SERVICE SELECTION GUIDELINES: MENTAL HEALTH SERVICES

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Note: Documents/appendices referenced in this attachments are not included as they are included as contract attachments P 3.4.1.1 (Person-Centered Planning Best Practice Guideline) and P 3.2.1 (Medical Necessity Criteria).

INTRODUCTION
to the SERVICE SELECTION GUIDELINES

The Michigan Department of Community Health (MDCH) Service Selection Guidelines (SSGs) provide utilization management criteria for certain levels of care and qualification guidelines for enhanced/extended care services. As such, the SSGs are a framework for determining what conditions are appropriate for which service (or combination of service components), at what level of intensity, and for how long. The SSGs: (a) identify the clinical variables to be considered in the needs assessment process; (b) include Level of Care Guidelines - Utilization Management Criteria Protocols in three basic categories; and (c) describe how Protocols are to be applied in the context of the Person-Centered Planning Process and within the parameters of the MDCH's Medical Necessity Criteria.

I. AN INTERACTIVE PLANNING CLIMATE

The most important characteristic of an effective mental health service delivery system is the appropriate matching of services and supports to consumer need, based upon individual clinical conditions and circumstances, and to the maximum extent possible, personal choice. The planning climate is influenced, in large measure, by three critical and interactive dimensions - clinical condition, the person-centered planning process, and a set of non-traditional medical necessity criteria adopted by the MDCH. It is fair to say that the relative importance or weight given to each of these dimensions will vary according to conditions and circumstances and is likely to change over time for individual consumers. No single algorithm or weighting can precisely represent the subtle variations in balance that will emerge. Nevertheless, the Level of Care Protocols provided herein provide considerable direction and guidance for consumers and service providers in reviewing these dimensions and making decisions based upon these considerations.

II. NEEDS ASSESSMENT PROCESS - CLINICAL VARIABLES

In order to develop an accurate estimation of the severity of a given illness and the required care setting or intensity of services and supports necessary to safely and appropriately treat the particular disorder, each Level of Care Protocol requires a clinical assessment of symptom acuity, functional impairments, and clinical stability (risk potential). An assessment of these variables, and the additional dimension of duration of the disorder, is generally sufficient to determine whether or not the precondition to qualify for mental health services has been met - a primary, validated DSM-IV or ICD-10 diagnosis (excluding v codes).

III. PROTOCOL CATEGORIES

In order to assist in service selection and/or utilization management, protocols are provided in three generic categories based on a composite assessment of clinical variables to estimate Severity of Illness (SI) and the needed Intensity of Service/Supports (IS) - High Acuity Level of Care Guidelines/Utilization Management Criteria, Enhanced Rehabilitation and

Support Service Selection Guidelines, and Mild/Moderate Disorders Treatment/Utilization Management Protocols.

A. High severity situations (intense, disabling symptomatology, loss of requisite functional abilities and/or high risk of self/other harm) generally trigger an emergency or urgent response. In such a circumstance, the objective is to stabilize the individual's current crisis situation and, in this urgent context, the individual's opportunity to make choices are likely to be circumscribed, implying consideration of service alternatives of high intensity but generally limited in duration. High Acuity Level of Care - Utilization Management Protocols will be useful here.

B. The clinical assessment for persons with serious mental illness or serious emotional disturbance will confirm a significant SI and multiple treatment, support, and rehabilitation needs. Under these circumstances, the person-centered planning process needs to be quite extensive and deliberate to ensure these multiple service needs are addressed, and that services are individualized or tailored to the person's condition and preferences. Although there are no preset limits on the type, amount, duration, or intensity of covered services, Mental Health Code requirements (e.g., least restrictive setting) reflected in medical necessity criteria may limit the duration of certain services (e.g., state hospital) if clinically appropriate alternatives are available. Service selection decisions for serious and persistent conditions should be guided by Enhanced Rehabilitation and Support Service Protocols.

C. A more moderate clinical presentation both permits and requires, within the person-centered planning process, a more in-depth focus on the individual's expressed needs and valued outcomes. However, the lower SI also implies, in the context of medical necessity criteria, a less intensive service response - type, amount, frequency, and duration may be limited. Service selection decisions under these circumstances should be guided by Treatment/Utilization Management Protocols for Mild/Moderate Disorders**.**

IV. A WORD ABOUT THE INTERFACE BETWEEN HEALTH AND HUMAN SERVICE SYSTEMS - BOUNDARY ISSUES

The three mental health service protocols described previously all presume that the symptoms, impairments, or disordered behavior that is the focus of concern are the result of a psychiatric disorder and, in most cases, a serious psychiatric disorder. The responsibility of the mental health service system for biologically and developmentally based serious psychiatric disorders is well established. The system's obligation toward or liability for other situations has historically been more difficult to demarcate.

The matter becomes particularly complex when the etiology of disordered behavior begins to encompass personality, familial/environmental disruptions, co-morbid conditions, societal and/or medical factors. In these circumstances, it may be difficult to differentiate whether symptomatology and/or disordered behavior is due to or a primary consequence of,

concomitant substance abuse, a personality pattern disturbance (anti-social diagnosis), situational stressors, educational impairments, and/or environmental/social support system disruptions.

Different health and human service agencies have been established to deal with the different facets of disordered behavior and role performance problems. As these entities go about their primary mission of protecting children, working with unstable family environment, offender disposition and rehabilitation, educational performance, primary health care concerns, addictive conditions, etc., they often come across individual symptoms/behavior or family difficulties suggestive of a psychiatric disorder.

Conflicts between service systems may emerge within these gray areas. Arguments over the nature and primacy of the condition may erupt, or disputes over who is the primary service entity and hence legally and financially responsible for care placement and services may develop. The different roles, mandates, funding streams and accountability concerns of these systems complicate resolution of such disputes. The emergence of capitated payment systems (Medicaid) and issues related to medical necessity may further aggravate these situations. Under the managed mental health services programs, capitated payments and state funds must be used to provide covered or mandated mental health services to eligible consumers or priority populations, and cannot be used to supplant other sources of payment or to pay for services that are the responsibility of another agency.

A. Approaches to Resolution of Boundary Disputes

The initial step in resolving boundary disputes is to identify the problem and to suggest possible systematic local approaches to resolution of such boundary issues. Since, as noted above, it may be difficult in an individual circumstance to differentiate whether symptomatic expression or disordered behavior reflects a primary psychiatric disorder or are a secondary manifestation of the situational, legal, medical, educational, addictive and/or social support difficulties, it is important that local resolution and/or coordination mechanisms be established.

Currently, there are few state-level parameters to clarify these situations. There is a Medicaid Policy Bulletin (draft) that attempts to explain the boundary between CMHSP responsibilities for mental health services and some older dual diagnosis criteria that were not widely distributed or implemented.

There are four possible approaches that local health and human services agencies may take to resolve these boundary disputes. A combination of the various solutions will likely be needed.

1. Memorandum of Understanding or Interagency Agreements: In many localities the major human service agencies have developed agreements that define scope of responsibilities, ensure collaboration and prescribe dispute resolution processes.

2. Service Protocols and Decision Algorithms: Some community agencies are attempting to develop protocols or decision matrixes that define responsibilities for services under various conditions.
3. Multi-Purpose Collaborative Bodies: the MPCBs are a vehicle for functional service system integration in many areas of the state and may be useful in developing local consensus regarding service responsibilities.
4. Pooled Funding: Since certain problems, situations, behaviors, and/or symptoms are related, some communities utilize shared or pooled funding mechanisms to jointly pay for services for consumers.

B. Considerations for CMHSPs in Dealing with Boundary Situations

1. What is the nature, extent and duration of the individual's or family's involvement with other human service systems, the educational system or the justice system?
2. What are the signs, symptoms, impairments or behaviors that have been identified as requiring mental health intervention?
3. Do the signs, symptoms, impairments and/or behaviors establish a diagnosable mental disorder?
4. Does the condition constitute a serious mental illness or serious emotional disturbance requiring specialized mental health services and supports?
5. If the condition does not constitute a serious disorder, are treatment services medically necessary?
6. Is the consumer an enrollee of a Medicaid health plan and does the condition meet the criteria for health plan mental health services?
7. Is the psychiatric disorder the primary condition, or are there other conditions that should be addressed first or concurrently?
8. Is any other entity or agency legally or contractually responsible for services?
9. Is it difficult to differentiate the primary etiology or nature of the consumer's problems, symptoms, and behaviors, and should service responsibilities be shared and funding for treatment pooled?

LEVEL of CARE GUIDELINES - UTILIZATION MANAGEMENT CRITERIA HIGH ACUITY CONDITIONS/SITUATIONS

The Service Selection Guidelines (SSGs) provide the framework for determining who is eligible for which service (or combination of service components), at what level of intensity, and for how long. The Level of Care Protocols for High Acuity Conditions is one of four documents comprising the SSGs and is intended to guide the determination of eligibility and level of care placement decisions for persons with mental illness who present with urgent or emergent clinical conditions.

