United Behavioral Health

Supplemental Clinical Criteria: Nebraska Medicaid

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INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum®[1]. 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 this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

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 a member'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.**

1. Admission Criteria
   - The member has significant functional impairments as a result of maladaptive behaviors associated with a developmental disability.
     AND
   - Maladaptive behaviors that negatively impact the member's ability to function successfully in home, community and/or school settings are present.
     AND
   - Of all reasonable options for available to the member, applied behavioral analysis will reasonably improve the member's behavioral functioning.
2. Continued Service Criteria
   - The member's condition continues to meet admission guidelines for this level of care.
     AND
   - The member does not require a more intensive level of care, and no less intensive level of care would be appropriate.
     AND
   - 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.
3. Discharge Criteria
   - The member has substantially met their treatment plan goals and objectives.
     AND

[1] Optum is a brand used by United Behavioral Health and its affiliates.

- The precipitating condition is stabilized such that the member's condition can be managed without professional external supports and interventions.

4. Clinical Best Practices
    - Evaluation and Service Planning
        - An initial Diagnostic Interview and a Functional Behavior Assessment has been completed prior to admission.
        - A clinical assessment indicates the member's baseline level of functioning and how the member 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 members, 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 member in multiple settings, being attentive to environmental factors;
            - The member's symptoms specific to the areas of social interaction, communication, play and language;
            - Aggression, self-injury or stereotypic behavior or movement;
                a. A functional behavior assessment and skill assessment may be needed if the member is displaying self-injurious, or other aggressive behaviors.
            - The use of standardized tools such as:
                a. Autism Behavior Checklist (ABC);
                b. Autism Diagnostic Observation Schedule (ADOS-2);
                c. Autism Diagnostic Interview (ADI);
                d. Childhood Autism Rating Scale (CARS);
                e. Checklist for Autism in Toddlers (M-CHAT);
                f. Communication and Symbolic Behavior Scales Developmental Profile – Infant/Toddler Checklist (CSBS-DP-IT).
            - 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:
                a. Communication skills;
                b. Language skills;
                c. Social interaction skills;
                d. Self-injurious, violent, destructive or other maladaptive behavior.
            - The treatment plan identifies:

a. The member's strengths and needs,
b. Considers community, family and other supports,
c. States measurable goals and interventions based on the member's needs, and
d. Identifies a discharge plan.

- The member's treatment plan is reviewed at a minimum every 90 days or more often as determined clinically necessary.
- After review, the treatment plan is updated as clinically indicated and signed by the supervising practitioner and other treatment team members, including the member and/or guardian being served.

- Service Delivery
  - 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 member'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 members.
    - 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.
  - 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 member'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.
  - Interventions may include:
    - Parent instruction,
    - De-escalation techniques,
    - Behavioral management techniques,
    - Coping skills,
    - Social and life skills development.
  - These services shall not be used in place of a school aide or other similar services not involving the parent.
  - Members are taught socially acceptable behaviors via modeling, prompting, roleplaying and reinforcing of appropriate behaviors.
  - Family/Caregiver training is provided to include acceptable behaviors via modeling, prompting, roleplaying, and reinforcing appropriate behaviors to promote consistency for the member.
  - 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.
  - Supervision includes:
    - Critical oversight of a treatment activity or course of action;
    - Review of the treatment plan and progress notes;
    - Member specific case discussion;
    - Periodic assessments of the member; 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

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

ASSERTIVE COMMUNITY TREATMENT

ASSERTIVE COMMUNITY TREATMENT The Assertive Community Treatment/Alternative Community Treatment (ACT) Team provides high intensity services, and is available to provide treatment, rehabilitation, and support activities seven days per week, twenty-four hours per day, and 365 days per year.

The team has the capacity to provide multiple contacts each day as dictated by the member's needs. The team provides ongoing continuous care for an extended period of time. Members admitted to the service who demonstrate a continued need for treatment, rehabilitation, or support will not be discharged except by mutual agreement between the member and the team.

