United Behavioral Health

Supplemental Clinical Criteria: Nebraska Medicaid

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INTRODUCTION & INSTRUCTIONS FOR USE

The following State or Contract Specific Clinical Criteria\(^1\) defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”)).

Other Clinical Criteria\(^2\) may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member’s specific benefit, the member’s specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

APPLIED BEHAVIORAL ANALYSIS

APPLIED BEHAVIOR ANALYSIS (ABA) seeks to identify maladaptive behaviors in order to replace those behaviors with socially acceptable behaviors through the use of counseling modalities and behavioral training which may involve interventions to:

- Change an individual’s behavior and emotional state;
- Address the function and efficiency of the problematic behavior in the least restrictive manner;
- Promote the development of alternative adaptive skills; and
- Improve socially significant behaviors.

Admission Criteria

- The individual has significant functional impairments as a result of maladaptive behaviors associated with a developmental disability.
- Maladaptive behaviors that negatively impact the individual’s ability to function successfully in home, community and/or school settings are present.
- Of all reasonable options for available to the individual, applied behavioral analysis will reasonably improve the individual's behavioral functioning.

Continued Service Criteria

- The individual’s condition continues to meet admission guidelines for this level of care.
- The individual does not require a more intensive level of care, and no less intensive level of care would be appropriate.
- There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.

Discharge Criteria

- The individual has substantially met their treatment plan goals and objectives.

\(^{1}\) Clinical Criteria (State or Contract Specific): Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.

\(^{2}\) Clinical Criteria (ASAM Criteria): Criteria used to make medical necessity determinations for substance-related disorder benefits.

\(^{3}\) Optum is a brand used by United Behavioral Health and its affiliates.
• The precipitating condition is stabilized such that the individual’s condition can be managed without professional external supports and interventions.

**Service Delivery**

**o Evaluation and Service Planning**
  - An initial Diagnostic Interview and a Functional Behavior Assessment has been completed prior to admission.
  - A clinical assessment indicates the individual's baseline level of functioning and how the individual will benefit from highly structured IBT interventions.
  - The following is completed as part of the ASD evaluation:
    - A structured diagnostic interview such as the Autism Diagnostic Interview-Revised (ADI-R) used to evaluate:
      - Family functioning;
      - Communication skills;
      - Motor skills;
      - Cognitive functioning; and
      - Adaptive functioning.
  - The collection of historical information to include:
    - Autism symptoms to include social relatedness, core ASD symptoms and repetitive or unusual behaviors;
    - Pregnancy, neonatal, and developmental history;
    - Previous ASD screening results, if applicable;
    - Medical history to include seizures, sensory deficits, hearing or visual impairments, or other medical and behavioral conditions;
    - History of observations from multiple sources including family individuals, teachers, other providers and child-care workers, incorporating the use of standardized tools when possible;
    - History of any developmental regression;
    - History of treatment interventions and response to treatment;
    - History of behavior patterns and functional skills.
  - Direct observations include:
    - The individual in multiple settings, being attentive to environmental factors;
    - The individual's symptoms specific to the areas of social interaction, communication, play and language;
    - Aggression, self-injury or stereotypic behavior or movement;
      - A functional behavior assessment and skill assessment may be needed if the individual is displaying self-injurious, or other aggressive behaviors.
    - The use of standardized tools such as:
      - Autism Behavior Checklist (ABC);
      - Autism Diagnostic Observation Schedule (ADOS-2);
      - Autism Diagnostic Interview (ADI);
      - Childhood Autism Rating Scale (CARS);
      - Checklist for Autism in Toddlers (M-CHAT);
    - A differential diagnosis from other medical, neurodevelopmental and behavioral conditions, including the identification of comorbidities is completed.
  - Once an ASD diagnosis has been established:
    - A functional assessment is used to identify behaviors for reduction, and a skills-based assessment to determine skills to be increased should be completed.
    - Targets include areas such as the following:
      - Communication skills;
      - Language skills;
      - Social interaction skills;
      - Self-injurious, violent, destructive or other maladaptive behavior.
    - The treatment plan identifies:
      - The individual's strengths and needs,
      - Considers community, family and other supports,
• States measurable goals and interventions based on the individual’s needs, and
• Identifies a discharge plan.
  o The individual’s treatment plan is reviewed at a minimum every 90 days or more often as determined clinically necessary.
  o After review, the treatment plan is updated as clinically indicated and signed by the supervising practitioner and other treatment team individuals, including the individual and/or guardian being served.

  • Service Expectations
  o The IBT interventions seek to address all of the following:
    ▪ Mitigate the core features of ASD such as impairment in social reciprocity, deficits in communication, and restricted or repetitive behaviors.
    ▪ Include the individual’s parents in parent training and the acquisition of skills in behavior modification to promote management of skills within the home.
    ▪ Include psychotherapy for higher functioning individuals.
    ▪ Target specific deficits related to imitation, attention, motivation, compliance and initiation of interaction, and the specific adaptive behaviors that are to be incrementally taught and positively reinforced.
    ▪ Tie to objective and quantifiable treatment goals that have projected timeframes for completion.
  o Have an appropriate level of frequency and intensity driven by:
    ▪ Changes in the targeted behavior(s);
    ▪ The demonstration and maintenance of management skills by the parents/guardians;
    ▪ Whether specific issues are being treated in a less intensive group format (e.g., social skills groups);
    ▪ The individual’s ability to participate in IBT given attendance at school, daycare or other treatment settings; and
    ▪ The impact of co-occurring behavioral or medical conditions on skill attainment.
  o Interventions may include:
    ▪ Parent instruction,
    ▪ De-escalation techniques,
    ▪ Behavioral management techniques,
    ▪ Coping skills,
    ▪ Social and life skills development.
  o These services will not be used in place of a school aide or other similar services not involving the parent.
  o Individuals are taught socially acceptable behaviors via modeling, prompting, roleplaying and reinforcing of appropriate behaviors.
  o Family/Caregiver training is provided to include acceptable behaviors via modeling, prompting, roleplaying, and reinforcing appropriate behaviors to promote consistency for the individual.
  o If ABA services are performed by a Board Certified Associate Behavior Analyst (BCaBA) or by a Registered Behavior Technician (RBT), supervision is provided under the direction of a Board Certified Behavior Analyst.
  o Supervision includes:
    ▪ Critical oversight of a treatment activity or course of action;
    ▪ Review of the treatment plan and progress notes;
    ▪ Individual specific case discussion;
    ▪ Periodic assessments of the individual; and
    ▪ Diagnosis, treatment intervention or issue specific discussion.
  o Involvement of the supervising practitioner must be reflected in the Initial Diagnostic Interview the treatment plan and the interventions provided.
  o After hours crisis assistance must be available

**Discharge Planning**
Transition and discharge planning must begin at the time of admission, be based on transitioning the individual to a different level of care, and address the individual's ongoing treatment needed to maintain and/or continue normal physical and mental development post discharge.

**ASSERTIVE COMMUNITY TREATMENT**

**ASSERTIVE COMMUNITY TREATMENT (ACT)** team provides high intensity services, and is available to provide treatment, rehabilitation, and support activities seven days per week, 24 hours per day, and 365 days per year. The team has the capacity to provide multiple contacts each day as dictated by individual need. The team provides ongoing continuous care for individuals determined to have met medical necessity criteria. Individuals admitted to the service who demonstrate any continued need for treatment, rehabilitation, and support will not be discharged unless it is determined the individual no longer meets medical necessity criteria. ACT services are available for a minimum of 12 hours per day, eight hours per day on weekends/holidays; staff on-call 24/7 and able to provide needed services and to respond to psychiatric crises.

**Admission Criteria**
- The individual has a DSM diagnosis (current edition) consistent with a long standing serious and persistent mental illness with symptoms of sufficient severity and duration that it is expected to cause significant, ongoing, disabling functional impairments. These impairments are beyond the scope of the person's informal support system to remediate and require professional assistance to guide the individual to recovery.
- The individual has a persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the individual's ability to function independently in an appropriate and effective manner in two of three functional areas: Vocational/Education, Social Skills, Activities of Daily Living.
- The individual has a significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed mental health services are not provided, and this pattern has existed for one year or longer and is likely to endure for one year or longer.
- The individual has a history of high utilization of psychiatric inpatient and emergency services.
- The individual has had less than satisfactory response to previous levels of treatment/rehabilitation interventions.

**Continued Service Criteria**
- Admission guidelines continue to be met.
- The individual does not require a more intensive level of services and no less intensive level of care is appropriate.
- There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
- The individual is making progress towards treatment/rehabilitation goals.
- The service is available to the individual as long as medical necessity criteria is met and in accordance with the discharge criteria on the program fidelity scale for ACT.

**Discharge Criteria**
- The individual has met their treatment plan goals and objectives.
- The precipitating condition and relapse potential is stabilized such that individual’s condition can be managed without professional external supports and interventions.
- The individual has alternative support systems secured to help the individual maintain stability in the community.

**Service Delivery**
- Evaluation and Service Planning
  - The precipitating condition and relapse potential is stabilized such that individual’s condition can be managed without professional external supports and interventions.
  - Individual has alternative support systems secured to help the individual maintain stability in the community.
Complete an initial diagnostic interview (IDI) if one has not been completed within the 12 months prior to admission to ACT to ensure the individual meets the DSM (current edition) criteria for having a severe and persistent mental illness. The IDI is to identify the need for ACT and outline the needed services and resources for the individual. The IDI will serve as the treatment plan until the comprehensive plan of care is developed.

If the IDI was completed within 12 months prior to admission, a licensed professional should review and update as necessary via an addendum to ensure the information is reflective of the individual’s current status and functioning. The review and update should be completed within 30 days of admission.

An initial Individual treatment, rehabilitation, and recovery plan is to be developed upon the individual’s admission to the ACT Team.

A comprehensive treatment, rehabilitation and recovery plan, developed under clinical guidance with the individual, should integrate individual strengths, needs and preferences, while, considering community, family and other informal supports important to the person served. It should state measurable, attainable goals and specific interventions that include a crisis/relapse prevention plan, completed within 21 days of the IDI.

Review and revise the individual’s treatment, rehabilitation, and recovery plan every six months, whenever there is a change in psychiatric condition and/or level of functioning during the individual’s course of treatment, or more often as necessary to actively review progress made towards goals.

Engage the individual in active involvement in the development of the treatment/service goals.

Involves pertinent agencies and individuals of the individual’s family and social network in the development of the treatment, rehabilitation, and recovery plans.

Provide the interventions necessary to ensure an individual receives treatment for identified psychiatric and/or physical conditions.

Provide individual, family, and group therapy to assist the individual to gain skills in interpersonal relationships, identify and resolve conflicts, and systematically work on identified individual goals. Referrals to appropriate support group services may be appropriate.

Provide medication prescribing, delivery, administration and monitoring.

Provide crisis intervention as required.

Provide rehabilitation services, including symptom management, skill development, vocational skill development, and psycho-educational services focused on activities of daily living, social functioning, and community living skills.

Provide supportive interventions which include direct assistance and coordination in obtaining basic necessities such as medical appointments, housing, transportation, and maintaining family/other involvement with the individual.

Offer opportunities for positive peer role modeling and peer support.

Clinical direction will be provided by the team psychiatrist, and/or team leader, weekly and may occur during daily team meetings, individual treatment, rehabilitation and recovery plan meetings, side-by-side and face-to-face supervision sessions and record review.

Conducts daily multidisciplinary team meetings. This may include, but is not limited to, activities such as reviewing the functional status and needs of individuals, proactively identifying issues and concerns, providing effective communication, and reviewing clinical issues.

Service Expectations

An ACT team is comprised of the following:

- Psychiatrist (at least 16 hours a week) or an APRN;
- Team leader (may have a master’s degree in nursing, social work, psychiatric rehabilitation, psychology, or counseling, or be a psychiatrist or a physician extender);
- Mental health professional (Licensed and/or provisionally licensed Psychologist, LMHP, Licensed and/or provisionally licensed LMHP/PLMHP);
- RN;
• Mental health worker (may be a LADC/PLADC; or have an associate or bachelor’s degree in behavioral sciences with experience working with individuals diagnosed with a severe and persistent mental illness and/or substance use disorder);
• Part time certified peer support specialist;
• Vocational specialist with at least one year training/experience in vocational rehabilitation and support; and
• Substance abuse specialists with at least one year training/experience in substance use disorder treatment, a LADC, PLADC, LMHP or PLMHP with specialized substance use disorder training.
  o All staff should be educated/trained in rehabilitation, recovery principles, and trauma informed care.
  o If the ACT team serves more than 50 individuals then the following additional staff individuals are needed:
    • At least one additional RN and mental health professional;
    • A full time Certified Peer Support Specialist; and
    • For every additional eight individuals, the Psychiatrist will be available an additional 2.6 hours.
    • Team individual to individual ratio is 1:10.
    • A full-time psychiatrist is required for programs of 100 persons served. Increases in the size of the program should reflect a proportional increase in psychiatrist hours and availability.
    • Programs serving 100 persons will provide two full-time RNs, two substance abuse specialists, and two vocational specialists.
    • For ACT teams over 100 individuals, there should be a proportional increase in staff hours for the RN, vocational specialist, and substance abuse treatment specialist to address needs of the additional individuals.
    • Team individual to individual ratio should not consider the team psychiatrist/APRN or those providing administrative support.

CHILD-PARENT PSYCHOTHERAPY

CHILD-PARENT PSYCHOTHERAPY An evidence-based treatment provided to children birth to age 5, who have experienced at least one traumatic event (e.g. maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including post-traumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child’s sense of safety, attachment, and appropriate affect and improving the child’s cognitive, behavioral, and social functioning. The length of treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the individual’s ability to benefit from treatment. Average number of sessions is 50.

Admission Criteria
  o The individual demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
  o There are significant symptoms, caused by the behavioral health diagnosis, that negatively impact a child’s ability to eat, sleep engage in age appropriate social behavior, and meet developmentally appropriate milestones.
  o This service is provided in the least restrictive setting that will produce the desired results in accordance with the needs of the individual.
  o CPP is supported by evidence that the treatment will improve symptoms and functioning for the individual individual’s behavioral health diagnosis.
  o There is an expectation that the individual has the capacity to make significant progress toward treatment goals to the point that CPP is no longer necessary.
  o CPP is required for reasons other than primarily for the convenience of the individual or the provider.
o Involvement of the individual and his/her family with a therapist for the purpose of changing a behavior health condition focusing on the level of family functioning as a whole and address issues related to the entire family system is the focus of treatment.

o Family therapy is recommended through thorough assessments completed by licensed clinicians as medically necessary to achieve goals/objectives for treatment of a behavior health condition.

**Continued Service Criteria**

o Admission guidelines continue to be met.

o Treatment planning is individualized and appropriate to the family's changing condition, with realistic and specific goals and objectives clearly stated.

o All interventions are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.

o Progress in relation to specific dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.

o Care is rendered in a clinically appropriate manner and focused on the family’s behavioral and functional outcomes as described in the discharge plan.

o There is documented active discharge planning.

**Discharge Criteria**

o The family has substantially met their treatment plan goals and objectives.

o Family has support systems secured to help them maintain stability in the community.

**Service Delivery**

o Evaluation and Service Planning
  o Young children should receive CPP services only after a recent appropriate medical evaluation to rule out conditions of a general medical nature.
  o Treatment Planning: A goal-oriented treatment plan with measurable outcomes, and a specific, realistic discharge plan must be developed with the individual (identified patient) and the identified, appropriate family members as part of the initial assessment and outpatient family therapy treatment planning process; the treatment and discharge plan must be evaluated and revised as medically indicated.
  o An Initial Diagnostic Interview must be completed prior to the beginning of treatment.
  o Assessment should be ongoing with treatment and reviewed each session.

• Service Expectations
  o Services must be treatment focused and not rehabilitative or habilitative in nature.
  o There will be a reasonable expectation that CPP will improve the child’s psychiatric symptoms so that the services will no longer be necessary.
  o Consultation and/or referral for general medical, psychiatric, psychological, and psychopharmacology needs.
  o Provided as family psychotherapy.

**Discharge Planning**

• Length of treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the individual’s ability to benefit from treatment.

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**COMMUNITY SUPPORT**

**COMMUNITY SUPPORT** services will provide rehabilitative and support services for individuals with a primary mental health diagnosis. Such services will include treatment for substance issues when that is an identified need for the client. Community Support Workers provide direct rehabilitation and support services to the individual in the community with the intention of supporting the individual to maintain stable community living, and preventing exacerbation of their mental illness and admission to higher levels of care. Service is not provided during the same service delivery hour of other rehabilitation services.