Urgent or emergency clinical situations involve intense, disabling symptomatology, loss of requisite functional abilities (unable to meet basic needs) and/or a high risk of self/other harm. These protocols describe a range of service settings and support activities that might be utilized to stabilize a high acuity clinical situation. The concepts of Severity of Illness (SI) and Intensity of Service (IS) are utilized to guide placement choices and service disposition decisions related to these situations. Severity of Illness refers to the nature and severity of the signs, symptoms, functional impairments and risk potential involved in the consumer's disorder. It is assumed that as the severity of illness increases, the level of care needed to treat the consumer will also intensify. Intensity of Services designates the setting of care, usually corresponding to the types and frequency of needed services and supports, and to the degree of restrictiveness of the setting.

The level of care selected as a response to an urgent or emergency situation will depend upon the clinical assessment of Severity of Illness (SI), consumer preferences (when possible), available care settings (Intensity of Service options) and attention to the concepts of treatment suited to condition, least restrictive clinically appropriate environment and medical necessity. It is recognized that some individuals presenting with an urgent or emergent mental health problem may not require admission to any of the levels of care described in this protocol because basic crisis intervention response activities (assessment, counseling, support, etc.) are sufficient to resolve the crisis situation.

The reader will note that the differences among the criteria for various levels of care contained in these protocols are often very subtle. This reflects the interplay and influence of three interacting and often overlapping concepts: symptom acuity, functional impairments, and risk potential (clinical stability). An appreciation of these variables and their relative intensity in any particular situation is crucial for developing an estimation of the severity of a given illness, and for determining the required care setting or service intensity necessary to safely and appropriately treat the particular mental disorder.

In all situations, eligibility or benefit coverage for high acuity levels of care requires that the selected level of intensity be medically necessary. Medically necessary services are generally considered to be those that (a) are adequate and essential for evaluation and/or treatment of an illness or condition, as defined by the standard diagnostic nomenclature (DSM-IV, ICD-10); (b) can reasonably be expected to improve an individual's condition or level of functioning; (c) are in keeping with national standards of mental health practice; and (d) are provided at the appropriate, least restrictive level of care. An expanded definition of the concept of medical necessity is contained in Contract Attachment P 3.2.1.

It is important to stress that these protocols do not constitute a standard of practice, nor are they a substitute for thorough assessment and sound clinical judgement. However, as guidelines, they are a part of a service selection and utilization management system intended to guide and monitor the appropriateness of care received by consumers of public mental health services.

These guidelines are intended to assist reviewers, practitioners and facilities in determining the appropriate level of care for consumers needing active treatment for a mental illness. Medicaid coverage for inpatient psychiatric services is limited to consumers with a current primary psychiatric diagnosis, as described in the criteria below. It is recognized that some consumers will have other conditions or disorders (e.g., developmental disabilities or substance abuse) which co-exist with a psychiatric disturbance. In regard to developmental disabilities, if a person with developmental disabilities presents with signs or symptoms of a significant, serious, concomitant mental illness, the mental illness will take precedence for purposes of care and placement decisions, and the consumer may be authorized/certified for inpatient psychiatric care under these guidelines.

For individuals who present with psychiatric symptoms associated with current active substance use or abuse, it may be difficult to determine whether symptoms exhibited are due to a primary mental illness or to substance abuse, and to make an informed level of care placement decision. A consumer exhibiting a psychiatric disturbance in the context of current active substance use or intoxication may require acute substance abuse detoxification services before an accurate assessment of the need for psychiatric inpatient services can be made. In these situations, the parties involved in care determination decisions (e.g., a hospital and the CMHSP) must confer to determine the appropriate location (acute medical setting or psychiatric unit) for the detoxification services.

INPATIENT ADMISSION CERTIFICATION CRITERIA: ADULTS

Inpatient psychiatric care may be used to treat a mentally ill person who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission are based upon the assumption that the consumer is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA - Must meet all three

I. **Diagnosis:**

The consumer must be suffering from a mental illness, reflected in a primary, validated, DSM-IV Axis I, or ICD-10 Diagnosis (not including V Codes).

II. **Severity of Illness:** (signs, symptoms, functional impairments and risk potential)

At least one of the following manifestations is present:

A. Severe Psychiatric Signs and Symptoms

* Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause seriously disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living so the person cannot function at a lower level of care.
* Disorientation, seriously impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
* A severe, life-threatening psychiatric syndrome or an atypical or unusually complex psychiatric condition exists that has failed, or is deemed unlikely to respond to less intensive levels of care, and has resulted in substantial current dysfunction.

B. Disruptions of Self-Care and Independent Functioning

* The person is unable to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living due to psychiatric disorder.

* There is evidence of grave impairment in interpersonal functioning and/or extreme deterioration in the person's ability to meet current educational/ occupational role performance expectations.

C. Harm to Self

* Suicide: Attempt or ideation is considered serious by the intentionality, degree of lethality, extent of hopelessness, degree of impulsivity, level of impairment (current intoxication, judgement, psychological symptoms), history of prior attempts, and/or existence of a workable plan.
* Self-Mutilation and/or Reckless Endangerment: There is evidence of current behavior, or recent history. There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.
* Other Self-Injurious Activity: The person has a recent history of drug ingestion with a strong suspicion of overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.

D. Harm to Others

* Serious assaultive behavior has occurred, and there is a risk of escalation or repetition of this behavior in the near future.
* There is expressed intention to harm others and a plan and/or means to carry it out, and the level of impulse control is non-existent or impaired (due to psychotic symptoms, especially command or verbal hallucinations, intoxication, judgement, or psychological symptoms, such as persecutory delusions and paranoid ideation).
* There has been significant destructive behavior toward property that endangers others.

E. Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care

* The person has experienced severe side effects of atypical complexity from using therapeutic psychotropic medications.
* The person has a known history of a psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the adjustment or reinitiation of medications following discontinued use requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the consumer's condition or to the nature of the procedures involved.
* There are concurrent significant physical symptoms or medical disorders that necessitate evaluation, intensive monitoring and/or treatment during

medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

Special Consideration: Concomitant Substance Abuse

The underlying or existing psychiatric diagnosis must be the primary cause of the consumer's current symptoms or represent the reason observation and treatment is necessary in the psychiatric unit or hospital setting.

III. Intensity of Service

The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least one of the following:

A. Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.

B. Close and continuous skilled medical observation is necessary due to otherwise unmanageable side effects of psychotropic medications.

C. Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) is needed to protect the consumer, others, and/or property, or to contain the consumer so treatment may occur.

D. A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the consumer's signs and symptoms.

INPATIENT ADMISSION CERTIFICATION CRITERIA: CHILDREN AND ADOLESCENTS

Inpatient psychiatric care may be used to treat a mentally ill/emotionally disturbed child or adolescent who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission are based on the assumption that the consumer is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA - Must meet all three

I. **Diagnosis**:

The consumer must be suffering from a mental illness, reflected in a primary, validated, DSM-IV Axis I, or ICD-10 Diagnosis (not including V Codes).

II. **Severity of Illness** (signs, symptoms, functional impairments and risk potential)

At least one of the following manifestations is present:

A. Severe Psychiatric Signs and Symptoms

* Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so the person cannot function at a lower level of care.
* Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
* Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction.

B. Disruption of Self-Care/Support or Severely Impaired Personal Adjustment

* Consumer is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder.
* The consumer exhibits significant inability to attend to age appropriate responsibilities, and there has been a serious deterioration/impairment of

interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance.

C. Harm to Self

* A suicide attempt has been made that is serious by degree of lethal intent, hopelessness, impulsivity.
* There is a specific plan to harm self with clear intent and/or lethal potential.
* There is self-harm ideation or threats without a plan that are considered serious due to impulsivity, current impairment or a history of prior attempts.
* There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk taking or other self-endangering behavior.
* There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.
* There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.

D. Harm to Others

* Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.
* There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired.
* There has been significant destructive behavior toward property that endangers others, such as setting fires.

E. Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care

* The person has experienced severe side effects of atypical complexity from using therapeutic psychotropic medications.
* The person has a known history of a psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the adjustment or reinitiation of medications following discontinued use requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the consumer's condition or to the nature of the procedures involved.
* There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

Special Consideration: Concomitant Substance Abuse

The underlying psychiatric diagnosis must be the primary cause of the consumer's current symptoms or represent the reason observation and treatment are necessary in the hospital setting.

III. Intensity of Service

The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least one of the following:

A. Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.

B. Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications.

C. Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the consumer, others, and/or property, or to contain the consumer so treatment may occur.

