarios are examples of how to apply these guidelines.

1. It would be more appropriate to admit an eating disorder patient in the starvation phase of the disease process into a medical unit until they are physically stable. In the starvation phase, the patient may experience electrolyte imbalances and cardiac arrhythmias, which can be life-threatening complications. These patients require medical management to achieve physical stability.
2. Eating disorder patients who also have a serious substance abuse problem. BHM recommends careful case management of the substance abuse problem to enable the medical staff to address the life threatening issues. Patients who present with both serious medical and behavioral health issues require co-management by both behavioral health professionals and medical-surgical specialists.

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