**Admission Criteria**
• The individual is 21 years or older and has been assigned a DSM diagnosis consistent with a Serious and Persistent Mental Illness (i.e. a primary diagnosis of Schizophrenia, major affective disorders, PTSD, OCD or other major mental illness and/or substance abuse disorder in the current edition of DSM).
• The individual’s Serious and Persistent Mental Illness and/or substance use disorder has been present for the last 12 months, or is expected to last at least 12 months resulting in a degree of limitation that seriously interferes with the individual’s ability to function independently and appropriately in (2) of the following (3) functional areas.
  • Vocational/Education:
    o Inability to obtain or maintain employment, or cannot maintain employment without extensive supports; or
    o Deterioration or decompensation of the individual’s mental illness resulting in the inability to establish or pursue educational goals within a normal time frame or without extensive supports; or
    o Inability to consistently and independently carry out home management tasks.
  • Social skills:
    o Repeated inappropriate or inadequate social behavior or inability to behave in a socially appropriate manner without extensive supports; or
    o Inability to participate in adult activities without extensive supports or limited to special activities established for persons with mental illness; or
    o History of dangerousness to self/others.
  • Activities of Daily Living:
    o Inability to consistently perform the range of practical daily living tasks required for basic adult functioning.
    o Symptoms and functional deficits are related to the primary diagnosis.
    o There is an expectation that the individual will benefit from rehabilitation services until services are no longer medically necessary.
    o The individual’s rehabilitation needs are best met by 1:1 direction with a paraprofessional.

Continued Service Criteria
• All of the following are necessary for continuing treatment at this level of care:
  ▪ The individual continues to meet admission criteria.
  ▪ The individual does not require a more intensive level of care and no other less intensive level of care is appropriate.
  ▪ There is reasonable likelihood of substantial benefit to the individual as demonstrated by objective behavioral measurements of improvement in functional areas.
  ▪ The individual is making progress toward rehabilitation goals.

Discharge Criteria
• The individual has met his/her treatment plan goals and objectives.
• The precipitating condition and relapse potential is stabilized such that individual’s condition can be managed without/or with decreased professional external supports and interventions.
• The individual has alternative support systems secured to help him/her maintain stability in the community.

Service Delivery
• Evaluation and Planning
  ▪ There has been a complete Initial Diagnostic Interview, no more than 12 months prior to admission to Community Support, to ensure that the individual meets the Severe and Persistent Mental Illness criteria.
  ▪ The Initial Diagnostic Interview must identify the need for Community Support and outline the needed services and resources for the individual. The IDI will serve as the treatment plan until the comprehensive plan of care is developed.
  ▪ If the IDI was completed within 12 months prior to admission, a licensed professional should review and update as necessary via an addendum to ensure the information is reflective of the individual’s current status and functioning. The review and update should be completed within 30 days of admit.
A strengths-based assessment which may include skills inventories, interviews and/or use of other tools for the purpose of identifying treatment and rehabilitation goals and plans with the individual, should be completed within 30 days of admission and may be completed by either non-licensed or licensed individuals on the individual's team.

There are Treatment, Rehabilitation, and Recovery Plans for the individual. The Treatment, Rehabilitation, and Recovery Plans will be completed within 30 days following admission and reviewed and updated every 90 days or as often as clinically necessary thereafter.

- **Service Expectations**
  - Services actively deliver rehabilitation and support interventions with focus on activities of daily living, psychoeducation, budgeting, medication adherence and self-administration (as appropriate and part of the overall treatment/recovery plan), relapse prevention, social skills, and other independent living skills that enable the individual to reside in their community.
  - Provide service coordination and case management activities, including coordination or assistance in accessing medical, psychiatric, psychological, social, education, housing, transportation or other appropriate treatment/support services as well as linkage to other community services identified in the treatment/rehabilitation/recovery plan.
  - Assist the individual with all health insurance issues including Share of Cost eligibility issues. Ensures individual understanding of financial benefits and procedures to use those benefits such as Medicaid spend downs, AABD, SSI and SSA, etc.
  - Develop and implement strategies to encourage the individual to become engaged and remain engaged in necessary mental health treatment services as recommended and included in the treatment/rehabilitation/recovery plan.
  - Participate with and report to treatment/rehabilitation team on the individual’s progress and response to community support intervention in the areas of relapse prevention, substance use/abuse, application of education and skills, and the recovery environment (areas identified in the plan).
  - Provide therapeutic support and intervention to the individual in time of crisis and work with the individual to develop a crisis relapse prevention plan.
  - Provide contact as needed with other service provider(s), individual family individual(s), and/or other significant people in the individual’s life to facilitate communication necessary to support the individual in maintaining community living.
  - If hospitalization or residential care is necessary, facilitate, in cooperation with the treatment provider, the individual’s transition back into the community upon discharge.

- **Discharge Planning**
  - Length of service is individualized and based on clinical criteria for admission and continued stay, as well as the client’s ability to make progress on individual treatment/recovery goals.

### COMMUNITY TREATMENT AIDE

**COMMUNITY TREATMENT AIDE** Community Treatment Aide (CTA) services are supportive interventions designed to assist the individual and parents or primary caregivers to learn and rehearse the specific strategies and techniques that can decrease the severity of, or eliminate, symptoms and behaviors associated with the individual’s mental illness that create significant impairments in functioning. Services are provided in the individual’s natural environment is primarily the individual’s home but may also include a foster home, school or other appropriate community locations conducive for the delivery of CTA services.

**Admission Criteria**

- There is an established DSM (current edition) diagnosis which requires and will respond to therapeutic intervention.
- There is the presence of psychological symptoms that require this level of care.
- The individual is enrolled in active outpatient treatment with a licensed therapist.
- The individual would require a more restrictive treatment environment without the services of a CTA.
- The individual is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.
• The individual must have sufficient medical need for active psychiatric treatment at the time of admission to justify the expenditure of the individuals and program’s time, energy, and resources.
• Of all reasonable options for active psychiatric treatment available to the individual, treatment in this program must be the best choice for expecting a reasonable improvement in the individual’s psychiatric condition.
• The Initial Diagnostic Evaluation must identify the need for this level of care for the individual.

Continued Service Criteria
• The individual’s condition continues to meet admission criteria for this level of care.
• The individual does not require a more intensive level of care, and no less intensive level of care would be appropriate.
• There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
• The individual is making progress toward goals and is actively participating in the interventions.

Discharge Criteria
• The individual has met their treatment plan goals and objectives.
• The precipitating condition and relapse potential is stabilized such that individual’s condition can be managed without professional external supports and interventions.
• The individual has alternative support systems secured to help him/her maintain stability in the community.

Service Delivery
• Evaluation and Service Planning
  o An Initial Diagnostic Interview must be completed prior to the beginning of treatment and will serve as the initial treatment plan until the comprehensive plan of care is developed.
  o The individual’s CTA plan will be a part of the comprehensive treatment plan developed by the individual’s outpatient psychotherapy provider and be developed in close collaboration with the therapy provider.
  o The CTA treatment plan must be reviewed and updated every 90 days or sooner as medically necessary and demonstrate collaboration with the outpatient therapist.
• Service Expectations
  o Outpatient services will be provided by licensed practitioners whose scope of practice includes mental health and/or substance use disorder services.
  o Treatment interventions should be based on the comprehensive assessment and focused on specific treatment goals inclusive of the culture, expectations and needs as identified by the individual and parent/caregiver.
  o The CTA staff is expected to provide interventions which may include: parent instruction, de-escalation techniques, behavioral management techniques, coping skills, and social and life skills development.
  o CTA services will not be used in place of a school aide or other similar services not involving the parent.
  o CTA services will be delivered under the direction and supervision of the therapist providing family and/or individual therapy.
  o The Supervising Practitioner must provide monthly supervision and direction to the CTA therapist. This contact may be by telephone and must be documented in the individual’s treatment record.
  o The parent/caregiver is fully engaged during all CTA services.
  o Clinical Direction by a licensed professional (Psychiatrist, APRN, RN, LMHP, PLMHP, LIMHP, Licensed Psychologist, Provisionally Licensed Psychologist); working with the program to provide clinical direction, consultation and support to community support staff and the individuals they serve.
  ▪ The Clinical Supervisor will review individual clinical needs every 30 days. The review should be completed preferably face to face but phone review will be accepted. The
review may be accomplished by the supervisor consulting with the worker on the list of assigned individuals and identifying any clinical recommendations in serving the individual.

- **Discharge Planning**
  - Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the individual’s ability to make progress on individual treatment/recovery goals.

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**CRISIS PSYCHOTHERAPY**

**CRISIS PSYCHOTHERAPY** Crisis outpatient individual or family therapy is an immediate, short-term treatment service provided to an individual. Crisis Psychotherapy is rendered in a professional office, clinic, home or other appropriate environment appropriate to the provision of psychotherapy service.

**Admission Criteria**

- The individual demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
- Presenting behavioral, psychological, and/or biological dysfunction and functional impairment are consistent and associated with the DSM (current edition) and/or reports a precipitating event.

**Discharge Criteria**

- The individual is able to remain stable in the community without this treatment.
- The individual will receive services to address safety and crisis resolution.

**Service Delivery**

- **Evaluation & Treatment Planning**
  - Psychotherapy is limited to 2 sessions.
  - If services are to continue, the provider will complete an IDI and develop a treatment plan if one has not already been completed.
- Includes active family involvement unless contraindicated.
- Services must be trauma informed and sensitive to potential personal safety risks such as suicidal intention.
- The therapist/provider must coordinate care with the individual’s primary medical provider and the therapy provider if on-going therapy is authorized.
- The intervention/safety plan identifies the crisis with steps for further resolution, outlines an individualized safety plan for the individual and/or family, and identifies additional formal and informal supports. The clinician will assist in making appropriate referrals.

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**CRISIS STABILIZATION SERVICES**

**CRISIS STABILIZATION SERVICES** provides a facility-based care where patients in urgent need can receive crisis stabilization services in a safe, structured setting. It provides continuous 24-hour observation and supervision for individuals who do not require intensive clinical treatment in an inpatient psychiatric setting and would benefit from emergency services prior to ongoing services being established. The primary objective of the crisis stabilization service is to promptly conduct an assessment of the patient and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the patient to a level of functioning that requires a less restrictive level of care.

**Admission Criteria**

- Individual demonstrates a significant incapacitating or debilitating disturbance in mood/thought interfering to the extent that immediate stabilization is required.
- Individual demonstrates active symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to intensive, structured intervention.
Clinical evaluation of the individual's condition indicates dramatic and sudden decompensation with a potential for danger to self or others and the individual has no available supports to provide continuous monitoring.

Individual requires 24 hour observation and supervision but not the constant observation of an inpatient psychiatric setting.

The individual can be effectively treated with short-term intensive crisis intervention services and returned to a less intensive level of care within a brief time frame.

A less intensive or restrictive level of care has been considered/attempted or clinical evaluation indicates the onset of a life-endangering psychiatric condition, but there is insufficient information to determine the appropriate level of care.

**Continued Stay Criteria**

- The individual's condition continues to meet admission guidelines at this level of care.
- The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
- Care is rendered in a clinically appropriate manner and focused on individual's behavioral and functional outcomes as described in the discharge plan.
- Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated.
- All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
- Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident.
- There is documented active discharge planning.

**Discharge Criteria**

- The member is not discharged until the individual is stabilized and meets the conditions of the discharge plan. These services should not exceed seven (7) days.

**Service Expectations**

- Services at this level of care include crisis stabilization, care management, medication management, and mobilization of family support and community resources.
- Complete an initial diagnostic interview (IDI) if one has not been completed within the preceding 12 months, or if one is not available.
- If the IDI was completed within 12 months prior to admission, and is available, a licensed professional should review and update as necessary via an addendum to ensure the information is reflective of the individual's current status and functioning.
- Substance use disorder assessment if deemed necessary in the IDI.
- A crisis stabilization plan, which includes relapse/crisis prevention and discharge plan components (consider community, family and other supports), developed within 24 hours of admission and adjusted as needed.
- Addictions treatment initiated and integrated into the treatment/recovery plan for co-occurring disorders identified in initial assessment process as appropriate.
- Discharge planning begins at admission.
- Individual, group, and family therapy services if medically necessary.
- Ancillary service referral as needed (dental, optometry, physical health, other mental health and/or social services, etc.)
- All staff should be educated/trained in recovery principles, and trauma informed care.

**DAY REHABILITATION**

**DAY REHABILITATION** services are designed to provide individualized treatment and recovery, inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and/or co-occurring disorders who are in need of a program operating variable hours. The intent of the service is to support the individual in the recovery process so that he/she can be successful in a community living setting of his/her choice. Day Rehabilitation operates during regularly scheduled days, evenings, or weekend hours with 24/7 on call access to a mental health provider.
Admission Criteria

- All of the following is present:
  - DSM (current edition) diagnosis consistent with a long standing serious and persistent mental illness with severity and duration that it is expected to cause significant, ongoing, disabling functional impairments. These impairments are beyond the scope of the person’s informal support system to remediate and require professional assistance to guide the individual to recovery.
  - The individual’s Serious and Persistent Mental Illness and/or substance use disorder has been present for the last 12 months, or is expected to last at least 12 months resulting in a degree of limitation that seriously interferes with the individual’s ability to function independently and appropriately in (2) of the following (3) functional areas.
  - Vocational/Education:
    - Inability to obtain or maintain employment, or cannot maintain employment without extensive supports; or
    - Deterioration or decompensation of the individual’s mental illness resulting in the inability to establish or pursue educational goals within a normal time frame or without extensive supports; or
    - Inability to consistently and independently carry out home management tasks.
  - Social skills:
    - Repeated inappropriate or inadequate social behavior or inability to behave in a socially appropriate manner without extensive supports; or
    - Inability to participate in adult activities without extensive supports or limited to special activities established for persons with mental illness; or
    - History of dangerousness to self/others.
  - Activities of Daily Living:
    - Inability to consistently perform the range of practical daily living tasks required for basic adult functioning such as:
      - Grooming, hygiene, washing clothes, meeting nutritional needs;
      - Care of personal business affairs;
      - Transportation and care of residence;
      - Procurement of medical, legal, and housing services;
      - Recognition and avoidance of common dangers or hazards to self and possessions.
  - Functional deficits of such intensity that require daily rehabilitative interventions three to five days a week and three to six hours per day in a structured day setting.
  - The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional manner if needed rehabilitation services are not provided as identified in the above bullet.
  - Symptoms and functional deficits are related to the primary diagnosis.
  - There is an expectation that the individual will benefit from rehabilitation services until services are no longer medically necessary.

Continued Service Criteria

- All of the following are necessary for continuing treatment at this level of care:
  - The individual continues to meet admission criteria.
  - The individual does not require a more intensive level of care and no other less intensive level of care is appropriate.
  - There is reasonable likelihood of substantial benefit to the individual as demonstrated by objective behavioral measurements of improvement in functional areas.
  - The individual is making progress toward rehabilitation goals.

Discharge Criteria

- The individual has met his/her treatment plan goals and objectives.
- The individual has met their treatment/recovery/rehabilitation plan goals and objectives
- The individual has achieved a level of functioning that does not require ongoing, intensive professional external supports and interventions.
- The individual has formal and informal support systems secured to maintain stability in a less restrictive environment.
Service Delivery

- Evaluation and Service Planning
  - There has been a complete Initial Diagnostic Interview, no more than 12 months prior to admission to Community Support, to ensure that the individual meets the Severe and Persistent Mental Illness criteria.
    - If the diagnostic interview was completed within 12 months prior to admission, a licensed professional should review and update as necessary via an addendum, to ensure information is reflective of the individual’s current status and functioning.
    - The review and update should be completed within 30 days of admission.
  - A strengths-based assessment which may include skills inventories, interviews and/or use of other tools for the purpose of identifying treatment and rehabilitation goals and plans with the individual, should be completed within 30 days of admission and may be completed by non-licensed or licensed individuals on the individual’s team.
  - An initial treatment/rehabilitation/recovery plan to guide the first 30 days of treatment developed within 72 hours of admission.
  - Alcohol and drug screening; assessment as needed.
  - A treatment/rehabilitation/recovery plan developed with the individual, integrating individual strengths & needs, considering community, family and other supports, stating measurable goals, that includes a documented discharge and relapse prevention plan completed within 30 days of admission.
  - Review the treatment/rehabilitation/recovery and discharge plan with treatment team, including the individual, every 90 days, making necessary changes then or as often as medically indicated. Each review should be signed by individuals of the treatment team, at a minimum the Clinical Supervisor, assigned therapist and individual/family/legally responsible person.