1. Admission Criteria
    - The member is 21 years or older.
      AND
    - The member is diagnosed with a persistent mental illness as demonstrated by the presence of a primary diagnosis of a psychotic disorder, major affective disorder, or other major mental illness under the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
      AND
    - The member has been diagnosed with a persistent mental illness for the last 12 months or is expected to have persistent symptoms of the diagnosis for 12 months or longer that results in a degree of limitation that interferes with the member's ability to function independently in two of three functional areas: Vocational/Education, Social Skills, Activities of Daily Living.
      AND
    - The member has a pattern of remaining at significant risk or a continuing a pattern of institutionalization or dysfunctional living if mental health services are not provided. This pattern has persisted for one year or longer and is likely to endure for one year or longer.
      AND
    - Functional deficits are present to the degree, that extensive professional multidisciplinary treatment, rehabilitation and support interventions with 24 hour capability are required.
      AND
    - The member has a history of high utilization of psychiatric inpatient and emergency services.
      AND
    - The member has had less than satisfactory response to previous levels of treatment/rehabilitation interventions.
2. Continued Service Criteria
    a. The member continues to meet admission criteria.
       AND
    b. The member does not require a more intensive level of services and no less intensive level of care is appropriate.
       AND
    c. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
       AND
    d. The member is making progress towards treatment/rehabilitation goals.
3. Discharge Criteria
    a. The member has substantially met the agreed upon treatment plan goals and objectives and is stable in a community setting.

4. Clinical Best Practices
    - Evaluation and Service Planning
        - An initial diagnostic interview is completed upon admission if one has not been conducted within the 12 months prior to admission. If an initial diagnostic interview was completed within 12 months prior to admission, a licensed professional reviews and, as necessary, updates the information via an addendum ensuring that the information reflects the member's current status and functioning. The review and update is completed within 30 days of admission.
        - An Initial Member Treatment, Rehabilitation, and Recovery Plan must be developed upon the member's admission to the ACT Team.
        - A Treatment, Rehabilitation, and Recovery plan, developed under clinical guidance with the member, should integrate member 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 completion of the initial diagnostic interview.
        - The ACT Team must review and revise the member's Member Treatment, Rehabilitation, and Recovery Plan every six months, or whenever there is a change in psychiatric condition and/or level of functioning during the member's course of treatment, or more often as necessary to actively review progress made towards goals.
        - The ACT Team is responsible for engaging the member in active involvement in the development of the treatment/service goals.
        - The ACT Team staff must involve pertinent agencies and members of the member's family and social network in the formulation of Member Treatment, Rehabilitation, and Recovery Plans.
    - Service Delivery
        - The ACT Team must provide the interventions necessary to ensure the member receives treatment for identified psychiatric and/or physical conditions.
        - The ACT Team must provide member, family, and group therapy or counseling to assist the member to gain skills in interpersonal relationships, identify and resolve conflicts, and systematically work on identified member goals. Referrals to appropriate support group services may be appropriate.
        - Medication prescribing, delivery, administration and monitoring.
        - Crisis intervention as required.
        - 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.
        - 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 member.
        - The ACT Team will offer opportunities for positive peer role modeling and peer support.
        - Clinical supervision must be provided by the team psychiatrist and/or team leader weekly and may occur during daily team meetings, member treatment, rehabilitation and recovery plan meetings, side-by-side and face-to-face supervision sessions and record review.
        - The Assertive Community Treatment team provides services such as the following to the member's family with the member's consent:
            - Education about the member's condition and its treatment;
            - Education about the member's strengths;
            - Education about the family's role in the member's treatment;
            - Assistance with resolving conflicts;
            - Interventions aimed at promoting the family's collaboration with the ACT team.