D. A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the consumer's signs and symptoms.

INPATIENT PSYCHIATRIC CARE - CONTINUING STAY CERTIFICATION: ADULTS, ADOLESCENTS, AND CHILDREN

After a consumer has been certified for admission to an inpatient psychiatric setting, services will be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arresting of potentially life threatening self/other harm inclinations, management of adverse biologic reactions to treatment and/or regulation of complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive level of care for treatment of the patient's problems and dysfunctions.

Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations or biologic/medication complications, similar to those that justified the patient's admission certification, remain present and continue to be of such a nature and severity that inpatient psychiatric treatment is still medically necessary. It is anticipated that in those reviews that fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the inpatient unit. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

CRITERIA

I. Diagnosis:

The consumer has a validated DSM IV Axis I or ICD-10 mental disorder (excluding V codes), which remains the principal diagnosis for purposes of care during the period under review.

II. Severity of Illness:

Persistence/intensification of signs/symptoms, impairments, harm inclinations or biologic/medication complications that necessitated admission to this level of care, and that cannot currently be addressed at a lower level of care:

* continued severe disturbance of cognition, perception, affect, memory, behavior or judgment;
* continued gravely disabling or incapacitating functional impairments or severely and pervasively impaired personal adjustment;
* continued significant self/other harm risk;

* use of psychotropic medication at dosage levels necessitating medical supervision, dosage titration of medications requiring skilled observation, or adverse biologic reactions requiring close and continuous observation and monitoring; and
* emergence of new signs/symptoms, impairments, harm inclinations, or medication complications meeting admission criteria.

III. Intensity of Service

The consumer requires close observation and medical supervision due to the severity of signs and symptoms, to control risk behaviors or inclinations, to assure basic needs are met, or to manage biologic/medication complications.

The consumer is receiving active, timely, intensive treatment delivered according to an individualized plan of care.

Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or biologic/medication complications that necessitated admission to inpatient care.

The consumer is making progress toward treatment goals as evidenced by a measurable reduction in signs/symptoms, impairments, harm inclinations, or biologic/medication complications, or if no progress has been made, there has been a major modification of the treatment plan and therapeutic program and there is a reasonable expectation of a positive response to treatment.

Discharge criteria and aftercare planning are documented in the consumer's record.

HOSPITAL-BASED CRISIS OBSERVATION CARE

Utilization of an observation or holding bed in a hospital-based, medically-staffed and psychiatrically-supervised care setting may be justified for persons who, as a result of a psychiatric disorder, are deemed likely to need protective, skilled medical observation, and supervision for the purpose of additional evaluation and stabilization of a mental disorder, prior to determination of an alternative disposition or movement to a different, clinically appropriate, level of care. The Severity of Illness (SI)/Intensity of Service (IS) criteria for utilization of this level of care are based upon the premise that while the consumer is displaying signs and symptoms of a serious psychiatric disorder, demonstrating disabling functional impairments, and/or manifesting a significant level of clinical instability (risk), there are indications that the individual's condition may stabilize and an appropriate alternative service or support setting may be identified within a 23-hour period or less.

Coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA - Must meet all three

I. **Diagnosis:**

The consumer must be suffering from a mental illness reflected in a primary, validated, DSM-IV Axis I, or ICD-10 Diagnosis (not including V Codes).

II. **Severity of Illness:** (signs, symptoms, functional impairments and risk potential)

At least one of the following manifestations is present:

A. Severe Psychiatric Signs and Symptoms

Psychiatric symptoms - features of significant cognitive impairment (delusions, disorientation, disordered speech, etc.), intense and shifting affective states, and/or evidence of perceptual disturbances (hallucinations) - severe enough to cause seriously disordered and/or bizarre behavior, impaired judgment or reality testing, impulse control problems, or extensive interference with activities of daily living.

B. Disruptions of Self-Care and Independent Functioning

Transient, but significant, interruption of the person's ability to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living due to psychiatric disorder.

C. Danger to Self

There is some danger to self, as indicated by statements of the individual, recent actions or gestures, or reckless activities related to confusion, poor judgement or impulsivity.

D. Danger to Others

There is some danger to others, as indicated by the expressed intention to harm others, recent assaultive actions, and impaired impulse control.

Special Consideration: Concomitant Substance Abuse

The underlying psychiatric diagnosis must be the primary cause of the consumer's current symptoms or represent the reason observation and treatment is necessary in the hospital setting.

III. Intensity of Service

The person meets the intensity of service requirements if utilization of crisis observation care is considered medically necessary, if there are indications that the individual's symptoms or impairments may stabilize within a 23-hour period, and if the person requires one of the following:

A. Skilled medical observation and supervision are necessary, on a short-term basis, to adequately evaluate and stabilize the condition and to make a determination of the most appropriate level of care.

B. Temporary observation and containment in a protected environment is needed to constrain impulsivity, compensate for impaired reality testing, ensure that basic needs are met and/or to protect the consumer or others from harm.

INTENSIVE CRISIS RESIDENTIAL SERVICES ADMISSION CRITERIA: ADULTS

Intensive crisis residential services may be used to treat a mentally ill person who requires short-term care in a structured, supervised and licensed residential facility as an alternative to inpatient care. Individuals utilizing such facilities are assumed to be experiencing an acute psychiatric crisis, or to be in need of an interim program in order to shorten the length of stay of psychiatric inpatient episode. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission presume that while the individual generally meets the basic criteria for inpatient care (e.g., displaying significant signs and symptoms of a psychiatric disorder, demonstrating serious functional impairments, some level of risk) he/she is not (at the time of admission) exhibiting as severe a degree of clinical instability (not at imminent risk of self/other harm) as those persons who require inpatient care, nor are there serious medication or medical complications that would necessitate treatment in a medical facility. Therefore, where available, crisis residential services may be a safe and appropriate alternative for persons who meet the SI/IS criteria for this level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA - Must meet all three

I. **Diagnosis:**

The consumer must be suffering from a mental illness reflected in a primary, validated, DSM-IV or ICD-10 Diagnosis (not including V Codes).

II. **Severity of Illness:** (signs, symptoms, functional impairments and risk potential)

At least one of the following manifestations is present:

A. Psychiatric Signs and Symptoms

A substantial disturbance of thought processes, perception, affect, memory or consciousness (due to a mental illness) exists and is severe enough to cause disordered/bizarre behavior, diminished impulse control, significantly flawed judgment, moderate psychomotor acceleration or retardation, impaired capacity to recognize reality, and/or impairments in activities of daily living. The disordered/bizarre behavior or level of agitation are not so severe or extreme to require frequent restraints or to pose a danger to others receiving services at the residence.

B. Disruptions of Self-Care and Independent Functioning

* The person has insufficient capability to adequately attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living, due to a psychiatric disorder.
* The person's interpersonal functioning is seriously impaired or dysfunctional, necessitating temporary separation from the natural support system and living arrangement.
* The person is acutely incapacitated in educational/occupational role performance due to an active psychiatric disorder.

C. Danger to Self

* There is some danger to self, reflected in self-harm ideations with or without a plan, recent gestures with low lethality/intent, or minor, non-severe, self-injurious behavior.
* There are intermittent expressions/verbalizations of self-harm inclinations, thoughts of self-mutilation, passive wishes to die, but no persistent or unrelenting self-harm preoccupations, and no recent significant physical actions (deliberate or reckless endangerment behavior) involving actual, direct, serious harm to self.
* There may have been recent significant self-harm actions, but these inclinations/behaviors are now clearly under control, and the individual is not considered to be at imminent or serious risk if monitored in a 24-hour program with adequate supervision and supports.

D. Danger to Others

* The person has expressed a wish to harm others, but has not made any plans or acquired the means to carry this out, and there is evidence of some impulse control and reality orientation.
* The person may have threatened others verbally, but there have been no assaultive actions, no preparation for such actions, and there is nothing in the person's recent behavior to suggest these threats will be carried out.
* There may have been minor destructive behavior toward property that has not materially endangered others.

E. Drug/Medication Compliance

Stabilization of symptoms related to the psychiatric crisis requires adherence to a medication regimen, and initial compliance cannot be reliably assured (due to impaired cognition, consciousness, memory or judgment) without recurrent monitoring and supervision.

III. Intensity of Service

The person meets the intensity of service requirements, crisis residential services are considered medically necessary, and the person requires at least one of the following:

A. The consumer requires a highly structured, supervised care setting to prevent elevation of symptom acuity, to recover functional living skills, and to strengthen internal coping resources.

B. Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations.

C. The consumer has reached a level of clinical stability (diminished risk) obviating the need for restrictive inpatient care, but continues to require a structured and supervised 24-hour program to consolidate inpatient progress.

D. Frequent monitoring of medication regimen and response is necessary and compliance is doubtful without consistent supervision and support.

E. The consumer needs to be temporarily separated from his/her natural environment, current living situation and/or support systems due to severely impaired interpersonal functioning and the risk of further deterioration of his/her condition and of support circumstances if an alternative setting is not utilized.