- Service Expectations
  - Therapeutic milieu providing active treatment/recovery/rehabilitation activities led by individuals trained in the provision of recovery principles.
  - The on-site capacity to provide medication administration and/or self-administration, symptom management, nutritional support, social, vocational, and life-skills building activities, self-advocacy, peer support services, recreational activities, and other independent living skills that enable the individual to reside in their community.
  - Ability to coordinate other services the individual may be receiving and refer to other necessary services.
  - Referral for services and supports to enhance independence in the community.

- Discharge Planning
  - Length of service is individualized and based on clinical criteria for admission and continued stay, as well as the individual’s ability to make progress on individual treatment/recovery goals.

DAY TREATMENT/PARTIAL HOSPITALIZATION ADULT

DAY TREATMENT/PARTIAL HOSPITALIZATION ADULT is a psychiatric treatment service, in a continuum of care, designed to prevent hospitalization or to facilitate the movement of the acute psychiatric individual to a status in which the individual is capable of functioning within the community with less frequent contact with the psychiatric health care provider. This service may be available seven days a week with a minimum availability of five days a week including days, evenings and weekends. The length of service is individualized and based on clinical criteria for admission and continuing stay.

Admission Criteria

- The individual demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
- There is an expectation that the individual has the capacity to make progress toward treatment goals to where services are no longer necessary.
- Unable to functioning outside the treatment program due to a mental health disorder as evidenced by the following:
- Psychiatric symptoms requiring medical stabilization.
- Inability to function in one of the following areas: social, occupational, vocational, educational or an absence of social support resources.
- Inability to perform activities of daily living (hygiene, self-care, meal preparation and nutrition), interpersonal and leisure skills.

The frequency, intensity and duration of contact provided in a day program is necessary as evidenced by:
- Failure to improve/stabilize with less intensive treatment.
- The individual is at risk of adverse consequences if treatment is not provided.
- The individual requires assistance to manage/monitor their medical, mental health and/or substance use needs.
- The individual cannot be safely maintained/effectively treated at a lower level of care.
- A higher level of care is not necessary.

**Continuing Stay Criteria**

- The individual's condition continues to meet admission guidelines for this level of care.
- The individual does not require a more intensive level of care, and no less intensive level of care would be appropriate.
- There is reasonable likelihood of benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
- The consumer is making progress toward goals and is actively participating in the interventions.

**Discharge Criteria**

- The individual has met their treatment plan goals and objectives.
- The precipitating condition and relapse potential is stabilized such that the individual’s condition can be managed without professional external supports and interventions.
- The individual has support systems to maintain stability in a less restrictive environment/level of care.

**Service Delivery**

- Evaluation and Service Planning
  - An initial diagnostic interview (IDI) will be completed prior to admission and function as the initial treatment plan until a comprehensive treatment plan is developed.
  - Provide the family opportunities to participate in all aspects of the individual’s treatment (assessment, treatment planning, therapy and discharge planning) if appropriate. This participation or lack of participation will be documented in the individual record.
  - Provide a flexible meeting schedule to include evenings and weekends.
  - The program will identify an on-call system of licensed practitioners available for crisis management when the individual is not in the program’s scheduled hours and/or the program is not in session.
  - Provide the following mandatory services:
    - Psychological diagnostic services that contribute to the diagnosis and plan of care for the individual.
    - One billable session of psychotherapy services, per scheduled treatment day, that demonstrate the individual is receiving active treatment for their psychiatric condition. These services may include: individual psychotherapy, group psychotherapy, and family psychotherapy if appropriate.
    - Pharmaceutical services: If medications are dispensed by the program, pharmacy services will be provided under the supervision of a registered pharmacy consultant, or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of a registered nurse.
    - Dietary services will be provided and/or contracted with a registered dietitian when meals are provided by a day treatment program.
    - Nursing services: A registered nurse will evaluate and provide for the care and treatment of the individuals medical nursing needs when medically indicated. In a
hospital based day treatment setting a nursing medical assessment will be completed within 24 hours of admission or the first business day.

- Clinically appropriate assessments, as determined necessary, to assess the individual for substance use disorders, eating disorders, or other specialized treatment needs.
- Transition and discharge planning will begin at admission, be based on transitioning the individual to a different level of care, and address the individuals ongoing treatment needs.
- Provide at least two of the following optional services. The individual must have a need for the services, a supervising practitioner must order the services, and the services must be a part of the individual's treatment plan.
- The following will be provided or supervised by a licensed or certified therapist: recreational therapy, speech therapy, occupational therapy, vocational skills therapy, and self-care services;
- Social work provided by a bachelor level social worker (case management activities);
- Social skills building; and/or
- Life survival skills;
- Provide either half day (three hours a day, five days a week) or full day (six hours a day, five days a week).
- Complete a treatment plan within 10 business days of admission. The treatment plan will be individualized and will include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; and the responsible professional.
- The individual treatment plan is reviewed at least every 30 days and more often as necessary, updated as medically indicated and signed by the supervising practitioner and other treatment team individuals, including the individual being served.
- Assessments and treatment should address mental health/substance use needs and emotional issues related to medical conditions.
- Supervising practitioners (physician or PhD) will be onsite a sufficient amount of time to provide for the psychiatric/clinical care of the individuals. The supervising practitioner's involvement will be reflected in the individual record. The supervising practitioner will conduct a face-to-face session every 30 days, separate from the treatment plan review.

- **Service Expectations**
  - **Staffing includes the following professionals:**
    - Physician
    - Nursing (APRN, RN with psychiatric experience preferred)
    - Licensed and provisionally licensed Psychologists
    - Licensed Independent Mental Health Practitioners (LIMHP)
    - Licensed and Provisionally Licensed Mental Health Practitioners (LMHP/PLMHP)
    - Direct care staff will have a bachelor's degree or higher in psychology, sociology, or related human service field, but two years of course work in the human services field and two years’ experience/training with demonstrated skills and competencies in treatment of individuals with mental illness is acceptable.
    - All staff should be educated/trained in recovery principles, and trauma informed care.
  - **Staffing Ratio Details:**
    - Clinical director to direct care staff ratio as needed to meet all responsibilities
      - Therapist/individual: 1:12

**DAY TREATMENT/PARTIAL HOSPITALIZATION YOUTH**

**DAY TREATMENT/PARTIAL HOSPITALIZATION ADULT** is a psychiatric treatment service, in a continuum of care, designed to prevent hospitalization or to facilitate the movement of the acute psychiatric individual to a status in which the individual is capable of functioning within the community with less frequent contact with the psychiatric health care provider. This service may be available seven days a week with a minimum availability of five days a week including days, evenings, and
weekends. The length of service is individualized and based on clinical criteria for admission and continuing stay.

**Admission Criteria**

- The individual demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
- Exacerbation or persistence of a long-standing psychiatric disorder results in symptoms of thought, mood, behavior, or perception that significantly impair functioning.
- The individual requires assistance to master age appropriate personal and interpersonal life skills (e.g. problem solving, assertiveness, self-advocacy, shopping, meal preparation, development of leisure skills, and the use of community resources).
- The individual is medically stable and does not require a higher level of care.
- The individual is determined to need outpatient level of care providing three to five hours of care up to five times a week.
- The individual can reasonably be expected to benefit from mental health/substance use disorder treatment at this level and needs structure for activities of daily living.

**Continuing Stay Criteria**

- All of the following guidelines are necessary for continuing treatment at this level of care:
  - The individual's condition continues to meet admission guidelines for this level of care.
  - The individual does not require a more intensive level of care, and no less intensive level of care would be appropriate.
  - There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
  - The individual is making progress toward goals and is actively participating in the interventions.

**Discharge Criteria**

- The individual has substantially met their treatment plan goals and objectives.
- The precipitating condition and relapse potential is stabilized such that individual's condition can be managed without professional external supports and interventions.
- Individual has support systems to maintain stability in a less restrictive environment/level of care.

**Service Delivery**

- Evaluation and Service Planning
  - Services are community based, family centered, culturally competent and developmentally appropriate.
  - Services involve the family in assessment, treatment planning, updating of the treatment plan, therapy and transition/discharge planning. Family involvement, or lack thereof, will be documented in the clinical record.
  - Meetings/sessions are scheduled in a flexible manner to accommodate including weekends and/or evenings.
  - The program will identify an on-call system of licensed practitioners available for crisis management when the individual is not in the program's scheduled hours and/or the program is not in session.
  - An Initial Diagnostic Interview (IDI) is completed prior to the beginning of treatment and functions as the initial treatment plan until a comprehensive treatment plan is developed.
  - Medication management will be available to all individuals participating in a day treatment service when medication is prescribed by an appropriately licensed practitioner. This service will be medically and clinically necessary for the mental health and/or substance use disorder requiring treatment. The practitioner prescribing the medication, whether within the program or outside of the program, will consult with the program periodically and may bill for all directly delivered medication
management services separate from the payment to the program for day treatment services.

- Special treatment procedures: if a child/adolescent needs behavior management and containment beyond unlocked time outs or redirection, special treatment procedures may be utilized. Special treatment procedures in day treatment are limited to physical restraint, and locked time out. Parents, legal guardian or the department case manager approve use of these procedures through informed consent and are required to be informed within 24 hours each time they are used. Facilities have to meet the following standards regarding special treatment procedures:
  - De-escalation techniques are taught to staff and used appropriately before the initiation of special treatment procedures.
  - Special treatment procedures may be used only when a child/adolescent's behavior presents a danger to self or others, or to prevent serious disruption to the therapeutic environment.
  - The child/adolescent's treatment plan will address the use of special treatment procedures and have a clear plan to decrease the behavior requiring LTO, or physical restraints.
  - Provide a minimum of three hours a day, five days a week.
  - Complete treatment plan within ten days. The treatment plan will be individualized and include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; and the responsible professional.
  - The individual treatment plan is reviewed at least every 30 days, or more often as necessary, updated as medically indicated and signed by the supervising practitioner and other treatment team individuals, including the individual and/or legal guardian being served.
  - Assessments and treatment should address mental health/substance use needs and emotional issues related to medical conditions.
  - Supervising practitioners (Physician or PhD) will be onsite a sufficient amount of time to provide for the psychiatric/clinical care of the patients. The supervising practitioner's involvement will be reflected in the individual record. The supervising practitioner will conduct a face-to-face session with the individual every 30 days, separate from the treatment plan review.
  - Psychotherapy and substance use disorder counseling services are required to be provided by clinical staff that are operating within their scope of practice and under the direction of the supervising practitioner.

- Service Expectations
  - The following services are required to be included in a program for day treatment to be approved:
    - One billable session of psychotherapy and/or substance use counseling services, per scheduled treatment day, that demonstrate the individual is receiving active treatment for their psychiatric condition. These services may include: individual psychotherapy, group psychotherapy, and family psychotherapy if appropriate.
    - Nursing services: medical services are provided by a qualified registered nurse who evaluates the medical nursing needs of each individual and provides for their medical care and treatment. In a hospital based day treatment setting a nursing medical assessment is be completed within 24 hours of admission or the first business day.
    - Clinically appropriate assessments, as determined necessary, to assess the individual for substance use disorders, eating disorders, sex offender behavior, or other specialized treatment needs.
    - Psychological diagnostic services include testing and evaluation services be performed by a licensed psychologist, or a specially licensed psychologist and contribute to the diagnosis and plan of care for the individual.
    - Pharmaceutical services: If medications are dispensed by the program, pharmacy services will be provided under the supervision of a registered
pharmacy consultant, or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of a registered nurse.

- Dietary services are provided and/or contracted with a registered dietitian when meals are provided by a day treatment program.
- Transition and discharge planning begins at admission, is based on transitioning the individual to a different level of care, and addresses the individual’s ongoing treatment needed to maintain and/or continue age appropriate physical and mental development post discharge.

- Provide at least two of the following optional services. The individual is required have a need for the services, a supervising practitioner has to order the services, and the services have to be a part of the individual’s treatment plan:
  - The following is provided or supervised by a licensed or certified therapist: recreational therapy; speech therapy; occupational therapy; vocational skills therapy; and self-care services.
  - Educational services provided by a teacher specially trained to work with individuals experiencing mental health or substance use problems (services, when required by law, will be available, though not necessarily provided by the day treatment program).
  - Social work provided by a bachelor level social worker (case management activities).
  - Social skills building.
  - Life survival skills.
  - Substance use disorder prevention/ intervention; or treatment by an appropriately certified alcohol and drug abuse counselor.

**ELECTROCONVULSIVE THERAPY**

**ELECTROCONVULSIVE THERAPY** ECT is a treatment where an electric current, which is medically controlled, is applied to either or both sides of the brain (unilaterally vs. bilaterally) for the purpose of producing a seizure that is modulated by anesthesia and muscle relaxants in order to provide relief from severe, acute, and debilitating symptoms of a psychiatric disorder.

**Admission Criteria**

- Documentation exists indicating that the individual is unresponsive to trials of effective medications of adequate dose and duration that are indicated for the individual’s condition (e.g., anti-depressants, anti-psychotics, etc., as appropriate).
- The individual is unable to tolerate effective medications or has a medical condition for which medication is contraindicated.
- The individual has had favorable responses to ECT in the past, and rapid response symptom alleviation is medically necessary.
- The individual is unable to safely wait until medication is effective (e.g. due to life-threatening conditions, psychosis, stupor, extreme agitation, high suicide or homicide risk, etc.).
- The individual is experiencing severe mania or depression during pregnancy; or
- The individual and the psychiatrist have agreed that ECT is the least restrictive treatment to effectively treat acute and persistent symptoms.

**Continued Service Criteria**

- Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
  - Persistence of problems or emergence of new problems that meet the outpatient criteria for electroconvulsive treatment as outlined in the admission criteria.
  - Attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on individual history and/or clinical findings, to result in exacerbation or worsening of the individual’s condition.
  - Clinical information is present, indicating a pending decompensation in the absence of the treatment; or
  - Robust medication management has not been sufficient to stabilize symptoms without the addition of ECT.
**Discharge Criteria**

- The individual no longer meets clinical criteria for admission to ECT treatment.
- The individual is able to respond effectively to a less intrusive treatment intervention.

**Service Delivery**

- **Evaluation and Service Planning**
  - Initial Diagnostic Interview by a licensed professional completed within 12 months prior to service initiation or upon beginning a new treatment episode, with ongoing assessment as needed.
  - The IDI will serve as the initial treatment plan until the comprehensive treatment plan is developed.
  - An individualized treatment plan must be developed prior to treatment and include all of the following:
    - Specific medications to be administered during ECT;
    - Choice of electrode placement during ECT; and
    - Stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
  - The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.

- **Service Expectations**
  - All of the following are required prior to the initial treatment:
    - A clinical summary prior to treatment consisting of a DSM (current edition) diagnosis that includes but is not limited to:
      - Current and recent symptom of severity supporting indications for ECT;
      - Psychiatric history with mental status;
      - Current functioning to include specific detailed evidence of past response to ECT, and medication trials and response; and
      - Medical history and examination focusing on neurological, cardiovascular and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT.
    - Documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:
      - The individual’s response to prior anesthetic inductions and any current anesthesia complications or risks; and
      - Required modifications in medications or standard anesthetic technique.
  - There is continuous physiologic monitoring during ECT treatment, addressing:
    - Seizure duration, including missed, brief and/or prolonged seizures, or lack of attaining desired seizure activity;
    - Electroencephalographic activity;
    - Vital signs;
    - Oximetry;
    - Cardiovascular effects;
    - Respiratory effects, including prolonged apnea; and
    - Other monitoring specific to the needs of the individual.
  - There are post-ECT stabilization and recovery services, including:
    - Medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects such as headache, muscle soreness and nausea are observed; and
    - Recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; and electrocardiogram if indicated.

- **Discharge Planning**
  - Duration of the service is individualized and must be medically necessary as determined based upon the psychiatrist's assessment and the individual’s response to treatment and according to the treatment plan.
FUNCTIONAL BEHAVIORAL ASSESSMENT – A Functional Behavioral Assessment (FBA) refers to a range of strategies used in the process of determining why an individual engages in significant behavioral disruption and how the behavior relates to the environment. The focus of a Functional Behavioral Assessment is on identifying significant, individual-specific factors associated with the occurrence (and non-occurrence) of specific behaviors.