- On average the member is seen 3 times per week. The Assertive Community Treatment team has the capacity to see the member more frequently. Reasons for more frequent contact include:
    - The member's signs and symptoms have worsened.
    - The member response to a new medication needs to be monitored.
    - The member is experiencing an acute serious life event.
- The Assertive Community Treatment team psychiatrist assesses the member's signs and symptoms, prescribes appropriate medication, and monitors the member's response to the medication.
- The Assertive Community Treatment team provides ongoing support and liaison services for members who are hospitalized or incarcerated.
- The Assertive Community Treatment team reaches out and maintains contact with the member when the member becomes isolated or is admitted to a higher level of care.
- The Assertive Community Treatment team conducts regularly scheduled planning meetings. The purpose of planning meetings is to:
    - Ensure that staff remain familiar with each member's Assertive Community Treatment plan;
    - Provide an opportunity to assess the member's progress and reformulate the Assertive Community Treatment plan as needed;
    - To problem-solve treatment issues;
    - To obtain input from the member, and incorporate the member into decisions about the Assertive Community Treatment plan.

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.

1. Admission Criteria
    - The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
      AND
    - 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.
      AND
    - This service is provided in the least restrictive setting that will produce the desired results in accordance with the needs of the member.
      AND
    - CPP is supported by evidence that the treatment will improve symptoms and functioning for the member member's behavioral health diagnosis.
      AND
    - There is an expectation that the member has the capacity to make significant progress toward treatment goals to the point that CPP is no longer necessary.
      AND
    - CPP is required for reasons other than primarily for the convenience of the member or the provider.
      AND
    - Involvement of the member 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.

AND

- 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.

2. Continued Service Criteria
   - Admission guidelines continue to be met.
     AND
   - Treatment planning is individualized and appropriate to the family's changing condition, with realistic and specific goals and objectives clearly stated.
     AND
   - All interventions are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
     AND
   - 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.
     AND
   - Care is rendered in a clinically appropriate manner and focused on the family's behavioral and functional outcomes as described in the discharge plan.
     AND
   - There is documented active discharge planning.
3. Discharge Criteria
   - The family has substantially met their treatment plan goals and objectives.
     AND
   - Family has support systems secured to help them maintain stability in the community.
4. Clinical Best Practices
   - Young children should receive CPP services only after a recent appropriate medical evaluation to rule out conditions of a general medical nature.Treatment Planning: A goal-oriented treatment plan with measurable outcomes, and a specific, realistic discharge plan must be developed with the member (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 An Initial Diagnostic Interview must be completed prior to the beginning of treatment.Assessment should be ongoing with treatment and reviewed each session.
   - Service Delivery
     - Services must be treatment focused and not rehabilitative or habilitative in nature.
     - There shall be a reasonable expectation that CPP 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, and psychopharmacology needs.
     - Provided as family psychotherapy.
     - It is the provider's responsibility to coordinate with other treating professionals as needed
     - The essential components of Child-Parent Psychotherapy (CPP) include:
     - Focus on the parent-child relationship as the primary target of intervention.
     - Focus on safety:
     - Focus on safety issues in the environment as needed;
     - Promote safe behavior;
     - Legitimize feelings while highlighting the need for safe/appropriate behavior;
     - Foster appropriate limit setting;
     - Help establish appropriate parent-child roles.
     - Affect regulation:
     - Provide developmental guidance regarding how children regulate affect and emotional reactions;
     - Support and label affective experiences;
     - Foster parent's ability to respond in helpful, soothing ways when child is upset;
     - Foster child's ability to use parent as a secure base;
     - Develop/foster strategies for regulating affect.
     - Reciprocity in Relationships:

- Highlight parent's and child's love and understanding for each other;
- Support expression of positive and negative feelings for important people;
- Foster ability to understand the other's perspective;
- Talk about ways that parent and child are different and autonomous;
- Develop interventions to change maladaptive patterns of interactions.
- Focus on the traumatic event:
- Help parent acknowledge what child has witnessed and remembered;
- Help parent and child understand each other's reality with regards to the trauma;
- Provide developmental guidance acknowledging response to trauma;
- Make linkages between past experiences and current thoughts, feelings, and behaviors;
- Help parent understand link between her own experiences and current feelings and parenting practices;
- Highlight the difference between past and present circumstances;
- Support parent and child in creating a joint narrative;
- Reinforce behaviors that help parent and child master the trauma and gain a new perspective.
- Continuity of Daily Living:
- Foster prosocial, adaptive behavior;
- Foster efforts to engage in appropriate activities;
- Foster development of a daily predictable routine.
- Reflective supervision

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

COMMUNITY SUPPORT

COMMUNITY SUPPORT Community Support services will provide rehabilitative and support services for individuals with a primary serious or persistent mental health diagnosis or when appropriate, substance use disorder 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, substance use disorder or ~~and~~ admission to higher levels of care. Service is not provided during the same service delivery hour of other rehabilitation services.