F. A concentrated, comprehensive, intensive program of treatments, services and supports is indicated by the complexity and/or the severity of the consumer's signs and symptoms.

INTENSIVE CRISIS RESIDENTIAL SERVICES ADMISSION CRITERIA: CHILDREN AND ADOLESCENTS

Intensive crisis residential services may be used to treat a mentally ill child or adolescent who requires short-term care in a structured, supervised and licensed residential facility as an alternative to inpatient care. Individuals utilizing such facilities are assumed to be experiencing an acute psychiatric crisis, or to be in need of an interim program in order to shorten the length of stay of psychiatric inpatient episode. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission presume that while the individual generally meets the basic criteria for inpatient care (e.g., displaying significant signs and symptoms of a psychiatric disorder, demonstrating serious functional impairments, some level of risk) he/she is not (at the time of admission) exhibiting as severe a degree of clinical instability (not at imminent risk of self/other harm) as those persons who require inpatient care, nor are there serious medication or medical complications that would necessitate treatment in a medical facility. Thus, where available, crisis residential services may be a safe and appropriate alternative for children or adolescents who meet the SI/IS criteria for this level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA - Must meet all three

I. **Diagnosis:**

The consumer must be suffering from a mental illness reflected in a primary, validated, DSM-IV or ICD-10 Diagnosis (not including V Codes).

II. **Severity of Illness:** (signs, symptoms, functional impairments and risk potential)

At least one of the following manifestations is present:

A. Signs and Symptoms

A substantial disturbance of thought processes, perception, affect, memory, consciousness, or behavior (due to a mental illness) exists and is severe enough to cause disordered/bizarre conduct, diminished impulse control, seriously flawed judgment, moderate psychomotor agitation or retardation, extreme fears/phobias, formidable obsessions/compulsions, impaired capacity to recognize reality and/or impairments in activities of daily living. The disordered/bizarre conduct or activity and/or the level of agitation are not so severe, extreme or unstable to require frequent restraints or to pose a danger to others who are receiving services at the crisis residential facility.

B. Disruptions of Self-Care and Independent Functioning

* The child/adolescent is unable or unwilling to fully attend to basic self-care tasks or to cooperate in the provision of basic physical needs.
* There is an acute psychiatric condition or severe developmental disturbance that significantly impairs social, interpersonal, familial and/or educational functioning, and requires periodic temporary separation from the natural support system and living arrangement to prevent further deterioration of these relationships and supports.

C. Danger to Self

* There is some danger to self, reflected in self-harm ideations with or without a plan, recent gestures with low lethality/intent, or minor, non-severe, self-injurious behavior.
* There are intermittent expressions/verbalizations of self-harm inclinations, thoughts of self-mutilation, passive wishes to die, but no persistent or unrelenting self-harm preoccupations, and no recent significant physical actions (deliberate or reckless endangerment behavior) involving actual, direct, serious harm to self.
* There may have been recent significant self-harm actions, but these inclinations/behaviors are now clearly under control, and the individual is not considered to be at imminent or serious risk if monitored in a 24-hour program with adequate supervision and supports.

D. Danger to Others

* The child/adolescent has expressed a wish to harm others, but has not made any plans or acquired the means to carry this out, and there is evidence of some impulse control and reality orientation.
* The child/adolescent may have threatened others verbally, but there have been no significant assaultive actions, no preparation for such actions, and there is nothing in the child's/adolescent's recent behavior to suggest these threats will be carried out.
* There may have been minor destructive behavior toward property that has not materially endangered others.
* There is no chronic or recent history of violence, fire-setting or sexual offenses.

E. Drug/Medication Compliance

Stabilization of symptoms related to the psychiatric crisis requires adherence to a medication regimen, and compliance cannot be reliably assured by either the child/adolescent or their natural support system without an initial period of recurrent monitoring and supervision.

III. Intensity of Service

The person meets the intensity of service requirements, crisis residential services are considered medically necessary, and the person requires at least one of the following:

A. The consumer requires a highly structured, supervised care setting to prevent elevation of symptom acuity, to recover age-appropriate living skills, and to strengthen internal coping resources.

B. Consistent observation and supervision of behavior is needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations.

C. The consumer no longer needs restrictive inpatient care, but continues to need a 24-hour, structured and supervised living arrangement and treatment program to consolidate inpatient progress prior to returning to their natural environment.

D. Frequent monitoring of medication regimen and response is necessary and compliance is doubtful without consistent supervision and support.

E. The consumer needs to be temporarily separated from his/her natural environment, current living situation, and/or support systems due to severely impaired interpersonal functioning and the risk of further deterioration of his/her condition and of support circumstances if an alternative setting is not utilized.

F. A concentrated, comprehensive, intensive program of treatments, services and supports is indicated by the complexity and/or the severity of the consumer's signs and symptoms.

PARTIAL HOSPITALIZATION ADMISSION CERTIFICATION CRITERIA: ADULTS

Partial hospitalization services may be used to treat a mentally ill person who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week, in a licensed setting. The use of partial hospitalization as a setting of care presumes that the consumer does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the consumer's present treatment needs. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission assume that the consumer is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in either self-care, daily living skill, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA - Must meet all three

I. **Diagnosis:**

The consumer must be suffering from a mental illness reflected in a primary, validated, DSM-IV or ICD-10 Diagnosis (not including V Codes).

II. **Severity of Illness:** (signs, symptoms, functional impairments and risk potential)

At least two of the following manifestations are present:

A. Psychiatric Signs and Symptoms

Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (e.g., intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing, and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation is not so severe, extreme or unstable to require frequent restraints or to pose a danger to others.

B. Disruptions of Self-Care and Independent Functioning

* The person seriously neglects self-care tasks (e.g., hygiene, grooming, etc.) and/or does not sufficiently attend to essential aspects of daily living (e.g., doesn't shop, prepare meals, maintain adequate nutrition, pay bills, complete housekeeping chores, etc.) due to a mental disorder.
* Consumer is able to maintain adequate nutrition, shelter or other essentials of daily living only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program.
* The person's interpersonal functioning is significantly impaired (e.g., seriously dysfunctional communication, extreme social withdrawal, etc.).
* There has been notable recent deterioration in meeting educational/ occupational responsibilities and role performance expectations.

C. Danger to Self

* There is modest danger to self reflected in intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, mild and infrequent self-harm gestures (low lethality/intent) or self-mutilation, passive death wishes, or slightly self-endangering activities.
* The consumer has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity, **or**, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.

D. Danger to Others

* Where assaultive tendencies exist, there have been no overt actions and there is reasonable expectation, based on history and recent behavior, that the consumer will be able to curb these inclinations.
* There have been destructive fantasies described and mild threats verbalized, but the consumer appears to have impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions.
* There has been minor destructive behavior toward property without endangerment of others.

E. Drug/Medication Complications

* The consumer has experienced side effects of atypical complexity resulting from psychotropic drugs and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the consumer's condition or to the nature of the procedures involved.
* The consumer needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.

III. Intensity of Service

The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least one of the following:

A. The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care.

B. The consumer has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive, treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments.

C. Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

PARTIAL HOSPITALIZATION ADMISSION CERTIFICATION CRITERIA: CHILDREN AND ADOLESCENTS

Partial hospitalization services may be used to treat a mentally ill or emotionally disturbed child or adolescent who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week, in a licensed setting. The use of partial hospitalization as a setting of care presumes that the consumer does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the consumer's present treatment needs. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission assume that the consumer is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in either self-care, daily living skill, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) does not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA - Must meet all three

I. **Diagnosis:**

The consumer must be suffering from a mental illness reflected in a primary, validated, DSM-IV or ICD-10 Diagnosis (not including V Codes).

II. **Severity of Illness:** (signs, symptoms, functional impairments and risk potential)

At least two of the following manifestations are present:

A. Psychiatric Signs and Symptoms

Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (e.g., intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation is not so severe, extreme or unstable to require frequent restraints or to pose a danger to others.

B. Disruptions of Self-Care and Independent Functioning

* The child/adolescent exhibits significant impairments in self-care skills (e.g., feeding, dressing, toileting, hygiene/bathing/grooming, etc.), in the ability to attend to age-appropriate responsibilities, or in self-regulation capabilities, due to a mental disorder or emotional illness.
* The child/adolescent is able to maintain adequate self-care and self-regulation only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program.
* There is recent evidence of serious impairment/incapacitation in the child's/adolescent's interpersonal and social functioning (e.g., seriously dysfunctional communication, significant social withdrawal and isolation, repeated disruptive, inappropriate or bizarre behavior in social settings, etc.).
* There is recent evidence of considerable deterioration in functioning within the family and/or significant decline in occupational/educational role performance due to a mental disorder or emotional illness.

C. Danger to Self

* There is modest danger to self reflected in: non-accidental self-harm gestures or self-mutilation actions that are not life-threatening in either intent or lethal potential, intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, passive death wishes, or slightly self-endangering activities.
* The consumer has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity, or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.