Functional Behavioral Assessments provide the practitioner with information necessary to develop a clinical formulation as to why the individual engages in the behavior, when the individual is most likely to demonstrate the behavior, and situations in which the behavior is most likely and least likely to occur. Generally, individuals with behavioral issues or functional impairments cannot adequately communicate why they are displaying particular behaviors or what they need to improve functional skills. By gathering data and conducting evaluations of environmental variables on the individual’s behaviors, the assessor can decipher the meaning of a behavior, why it is occurring and help to design and recommend a program of behavioral intervention with the individual and their caregivers that can help the individual acquire needed skills and reduce problematic behaviors.

Admission Criteria

- The Functional Behavioral Assessment is necessary in order to identify and address problematic behaviors in the youth’s functioning that are attributed to developmental, cognitive and/or communication impairments.
- The recommendation for this Functional Behavioral Assessment is being made by a clinician (i.e., pediatrician or behavioral health professional) who has identified that the youth’s clinical presentation and functional impairments need specialized behavioral assessment, treatment planning and interventions.
- Other assessments, such as an Initial Diagnostic Interview, would be insufficient to fully identify the root cause of the problematic behaviors or to develop a thorough behavioral modification/behavior replacement plan.
- The youth’s maladaptive functioning requires assessment by a provider with specific expertise and training in behavioral assessment and modification therapies to develop appropriate treatment intervention strategies.
- The individual presents with severe behaviors that cause significant impairments in all domains of the individual’s life and, without specialized behaviorally-focused assessment and treatment to address, will likely lead to disrupted placement in school and living environment.
- The individual’s clinical condition causes an absence in critical skills of self-care, social interaction and/or safety awareness, and the FBA is expected to identify those deficits and the treatment recommendations/interventions to support functional improvement and skill development.
- The individual is authorized for medically necessary intensive and/or specialized treatment to address these significant behavior impairments and the FBA is necessary to inform treatment planning approaches.

Discharge Criteria

- The therapists will determine the function of the maladaptive behavior and use the information from the assessment to design an effect treatment plan to teach the individual functional behaviors to replace the maladaptive behaviors. As a result, the individual will improve their ability to interact within the family, social, and educational constructs of their daily life.

Service Delivery

- Evaluation and Service Planning
  - An Initial Diagnostic Interview must be completed first and must identify the need for the FBA.
  - The FBA must occur prior to the initiation of treatment interventions and must include reviewing situational variables, including environmental circumstances, individual caretaker management practices, physical health considerations, and academic and social demands.
  - Direct Assessment and Data Analysis are required assessment techniques for this service and are defined as:
- Direct Assessment – In-person observation and recording of situational factors and the individual's behaviors.
- Data Analysis – Comparison and analysis of collected data must be completed to determine whether or not there are patterns associated with the behavioral, emotional and mental health conditions of interest.
  - The FBA must describe the relationship between the significant behavioral disruption(s) and environmental, cognitive, and/or emotional variables that contribute to its occurrence.
  - The FBA must be conducted by a psychologist or other independent licensed and/or certified practitioner with specific training and expertise in conducting FBAs.
  - The FBA must identify strengths, problems and needs, goals and objectives, and determine appropriate strategies and methods of behavioral intervention for the individual.
  - The FBA must include, but is not limited to, the following components:
    - Reason for assessment/Presenting issue;
    - Relevant bio-psychosocial and developmental information;
    - Relevant treatment history/response to treatment efforts;
    - Identification of the disruptive behavior;
    - Definition of the behavior in concrete terms;
    - Identification of the contextual factors that contribute to the disruptive behavior (including affective and cognitive factors);
    - Strengths and resources the youth and family have;
    - Explanation of data collection methodology; in most cases a combination of natural observation across multiple settings, use of validated rating scales/tools, parent/caregiver interviews, etc., will be used to ensure thorough assessment of problem behaviors;
    - Data and assessment summary to include: a description of problem behaviors; identification of antecedents, predictors, consequences and reinforcers that maintain the behavior; clinical formulation regarding the general condition under which the disruptive behavior usually occurs and probable behavioral and social consequences that serve to maintain the disruptive behavior; and
    - Targeted behavior management plan including the targeted problematic behavior, positive and negative reinforcement findings, behavior replacement/modification interventions, plan monitoring, data collection, and review schedule.
  - Documentation expectations include a typed report which includes the components listed above resulting in treatment recommendations. The report must be signed by all fully licensed clinicians who participated in the formation of the report, including the Supervising Practitioner, when applicable.
  - The FBA must include collateral contact information (with appropriate signed releases) for significant others or family individuals to gather relevant information about individual and family functioning, and through collateral contacts with former and current healthcare providers, friends, and school officials to verify medical and functional history across environments.
  - With appropriate releases of information, it is expected that this assessment will be shared with other professionals involved in the individual's assessment and treatment.

**FUNCTIONAL FAMILY THERAPY**

**FUNCTIONAL FAMILY THERAPY** (FFT) is an evidenced-based family therapy targeted at children ages 10-18; however youth of other ages can receive the service if medically necessary. FFT provides clinical assessment and treatment for the individual and their family to improve communication, problem solving, and conflict management in order to reduce problematic behavior of the individual. It is a short-term treatment strategy that is built on a foundation of respect of individuals, families and cultures. The model includes an emphasis on assessment in understanding the purpose behavior problems serve within the family relationship system, followed by treatment strategies that pave the way for motivating the individual and their families to become more adaptive and successful in their lives. FFT is designed to improve family communication and supports, while decreasing intense negativity and dysfunctional patterns of behavior. Therapy also includes training parents how to assist their child based on the child’s medical diagnosis.
Admission Criteria

- Acting out behaviors will be present to the degree that functioning is impaired and the following terms are met:
  - Individuals are typically referred by other service providers and agencies on behalf of the individual and family, though other referral sources are also appropriate.
  - At least one adult caregiver is available to provide support and is willing to be involved in treatment.
  - DSM V (current edition) diagnosis as primary focus of treatment. Symptoms and impairment are the result of a primary disruptive/externalizing behavior disorder, although internalizing psychiatric conditions and substance use disorders may be secondary.
  - Individual displays externalizing behavior which adversely affects family functioning. Individual’s behaviors may also affect functioning in other systems.

Continued Service Criteria

- Admission criteria must be met
- Progress is being made but not yet ready for discharge.
- There is reasonable likelihood of benefit as a result of active continuation in the therapy, as demonstrated by behavioral improvement.
- Documented evidence that continuation of FFT services is necessary to regain family functioning.
- The individual and family are actively participating in treatment.

Discharge Criteria

- The therapists will determine the function of the maladaptive behavior and use the information from the assessment to design an effect treatment plan to teach the individual functional behaviors to replace the maladaptive behaviors. As a result, the individual will improve their ability to interact within the family, social, and educational constructs of their daily life.
  - To have less frequent incidents of disruptive behavior in the family home.
  - To increase the frequency of prosocial family interaction.

Service Delivery

- Evaluation and Service Planning
  - An Initial Diagnostic Interview (IDI) will be completed prior to the beginning of treatment and will serve as the initial treatment plan until a comprehensive treatment plan is completed.
  - Assessments and treatment will address mental health/substance abuse needs, and mental health and/or emotional issues related to medical conditions.
  - The treatment plan will be individualized and will include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; and the responsible professional. The treatment plan will be developed with the individual and the identified, appropriate family individuals as part of the outpatient family therapy treatment planning process.
  - Treatment plans will be reviewed every 90 days or more often if clinically indicated.
  - The three core principles of FFT are as follows:
    - Core principle one: Understanding individual – This is a process whereby the therapist comes to understand the individual and family in terms of their strengths on the individual, family system and multi-systemic level.
    - Core principle two: Understanding the individual systemically – This is a process whereby the therapist conceptualizes the individual’s behaviors in terms of their biological, relational, family, socio-economic and environmental etiology. Subsequently, the therapist assesses the individual’s relationships with family, parents, peers, their school and their environment and how these roles/relationships contribute to the maintenance and change of problematic behaviors.
Core principle three: Understanding therapy and the role of the therapist as a fundamentally relational process – This is a process where the therapist achieves a collaborative alliance with the individual and family. Subsequently, the therapist ensures that the therapy is systematic and purposeful, while maintaining clinical integrity. More specifically, the therapist follows the model but also responds to the emotional processes (needs/feelings/behaviors) that occur in the immediacy during clinical practice.

- The five major components of FFT’s treatment modality include:
  - Engagement;
  - Motivation to change;
  - Relational/interpersonal assessment and planning for behavior change;
  - Behavior change; and
  - Generalization across behavioral domains and multiple systems.

- The treating provider will consult with and/or refer to other providers for general medical, psychiatric, and psychological needs as indicated.

- It is the provider’s responsibility to coordinate with other treating professionals as needed.

- All psychiatric/psychotherapy services will be prescribed and provided under the supervision and direction of a supervising practitioner (physicians; licensed psychologists; and/or Licensed Independent Mental Health Practitioners). Supervision is not a billable service.

- Supervision entails: critical oversight of a treatment activity or course of action; review of the treatment plan and progress notes; individual specific case discussion; periodic assessments of the individual; and diagnosis, treatment intervention or issue specific discussion. Involvement of the supervising practitioner will be reflected in the IDI, the treatment plan and the interventions provided.

- After hours crisis assistance is to be available.

- Services will be trauma informed, culturally sensitive, age and developmentally appropriate and incorporate evidence based practices when appropriate.

## INPATIENT TREATMENT

INPATIENT TREATMENT An acute inpatient program is designed to provide medically necessary, intensive assessment, psychiatric treatment and support to individuals with a DSM (current edition) diagnosis and/or co-occurring disorder experiencing an acute exacerbation of a psychiatric condition. The acute inpatient setting is equipped to serve individuals at imminent risk of harm to self or others and in need of a safe, secure, lockable setting. The purpose of the services provided within an acute inpatient setting is to stabilize the individual’s acute psychiatric conditions.

### Admission Criteria

- The individual demonstrates acute exacerbation of symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.

- The individual requires 24 hour access to the full spectrum of psychiatric staffing in a controlled environment that may include but is not limited to medication monitoring and administration, therapeutic intervention, quiet room, restrictive safety measures, and suicidal/homicidal observation and precautions.

- Due to the risk of mental health instability the need for confinement beyond 23 hours with intensive medical and therapeutic intervention is clearly indicated.

- There is a clear and reasonable inference of imminent serious harm to self/others as evidenced by having any one of the following:
  - An imminent plan/intent to harm self or others;
  - Recent attempts to harm self or others with continued risk due to poor impulse control or an inability to plan reliably for safety;
  - Violent, unpredictable or uncontrolled behavior related to the behavioral health disorder that represents an imminent risk of serious harm to self or others; or
  - An imminently dangerous inability to care adequately for their own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior.
• The individual requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting could potentially lead to serious imminent and dangerous deterioration of the individual’s general medical or mental health.

Continuing Stay Criteria
• The individual must continue to meet the admission criteria identified above.
• Continuing evidence of symptoms and/or severe behaviors reflecting significant risk, imminent danger, or actual demonstrated danger to self or others; requiring suicide/homicide precautions, close observation.
• Monitoring/adjustment of psychotropic medication(s) related to lack of therapeutic effect/complication(s) in the presence of complicating medical and psychiatric conditions necessitating 24-hour medical supervision and supported by medical record documentation.
• Persistence of psychotic symptoms and continued temporary (not chronic) inability of the individual to perform the activities of daily living or meet their basic needs for nutrition and safety due to a psychiatric disorder or the temporary mental state of the individual.
• Continued need for 24-hour medical supervision, reevaluation and/or diagnosis of an individual exhibiting behaviors consistent with an acute psychiatric disorder.

Discharge Criteria
• The individual has met their treatment plan goals and objectives.
• The precipitating condition and relapse potential is stabilized such that the individual’s condition can be managed without professional external supports and interventions.
• The individual has alternative support systems secured to help them maintain stability in the community.

Service Delivery
• Evaluation and Service Planning
  o The following assessments must be conducted: Initial Diagnostic Interview (IDI), nursing assessments, laboratory, radiological, substance use disorder; physical and neurological exams and other diagnostic tests as necessary.
  o The IDI will serve as the initial treatment plan until the comprehensive plan of care is developed.
  o Family individuals are encouraged to participate in the assessment/treatment of the individual as appropriate and approved by the individual, and their participation or lack of participation is documented in the individual’s record.
  o Provide a flexible meetings schedule to include evenings and weekends to facilitate family participation.
  o Provide an intensive and comprehensive active treatment program that includes professional psychiatric, medical, surgical, and nursing, social work, psychological, and activity therapies required to carry out an individual treatment plan for each individual and their family.
  o Hospitals which provide inpatient psychiatric services must be staffed with the number of qualified professional, technical, and supporting personnel, and consultants required carrying out and implementing comprehensive assessments and treatment plans.
  o Develop and implement an active treatment plan with provisions for: resolution of acute mental health and medical problems; evaluation of, and needs assessment for, medications; protocol to ensure individual’s safety; discharge plan initiated at the time of admission.
  o The treatment plan must be reviewed weekly or as medically necessary.
  o Face to face evaluation and treatment by a physician, or a physician extender, six out of seven days.
  o Psychiatric nursing interventions are available to individuals 24/7.
  o Provide medication management services for the provision and monitoring of psychotropic medications.
  o Individual, group, and family therapy is available and offered as tolerated and/or appropriate.
  o Provide social services to engage in discharge planning and help the individual develop community supports and resources and consult with community agencies on behalf of the individual.
• Service Expectations
  o Special staff requirements for psychiatric hospitals:
    • Physician (Psychiatrist preferred)
    • Physician assistant
    • Psychologist, LIMHP, LMHP, PLMHP, LMHP/LADC
    • Psychiatric RN(s) and APRN(s) (psychiatric experience preferable)
    • Social worker(s) (at least one social worker, director or otherwise, holding an MSW degree)
    • Direct care: The direct care staff will meet one of the following requirements:
      ▪ A bachelor’s degree or higher in psychology, sociology or related human service field; or
      ▪ Be 21 years of age and have a minimum of two years’ experience working with behavioral health, two years education in the human service field or a combination of work experience and education with one year of education substituting for one year of experience.
  o Availability of medical personnel must be sufficient to meet psychiatric/medically necessary treatment needs for individuals served.
  o Psychiatric RN availability must be assured 24 hours each day.
  o The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with individual census and each individual’s active treatment program.

### INTENSIVE OUTPATIENT TREATMENT ADULT

**INTENSIVE OUTPATIENT TREATMENT ADULT** Intensive outpatient (IOP) services are non-residential, intensive, structured interventions consisting of counseling and education regarding the needs of the targeted population. IOP interventions include: ongoing assessment, individual, group, and family psychotherapy and psycho-educational services. Services are goal oriented interactions in preparing the individual to apply learned skills in “real world” environments. Length of service is individualized and based on clinical criteria for admission and continuing stay. The frequency and duration varies according to the needs of the individual and the individual’s response to the day-to-day treatment intervention.

**Admission Criteria**

- The individual is assessed and meets the diagnostic criteria for a mental health Disorder as defined in the most recent DSM.
- Difficulty maintaining stability or lack of follow through with a variety of outpatient services necessitating use of IOP to enhance the opportunities and experiences known to improve the possibility of successful stability.
- Of all reasonable options for active psychiatric treatment available to the individual, this program is to be the best choice for expecting reduction in treatment.

**Continuing Stay Criteria**

- The persistence of problems that caused the admission.
- The emergence of additional problems that meet the admission criteria.
- Reasonable improvement in the individual’s psychiatric condition.
- Attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the referral reason to the degree that would necessitate continued intensive outpatient treatment.

**Discharge Criteria**

- The individual has met the treatment plan goals and objectives.
- The precipitating condition and relapse potential is stabilized such that the individual’s condition can be managed without professional external supports and intervention.
- The individual is able to remain stable a less intensive level of treatment or support.
- The individual has support systems in place to help them maintain stability.