1. Admission Criteria
   - The member 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).
     AND
   - The member'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 member'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 member'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.

  AND
- Symptoms and functional deficits are related to the primary diagnosis.
  AND
- There is an expectation that the member will benefit from rehabilitation services until services are no longer medically necessary.
  AND
- The member's rehabilitation needs are best met by 1:1 direction with a paraprofessional.

2. Continued Service Criteria
    - All of the following are necessary for continuing treatment at this level of care:
        - The member continues to meet admission criteria.
        - The member 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 member as demonstrated by objective behavioral measurements of improvement in functional areas.
        - The member is making progress toward rehabilitation goals.
3. Discharge Criteria
    - The member has met his/her treatment plan goals and objectives.
      AND
    - The precipitating condition and relapse potential is stabilized such that member's condition can be managed without/or with decreased professional external supports and interventions.
      AND
    - The member has alternative support systems secured to help him/her maintain stability in the community.
4. Clinical Best Practices
    - 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 member 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 member. The IDI shall 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 member, should be completed within 30 days of admission and may be completed by either non-licensed or licensed members on the member's team.
        - There are Treatment, Rehabilitation, and Recovery Plans for the member. The Treatment, Rehabilitation, and Recovery Plans shall be completed within 30 days following admission and reviewed and updated every 90 days or as often as clinically necessary thereafter.
    - Service Delivery
        - 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 member 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 member with all health insurance issues including Share of Cost eligibility issues. Ensures member 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 member 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 member'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 member in time of crisis and work with the member to develop a crisis relapse prevention plan.
    - Provide contact as needed with other service provider(s), member family member(s), and/or other significant people in the member's life to facilitate communication necessary to support the member in maintaining community living.
    - If hospitalization or residential care is necessary, facilitate, in cooperation with the treatment provider, the member'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 member'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.

1. Admission Criteria
    - There is an established DSM (current edition) diagnosis which requires and will respond to therapeutic intervention.
      AND
    - There is the presence of psychological symptoms that require this level of care.
      AND
    - The member is enrolled in active outpatient treatment with a licensed therapist.
      AND
    - The member would require a more restrictive treatment environment without the services of a CTA.
      AND
    - The member is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.
      AND
    - The member must have sufficient medical need for active psychiatric treatment at the time of admission to justify the expenditure of the members and program's time, energy, and resources.

AND

- Of all reasonable options for active psychiatric treatment available to the member, treatment in this program must be the best choice for expecting a reasonable improvement in the member's psychiatric condition.
  AND
- The Initial Diagnostic Evaluation must identify the need for this level of care for the member.

2. Continued Service Criteria
   - The member's condition continues to meet admission criteria for this level of care.
     AND
   - The member does not require a more intensive level of care, and no less intensive level of care would be appropriate.
     AND
   - 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.
     AND
   - The member is making progress toward goals and is actively participating in the interventions.
3. Discharge Criteria
   - The member has met their treatment plan goals and objectives.
     AND
   - The precipitating condition and relapse potential is stabilized such that member's condition can be managed without professional external supports and interventions.
     AND
   - The member has alternative support systems secured to help him/her maintain stability in the community.
4. Clinical Best Practices
   - Evaluation and Service Planning
     - 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.
     - The member's CTA plan shall be a part of the comprehensive treatment plan developed by the member's outpatient psychotherapy provider and be developed in close collaboration with the therapy provider.
     - 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 Delivery
     - Outpatient services shall be provided by licensed practitioners whose scope of practice includes mental health and/or substance use disorder services.
     - 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 member and parent/caregiver.
     - 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.
     - CTA services shall not be used in place of a school aide or other similar services not involving the parent.
     - CTA services shall be delivered under the direction and supervision of the therapist providing family and/or individual therapy.
     - 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 member's treatment record.
     - The parent/caregiver is fully engaged during all CTA services.
     - 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 member's ability to make progress on individual treatment/recovery goals.