D. Danger to Others

* Assaultive tendencies exist, and some assaultive behavior may have occurred, but any overt actions have been without any serious or significant injury to others, and there is reasonable expectation, based upon history and recent behavior, that the consumer will be able to curb any serious expression of these inclinations.
* There have been destructive fantasies described and mild threats verbalized, but the consumer appears to have adequate impulse control, judgement, and reality orientation sufficient to suppress urges to act on these imaginings or expressions.
* There has been minor destructive behavior toward property without endangerment of others.

E. Drug/Medication Complications

* The consumer has experienced side effects of atypical complexity resulting from psychotropic drugs and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the consumer's condition or to the nature of the procedures involved.
* The consumer needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.

III. Intensity of Service

The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least one of the following:

A. The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care.

B. The consumer has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive, treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments.

C. Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

PARTIAL HOSPITALIZATION CONTINUING STAY CERTIFICATION CRITERIA: ADULTS, ADOLESCENTS, AND CHILDREN

After a consumer has been certified for admission to a partial hospitalization program, services will be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in a partial hospitalization setting. Treatment within a partial hospitalization program is directed at resolution or stabilization of acute symptoms, elimination or amelioration of disabling functional impairments, maintenance of self/other safety, and/or regulation of precarious or complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the partial program remains the most appropriate, least restrictive level of care for treatment of the patient's problems and dysfunctions.

Continuing treatment in the partial hospitalization program may be certified when symptoms, impairments, harm inclinations, or medication complications similar to those that justified the patient's admission certification remain present, and continue to be of such a nature and severity that partial hospitalization treatment is still medically necessary. It is anticipated that in those reviews that fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the program. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

CRITERIA

I. Diagnosis:

The consumer has a validated DSM IV or ICD-10 mental disorder (excluding V Codes), that remains the principal diagnosis for purposes of care during the period under review.

II. Severity of Illness:

* Persistence of symptoms, impairments, harm inclinations or medication complications that necessitated admission to this level of care, and that cannot currently be addressed at a lower level of care.
* Emergence of new symptoms, impairments, harm inclinations or medication complications meeting admission criteria.

III. Intensity of Service

* The consumer is receiving active, timely, intensive, structured multi-modal treatment delivered according to an individualized plan of care.

* Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations, or medication complications that necessitated admission to the program.
* Consumer is making progress toward treatment goals, or if no progress has been made, the treatment plan and therapeutic program have been revised accordingly, and there is a reasonable expectation of a positive response to treatment.
* Discharge criteria and aftercare planning are documented in the consumer's record.

INTENSIVE CRISIS STABILIZATION SERVICES CRITERIA: ADULTS, ADOLESCENTS, AND CHILDREN

Intensive Crisis Stabilization Services are an intensive combination of community-based treatment and supports provided to a persons in crisis at a place or places chosen by the person and his/her support system, intended as a substitute for hospital emergency room services and/or inpatient psychiatric care. It is the intensity of the services and supports provided, rather than the setting, that distinguishes this level of care. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission are based upon the assumption that the consumer is experiencing a severe psychiatric crisis (signs and symptoms of an mental disorder, impaired functioning and coping abilities, a significant degree of clinical instability) and is considered to be at risk of inpatient hospitalization or out-of-home placement unless considerable support and intensive interventions are provided. Intensive crisis stabilization services may also be appropriate for individuals recently discharged from protective care facilities, if such services are used to decrease the length of stay in the protective environment or to forestall the need for readmission to the facility.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA - Must meet all three

I. Condition:

The consumer must be suffering from an acute problem of disturbed thought, memory, perception, behavior, mood or social relationship (reflected in a primary, validated, DSM-IV or ICD-10 Diagnosis, not including V Codes) that requires both immediate intervention and sustained support over a limited period of time. Persons exhibiting residual impairments after discharge from an inpatient psychiatric stay may also be suitable for application of this level of care intensity if it will significantly reduce the risk of relapse.

II. Severity of Illness: (signs, symptoms, functional impairments and risk potential)

At least two of the following manifestations are present:

A. Emotional Distress - Psychiatric Signs and Symptoms

* Acute, substantial, disturbance of cognition, memory, mood/affect, perception, and/or behavior due to severe emotional distress or mental illness, with conjoint functional impairments.
* Symptom acuity does not pose an immediate risk of substantial harm to the person or others, or if a risk of substantial harm exists, protective care (with appropriate medical/psychiatric supervision) has been arranged.

B. Disruptions of Self-Care and Independent Functioning

* The person exhibits an acutely diminished ability to perform activities of daily living independently, appropriately and/or effectively, and/or to function adequately in familial, social, and educational/occupational roles due to substantial emotional distress or an acute mental disorder.
* The person is able to attain or maintain adequate ability/performance in self-care, daily living skills, interpersonal/social, and/or educational/occupational domains only with sustained support and assistance.
* Current impairment/incapacitation in functioning represents a change from baseline ability/performance, and will likely remit or subside with time-limited intensive support and assistance.

C. Danger to Self/Others

* Person verbalizes passive death wishes or ideas, intermittent self-harm ideation without a plan, fleeting thoughts of methods/means without sustained intent, expressed ambivalent inclinations.
* Person engages in non-serious, mildly self-injurious actions (minor self-mutilation) as a gesture of discontent or as a parasuicidal coping mechanism (personality disorder).
* Person has not made any recent, significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity.
* Person verbalizes minor threats or expresses non-specific hostility toward others, but appears to have sufficient judgement and impulse control to avoid acting on these impulses. There is no recent history of violent or seriously destructive acts.

III. Intensity of Service

The person meets the intensity of service requirements if intensive crisis stabilization services are considered medically necessary to ameliorate disabling effects of the crisis situation, improve the consumer's condition and/or allow the person to function without more restrictive care, and the person requires at least one of the following:

A. The person is experiencing an acute psychiatric crisis and requires intensive, coordinated and sustained treatment services and supports at multiple sites to maintain functioning, arrest regression and forestall the need for inpatient care.

B. The consumer has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive, coordinated, services and supports at multiple sites for a limited time to address residual functional impairments.

ENHANCED REHABILITATION
for MENTAL DISORDERS of MODERATE SEVERITY

This protocol is designed to identify those persons with serious and persistent conditions whose needs are likely to include multiple treatment options, support, and rehabilitation services. A broad range of services and supports must be available to treat individuals with these conditions and, although a baseline need for service may remain constant, the particular mix or array and intensity of services required at any given point in time is likely to be variable. In arranging services and supports for any given individual with a serious and persistent condition, the emphasis must be placed on the person-centered planning process. Within the context of this process, a wide array of service and support needs may be identified related to care coordination, housing, socialization, personal care, training in community living, mobile supports, family assistance, behavior management, skill development and vocational/educational opportunities.

This protocol is not intended to prescribe the mix of services and supports that should be provided to each individual with a serious and persistent condition. As noted, the person-centered planning process is the appropriate vehicle for determination of the scope, frequency, and intensity of services and supports for a particular individual. This protocol merely offers a method and provides a simple algorithm for identifying consumers who require enhanced services and supports.

Persons with serious and persistent conditions are a major focus of community mental health services. The group is not defined by a single illness that requires a single treatment approach, but encompasses a range of disorders, degrees of impairment, and/or disability and differential rehabilitation, support and recovery needs. Referred to by various designations (e.g., community support system, comprehensive systems of care, etc.), the service array, typically utilized by persons with serious conditions, includes: medication/psychiatric services, residential/housing, crisis response, inpatient care, varying levels of case management support, psychosocial rehabilitation services, in vivo community training and skill building, outreach and home-based services, employment services, and peer support.

CONCEPTUAL FRAMEWORK
FOR IDENTIFICATION OF PERSONS WITH SERIOUS DISORDERS

A variety of approaches have been developed to identify persons with serious and persistent mental disorders or serious emotional disturbances. For purposes of managing the Medicaid specialized ambulatory mental health benefits, severe and persistent mental illness and severe emotional disturbance are defined in MSA Bulletin 95-03:

"For purposes of this policy and for HMO or Clinic Plan enrollees only**,** severe and persistent mental illness and severe emotional disturbance are defined by:

diagnosis and degree of disability, or
diagnosis and duration of illness, or
diagnosis and prior service utilization criteria.

ADULTS: - Severe and Persistent Mental Illness:

Diagnoses as defined by Diagnostic and Statistical Manual - IV Version (DSM-IV) - Schizophrenia and Other Psychotic Disorder (295.xx: 297.1 ; 297.3: 298.8: 298.9), Mood Disorders, or Major Depressions and Bipolar Disorders 296.xx).

Degree of Disability - Substantial disability/functional impairment in three or more primary aspects of daily living such that self-sufficiency is markedly reduced. This includes:

personal hygiene and self-care,
self-direction,
activities of daily living,
learning and recreation, or
social transactions and interpersonal relationships.