**Service Delivery**
Evaluation and Service Planning
- An Initial Diagnostic Assessment (IDI) and when applicable, for co-occurring disorders, a Substance Use Disorder (SUD) assessment by a licensed clinician prior to the beginning of IOP treatment.
- The IDI will serve as the initial treatment plan until the comprehensive treatment plan is developed.
- Individualized treatment/recovery plan, including discharge and relapse prevention, developed with the individual within 14 days of admit.
- Therapies/interventions may include individual, family, and group psychotherapy, educational groups, motivational, enhancement and engagement strategies.
- Provision of nine or more hours per week of skilled treatment, with at least three hours of availability per day. Scheduled hours at minimum are three times per week, and may be available up to seven days per week. The hours and days of treatment are to be reduced as clinically defined when an individual nears completion of the program.
- Review and update of the treatment/recovery plan under clinical guidance with the individual and other approved family/supports every 30 days or more often as medically indicated.
- Access to a licensed mental health/substance abuse professional on a 24/7 basis for crisis management.
- Monitoring stabilized comorbid medical and psychiatric conditions.
- Consultation and/or referral for general medical, psychiatric, needs.

Service Expectations
- Clinical director is responsible for the clinical direction of the program and for individualized treatment.
- Clinical director may include the following: physician, APRN, psychologist, provisionally licensed psychologist, LIMHP, or a LMHP.
- Appropriately licensed and credentialed professionals:
  - Physicians
  - Physician assistant
  - APRN
  - Psychologist
  - Provisionally licensed psychologist
  - LIMHP
  - LMHP/LADC
  - PLMHP/PLADC
  - LMHP
  - PLMHP
  - Direct care staff will have a bachelor’s degree or higher in psychology, sociology, or related human service field, but two years of course work in the human services field and two years’ experience/training with demonstrated skills and competencies in treatment of youth with mental illness is acceptable.
- All staff is required to work within their scope of practice to provide mental health or co-occurring mental health and substance use disorder outpatient treatment.
- All staff will have documented education, experience, training, expertise and competency with the treatment population served.
- Staffing ratio will be 1:1 individual; 1:1 family; 1:3 minimum and no more than 1:12 maximum for group treatment.
environments. The duration of the IOP services may vary according to the individual’s needs and their response to the day-to-day treatment intervention.

Admission Criteria

- The individual is assessed and meets the diagnostic criteria for a mental health or substance-related Disorder as defined in the most recent DSM, or has a documented history of sexually harmful behaviors, or an eating disorder.
- Difficulty maintaining stability or lack of follow through with a variety of outpatient services necessitating use of IOP to enhance the opportunities and experiences known to improve the possibility of successful stability.
- Of all reasonable options for active psychiatric or substance use disorder treatment available to the individual, this program is the best choice for expecting a reduction in symptoms.
- For individuals who present with co-occurring mental health and substance use disorder symptoms and diagnoses, the provider will refer to the ASAM Criteria (current edition) Intensive Outpatient Level 2.1.
- Admission guidelines for substance use disorder IOP: The individual is assessed as meeting the diagnostic criteria for a substance-related disorder, including substance use disorder or substance-induced disorder, as defined in the most recent DSM.
- The following six dimensions and criteria are abbreviated:
  - Dimension 1: ACUTE INTOXICATION &/OR WITHDRAWAL POTENTIAL: Minimal risk of severe withdrawal.
  - Dimension 2: BIOMEDICAL CONDITIONS & COMPLICATIONS: None or not a distraction from treatment. Such problems are manageable at Level 2.1.
  - Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS: Mild severity, w/potential to distract from recovery; needs monitoring.
  - Dimension 4: READINESS TO CHANGE: Has variable engagement in treatment, ambivalence, or lack of awareness of the substance use or mental health problem, and requires a structured program several times a week to promote progress through the stages of change.
  - Dimension 5: RELAPSE, CONT. USE OR CONT. PROBLEM POTENTIAL: Intensification of addiction or mental health symptoms indicate a high likelihood of relapse or continued use or continued problems without close monitoring and support several times a week.
  - Dimension 6: RECOVERY ENVIRONMENT: Recovery environment is not supportive but, with structure and support, the individual can cope.

Continuing Stay Criteria

- The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals;
- The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals; and/or
- New problems have been identified that are appropriately treated at this level of care.
- This level of care is the least intensive level of care at which the individual’s new problems can be addressed effectively.

Discharge Criteria

- The individual has met his/her treatment plan goals and objectives.
- The precipitating condition and relapse potential is stabilized such that individual’s condition can be managed without professional external supports and intervention.
- Individual is able to remain stable at a less intensive level of treatment or support.
- Individual has support systems to help them maintain stability.

Service Delivery

- Evaluation and Service Planning
• An Initial Diagnostic Interview (IDI) and when applicable, for co-occurring disorders, a Substance Use Disorder (SUD) assessment by a licensed clinician prior to the beginning of IOP treatment.
• The IDI will serve as the initial treatment plan until the comprehensive treatment plan is developed.
• IOP programs may be developed with a particular focus to treat a mental health co-occurring, and other co-occurring diagnoses such as eating disorders, or dysfunctions such as sexual offending.
• Individualized treatment/recovery plan, including discharge and relapse prevention, are to be developed with the individual within 14 days of admission.
• Therapies/interventions may include individual, family, and group psychotherapy, and motivational enhancement and engagement strategies.
• Provision of nine or more hours per week of skilled treatment, with at least three hours of availability per day. Scheduled hours at minimum are three times per week, and may be available up to seven days per week. The hours and days of treatment are to be reduced as clinically defined when an individual nears completion of the program.
• Review and update of the treatment/recovery plan under clinical guidance with the individual and other approved family/supports every 30 days or as often as medically indicated.
• Access to a licensed mental health/substance abuse professional on a 24/7 basis for crisis management.
• Other services could include family education, self-help group and support group orientation.
• Therapists of youth with more than one mental health/substance use disorder provider will communicate and document coordinated services with any other mental health/substance provider for the family or individual.
• Monitoring stabilized comorbid medical and psychiatric conditions.
• Consultation and/or referral for general medical, psychiatric, needs.

Service Expectations
• Clinical director is responsible for the clinical direction of the program and for individualized treatment.
• Clinical director may include the following: physician, APRN, psychologist, provisionally licensed psychologist, LIMHP, or LMHP.
• For SUD IOP services, the clinical direction may include all of above and a LADC.
• Appropriately licensed and credentialed professionals:
  - Physicians
  - Physician Assistant
  - APRN
  - Psychologist
  - Provisionally licensed psychologist
  - LIMHP
  - LMHP/LADC
  - PLMHP/PLADC
  - LMHP
  - PLMHP
  - LADC (SUD only)
  - PLADC (SUD only)
• Direct care staff: must be 21 years of age and meet one of the following requirements:
  - have a minimum of two years’ experience working with children, or
  - two years education in the human service field or a combination of work experience and education with one year of education substituting for one year of experience.
• All staff are required to work within their scope of practice to provide mental health or co-occurring mental health and substance use disorder outpatient treatment.
• All staff are to have documented education, experience, training, expertise and competency with the treatment population served.
MULTISYSTEMIC THERAPY - MST is an evidenced based intensive treatment process that focuses on diagnosed behavioral health disorders and on environmental systems (family, school, peer groups, culture, neighborhood and community) that contribute to, or influence a youth’s involvement, or potential involvement in the juvenile justice system. The therapeutic modality reinforces positive behaviors, and reduces negative behavior, uses family strengths to promote positive coping activities and helps the family increase accountability and problem solving. Beneficiaries accepting MST receive assessment and home based treatment that strives to change how youth, who are at risk of out-of-home placement or who are returning home from an out of home placement, function in their natural settings to promote positive social behavior while decreasing anti-social behavior.

MST's therapeutic model aims to uncover and assess the functional origins of adolescent behavioral problems by altering the youth’s bio-psychosocial system in a manner that promotes prosocial conduct while decreasing aggressive/violent, antisocial, substance using or delinquent behavior by keeping the youth safely at home, in school and out of trouble. Treatment is used at the onset of behaviors that could result in (or have resulted in) criminal involvement by treating the youth within the environment that has formed the basis of the problem behavior.

Admission Criteria

- The individual is not in imminent or current risk of harm to self, others, and/or property.
- The target age of the individual is 12-17 years old.
- The individual exhibits significant externalizing behavior, such as chronic or violent juvenile offenses.
- The individual is at risk for out-of-home placement or is transitioning back from an out-of-home setting.
- The individual has externalizing behaviors and symptomatology resulting in a DSM-5 diagnosis of Conduct Disorder or other diagnoses consistent with such symptomatology.
- There is ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems.
- Less intensive treatment has been ineffective or is inappropriate.
- One of the following must be met in addition to the mandatory criteria:
  - The individual with behavioral health issues manifests in outward behaviors that negatively impact multiple systems (e.g., family, school, community); or
  - Individuals with substance use disorder issues may be included if they meet the mandatory criteria, and MST is deemed clinically more appropriate than focused drug and alcohol treatment.

Continued Service Criteria

- Individuals receiving MST services must meet all of the following criteria for continuing treatment with MST:
  - Treatment does not require more intensive level of care.
  - The treatment plan has been developed, implemented and updated based on the individual’s clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated.
  - Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident.
  - The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

Discharge Criteria

- Individuals who meet the following criteria no longer meet medical necessity criteria for MST and will be discharged from MST treatment:
  - The individual’s treatment plan goals or objectives have been substantially met.
  - The individual meets criteria for a higher or lower level of treatment, care or services.
  - The individual, family, guardian and/or custodian are not engaging in treatment or not following program rules and regulations, despite attempts to address barriers to treatment.
Consent for treatment has been withdrawn, or the individual and/or family have not benefitted from MST, despite documented efforts to engage, and there is no reasonable expectation of progress at this level of care, despite treatment.

Service Delivery

- **Evaluation and Service Planning**
  - An Initial Diagnostic Interview (IDI) must be completed prior to the beginning of treatment and will serve as the initial treatment plan until a comprehensive treatment plan is completed.
  - Assessments and treatment should address mental health/substance abuse needs, and mental health and/or emotional issues related to medical conditions.
  - The treatment plan must be individualized and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; and the responsible professional.
  - The treatment plan must be developed with the individual and the identified, appropriate family individuals as part of the outpatient family therapy treatment planning process.
  - Treatment plans must be reviewed every 90 days or more often if clinically indicated.

- **Service Expectations**
  - The treating provider must consult with and/or refer to other providers for general medical, psychiatric, and psychological needs as indicated.
  - It is the provider's responsibility to coordinate with other treating professionals as needed.
  - All psychiatric/psychotherapy services must be prescribed and provided under the supervision and direction of a supervising practitioner (Physicians; Licensed Psychologists; and/or Licensed Independent Mental Health Practitioners). Supervision is not a billable service.
  - Supervision entails: critical oversight of a treatment activity or course of action; review of the treatment plan and progress notes; individual specific case discussion; periodic assessments of the individual; and diagnosis, treatment intervention or issue specific discussion. Involvement of the supervising practitioner must be reflected in the Initial Diagnostic Interview the treatment plan and the interventions provided.
  - After hours crisis assistance must be available.
  - Services must be trauma informed, culturally sensitive, age and developmentally appropriate and incorporate evidence based practices when appropriate.
  - Therapeutic contacts emphasize the positive and use systemic strengths as levers for change.
  - Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family individuals.
  - Interventions are present-focused and action-oriented, targeting specific and well-defined problems.
  - Interventions target sequences of behavior within and between multiple systems that maintain the identified problems.
  - Interventions are developmentally appropriate and fit the developmental needs of the individual.
  - Interventions are designed to require daily or weekly efforts by family individuals.
  - Intervention effectiveness is evaluated continuously from multiple perspectives, with the provider assuming accountability for overcoming barriers to successful outcomes.
  - Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family individuals' needs across multiple systemic contexts.
  - MST is designed to accomplish the following:
    - Reduce the frequency of referral behaviors and increase pro-social behaviors, reduce symptoms, maladaptive and externalizing behaviors, so that the child/youth can be treated in a lower level of community-based care.
    - Child/youth no longer demonstrating ongoing risk of deliberate attempts to inflict serious injury on self or others.
- Decrease association with deviant peers and increase association with pro-social peers and involvement in positive recreational activities.
- Help caregivers develop effective parenting skills and skills to manage the individual’s mental health needs, improve caregiver decision-making and limit setting.
- Improve family relationships.
- Improve school or vocational success, as indicated by improved grade point average, a decrease in disciplinary referrals, unexcused absences and tardiness and/or a decrease in job terminations.
- Support involvement in restorative measures, such as community services, if involved with Juvenile Justice (Office of Children, Youth and Families resources will oversee and fund the participation in restorative measures, rather than the MST service provider).
- Reduce likelihood of out-of-home placement and reduce the utilization of out-of-home therapeutic resources (i.e., therapeutic foster care, residential treatment facility, etc.).
- Develop natural supports for the individual and family.
  - Specific treatment goals will always be individualized and tied to behavioral health needs.
  - On average, families receive about 60 hours of face-to-face treatment over a four-month period, as well as about 35 hours of non-direct contact provided to the ecology of the youth (e.g., consultation and collaboration with other systems).
  - Services occur in the family’s home or community at times that are convenient for the family. Therapists and/or their supervisors are on call for families 24/7. Supervisors are available to therapists around-the-clock for support.
  - Each therapist carries a small caseload (four to six families) at any one time.
- Discharge Planning
  - Length of treatment is individualized and based on the progress of the youth and family according to their treatment goals. Duration of treatment is an average of four months with an expected range of three to five months.

NEBRASKA THERAPEUTIC COMMUNITY—FAMILY BASED SUPPORT

THERAPEUTIC COMMUNITY is intended for adults with a primary substance use disorder for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of substance use disorder on the individual’s life or because of a history of repeated short-term or less restrictive treatment failures. This service provides psychosocial skill building through a set of longer term, highly structured treatment strategies that define progress toward individual change and rehabilitation. The individual’s progress is to be marked by advancement through these phases to less restriction and more personal responsibility.

FAMILY-BASED THERAPEUTIC COMMUNITY The Family-Based approach to Therapeutic Community allows parents with substance use disorders and if present, a co-occurring mental health diagnosis, to keep their children with them while in residential treatment. Family-based treatment programs consider the family unit as a whole and provide services to both children and families as a part of the substance abuse treatment plan so that the family does not need to be separated in order for the individual to receive benefit from treatment and recovery services.

Admission Criteria
  - The individual meets the diagnostic criteria for a substance-related disorder, as defined in the DSM (current edition), as well as the ASAM six dimensional criteria for admission. The ASAM Criteria should be used to complete dimensional criteria.
  - The individual is likely to benefit from Community Support in his/her home and community.
  - Criteria for Family Therapeutic Community includes all of the following:
    - There is a need for a family-based treatment approach to therapeutically support a child as well as the individual in a residential treatment setting while the individual receives substance abuse treatment.
    - Without a family-based treatment approach the family and child are at high risk of child abuse, neglect, developmental problems, and/or adolescent substance use.
• The individual may be at risk of not entering or exiting treatment as a result of separation from his/her child.
• There is a need for the individual as a part of his/her treatment to learn to effectively parent sober or receive the appropriate treatment and care in order to have a safe birth and delivery.

Continued Service Criteria
• It is appropriate to retain the individual at the present level of care if:
  o The individual is making progress but has not yet achieved the goals articulated in the treatment plan.
  o Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals;
  o The individual is not yet making progress, but has the capacity to resolve his or her problems.
  o The individual is actively working toward the goals in the treatment plan; and/or
  o New problems have been identified that are appropriately treated at this level of care.
  o This level of care is the least intensive level of care at which the individual’s new problems can be addressed effectively.

Discharge Criteria
• The individual has met their treatment plan goals and objectives.
• The precipitating condition and relapse potential is stabilized such that individual’s condition can be managed without professional external supports and interventions.
• The individual has alternative support systems secured to help the individual maintain stability in the community.

Service Delivery
• Evaluation and Planning
  o A substance use disorder (SUD) assessment by a licensed clinician prior to the beginning of treatment.
  o If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information than an SUD addendum would be necessary.
  o All individuals are to be screened for co-occurring conditions throughout the assessment. If the clinician is a LADC or a PLADC and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders.
  o Individualized treatment/recovery plan, including discharge and relapse prevention, developed under clinical supervision with the individual (consider community, family and other supports) developed within seven days of admission to guide the first 30 days of treatment.
  o Review and update of the treatment/recovery plan under clinical supervision with the individual and other approved family/supports every 30 days or more often as clinically indicated.
• Service Expectations
  o Consultation and/or referral for general medical, psychiatric, psychopharmacology and psychological needs.
  o Monitoring stabilized co-occurring mental health problems.
  o A minimum of 30 hours of treatment and recovery focused services weekly including individual, family, and group psychotherapy, educational groups, motivational enhancement and engagement strategies.
  o The therapy will offer planned clinical activities designed to stabilize the individual’s mental health problem and psychiatric symptoms and to maintain a stable life.
  o The goals of therapy apply to both the substance use disorder and any co-occurring mental health disorder. Specific attention is given to medication education and management.
Treatment is directed toward overcoming the individual’s lack of awareness of the effects of substance-related problems on their lives, as well as enhancing their readiness to change.