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.

1. Admission Criteria
   - The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
     AND
   - 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.

2. Discharge Criteria
   - The individual is able to remain stable in the community without this treatment.
     AND
   - The individual will receive services to address safety and crisis resolution.
3. Clinical Best Practices
   - Evaluation & Treatment Planning
     - Psychotherapy is limited to 2 sessions.
       - If services are to continue, the provider shall 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.

CRISIS STABILIZATION SERVICES

CRISIS STABILIZATION SERVICES Crisis Stabilization is intended to provide immediate, short-term, individualized, crisis-oriented treatment and recovery needed to stabilize acute symptoms of mental illness, alcohol and/or other drug use, and/or emotional distress. Members in need exhibit a psychiatric and/or substance use disorder crisis with a moderate to high risk for harm to self/others and need short-term, protected, supervised, residential placement. The intent of the service is to treat and support the member throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the member's typical living situation.

1. Admission Criteria
   - The member demonstrates a significant incapacitating or debilitating disturbance in mood/thought interfering with ADLs to the extent that immediate stabilization is required

AND
- The member demonstrates active symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to intensive, structured intervention
AND
- A clinical evaluation of the member's condition indicates dramatic and sudden decompensation with a strong potential for danger (but not imminently dangerous) to self or others and member has no available supports to provide continuous monitoring
AND
- The member requires 24 hour observation and supervision but not the constant observation of an inpatient psychiatric setting
AND
- A clinical evaluation indicates that the member 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; and
AND
- A less intensive or restrictive level of care has been considered/tried or clinical evaluation indicates the onset of a life-endangering psychiatric condition, but there is insufficient information to determine the appropriate level of care.

2. Continued Service Criteria
   - The member's condition continues to meet admission guidelines at this level of care.
   AND
   - The member's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
   AND
   - Care is rendered in a clinically appropriate manner and focused on member's behavioral and functional outcomes as described in the discharge plan.
   AND
   - Treatment planning is individualized and appropriate to the member's changing condition with realistic and specific goals and objectives stated.
   AND
   - All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
   AND
   - 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.
   AND
   - When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
   AND
   - There is documented active discharge planning.
3. Discharge Criteria
   - Symptoms are stabilized and the member no longer meets clinical criteria for crisis stabilization.
   AND
   - The precipitating condition and relapse potential is stabilized such that member's condition can be managed with professional external supports and interventions outside of the crisis stabilization facility.
4. Clinical Best Practices
   - Evaluation & Treatment Planning Crisis Stabilization
     - Multidisciplinary/bio-psychosocial assessments, including a history and physical, and substance use are completed within 24 hours of admission.
     - Assessments and treatment must integrate strengths and needs in both MH/SUD domains.
     - A crisis stabilization plan, which includes relapse/crisis prevention and discharge plan components (consider community, family and other supports), is developed within 24 hours of admission and adjusted daily or as indicated.
   - Service Delivery Crisis Stabilization

- Interdisciplinary treatment team meetings occur daily or as often as medically necessary including the member, family, and other supports as appropriate.
- Psychiatric nursing interventions are available to patients 24/7.
- Medication management is available.
- Member, group, and family therapy is available and offered as tolerated and/or appropriate using a brief therapy/solution focused approach.
- Addictions treatment is initiated and integrated into the treatment/recovery plan for co-occurring disorders identified in initial assessment process as appropriate.
- Intense discharge planning begins at the time of admission.

- Evaluation & Treatment Planning Crisis Assessment
  - A culturally sensitive assessment is completed by appropriately licensed behavioral health professional that includes at a minimum:
    - Behavioral health diagnosis, risk of dangerousness to self and/or others, and recommended behavioral health services.