In older persons (55 or older), loss of functional capacity might also include:

loss of mobility,
sensory impairment,
physical stamina to perform activities of daily living or ability to communicate immediate needs as the result of medical conditions requiring professional supervision, or
conditions resulting from long-term institutionalization.

Duration -

a) evidence of six continuous months of illness, symptomatology, or dysfunction, or six cumulative months of symptomatology/dysfunction in a 12-month period, or
b) based on current condition and diagnosis, there is a reasonable expectation that the symptoms/dysfunctions will continue for more than six months.

Prior Service Utilization -

a) four or more admissions to a community inpatient unit/facility in a calendar year,
b) community inpatient hospital days of care in a calendar year exceeding 30 days,
c) state hospital utilization of over 60 days in a calendar year, or
d) utilization of over 20 mental health visits (e.g., individual or group therapy) in a calendar year.

Children and Adolescents - Severe Emotional Disturbance

Diagnoses as defined by DSM-IV -

Schizophrenia and Mood Disorders (Major Depressions and Bipolar Disorders),
Reactive Attachment Disorder (313.39),
Medicaid-Covered Gender Identity Disorder (302-.6, 302.85),
Autism with Accompanying Mental Disorder, or
Conduct Disorders.

Degree of Disability - Marked to severe emotional/behavioral impairment (not solely the result of mental retardation or other developmental disability, epilepsy, drug abuse, or alcoholism) that results in substantial functional limitation of major life activities in two or more of the following areas:

self-care at an appropriate developmental level,
self-direction, including behavioral control,
capacity for living with family or family equivalent,
social functioning,
learning, or
perceptive and expressive language.

Duration -

evidence of six continuous months of illness, symptomatology or dysfunction,
six cumulative months of symptomatology/dysfunction in a 12-month period, or
on the basis of a specific diagnosis (e.g., schizophrenia) disability is likely to continue for more than one year.

Prior Service Utilization -

four or more admissions to a community inpatient unit/facility in a calendar year,
community inpatient hospital days of care in a calendar year exceeding 45 days,
state hospital utilization of over 60 days in a calendar year, or
utilization of over 20 mental health visits (e.g., individual or group therapy) in a calendar year.

The definitions referenced above are used to distinguish those Medicaid Health Plan enrollees who should receive their outpatient mental health services through the Health Plan from those who have more severe conditions and hence, should be referred to CMHSPs for specialized services. While MSA Bulletin 95-03 only mentions Health Plan (Health Maintenance Organizations and Clinic Plans) enrollees, most CMHSPs have viewed these criteria as the basic admission parameters for Medicaid specialized mental health services, regardless of the consumer's health plan status.

CMHSPs should employ the Medicaid bulletin criteria in making determinations about which Medicaid recipients (particularly those enrolled in Health Plans) qualify for enhanced rehabilitative services and supports.

However, CMHSPs are responsible for Code-defined priority populations (many of whom are not Medicaid beneficiaries), as well as Medicaid recipients, and must make decisions regarding which individuals seeking services should be afforded a more intensive and extensive set of services and supports. Medicaid policy is not the ultimate arbitrator in these decisions and CMHSPs often use a variety of methods to identify individuals who need enhanced rehabilitation and support services. Two supplemental decision-making models are described below. These approaches are offered as one way of investigating and solving the problem of service eligibility determination. As such, these approaches are heuristic devices, not definitive formulations, and CMHSPs are not required to utilize them for non-Medicaid clients. CMHSPs must, however, have some impartial method for making decisions regarding services and supports determination for non-Medicaid clients.

A. Determination of Adults with Serious and/or Persistent Conditions:

The National Institute of Mental Health (NIMH) has, in previously published work, provided a methodology for identifying persons with serious and/or persistent conditions. In this formulation, three interrelated dimensions are necessary and required to demarcate the boundary around the target groups of serious and/or persistently mentally ill individuals: a diagnosis that is the primary cause of disability, functional limitation and duration of the severe dysfunction. In the application of this NIMH protocol, different combinations of the three factors define four clinically related groups (CRGs):

CRG 1. Persons in this group are recently severely impaired and the duration or expected duration of impairment totals six months or longer.

CRG 2. Persons in this group are currently/recently severely impaired but the duration of the severe impairment is anticipated to be less than six months. These individuals may have required acute inpatient care at the onset of the severe condition.

CRG 3. Persons in this group are not recently severely impaired but have been severely impaired for six months or more sometime in the past and are assessed as needing services to prevent relapse.

CRG 4. Persons in this group are not now, nor have they been recently, severely impaired. Their condition may be considered mild to moderate.

While Michigan's Mental Health Code does not define persons with serious and enduring conditions in quite the same way or with the same taxonomy listed above, the various sections of the Mental Health Code establishing definitions and priorities are generally consistent with the target population identified through the NIMH formulation[1]

[1] "Serious mental illness" means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDCH and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and

Although these groups are related, they are considered separately, reflecting clinical realities. There are clients who are severely, but not persistently, disabled (e.g., those in a first acute episode, without persistent residual impairments). Conversely, there are clients who have a persistent disability that is not currently severe. In some cases, this is due to the benefits derived from treatment and support services, without which the disability would again become severe. Some individuals in this group require continued support and their relatively good level of functioning must not disqualify them from benefits or service priorities.

For purposes of this protocol, groups #1 and #3 identify the delimited population qualified for enhanced services as described below (individuals in group #2 are generally served through the high acuity levels of care, befitting the immediate severity of their condition. If these individuals have residual impairments or service needs after such care, then they would also be included in the group of eligible consumers).

Operational Definitions Related to Adult Classifications

1. Diagnosis:

The individual must be diagnosed with a designated mental illness, specifically, a DSM-IV diagnosis in the diagnostic code range of 290-319 (or ICD-9-CM equivalent) other than (or in addition to): (a) alcohol or drug disorders (b) developmental disabilities, (c) organic brain syndromes, dementias (except for dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance) or mental disorders due to general medical conditions, except those with predominant psychiatric features, or (d) social conditions (V Codes). The following list of diagnostic categories is illustrative, but is not a comprehensive list, of the mental disorders that may establish eligibility (in combination with other dimensions) for Enhanced Services:

295(all) - Schizophrenia
296(all) - Major Depressive Disorder, Bipolar Disorder
297(all) - Delusional Disorder, Shared Psychotic Disorder
300.01 - Panic Disorder without Agoraphobia
300.02 - Generalized Anxiety Disorder
300.11 - Conversion Disorder

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dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:

(a) A substance abuse disorder.
(b) A developmental disorder.
(c) A "V" Code in the diagnostic and statistical manual of mental disorders.

(Michigan Mental Health Code, Section 100d(3))

With regard to serious mental illness, substantial interference or limitation of role functioning in 1 or more major life activities includes basic living skills such as eating, bathing, and dressing; instrumental living skills such as maintaining a household, managing money, getting around the community, and taking prescribed medication; and functioning in social, vocational, and educational contexts.
(Michigan Mental Health Code, Section 100b(5)(b))

The MDCH shall give priority to the following services:

(i) Services for individuals with the most severe forms of serious mental illness

(Michigan Mental Health Code, Section 116(2)(a)

300.12 - Dissociative Amnesia
300.13 - Dissociative Fugue
300.14 - Dissociative Identity Disorder
300.21 - Panic Disorder with Agoraphobia
300.22 - Agoraphobia without history of Panic Disorder
300.3 - Obsessive Compulsive Disorder
300.4 - Dysthymic Disorder
300.6 - Depersonalization Disorder
300.7 - Hypochondriasis, Body Dysmorphic Disorder
300.81 - Somatization Disorder
301.0 - Paranoid Personality Disorder
301.20 - Schizoid Personality Disorder
301.22 - Schizotypal Personality Disorder
301.81 - Narcissistic Personality Disorder
301.83 - Borderline Personality Disorder
301.13 - Cyclothymic Disorder
307.1 - Anorexia Nervosa
307.51 - Bulimia Nervosa
309.81 - Post Traumatic Stress Disorder

2. Functional Disability

For each individual considered eligible by diagnosis, a determination must be made regarding the degree of functional disability. The NIMH model proposes **four areas** for the assessment of functional limitations. These areas correspond to dimensions reviewed by the Social Security Administration in making psychiatric disability determinations. Each area is assessed based upon the following five-point scale:

1 - no limitation/dysfunction
2 - mild limitations/dysfunction
3 - moderate limitations/dysfunction
4 - marked limitations/dysfunction
5 - extreme limitations/dysfunction

The scales for assessing each of the four areas of functioning are found in Attachment C. The four areas are described below:

a. **Activities of daily living** - activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, grooming and hygiene, using telephones and directories, using a post office, etc. An individual's independence, appropriateness and effectiveness in performing these tasks, as well as their ability to initiate and participate in such activities independently of supervision and direction, are to be taken into account in assessing this area of functioning.

b. **Interpersonal functioning** - an individual's capacity to interact appropriately and communicate effectively with other persons. This refers broadly to the person's ability to get along with others in his or her family and in the community. Deficits in this area are reflected in events such as a history of altercations, evictions, or firing; fear of strangers; avoidance of

interpersonal relationships and social isolation. Conversely, strength in social functioning is reflected in such events as the ability to initiate social contact and to participate actively in group activities.

c. **Concentration, persistence and pace** - ability to sustain focused attention for a long enough time to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings. An individual exhibits limitations in this functional area when he or she has difficulties in concentration, is unable to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks.

d. **Adaptation to change** - repeated failure on the part of an individual to adapt to stressful circumstances associated with work, school, family, or social interaction. Any unexpected environmental change may cause agitation or exacerbation of signs and symptoms associated with the illness, or withdrawal from the stressful situation.