- Treatment is focused on preventing relapse, continued problems and/or continued use, and promoting the eventual reintegration of the individual into the community.
- Monitoring to promote successful reintegration into regular, productive daily activity such as work, school or family living.

- Family Therapeutic Community interventions:
  - Assure children’s safety,
  - Assist the parent in accessing needed medical services and child care,
  - Assess infant/children’s developmental and educational needs, and
  - Ensure that a plan has been put into place to meet all special needs that the children may have. The program not only addresses the children’s special needs that have resulted from a mother’s use during pregnancy, but it will also assist her in processing the shame and grief that comes with her child’s special needs.
  - Provide parenting/modeling groups
  - Provide family therapy with parent(s) and child
  - Provide children play therapy groups
  - Provide parent and children family activity time—which may clinical staff participation to model/direct/support treatment issues relevant to parenting and learning to live successfully as a sober parent
  - Provide structured family interaction therapy
  - Provide parenting Classes (including Love & Logic, Nurturing Parent, Circle of Security)
  - Have family Team Meetings
  - Provide family Case Management

- Discharge Planning
  - Length of service is individualized and based on clinical criteria for admission and continued stay, as well as the client’s ability to make progress on individual treatment/recovery goals.

**OBSERVATION ROOM**

**OBSERVATION ROOM** is emergency psychiatric observation provides less than 24 hours of care in a secure, medically supervised hospital setting for evaluation and stabilization of acute psychiatric and/or substance use disorder symptoms.

**Admission Criteria**
- The individual must meet all of the following admission guidelines to be admitted to this service:
  - The individual presents with symptoms consistent with a psychiatric crisis that requires a period of observation, assessment and treatment.
  - The individual’s medical needs are stable.
  - Based on current information, there may be a lack of diagnostic clarity and further evaluation is necessary to determine the individual’s service needs.

**Continuing Stay Criteria**
- If it is determined that continued care is needed beyond the 24 hour period the individual is considered as inpatient hospitalization and prior authorization requirements apply.

**Discharge Criteria**
- Symptoms are stabilized and the individual no longer meets clinical guidelines.
- Sufficient supports are in place and the individual can return to a less restrictive environment.
- Admission to a higher level of care if medically appropriate.

**Service Delivery**
- Evaluation and Service Planning
- Complete a trauma-informed mental health assessment beginning with a face-to-face, assessment and continuing with an emergency psychiatric observation level of care during a period of less than 24 hours.
- A substance use disorder screening is completed during the observation period.
- A health screening/nursing assessment is conducted by a registered nurse (RN).
- A discharge plan, with emphasis on crisis intervention and referral for relapse prevention and other services developed under the direction of a physician (psychiatrist preferred).
- Provide medication evaluation and management services.
- Service Expectations for Staffing to include:
  - Psychiatrist (preferred) or Physician
  - Physician Assistant
  - APRN or RN with psychiatric experience
  - LIMHP
  - LMHP (preferred dual diagnosed LMHP/LADC)
  - PLMHP
  - Social worker(s)
  - All positions staffed in sufficient numbers to meet hospital accreditation guidelines.

OUTPATIENT ASSESSMENT & TREATMENT

ADULT OUTPATIENT INDIVIDUAL THERAPY / YOUTH MENTAL HEALTH AND SUBSTANCE USE DISORDER includes outpatient individual psychotherapy is therapeutic encounters between the licensed clinician and the individual for the purposes of treating a mental health /youth substance use disorder condition through scheduled therapeutic visits. The focus of outpatient therapy is to improve or alleviate symptoms that may significantly interfere with functioning in at least one life domain of the individual (e.g. familial, social, occupational, educational, etc.). The length of treatment is individualized and based on clinical criteria for admission, the progress in the treatment, and the individual’s ability to benefit from individual treatment/recovery goals.

Admission Criteria
- The individual demonstrates symptomatology consistent with a mental health or substance use disorder, DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
- There are significant symptoms, caused by the mental health, or substance use disorder diagnosis, that interfere with the individual's ability to function in at least one life area.
- There is an expectation that the individual has the capacity to make significant progress toward treatment goals to where services are no longer necessary.
- This level of care is the least restrictive setting that will produce the desired results in accordance with the needs of the individual.

Continuing Stay Criteria
- The individual's condition continues to meet clinical criteria admission guidelines at this level of care.
- The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.

Discharge Criteria
- The individual has met their treatment plan goals and objectives.
- The precipitating condition and relapse potential is stabilized such that the individual’s condition can be managed without professional external supports and interventions.
- The individual has support systems secured to help the individual maintain stability in the community.

Service Delivery
- Specific to Mental Health Therapy:
  - An initial diagnostic interview (IDI) must be completed prior to the beginning of treatment and will include an initial diagnosis and plan for treatment.
Treatment will address mental health needs and mental health and/or emotional issues identified in the IDI as being related to the medically necessary condition.

The treatment plan must be individualized to the individual and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual’s progress.

Treatment plans must be reviewed every 90 days or more often if clinically indicated.

If there is a supervision practitioner involved, their involvement must be reflected in the IDI.

Specific to Youth SUD Counseling:

- A substance use disorder (SUD) assessment must be completed prior to the beginning of treatment.
- All individuals must be screened for co-occurring conditions throughout the assessment. If the clinician is a LADC or a PLADC, and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders.
- If there is a supervising practitioner involved, their involvement must be reflected in the SUD assessment.

Required for Adult and Youth Therapy and Youth SUD Services:

- The treatment plan must be individualized and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates and methods for evaluating the individual's progress.
- Treatment plans must be reviewed every 90 days or more often if clinically indicated.
- The treating clinician must consult with and/or refer to other providers for general medical, psychiatric, and psychological needs as indicated.
- It is the provider’s responsibility to coordinate with other treating professionals as needed.
- After hours crisis assistance is to be available.
- Services must be trauma informed, culturally sensitive, age and developmentally appropriate and incorporate evidence based practices when appropriate.
- Assessments and treatment should address mental health/substance use needs, as related to the medical necessity criteria.
- All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
- There is documented active discharge planning.
- All staff are to be educated/trained in recovery and trauma informed care.
- Supervision of service as required by the practitioner’s license.
- All psychotherapy and substance use disorder practitioners are to provide services within their scope of practice.

Clinician Staffing Expectations include:

- Physician
- Physician Assistant (PA)
- Advanced Practice Registered Nurse (APRN)
- Licensed Psychologist
- Provisionally Licensed Psychologist
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)

In addition to all of the above the youth substance use disorder clinicians may include the following:

- Licensed Alcohol and Drug Counselor (LADC) for substance use disorder only.
- Provisionally Licensed Alcohol and Drug Counselor (PLADC) for substance use disorder only.
PARENT-CHILD INTERACTION THERAPY (PCIT) An evidence-based service provided to children age 2-12. This therapy places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. As such, it is used to treat clinically significant disruptive behaviors due to the child’s primary mental health disorder. Participation of the caregiver in each session is a necessary component of treatment.

Admission Criteria

- The individual demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
- There are significant symptoms, caused by the behavioral health diagnosis, that interfere with the individual's ability to function in at least one life area.
- This service is provided in the least restrictive setting that will produce the desired results in accordance with the needs of the individual.
- There is an expectation that the individual has the capacity to make significant progress toward treatment goals to the point that services are no longer necessary.
- PCIT is required for reasons other than primarily for the convenience of the individual or the provider.
- PCIT involves the individual and his/her family with a therapist for the purpose of improving a behavioral health condition, focusing on the level of family functioning as a whole and addressing issues related to the entire family system.
- Family therapy is recommended through thorough assessments completed by licensed clinicians as medically necessary to achieve goals/objectives for treatment of a behavior health condition.

Continued Service Criteria

- Admission criteria continue to be met.
- Treatment planning is individualized and appropriate to the family's changing condition, with realistic and specific goals and objectives clearly stated.
- All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
- Progress in relation to specific dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.
- Care is rendered in a clinically appropriate manner and focused on the family's behavioral and functional outcomes as described in the discharge plan.
- There is documented active discharge planning.

Discharge Criteria

- The family has substantially met their treatment plan goals and objectives.
- The family has support systems secured to help them maintain stability in the community.

Service Delivery

- Evaluation and Service Planning
  - An Initial Diagnostic Interview must be completed prior to the beginning of treatment.
  - Children should receive PCIT services only after a recent appropriate medical evaluation to rule out conditions of a general medical nature.
  - A goal-oriented treatment plan with measurable outcomes and a specific, realistic discharge plan must be developed with the individual (identified patient) and the identified, appropriate family individuals as part of the initial assessment and outpatient family therapy treatment planning process.
    - The treatment and discharge plan must be evaluated and revised as medically indicated.
  - Assessment should be ongoing with treatment and reviewed each session.
- Service Expectations
  - Services must be treatment focused and not rehabilitative or habilitative in nature.
There will be a reasonable expectation that PCIT will improve the child’s psychiatric symptoms so that the services will no longer be necessary.
- Consultation and/or referral for general medical, psychiatric, psychological.
- Provided as family psychotherapy.
- It is the provider’s responsibility to coordinate with other treating professionals as needed.
- The average length of service is typically 12-20 sessions and focused on changing negative parent/caregiver/child patterns as a result of an experienced trauma.
- The goals of treatment are:
  - An improvement in the quality of the parent/child relationship or other caregiver relationships.
  - A decrease in child behavior problems with an increase in prosocial behaviors.
  - An increase in parenting skills, including positive discipline.
  - A decrease in parenting stress.

- Discharge Planning
  - Length of treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the individual’s ability to benefit from treatment.

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**PEER SUPPORT SERVICES**

**PEER SUPPORT SERVICES** are provided by individuals who have lived experience with Mental Health or Substance Use Disorders (SUD). The service is designed to assist individuals in initiating and maintaining the process of long-term recovery and resiliency to improve their quality of life, increase resiliency, health, and wellness by living self-directed lives and striving to reach their full potential. Peer support is person centered and supports dignity, self-advocacy, and empowerment. The core element of this service is the development of a relationship based on shared lived experience and mutuality between the provider and individual. This service can be provided to Medicaid eligible individuals and their families in individual and group settings.

**Admission Criteria**
- An established DSM (current edition) diagnosis which requires and will respond to therapeutic intervention;
- Presence of a mental health and/or a substance use disorder diagnosis that would benefit from this service;
- The individual is enrolled in active behavioral health services;
- The services must meet medical necessity;
- Presents with symptoms and/or functional deficits that interfere with the individual’s ability to aid in their own recovery;
- To receive family peer support the parent/guardian must have a child who meets the criteria listed above.

**Continuing Stay Criteria**
- The individual continues to meet the admission guidelines for peer support services;
- There is reasonable likelihood of substantial benefit as a result of active continuation of this service as demonstrated by objective behavioral measurements of improvements;
- The individual is making progress toward goals and is actively participating in the interventions.

**Discharge Criteria**
- The individual has achieved maximum benefit from the service or no longer wishes to receive the service;
- The precipitating condition and relapse potential is stabilized such that the individual’s condition can be managed without professional or external supports and interventions;
- The individual demonstrates the ability to identify their strengths, needs, access resources and successfully navigate various systems to engage with those resources;
- The individual has formal and informal supports in place;
- The individual has developed a discharge plan that can be sustained post discontinuation of service.
Service Delivery

- Evaluation and Service Planning
  - Complete an Initial Diagnostic Interview (IDI) if one has not been completed within the 12 months prior to initiating peer support services. The IDI will serve as the initial treatment plan until the comprehensive plan of care is developed. An IDI is not necessary if peer support services are provided for treatment of a substance use disorder. An IDI must be completed by a licensed clinician authorized to perform that service;
  - Complete a Substance Use Disorder (SUD) assessment, if one has not been completed by a licensed clinician prior to initiating peer support services. A SUD assessment is not necessary if peer support services are provided for treatment of a mental health disorder;
  - The treatment plan is to be developed through shared decision making inclusive of the individual and must identify specific areas to be addressed; clear and realistic goals and objectives; strategies, and recovery support services to be implemented; criteria for achievement; target dates; methods for evaluating the individual’s progress; a discharge plan, wellness plan, and crisis prevention plan that includes defining early warning signs and triggers;
  - The individual treatment plan will be completed within 30 days following admission, reviewed and updated every 90 days, or as often as clinically necessary thereafter while receiving services. The individual will sign the plan to indicate involvement in the planning; refusal to sign will be noted on the treatment plan. The supervisor is responsible for reviewing and signing off on the treatment plan;
  - Development of a mutual set of expectations for the peer relationship within one month of admission;
  - Peer support services are provided in conjunction with one or more behavioral health services;
  - Peer support services are based on the relationship between the Certified Peer Support Provider and the individual. Activities of the peer support provider are to serve and support individuals through sharing their knowledge, beliefs and experiences that promote recovery and wellness are possible, and that the individuals being served have the ability to manage their behavioral health symptoms successfully;
  - Peer support services are designed as a means of supporting individuals on their recovery journey as that individual defines it by utilizing the following recovery support services as applicable:
    - Peer coaching to facilitate system navigation, accessing community resources, and engagement with formal and informal resources and supports, all of which are designed to enhance the individual’s resilience and ability to achieve their individual goals;
    - Building on current strengths of the individual to empower them with advocacy and self-help skills to enhance their process of recovery and increase their capacity to utilize wellness options available;
    - Assist clients to locate and join existing self-help groups;
    - Educating the individual about the peer support relationship to include topics such as healthy personal boundaries, individual rights, and the significance of shared decision making;
    - Sharing of experiences, skills, strengths, supports, and resources used in order to benefit the individual by demonstrating wellness through their own effective symptom management;
    - Meeting the individual “where they are at” in their recovery process and encouraging engagement into services;
    - Model and present self-help activities that cultivate the individual’s ability to make informed, independent choices and decisions as well as activities designed to assist in developing a personal network of support, enhance problem solving abilities, and to build the personal confidence necessary to enhance and improve health and well-being;
- Serve as a recovery agent by providing the opportunities and advocating for any effective services that will aid in daily living, coping, or symptom management;
- Collaborate with the individual served as a treatment team individual to develop a person centered treatment plan that incorporates the elements identified above and assist by determining the steps needed in order to achieve the goals identified in the treatment plan;
- Specific to youth services: the peer support provider will include the individual's caregiver/family in order to help them understand the role of the peer support provider in their child's care.

### Service and Staffing Expectations

- Peer support providers are expected to have received training on Trauma Informed Care and be able to incorporate that training into their interactions with the individuals;
- Supervision between the supervising practitioner and the peer support provider must occur at least twice per month for clinical consultation;
- The supervising practitioner must conduct at least one face to face contact with the individual within 30 days of the individual being assigned a peer support provider and no less frequently than every 60 days thereafter to monitor the individual's progress and the effectiveness of the peer support services;
- Group setting: the peer support provider develops relationships with individuals to share their experiences, skills, strengths, supports and resources used in order to show that recovery is an achievable lifelong process; and model and share problem solving skills;
- Exploration of community resources related to the individual's independence and recovery, and assist the individual through the relationship developed to become empowered to work towards goals as defined by the individual.
- The peer support provider must meet the following criteria:
  - Be 19 years of age or older;
  - Self-identify as having lived experience as an individual diagnosed with a mental health/substance use disorder or as a parent to a child with a mental health/substance use disorder;
  - Be able to demonstrate, via attestation, one year navigating a personal recovery and resiliency journey using relevant indicators such as ongoing use of illicit drugs or alcohol, or avoidance of frequent inpatient levels of care;
  - Have a high school diploma or equivalent with a minimum of two years of paid or volunteer experience working in a human service field;
  - Obtain state and/or national certification as a peer support provider;
  - Maintain state and/or national certification by completing continuing education requirements as identified by the certifying organization.

- The supervising practitioner assumes professional responsibility for the services provided by the peer support provider. Supervising practitioners must be licensed as one of the following:
  - Psychiatrist;
  - Licensed Psychologist;
  - Provisionally Licensed Psychologist;
  - Advanced Practice Registered Nurse (APRN) or Nurse Practitioner (NP);
  - Licensed Independent Mental Health Practitioner (LIMHP);
  - Licensed Mental Health Practitioner (LMHP);
  - Provisionally Licensed Mental Health Professional (PLMHP);
  - Licensed Alcohol and Drug Counselor (LADC) for substance use only; and
  - Provisionally Licensed Alcohol and Drug Counselor (PLADC) for substance use only.