DAY REHABILITATION

DAY REHABILITATION Day Rehabilitation services are designed to provide individualized treatment and recovery, inclusive of psychiatric rehabilitation and support for members 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 member 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.

1. Admission Criteria
   - The member'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 member'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 member'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.

   AND

- 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.
  AND
- The member 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.
  AND
- Symptoms and functional deficits are related to the primary diagnosis.
  AND
- There is an expectation that the member will benefit from rehabilitation services until services are no longer medically necessary[i].

2. Continued Service Criteria
   - All of the following are necessary for continuing treatment at this level of care:
     - The member continues to meet admission criteria.
     - The member 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 member as demonstrated by objective behavioral measurements of improvement in functional areas.
     - The member is making progress toward rehabilitation goals.
3. Discharge Criteria
   - The member has met his/her treatment plan goals and objectives.
     AND
   - The member has met their treatment/recovery/rehabilitation plan goals and objectives
     AND
   - The member has achieved a level of functioning that does not require ongoing, intensive professional external supports and interventions.
     AND
   - The member has formal and informal support systems secured to maintain stability in a less restrictive environment.
4. Clinical Best Practices
   - 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 member 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 member'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 member, should be completed within 30 days of admission and may be completed by non-licensed or licensed members on the member'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 member, integrating member 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 member, every 90 days, making necessary changes then, or as often as medically indicated. Each review should be signed by members of the treatment team, at a minimum the Clinical Supervisor, assigned therapist and member/family/legally responsible person.
   - Service Delivery

- Therapeutic milieu providing active treatment/recovery/rehabilitation activities led by members 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 member to reside in their community
- Ability to coordinate other services the member 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 member's ability to make progress on member treatment/recovery goals.

DAY TREATMENT ADULT

DAY TREATMENT ADULTS Psychiatric and substance use day treatment is a service in a continuum of care designed to prevent hospitalization or to facilitate the movement of the acute psychiatric member to a status in which the member is capable of functioning within the community with less frequent contact with the psychiatric health care provider.

1. Admission Criteria
   - Adults:
     - The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
       AND
     - There is an expectation that the member has the capacity to make progress toward treatment goals to where services are no longer necessary.
       AND
     - The member is 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.

       AND
     - 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 member is at risk of adverse consequences if treatment is not provided.
       - The member requires assistance to manage/monitor their medical, mental health and/or substance use needs.
       - The member cannot be safely maintained/effectively treated at a lower level of care.
       - A higher level of care is not necessary.
2. Continued Service Criteria
   - The member's condition continues to meet admission guidelines for this level of care.
     AND
   - The member does not require a more intensive level of care, and no less intensive level of care would be appropriate.
     AND
   - 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.
     AND
   - The member is making progress toward goals and is actively participating in the interventions.

3. Discharge Criteria
    - The member has met his/her treatment plan goals and objectives.
      AND
    - The precipitating condition and relapse potential is stabilized such that member's condition can be managed without professional external supports and interventions
      AND
    - Member has support systems to maintain stability in a less restrictive environment
4. Clinical Best Practices
    - Evaluation and Service Planning
        - An initial Diagnostic Interview must be completed prior to admission and functions as the initial treatment plan until a comprehensive treatment plan is developed.
        - The family is provided with opportunities to participate in all aspects of the member's treatment (assessment, treatment planning, therapy and discharge planning) if appropriate. This participation or lack of participation must be documented in the member record.
        - Complete a treatment plan within 10 business days of admission.
        - The treatment plan must be individualized to the member 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 member's progress; and the responsible professional.
        - The member 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 members, including the member being served.
        - Assessments and treatment should address mental health/substance use needs and emotional issues related to medical conditions.
    - Service Delivery
        - Services must be community based, family centered, culturally competent and developmentally appropriate.
        - Provide a flexible meeting schedule to include evenings and weekends.
        - Provide the following mandatory services:
            - Psychological diagnostic services that contribute to the diagnosis and plan of care for the member.
            - One hour of psychotherapy and substance use counseling services, per scheduled treatment day, that demonstrate the member is receiving active treatment for their psychiatric condition. These services may include: Member psychotherapy, group psychotherapy, and family psychotherapy if appropriate.
            - Pharmaceutical services must be provided under the supervision of a registered pharmacy consultant or through a contract agreement with a licensed certified facility.
            - Dietary services must 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 members medical nursing needs when medically indicated. In a hospital-based day treatment setting, a nursing medical assessment must be completed within 24 hours of admission or the first business day.
            - Clinically appropriate assessments, as determined necessary, to assess the member for substance use disorders, eating disorders, or other specialized treatment needs.
            - Provide either half-day (3 hours a day, 5 days a week), or full-day (6 hours a day, 5 days a week).
        - The program shall identify an on-call system of licensed practitioners available for crisis management when the member is not in the program's scheduled hours and/or the program is not in session.