3. Duration of Disability

Because of the episodic nature of mental disorders, meaningful information about duration concerns the length of time of functional disability, rather than time since onset of the disorder. A 12-month duration is the criterion or threshold for consideration of persistence. Further, since functional limitations fluctuate even within acute episodes, the criterion of duration is considered satisfied if there was dysfunction in at least 6 cumulative out of 12 continuous months or if, based upon current condition and diagnosis, there is a reasonable expectation that the symptoms/dysfunctions will continue for more than six months.

C. Decision Process for Adults

The decision process involved in the clinical assessment of an individual and subsequent designation of CRG membership consists of a series of questions that are answered on the basis of the completed assessment. The process follows the logical sequence of questions and assessments:

Q#1 Does the individual have a psychiatric diagnosis?

Q#2 Is the person currently severely disabled, per assessment on (a) activities of daily living, (b) social interaction, (c) concentration, persistence, and pace, (d) adaptation to change?

Q#3 (a) Has there ever been a period of at least 6 months of disability, per same four areas as in Q#2? If the course was variable, the rating should characterize the severity during at least 6 of the 12 months.

Or

(b) Based on current condition or diagnosis, is there a reasonable expectation that the symptoms/dysfunctions will continue for more than six months?

Q#4 Has the person been severely disabled during the past 12 months, per the same four areas and same rule concerning duration?

The matrix of answers yes or no to these four questions provides a convenient means for CRG designation as illustrated below. For the purpose of determining a yes or no response to the questions concerning severity of functional impairment, the following scale score patterns define Severely Functionally Disabled:

Any one #5, or "extreme" dysfunction/disability.
At least two #4s, or "marked" disability and no #1 or "no" disability.
At least one #4, or "marked" and three #3s or "moderate" disability.

	Answers to Four Questions			
	Q#			
	1	2	3	4
CRG Designation				
No CRG	No	No	No	No
CRG #4 mild/moderate	Yes	No	No	No
CRG #3 persistently disabled	Yes	No	Yes	No - enhanced eligible
CRG severely disabled	Yes	Yes	No	No
CRG #1 PSPMI	Yes	Yes	Y/N	Yes - enhanced eligible

D. Operational Definitions Related to Child and Adolescent Classifications

Decisions regarding whether a child or adolescent is seriously emotionally disturbed and in need of enhanced services and supports utilize the same dimensions as does the adult criteria. The dimensions include a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities and duration of the condition. The CAFAS scale is used to make discriminations within the functional impairment dimension. All of the dimensions must be considered when determining if a child is eligible for enhanced support and services.

The criteria defined below relate primarily to children and adolescents between the ages of 7-17. A separate set of enhanced service eligibility criteria for children under age 7 is currently being considered within the MDCH and will be circulated as an addendum to this manual once it has been reviewed by consumers, advocacy groups, providers and CMHSPs.

1. Diagnosis

The child/adolescent currently or any time in the past year had a diagnosable behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV excluding those with a diagnosis, other than (or in addition to): (a) alcohol or drug disorders (b) a developmental disorder, or (c) social conditions (V Codes). The following list of diagnostic categories is illustrative, but is not a comprehensive list of the mental disorders typically eligible for enhanced services:

295(all)	Schizophrenia
296(all)	Major Depressive Disorder, Bipolar Disorder
300.4	Dysthymic Disorder, when coexisting with one additional Axis I or Axis II diagnosis, not including alcohol or drug disorders, a developmental disorder, or V code.
297(all)	Delusional Disorder, Shared Psychotic Disorder
313.89	Reactive Attachment Disorder
302.6	Gender Identify Disorder - Child
302.85	Gender Identity Disorder - Adolescent
312.8	Conduct Disorder
313.81	Oppositional Defiant Disorder
307.23	Tourette's Disorder
307.7	Encopresis
307.6	Enuresis
313.89	Reactive Attachment Disorder
314(all)	Attention-Deficit /Hyperactivity Disorder

2. Functional Impairment

The concept of functional impairment is an integral part of the Mental Health Code definition of serious emotional disturbance. While the Code indicates that functional impairment refers to a "substantial interference with or limitation of" the child's proficiency in performing certain age-appropriate skills, it does not provide any definition of "substantial" or describe a means to measure the severity of a functional impairment.

The Child and Adolescent Functional Assessment Scale (CAFAS) is being employed by a number of states, including Michigan, to rate functional impairments in children ages 7-17. The CAFAS is comprised of eight scales on which the youth is rated, plus two scales to rate the youth's caregivers and/or caregiving resources. The following is a listing of the various scales:

Child/Adolescent:
School/Work - Ability to function satisfactorily in a group educational environment.
Home - Ability to observe reasonable rules and perform age-appropriate tasks.
Community - Ability to respect the rights of others and their property and act lawfully.

Behavior toward others - Appropriateness of youth's daily behavior.
Moods/Emotions - Modulation of youth's emotional life.
Self-Harmful Behavior - Extent to which the youth can cope without resorting to self-harmful behavior or verbalizations.

Substance Use:
Thinking - Ability of youth to use rational thought processes.
Caregiver/Caregiving Resources:
Family Material Needs - Extent to which the youth's functioning is interfered with due to lack of resources, such a food, clothing, housing, medical attention or neighborhood safety.
Family/Social Support - (a) Lack of sufficient resources relative to the child's needs; (b) Impaired care giver functioning; (c) Rejection of youth; (d) Inadequate supervision; (e) Poor conflict management; and (f) Abuse of youth, or poor care for previously abused youth.

Preliminary investigation of CAFAS research data suggests that the instrument can be utilized in eligibility determination for enhanced services. For purposes of qualification for enhanced services, children and adolescents with two or more elevated (rated at 20 or 30) subscale scores on the Child/Adolescent section of the CAFAS and a total impairment score (8 scale sum) > 80 may be considered markedly or severely functionally impaired. Reviews must proceed with caution, however, when there are elevations in the Role Performance or Substance Abuse Scales, since these may indicate that impairments are due to circumstances/ conditions other than severe emotional illness.

3. Duration

The following specify the length of time the youth's functional disability has interfered with his daily living and led to his/her referral for enhanced services and support services.

a. evidence of six continuous months of illness, symptomology, or dysfunction; or
b. six cumulative months of symptomatology/dysfunction in a twelve month period; or
c. on the basis of a specific diagnosis (e.g., schizophrenia), disability is likely to continue for more than one year.

ENHANCED SERVICE SELECTION PROCESS FOR ADULTS AND CHILDREN

The clinical assessments/decision processes described above are necessary to determine eligibility for Enhanced Services, but not sufficient for development of an individualized plan of service. Once eligibility has been confirmed, MDCH Person-Centered Planning Practice Guidelines as well as the general parameters surrounding Medical Necessity Criteria must guide the matching of individual needs and services. The reader is also referred to the MDCH Service Array for Adults with Mental Illness and Children with Emotional Disturbances for a list of potential CMHSP services from which an individualized service plan may be selected.

This protocol recognizes that there are multiple factors – the degree of psychiatric stability, extent and nature of individual functional impairments, previous episodes of the illness and response to treatment, particular personal strengths and assets, family relationships, environmental considerations, health status, available social network, etc. – involved in planning and delivering services and supports to persons with serious mental illness or serious emotional disturbances. It is difficult, if not impossible, to generalize these considerations into a description of preset or automatic service "packages" that would routinely be used for situations of a given level of severity. Thus, this protocol does not advise any specific intervention or support. Any of the available services, supports, and treatments may be used in various sequences and combinations to achieve the goals of growth, rehabilitation, recovery, improved functioning, and community integration. The protocol does presume that all relevant domains of client need are explored in the person-centered process, and that the services and supports selected are at a sufficient level of intensity, frequency, and scope to adequately and safely treat the condition and to sustain the individual in the community.