- Staffing Ratios
  - The ratio for supervising practitioner to peer support provider is 1:6.
  - Caseloads for peer support providers must not exceed 1:25.
  - Groups are a minimum of three and a maximum of 12.
PSYCHIATRIC NURSING

PSYCHIATRIC NURSING The Psychiatric Registered Nurses or the Advanced Practitioner Registered Nurses offer primary care services to the mental health population in the primary residence of the individual. The nurses assess, diagnose, and treat individuals with psychiatric disorders or the potential for such disorders using their full scope of therapeutic skills, including the prescription of medication and administration of psychotherapy. The service is provided by a registered nurse (RN) or an Advanced Practitioner Registered Nurse (APRN) to individuals who are unable to access office-based services. This service is available based on the individual’s medical condition, medical necessity, and appropriateness for the provision of services.

Admission Criteria

- The individual demonstrates symptomatology consistent with an active DSM diagnosis which will respond to therapeutic intervention and is a result of a mental illness.
- The individual is receiving treatment services under a physician.
- Stabilization of the individual’s mental health condition requires psychiatric nursing.
- Psychiatric nursing will allow the individual the best opportunity for stabilization of the mental health condition and is the least restrictive level of care for the individual.
- The treatment plan clearly identifies the types of services and interventions needed as a part of the mental health psychiatric health service.

Continued Service Criteria

- The individual continues to meet admission criteria.
- The individual is maintaining stability of his/her mental health condition.
- The individual is making progress as evidenced by improvement in the individual’s symptoms, problems and impairments.
- Psychiatric nursing care remains the least restrictive level of intervention for this individual.
- The physician has evaluated the individual’s progress by review of the treatment plan and the progress every 60 days.

Discharge Criteria

- The individual has established the necessary supports and there has been an increase the individual’s involvement with rehabilitation services in the community.

Service Delivery

- Evaluation and Service Planning
  - The Initial Diagnostic Interview and additional nursing assessment, conducted by appropriate practitioners working within their scope of practice, will be completed prior to the initiation of services.
  - A physician's order is required to initiate this service.
  - The treatment plan must be individualized to the individual and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual’s progress; and the responsible professional.
  - A reasonable discharge plan must be developed as part of the treatment plan that includes a plan for transitioning to a community based service.
  - The Treatment plan must be developed and reviewed every 60 days by the treatment team, the individual, their family/significant others as appropriate, and the Supervising Practitioner. Updates/reviews of the plan must be signed by all of those involved in the review.
- Service Expectations
  - Services may include medication administration, assistance in setting up a medication system, teaching and monitoring of medication, and observation of the physical well-being in relation to medication side effects.
  - This service is not intended to replace the direct involvement of a physician for the mental health treatment of the individual.
- Discharge Planning
The frequency and duration may vary based upon the needs of the individual, but will not exceed 35 days in the first 60-day authorization, and a maximum of 12 days for each subsequent 60-day authorization period.

The service must provide or otherwise demonstrate that individuals have on-call access to a mental health provider on a 24-hour, seven-day per week basis.

**PSYCHIATRIC RESIDENTIAL REHABILITATION**

**PSYCHIATRIC RESIDENTIAL REHABILITATION** is designed to provide individualized treatment and recovery inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and/or co-occurring disorder who are in need of recovery and rehabilitation activities within a residential setting. The intent of the service is to support the individual in the recovery process so that he/she can be successful in a community living setting of his/her choice.

**Admission Criteria**

- DSM (current version) diagnosis consistent with a serious and persistent mental illness i.e. a primary diagnosis of a psychotic disorder, major affective disorder, or other major mental illness in the current edition of DSM.
- The persistent mental illness is demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the individual’s ability to function independently in an appropriate manner in two of three functional areas.
- The presence of functional deficits in two of the three following functional areas:
  - Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
  - Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
  - Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in three of five of the following:
    - Grooming, hygiene, washing clothes, meeting nutritional needs;
    - Care of personal business affairs;
    - Transportation and care of residence;
    - Procurement of medical, legal, and housing services; or
    - Recognition and avoidance of common dangers or hazards to self and possessions.
- Functional deficits of such intensity requiring professional interventions in a 24 hour psychiatric residential setting.
- The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed residential rehabilitation services are not provided.
- Requires 24-hour awake staff to assist with psychiatric rehabilitation.

**Continued Service Criteria**

- The individual continues to meet admission criteria.
- The symptoms or behaviors demonstrated are based on the DSM diagnosis.
- The individual does not require a more intensive level of services and no less intensive level of care is appropriate.
- There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
- The individual is making progress towards rehabilitation goals.
- Continues to require 24-hour awake staff to assist with psychiatric rehabilitation.
Discharge Criteria

- The individual has met their treatment/rehabilitation/recovery plan goals and objectives.
- The precipitating condition and relapse potential is stabilized such that the individual’s condition can be managed with professional external supports and interventions outside of the psychiatric residential rehabilitation facility.
- The individual has support systems secured to maintain stability in a less restrictive environment.

Service Delivery

Evaluation and Service Planning

- A diagnostic interview conducted by a licensed, qualified clinician and credentialed mental health professional prior to admission OR completed within 12 months prior to the date of admission.
  - If the diagnostic interview was completed within 12 months prior to admission, a licensed, qualified clinician should review and update as necessary via an addendum, to ensure information is reflective of the individual’s current status and functioning. The review and update should be completed within 14 days of admission.
- A strengths-based assessment which may include skills inventories, interviews and/or use of other tools for the purpose of identifying treatment and rehabilitation goals and plans with the individual, should be completed within 30 days of admission and may be completed by non-licensed or licensed individuals on the individual’s team.
- An initial treatment/rehabilitation/recovery plan (orientation, assessment schedule, etc.) to guide the first 14 days of treatment developed within 72 hours of admission.
- Alcohol and drug screening assessment as needed.
- A treatment/rehabilitation/recovery plan developed with the individual, integrating individual strengths & needs, considering community, family and other supports, stating measurable goals, that includes a documented discharge and relapse prevention plan completed within 30 days of admission.
- A review the treatment/recovery and discharge plan with the individual, other approved family/supports, and the Clinical Supervisor every 90 days or more often as needed; updated as medically indicated; approved and signed by the Clinical Supervisor, other team individuals, and the individual being served.

Service Expectations

- Psychiatric services are arranged as needed.
- There is an ability to arrange for general medical, pharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic and treatment services.
- Ancillary service referral will be provided as needed: (dental, optometry, ophthalmology, other mental health and/or social services including substance use disorder treatment, etc.).
- Therapeutic milieu offering 25 hours of staff led active treatment/rehabilitation/recovery activities per individual available 7 days/week.
- There is an on-site capacity to provide medication administration and/or self-administration, symptom management, nutritional support, social, vocational, and life-skills building activities, self-advocacy, peer support services, recreational activities, and other independent living skills that enable the individual to reside in their community.
- There is an ability to coordinate and offer a minimum of 20 hours/week of additional off-site rehabilitation, vocational, and educational activities.
- There is an ability to coordinate other services the individual may be receiving and refer to other necessary services.
- Referral for services and supports to enhance independence in the community will be provided.

Discharge Planning

- Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the individual’s ability to make progress on individual treatment/recovery goals.
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) Children and Adolescents

A PRTF is a facility provides inpatient psychiatric services to individuals under the age of 19. A PRTF must provide inpatient psychiatric services under the direction of a physician must be accredited and must comply with all the requirements of applicable state and federal regulations.

PRTF is delivered to individuals who have functional impairments resulting from a behavioral health condition that has not responded to treatment in other community settings.

Specialized PRTF Programs:
- Sexual Offender PRTF – The individual has a sexual offense that has resulted in a legal charge or adjudication and a sex offender specific assessment has been conducted and the individual has been determined to be at high risk to reoffend.
- Substance Use – The individual is diagnosed with a Substance Use Disorder that meets ASAM level of care 3.7.

Admission Criteria
- PRTF has been recommended by a team, including a physician and the team has determined through evaluation and diagnosis that a physician supervised 24-hour residential/inpatient setting is the most clinically appropriate service.
  - Individuals determined to be appropriate for PRTF may not be disqualified from this level of care based solely on a diagnosis of borderline intellectual functioning or mild intellectual disability if it is determined that the individual could participate in PRTF and benefit from treatment.
- Alternative or less restrictive levels of care have not met the individual’s treatment needs:
  - Alternative or less restrictive levels of care have been attempted and were unsuccessful; or
  - Alternative or less restrictive levels of care were determined to not be appropriate to meet the individual’s needs.
- The individual’s psychiatric condition requires 24-hour care under the direction of a physician as demonstrated by:
  - Severe and persistent symptoms and functional impairments consistent with a DSM, current edition, diagnosis that requires 24 hour residential psychiatric treatment under the direction of a physician.
  - The individual’s symptoms/severe functional impairment include at least one of the following:
    - Suicidal/homicidal ideation;
    - Substance Use Disorder that meets ASAM level of care 3.7;
    - Persistent or medically significant self-injurious behaviors;
    - A pattern of physical and verbal aggression due to a treatable behavioral health condition;
    - Significant eating disorder symptoms;
    - Severe mood instability;
    - Psychotic symptoms;
    - Sexually harmful behaviors.
- PRTF can reasonably be expected to improve the individual’s condition or prevent further regression so that the services will no longer be needed.

Continued Service Criteria
- All of the following are necessary for continuing treatment at this level of care:
  - The primary reason(s) the individual met admission criteria continue to require ongoing treatment, or are replaced with other symptoms or functional impairments that meet admission criteria.
  - The services continue to be reasonably expected to improve the individual’s condition or prevent further regression so that the services will no longer be needed.
  - The active treatment plan includes intensive family interventions.
    - If this requirement cannot be met, the reasons must be reported, and efforts to involve family individuals continued. Under some circumstances an...
alternative plan, aimed at enhancing the individual connection with other family individuals or supportive adults may be an appropriate substitute.

- A less restrictive level of care cannot yet meet the individual’s treatment needs.
- There is reasonable likelihood of substantial benefit to the individual as demonstrated by objective behavioral measurements of improvement in functional areas.

Discharge Criteria

- Symptoms are stabilized and the individual no longer meets clinical guidelines for PRTF level of care.
- The individual has made substantial progress on his/her self-developed recovery plan goals and objectives, and developed a crisis relapse/prevention plan.
- The individual is able to be safely treated in the community.
- Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the individual’s ability to make progress on individual treatment/recovery goals.

Service Delivery

- Service Expectations
  - Requires a certificate of need by an independent team that includes a physician.
  - The certificate of need must identify community resources do not meet the individuals need, the individual requires inpatient services, and the services can be expected to improve the individuals condition or prevent further regression.
  - Inpatient psychiatric service must involve “active treatment” which means implementation of a professionally developed and supervised individual plan of care, which is designed to achieve the individual’s discharge from inpatient status at the earliest possible time.
  - An Initial Diagnostic Interview (IDI) is completed prior to the beginning of treatment, and functions as the initial treatment plan until a comprehensive treatment plan is developed.
  - A treatment plan must be developed by an interdisciplinary team, the individual, and their family/legal guardians within 14 days of admission. The treatment plan must be based on evaluations of the individual’s medical, psychological, social, behavioral and developmental needs. The treatment plan will identify objectives, the therapies/activities designed to meet those objectives and a discharge plan.
  - The discharge plan must identify the anticipated caregiver, what school the individual will attend, recommendations for the IEP, outline the aftercare treatment plan, and identify potential barriers to the community reintegration and what has/is being done to address those barriers.
  - The treatment plan must be reviewed every 30 days by the team.
  - A PRTF individual will receive 40 hours of psychotherapy and other treatment interventions each week which include: individual, group and family psychotherapy/substance abuse counseling; OT/PT; speech; laboratory services; transportation; medical services as necessary; and nursing services available 24/7 (may be on call during sleep hours).
  - The following educational services must be provided for individuals with identified need in these areas: crisis intervention; life skills; social skills; substance abuse; self-care; medication; health care (nutrition, hygiene and personal wellness); vocational planning; and recreational activities.
  - Use of restraint and seclusion will be in compliance with federal standards and facility licensing requirements.
  - Facilities will be in compliance with CFR title 42; Chapter IV; Subchapter G; Part 483; Subpart G regarding use of restraint or seclusion in Psychiatric Residential Treatment Facilities providing individual psychiatric services for individual under Age 21.

- Discharge Planning
  - Length of service is individualized and based on clinical criteria for admission and continued stay, as well as the individual’s ability to make progress on individual treatment/recovery goals.
RISK ASSESSMENT FOR YOUTH WHO SEXUALLY HARM

Children and Adolescents

The purpose of the risk assessment is to identify how mental health/substance use disorder diagnoses relate to sexually harmful behavior and to provide a risk assessment to develop treatment recommendations, if indicated. This is not a forensic evaluation, but is intended to guide treatment.

Admission Criteria

- The recommendation for this specialized risk assessment is being made by a clinician with specific expertise and training in assessing individuals with sexually harmful behavior, and is being made only after a full review of documented evidence of the individual's sexually harmful behavior or after completing a face-to-face assessment of the individual and a determination has been made that the individual's presenting problems cannot be adequately assessed through the use of other assessments such as an Initial Diagnostic Interview or standardized psychological testing.
- There is an age and/or developmental differential between the alleged perpetrator/individual and victim or non-consensual sexual contact with a peer of similar age and/or developmental ability is alleged.
- The behaviors are assaultive in nature and falls outside of what would be considered developmentally appropriate or acceptable for child or adolescent sexual behavior, and there is evidence that the behavior is disabling the individual from being able to adequately function in the home, school and/or community or complete activities of daily living.
- The individual is involved and capable of participating in the risk assessment.
- The individual is 20 years old or younger.
- Referral for a risk assessment must be accompanied by court adjudication, police reports, investigation summaries or other official reports or evidence of sexually harmful behavior.

Discharge Criteria

- The individual will receive a comprehensive assessment that includes information on the risk for re-offending, mental health and substance use disorders.

Service Delivery

- Evaluation and Service Planning
  - This is a service provided for individual aged 20 or younger.
  - The need for this assessment is based on medical necessity as determined by a licensed clinical psychologist or psychiatrist upon completion of an Initial Diagnostic Interview.
  - The practitioner completing the assessment will collaborate and disseminate the assessment results with other professionals involved.
  - The components for a sexual offender risk assessment include:
    - Demographic: the reason for the assessment (police, IDI and court records); interviews with family, individual and other relevant contacts; review of previous assessments/testing.
    - Biopsychosocial: family dynamics/relations; individual background information i.e. social, school, legal, mental health, substance abuse, sexual offense history, trauma/victimization history, and personal strengths.
    - Psychological evaluation: cognitive/adaptive functioning, behavior, personality measures; use of risk assessment instruments measuring both dynamic and static factors (i.e., ERASOR-2, ASO Questionnaire, Juvenile Risk Assessment Scale).
    - Treatment recommendations which will include an assessment of the risk for reoffending.
  - Addendums to the risk assessment are appropriate when the individual has had a subsequent offense and the assessing provider had completed a full risk assessment previously. In these cases, the provider must conduct an updated risk assessment and also update other pertinent information contained in the original/prior assessment(s). The original risk assessment must be attached to the addendum in order to provide a complete clinical assessment.
The cost for psychological testing is included in the reimbursement and may not be billed separately.

- Discharge Planning
  - One assessment is the length of this service.

**SECURE PSYCHIATRIC RESIDENTIAL**

**SECURE PSYCHIATRIC RESIDENTIAL** is intended to provide individualized recovery, psychiatric rehabilitation, and support as determined by a strengths-based assessment for individuals with a mental illness and/or co-occurring substance use disorder demonstrating a high-risk for harm to self/others and in need of a secure, recovery/rehabilitative/therapeutic environment. The length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the individual’s ability to make progress on treatment/recovery goals. An individual may decline continuation of the service, unless under mental health board commitment, court order, or at the direction of their legal guardian.