- Transition and discharge planning must begin at admission, be based on transitioning the member to a different level of care, and address the members ongoing treatment needs.
- Provide at least 2 of the following optional services. The member must have a need for the services, a supervising practitioner must order the services, and the services must be a part of the member's treatment plan:
  - The following must 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 (3 hours a day, 5 days a week) or full day (6 hours a day, 5 days a week)
- Supervising practitioners (physician or PhD) must be onsite a sufficient amount of time to provide for the psychiatric/clinical care of the patients.
- Psychotherapy and substance abuse counseling services must be provided by clinical staff who is operating within their scope of practice and under the direction of the supervising practitioner.

- Discharge Planning
  - Length of service is individualized and based on clinical criteria for admission and continuing stay, but considering its time-limited expectations, a period of 21-90 days with decreasing days in attendance is typical.

DAY TREATMENT YOUTH

DAY TREATMENT YOUTH Psychiatric and substance use day treatment is a service in a continuum of care designed to prevent hospitalization or to facilitate the movement of the acute psychiatric member to a status in which the member is capable of functioning within the community with less frequent contact with the psychiatric health care provider.

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

- The member 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 member is making progress toward goals and is actively participating in the interventions.

3. Discharge Criteria
   - The member has met his/her treatment plan goals and objectives.
     AND
   - The precipitating condition and relapse potential is stabilized such that member's condition can be managed without professional external supports and interventions
     AND
   - Member has support systems to maintain stability in a less restrictive environment
4. Clinical Best Practices
   - Evaluation and Service Planning
     - An initial Diagnostic Interview must be completed prior to admission and functions as the initial treatment plan until a comprehensive treatment plan is developed.
     - The family is provided with opportunities to participate in all aspects of the member's treatment (assessment, treatment planning, therapy and discharge planning) if appropriate. This participation or lack of participation must be documented in the member record.
     - Complete a treatment plan within 10 business days of admission.
     - The treatment plan must be individualized to the member 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 member's progress; and the responsible professional.
     - The member 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 members, including the member being served.
     - Assessments and treatment should address mental health/substance use needs and emotional issues related to medical conditions.
   - Service Delivery
     - Services must be community based, family centered, culturally competent and developmentally appropriate.
     - For youth, services must involve the family in assessment, treatment planning, updating of the treatment plan, therapy and transition/discharge planning. Family involvement, or lack thereof, shall be documented in the clinical record
     - Provide a flexible meeting schedule to include evenings and weekends.
     - Provide the following mandatory services:
       - Psychological diagnostic services that contribute to the diagnosis and plan of care for the member.
       - One hour of psychotherapy and substance use counseling services, per scheduled treatment day, that demonstrate the member is receiving active treatment for their psychiatric condition. These services may include: Member psychotherapy, group psychotherapy, and family psychotherapy if appropriate.
       - Pharmaceutical services must be provided under the supervision of a registered pharmacy consultant or through a contract agreement with a licensed certified facility.
       - Dietary services must be provided and/or contracted with a registered dietitian when meals are provided by a day treatment program.
       - Nursing services. Medical services 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 must be completed within 24 hours of admission or the first business day.