It is also recognized that some individuals have such incapacitating symptoms, pervasive suicidal, self-destructive or violent inclinations due to their illness, extraordinarily severe psychopathology and/or an inability/unwillingness to participate in community treatments that placement in more restricted settings for an extended time may be necessary. Because the course of an individual's illness is difficult to predict, there must be regular re-evaluation of the need for extended placement in these restricted settings, since the conditions that originally prompted the placement are subject to change. It is particularly important to ensure that community placement is not impeded solely due to the unavailability of commonly used (standard of practice), effective and appropriate local treatment resources, options or supports.

Placement of children or adolescents in extended out-of-home restricted care settings poses particular problems. It may be difficult to differentiate and isolate problem behaviors that result from a serious emotional disturbance, an addictive disorder, a conduct disorder and/or extreme family disruption or dysfunction. Restrictive care placement of children for mental health purposes must examine whether the situation or condition necessitating placement is truly related to a serious emotional disturbance that cannot be contained or managed in a less restrictive, community-based care setting.

It should be noted that eligibility for Enhanced Services and specifications of needed service do not constitute an entitlement to the upper limits of care, but only to those services and supports that are

necessary and appropriate and of "…sufficient amount, duration and scope to reasonably achieve their purpose." This necessitates a thorough assessment of needs and access to the least intrusive or restrictive services available, as well as special assistance in meeting individual needs. Key steps in determining service and support needs are:

* All relevant areas related to client needs must be explored, including mental health treatment needs, safety concerns, community living supports, rehabilitative activities, housing, family assistance, educational/vocational arrangements and care coordination requirements.
* All significant sources of information (e.g., response to past treatments, reports from schools, etc.) should be utilized in the planning process, consistent with client confidentiality consent.
* Co-morbid conditions must be identified and addressed.
* Collaboration with other health and human service agencies serving the client (consistent with client approval) must be pursued as an essential part of care coordination activities.
* The values of recovery, cultural competence, and family involvement should guide the service selection process.
* Consumer choice of services and supports must be a primary factor to the maximum extent possible; services should be flexible and individualized.
* Willingness is closely associated with consumer choice and must be considered. Persons may be temporarily satisfied with their lives and circumstances, not desiring to begin work on more progressive goals and objectives. Willingness must be cautiously evaluated by case managers and must not be used as an excuse for under-serving.
* Social resources and natural supports available to consumers are an important factor in decisions concerning intensity of service.
* Safety concerns must be addressed in determining appropriate service location and level of intensity.
* The treatment, services and supports selected must be of sufficient intensity, frequency and scope to appropriately and safely sustain the consumer within the community.
* All services and supports must be medically necessary (see Medical Necessity Criteria).

TREATMENT PROTOCOLS for MENTAL DISORDERS of MODERATE SEVERITY

These protocols are intended for persons who are not exhibiting characteristics related to high acuity mental health conditions and who are not classified as seriously and/or persistently mentally ill or emotionally disturbed. Generally these are persons experiencing moderate psychiatric symptoms of sufficient intensity to cause some subjective distress or disordered behavior, some impairment in functioning (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and little clinical (self/other harm risk) instability. In some instances, these symptoms may be related to a significant life event (stressor), environmental difficulties, family or interpersonal conflicts, lack of an adequate social network or legal problems.

Individuals with this kind of Severity of Illness (SI) profile generally utilize mental health assessment, psychiatric evaluation, psychotherapy, and/or medication management services, provided in office, clinic, or other settings appropriate to the provision of such service. The moderate severity of illness is consistent with a lower Intensity of Service (IS) response – the type, amount, frequency, and duration of services may be limited in accordance with medical necessity criteria.

Medicaid consumers enrolled in Medicaid-contracted health plans who have a mild/moderate condition or who have a therapeutically stable chronic condition with minimal support and/or rehabilitative needs, should receive required mental health services for these conditions through their health plan. Medicaid consumers with these conditions who are not in Medicaid-contracted health plans may contact a Type 10/11 provider to acquire needed services, or they may seek such services through a community mental health services program. For individuals not covered by Medicaid, it should be noted that while the Mental Health Code permits a CMHSP to serve individuals "…who have other mental disorders that meet criteria specified in the most recent diagnostic and statistical manual of mental health disorders published by the American Psychiatric Association," the CMHSP must give priority to the "…provision of services to individuals with the most severe forms of serious mental illness, [and] serious emotional disturbance."

Most individuals or families who seek treatment do so at points of life stress (instances of loss, developmental changes, environmental pressures, and traumatic events) when their capacity to find solutions independently is impeded. Outpatient treatment is directed to the restoration of the individual's or family's capacity to find solutions and make necessary adaptations, consistent with the situation. To the maximum extent possible, an individual treatment plan for outpatient services should be shaped using methods and techniques consistent with the MDCH's Person-Centered Planning Practice Guideline.

While person-centered or family-focused planning provides the context for service selection criteria, the concept of medical necessity implies that the type, scope, intensity and duration of care for these conditions will be circumscribed, the focus of treatment (individual, family, support system), the intervention modalities, and the actual hours of service must be established through negotiation with the consumer and should be consistent with the standards of medical necessity

Separate protocols are presented for Brief Outpatient Services and for Intermediate - Therapeutic Stabilization.

BRIEF OUTPATIENT TREATMENT

I. Service Description

Brief Outpatient Treatment is focused psychotherapy and/or other appropriate therapeutic intervention (e.g., psychopharmacological treatment) designed to relieve symptomatic distress, resolve a crisis, or return the individual to a stable level of functioning.

II. Severity of Illness Criteria for Brief Outpatient Treatment

Consumer must be suffering from a mental illness or emotional disorder reflected in a primary, validated, DSM-IV or ICD-10 Diagnosis (not including V Codes) and,
At least one of the following manifestations is present:

A. Psychiatric Signs and Symptoms

Psychiatric symptoms - cognitive, perceptual, affective, and/or somatic (due to a mental illness) disturbances or impaired developmental progression (children and adolescents) of sufficient intensity to cause subjective distress, disordered behavior and/or other dysfunctional consequences.

The level of distress and/or the disordered behavior is not severe enough to endanger the welfare of the person and/or others.

B. Impairments of Functioning

The person is experiencing disruption of self-care, daily living skills, social/ interpersonal functioning and/or educational/vocational role performance.

Family/community support systems can be relied on to provide the essentials of care at this time.

C. Danger to Self/Others

Self/Other Harm: the person is considered to be at minimal immediate risk of self-harm. While fleeting ideation or passive wishes might be present, there has been no recent serious attempt to harm self, nor is there any substantial plan with significant intent/lethality. The person has made no serious, recent attempt to harm others and/or property.

III. Intensity of Service

The person meets the intensity of service requirements for brief outpatient treatment if ambulatory clinical/therapeutic services (psychotherapy, medication evaluation and monitoring) are considered adequate and essential for treatment of a mental disorder and:

A. The individual/family can identify, with the assistance of the clinician, an explicit goal (e.g., symptom relief), a focal issue, conflict, or concern for therapeutic intervention.

B. A treatment plan is developed specifying therapeutic goals in measurable terms of symptom alleviation, cognitive alteration; behavioral change, family competence and/or improvement in social, occupational, and or scholastic functioning.

C. The individual/family demonstrates adequate judgement and is (are) capable to assume responsibility for treatment involvement and behavioral change.

INTERMEDIATE CARE OR THERAPEUTIC STABILIZATION SERVICES

Intermediate care or therapeutic stabilization services are clinical interventions (prolonged intermittent psychotherapeutic contact, low intensity case management services, family support services, extended medication management) designed for individuals who require more extensive support and sustained treatment involvement in order to achieve or maintain symptomatic remission and/or a stable level of functioning, and to prevent the use of more intensive levels of care.

I. Severity of Illness Criteria for Intermediate Outpatient Treatment

Consumer must be suffering from a mental illness or emotional disorder, reflected in a primary, validated, DSM-IV or ICD-10 Diagnosis (not including V Codes) and, at least one of the following manifestations is present:

A. Psychiatric Signs and Symptoms

Psychiatric symptoms - persistence or recurrence of moderate cognitive, perceptual, affective, and/or somatic (due to a mental illness) disturbances or impaired developmental progression (children and adolescents).

B. Impairments of Functioning

Sustained deficiencies in self-care, daily living skills, social/interpersonal adjustment and/or educational/vocational role performance.

C. Danger to Self/Others

Self/Other Harm: some concerns regarding self/other harm because the individual's judgement and/or impulse control capabilities are suspect or unreliable.

II. Intensity of Service

The person meets the intensity of service requirements for intermediate care – therapeutic stabilization if extended ambulatory clinical/therapeutic services and supports are considered adequate and essential for treatment of a mental disorder, and:

A. The individual/family requires such care to achieve and/or maintain symptomatic remission and/or a stable level of functioning.

B. Intermediate care or therapeutic stabilization services are necessary to prevent utilization of more intensive or restrictive levels of care.