**Admission Criteria**

- Individual has to meet #1 and either #2 and/or #3 of the following admission guidelines to be admitted to this service:
  - 1) High risk of relapse or symptoms reoccurrence, as evidenced by the following (has to meet ALL criteria):
    - Active symptomology consistent with DSM (current version) diagnoses;
    - High need for professional structure, intervention and observation;
    - High risk for re-hospitalization without 24-hour supervision; and
    - Unable to safely reside in less restrictive residential setting and requires 24-hour supervision.
  - 2) High risk of danger to self as a product of the principal DSM (current version) diagnosis, as evidenced by any of the following:
    - Attempts to harm self, which are life threatening or could cause disabling permanent damages with continued risk without 24-hour behavioral monitoring.
    - Suicidal ideation.
    - A level of suicidality that cannot be safely managed without 24-hour behavioral monitoring.
    - At risk for severe self-neglect resulting in harm or injury.
  - 3) High risk of danger to others, as a product of the principal DSM (current version) diagnosis, as evidenced by any of the following:
    - Life threatening action with continued risk without 24-hour behavioral supervision and intervention.
    - Harmful ideation.

**Continuing Stay Criteria**

- Individual has to meet all of the following continued stay guidelines to continue receiving this service:
  - Valid DSM (current version) diagnosis or co-occurring disorder that results in a pervasive level of impairment.
  - The reasonable likelihood of substantial benefit as a result of recovery/rehabilitation therapeutic activities that necessitates the 24-hour secure care setting.
  - Able to participate in recovery/rehabilitation/therapeutic activities.
  - Achieve progress towards recovery goals.
  - That symptoms or behaviors demonstrated are based on the DSM diagnosis (current version) as a result of a mental illness.
  - The judgment that a less intensive level of care and supervision would be insufficient to safely support the individual.

**Discharge Criteria**

- Symptoms are stabilized and the individual no longer meets clinical guidelines for secure residential care.
• Individual has made progress on his/her self-developed recovery plan goals and objectives, and developed a crisis relapse/prevention plan.
• Individual is able to be safely treated in the community.

Service Delivery

• Evaluation and Service Planning
  o History and physical within 24 hours of admission by a physician or Advanced Practice Registered Nurse (APRN). A history and physical may be accepted from previous provider if completed within the last three months. An annual physical is required.
  o Initial Diagnostic Interview (IDI) within 24 hours of admission by a psychiatrist, (if necessary).
  o Nursing assessment within 24 hours of admission.
  o Other assessments as needed, and on an ongoing basis all of which should integrate mental health and substance use disorder treatment needs.
  o Initial treatment/recovery plan completed within 24 hours of admission with the psychiatrist as the supervisor of clinical treatment and direction.
  o An individual recovery/discharge/relapse prevention plan developed with the individual and chosen supports’ input (with informed consent) within 14 days of admission and reviewed weekly by the individual and recovery team.
  o Integration of substance use disorder and mental health needs and strengths in assessment, treatment/recovery plan, and programming.
  o Consultation services available for general medical, dental, pharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic services as needed.
  o Face-to-face with a psychiatrist at a minimum of every 14 days or as often as medically necessary.
  o 42 hours of active treatment available/provided to each individual weekly, seven days per week.
  o Access to community-based rehabilitation/social services to assist in transition to community living.
  o Medication management (administration and self-administration), and education.
  o Psychiatric and nursing services.
  o Individual, group, and family therapy and substance use disorder treatment as appropriate.
  o Life skill services including daily living, social skills, community living, family education, transportation to community services, peer support services, advance directive planning, and self-advocacy, recreation, vocational and financial.

• Staffing Expectations
  o Medical director: Psychiatrist with adequate time to meet the requirements as identified in the service expectations.
  o Program director (APRN, LMHP, LIMHP, or licensed, clinical psychologist) is to have the ability to create and manage a clinical team.
  o Direct care staff, holding a bachelor’s degree or higher in psychology, sociology or a related human service field are preferred but two years of coursework in a human services field and/or two years of experience/training or two years of lived recovery experience with demonstrated skills and competencies in treatment with individuals with a behavioral health diagnoses is acceptable.
  o Therapist: Psychologist, Provisionally licensed psychologist, APRN, LIMHP, LMHP or PLMHP.
  o Nursing: 24 hours per day. APRN, RN with psychiatric experience.
  o All staff should be educated/trained in rehabilitation, recovery principles and trauma informed care.
  o One direct care staff to four individuals during individual awake hours (day and evening shifts).
  o One awake staff to six individuals with on-call availability of additional support staff during individual sleep hours (overnight).
  o Therapist to individual, 1:8.
Access to on-call, licensed mental health professionals 24/7.

Consider appropriate care staff coverage to provide a variety of recovery/rehabilitative, therapeutic activities and groups for individuals throughout weekdays and weekends.

RN services are provided in a RN/individual ratio sufficient to meet individual care needs.

**SUBACUTE INPATIENT TREATMENT**

**SUBACUTE INPATIENT** Subacute services are provided in a psychiatric hospital or general hospital with a psychiatric unit. The purpose of subacute care is to provide stabilization, engage the individual in comprehensive treatment, rehabilitation and recovery activities, and transition the individual to the least restrictive setting as rapidly as possible.

**Admission Criteria**

- The following guideline is necessary for admission: Criteria A, B, C and D must be met to satisfy the criteria for severity of need.
- A. Individual has been evaluated by a licensed clinician and demonstrates symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
- B. Either:
  - 1) there is clinical evidence that the individual would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*
  - 2) As a result of the individual’s mental disorder, there is an inability to adequately care for one’s physical needs, and caretakers/guardians/family individuals are unable to safely fulfill these needs, representing potential serious harm to self.
- C. The individual requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include, but is not limited to, medication monitoring and administration, other therapeutic interventions, restrictive safety measures, and suicidal/homicidal observation and precautions.
- D. The patient requires supervision seven days per week, 24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him/her to live outside of a sub-acute hospital setting.

**Continued Service Criteria**

- Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for continued stay.
  - A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
    - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
    - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
    - 3) That disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.
  - B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the individual can be discharged from this level of care.
  - C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the individual’s ability to return to a less-intensive level of care.
  - D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the psychiatrist.
E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate treatment resources after the subacute hospitalization.

G. Care is rendered in a clinically appropriate manner and focused on the individual’s behavioral and functional outcomes as described in the discharge plan.

Discharge Criteria

- Symptoms are stabilized and the individual no longer meets clinical guidelines for acute care.
- Sufficient supports are in place and the individual can move to a less restrictive environment.
- Treatment plan goals and objectives are substantially met.

Service Delivery

- Evaluation and Service Planning
  - The following assessments must be conducted: Initial Diagnostic Interview (IDI), nursing assessments, laboratory, radiological, substance use disorder; physical and neurological exams and other diagnostic tests as necessary. Some of the required assessments may be covered under the medical benefit.
  - Family individuals are encouraged to participate in the assessment/treatment of the individual as appropriate and approved by the individual and their participation or lack of participation is documented in the individual’s record.
  - A treatment plan is designed and implemented to address the needs identified by the assessments. The treatment plan must include a specific, realistic and individualized discharge plan. The treatment plan must be reviewed three (3) times a week.

- Service Expectations
  - Flexible meetings are scheduled to include evenings and weekends to facilitate family participation.
  - An intensive and comprehensive active treatment program that includes professional psychiatric, medical, surgical, nursing, social work, psychological, and activity therapies required to carry out a individual treatment plan for each patient and their family is provided.
  - The individual receives face to face evaluation and treatment by a psychiatrist three times a week or more often as necessary.
  - Psychiatric nursing interventions are available to patients 24/7.
  - Qualified staff are available to provide treatment intervention, social interaction and experiences, education regarding psychiatric issues such as medication management, nutrition, signs and symptoms of illness, substance abuse education, recovery, appropriate nursing interventions and structured milieu therapy.
  - Available services must include individual, group, and family therapy, group living experiences, occupational and recreational therapy and other prescribed activities to maintain or increase the individual’s capacity to manage his/her psychiatric condition and activities of daily living.
  - Medication management services are provided for the provision and monitoring of psychotropic medications.
  - Individual, group, and family therapy available are offered as tolerated and/or appropriate.
  - Social Services engage in discharge planning and help the individual develop community supports and resources and consult with community agencies on behalf of the individual.

- Discharge Planning
  - Medical necessity for a individual to remain at this level of care determines length of service.
TESTING GUIDELINES

Please apply the below NE service definition and apply with Optum’s Clinical Criteria: Psychological and Neurological Testing.

Psychological testing involves the culturally and linguistically competent administration and interpretation of standardized tests to assess an individual's psychological or cognitive functioning.

Prior to testing, the client must be assessed by a licensed psychologist using best practices and a standard model of care.

- Psychological testing is considered when a diagnostic interview and behavioral observations are not able to differentially diagnose.
- Requests for psychological testing should include which elements of a diagnosis are in question and an explanation as to why these elements cannot be determined by an interview or through observation.
- Testing may also be viewed as a potentially helpful second opinion for treatment strategies and/or difficult to diagnose cases.
- Requested tests must be standardized, valid and reliable.
- The instrument must be age, developmentally, linguistically and culturally appropriate to the client.
- Testing requests must meet medical necessity criteria.
- The time per test will be a maximum of one and one-half the time the standard time it takes to administer the test.
- The service is inclusive of the administration, observation, scoring, interpretation and report writing.
- Results of psychological testing must include the following:
  - demographic information,
  - dates of services,
  - the presenting problem,
  - results of the testing,
  - interpretation and explanation of the validity of the results,
  - Diagnostic recommendations derived from the testing.

THERAPEUTIC GROUP HOME

THERAPEUTIC GROUP HOME Therapeutic Group Homes deliver an array of clinical, treatment and related services, including psychiatric supports, integration with community resources and skill-building taught within the context of a home-like setting.

Treatment is focused on reducing the severity of the behavioral health issues that were identified as the reasons for admission. Most often, targeted behaviors relate directly to the individual’s ability to function successfully in the home and school environments (e.g., compliance with reasonable behavioral expectations, safe behavior and appropriate responses to social cues and conflicts).

Admission Criteria

- The individual’s behavioral health condition can only be safely and effectively treated in a 24 hour therapeutic milieu with onsite behavioral health therapy due to significant impairments in home, school and community functioning caused by current mental health symptoms consistent with the DSM-5 diagnosis.
- Less restrictive community based services were unable to meet the individual’s needs as indicated by documentation of one of the following:
  - Less restrictive services have been given a fully adequate trial, and were unsuccessful or
  - Less restrictive services were considered, but not attempted as they were not clinically appropriate
- The individual doesn’t require a more intensive level of care.
- The individual doesn’t require primary medical or surgical treatment.
- Therapeutic Group Home has been prescribed by a psychiatrist or psychologist who has documented that a residential setting is the least restrictive clinically appropriate service that can meet the specifically identified treatment needs of the individual.
Therapeutic Group Home must not be utilized for clinically inappropriate reasons such as:
- An alternative to incarceration, for preventative detention (e.g. to prevent running away or truancy), or as a means of ensuring community safety in an individual exhibiting primarily delinquent or antisocial behavior, or
- The equivalent of safe housing or permanency placement, or
- An alternative to parents’, guardian’s or agency’s capacity to provide a place of residence for the individual, or
- A treatment intervention, when other less restrictive alternatives are available.
- The individual’s treatment goals are included in the pre-admission psychiatric or psychological evaluation and include behaviorally defined objectives that require, and can reasonably be achieved within a Therapeutic Group Home setting.
- Therapeutic Group Home is medically necessary.

Continued Service Criteria

All of the admission criteria continue to be met and this is supported by the written clinical documentation.
- There is a written, up-to-date Discharge Plan that:
  - Identifies the custodial parent or custodial caregiver at discharge,
  - Identifies the school the individual will attend at discharge,
  - Includes IEP recommendations, if necessary,
  - Outlines the aftercare treatment plan (discharge to another residential LOC is not an acceptable discharge goal), and
  - Lists barriers to community reintegration, and progress made on resolving these barriers since last review.
- The individual is demonstrating progress in treatment and/or there is clinical evidence that continued Therapeutic Group Home services can reasonably be expected to improve the individual’s symptoms, so that Therapeutic Group Home services will no longer be necessary.
- The Active Treatment Plan includes:
  - Intensive family interventions with a frequency of one family therapy session per week, although twice per month is minimally acceptable.
  - Family involvement begins immediately upon admission. If the minimum requirement cannot be met, the reasons must be reported, and continued efforts to involve family individuals must also be documented.
  - Under certain circumstances an alternate plan, aimed at enhancing the individual’s connections with other family individuals and/or supportive adults may be an appropriate substitute.
- Less restrictive treatment options have been considered, but cannot yet meet the individual’s treatment needs. There is sufficient current clinical information to show that Therapeutic Group Home continues to be the least restrictive level of care that can meet the individual’s mental health treatment needs.

Discharge Criteria
- The individual has met his/her treatment plan goals and objectives.
- Discharge planning begins upon admission, with concrete plans for the individual to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the treatment plan.

4 The need for treatment services which are necessary to diagnose, treat, cure or prevent regression of significant functional impairments resulting from symptoms of a mental health or substance use disorder diagnosis. Treatment services shall:
  1. Be provided in the least restrictive level of care that is appropriate to meet the needs of the individual; and
  2. Be supported by evidence that the treatment improves symptoms and functioning for the individual individual’s mental health or substance use disorder diagnosis; and
  3. Be reasonably expected to improve the individual’s condition or prevent further regression so that the services will no longer be necessary; and
  4. Be required for reasons other than primarily for the convenience of the individual or the provider.
• Length of service is individualized and based on clinical criteria for admission and continuing stay. The duration of the stay varies according to the individual needs of the individual and the individual's response to the day-to-day treatment intervention.

**Service Delivery**

- The program has formal arrangements for access to:
  - Nursing care (24 hours per day)
  - Psychological services
  - Pharmacy services
  - Dietary services
- The program incorporates research-based, trauma-informed programming and training.
- Evaluation and Service Planning
  - An Initial Diagnostic Assessment (IDI) Assessment must have documented evidence of the need for Therapeutic Group Home prior to treatment. The Physician or a Psychologist must be the referring clinician as well as the individual that signs off on the application for placement.
  - A treatment plan is completed within 7 days of admission. The treatment plan is individualized and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; and the name of the responsible professional.
  - The treatment plan is reviewed at least every 14 days or more as necessary, updated as medically indicated and signed by the supervising provider and other treatment team individuals including the individual and/or their legal guardian.
  - Parental/caregiver involvement in treatment is essential and evidence based and includes parents/caregivers in therapy as the expectation of treatment.
    - Unless otherwise prohibited, providers will involve the family in assessment, treatment planning and updating of the treatment plan, therapy and transition/discharge planning.

- Service Expectations
  - Focus is on:
    - Reducing the behavior and symptoms of the mental health and/or substance use disorder that necessitated the removal of the individual from his or her usual living situation.
    - Increase developmentally appropriate, normative and pro-social behavior in individuals who are in need of out-of-home treatment.
    - Transition individuals from Therapeutic Group Homes to home, or community-based living with outpatient treatment (e.g., individual and/or family therapy).
  - The Therapeutic Group Home must provide 21 hours of active and rehabilitation treatment that will include, but not be limited to:
    - Three hours of weekly individual Psychotherapy, Substance Use Disorder Counseling and/or Group Psychotherapy and/or Substance Use Disorder Counseling
    - Twice monthly Family Psychotherapy and/or Family Substance Use Disorder Counseling
    - Psycho-educational groups and individual psycho-educational therapy services may include, but are not limited to:
      - Crisis intervention plan and aftercare planning
      - Social skills building
      - Life survival skills
      - Substance use disorder prevention intervention
      - Self-care services
      - Recreational activity
      - Medication education and medication compliance groups
      - Health care issues group (may include nutrition, hygiene and personal wellness).
Discharge Planning

- Discharge planning begins upon admission, with concrete plans for the individual to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the treatment plan.
- Length of service is individualized and based on clinical criteria for admission and continuing stay. The duration of the stay varies according to the individual needs of the individual and the individual's response to the day-to-day treatment intervention.
- The program coordinates with the individual's community resources, including schools, with the goal of transitioning the individual out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.

REFERENCES


REVISION HISTORY

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<tr>
<th>Date</th>
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<tbody>
<tr>
<td>01/2017</td>
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<td>01/31/2020</td>
<td>• Version 3; Annual review</td>
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471 Nebraska Administrative Code 1-002.02A Medical Necessity: Health care services and supplies which are medically appropriate and:

1. Necessary to meet the basic health needs of the individual;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the individual or his or her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intense level of service than can be safely provided.