- Clinically appropriate assessments, as determined necessary, to assess the member for substance use disorders, eating disorders, sex offender behavior or other specialized treatment needs.
- Medication management must be available to all members participating in a Day Treatment service when medication is prescribed by an appropriately licensed practitioner. This service shall 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, shall 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 (LTO). Parents or legal guardian or the Department case manager must approve use of these procedures through informed consent and must be informed within 24 hours each time they are used. Facilities must meet the following standards regarding special treatment procedures:
    a. De-escalation techniques must be taught to staff and used appropriately before the initiation of special treatment procedures;
    b. 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; and
    c. The child/adolescent's treatment plan must 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 3 hours a day, 5 days a week.
- The program shall identify an on-call system of licensed practitioners available for crisis management when the member is not in the program's scheduled hours and/or the program is not in session.
- Transition and discharge planning must begin at admission, be based on transitioning the member to a different level of care, and address the members ongoing treatment needs.
- Provide at least 2 of the following optional services. The member must have a need for the services, a supervising practitioner must order the services, and the services must be a part of the member's treatment plan:

The following must 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 (3 hours a day, 5 days a week) or full day (6 hours a day, 5 days a week)

- Supervising practitioners (physician or PhD) must be onsite a sufficient amount of time to provide for the psychiatric/clinical care of the patients. The supervising practitioner's involvement must be reflected in the member record.
- Psychotherapy and substance abuse counseling services must be provided by clinical staff who is operating within their scope of practice and under the direction of the supervising practitioner.

- Discharge Planning
    - Length of service is individualized and based on clinical criteria for admission and continuing stay.

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.

1. Admission Criteria
    - Documentation exists indicating that the member is unresponsive to trials of effective medications of adequate dose and duration that are indicated for the member's condition (e.g., anti-depressants, anti-psychotics, etc., as appropriate).
      AND
    - The member is unable to tolerate effective medications or has a medical condition for which medication is contraindicated.
      AND
    - The member has had favorable responses to ECT in the past, and rapid response symptom alleviation is medically necessary.
      AND
    - The member 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.).
      AND
    - The member is experiencing severe mania or depression during pregnancy.
      OR
    - The member and the psychiatrist have agreed that ECT is the least restrictive treatment to effectively treat acute and persistent symptoms.
2. 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 member history and/or clinical findings, to result in exacerbation or worsening of the member'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.
3. Discharge Criteria
    - The member no longer meets clinical criteria for admission to ECT treatment.
      AND
    - The member is able to respond effectively to a less intrusive treatment intervention.
4. Clinical Best Practices
    - 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 shall 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 Delivery
    - 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 member'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 member.
    - 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 member's response to treatment and according to the treatment plan.

FUNCTIONAL BEHAVIORAL ASSESSMENT

FUNCTIONAL BEHAVIORAL ASSESSMENT

A Functional Behavioral Assessment (FBA) refers to a range of strategies used in the process of determining why a member engages in significant behavioral disruption and how the behavior relates to the environment. The focus of a Functional Behavioral Assessment is on identifying significant, member-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 member engages in the behavior, when the member is most likely to demonstrate the behavior, and situations in which the behavior is most likely and least likely to occur. Generally, members 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 member'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 member and their caregivers that can help the member acquire needed skills and reduce problematic behaviors.

1. 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.
      AND
    - 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.
      AND
    - 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.
      AND
    - 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.
      AND
    - The member presents with severe behaviors that cause significant impairments in all domains of the member's life and, without specialized behaviorally-focused assessment and treatment to address, will likely lead to disrupted placement in school and living environment.
      AND
    - The member'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.
      AND
    - The member 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.
2. 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 member functional behaviors to replace the maladaptive behaviors. As a result, the member will improve their ability to interact within the family, social, and educational constructs of their daily life.
3. Clinical Best Practices
    - 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, member 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 member'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 member.
- 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 members to gather relevant information about member 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 member's assessment and treatment.

FUNCTIONAL FAMILY THERAPY

FUNCTIONAL FAMILY THERAPY A Functional Behavioral Assessment (FBA) refers to a range of strategies used in the process of determining why a member engages in significant behavioral disruption and how the behavior relates to the environment. The focus of a Functional Behavioral Assessment is on identifying significant, member-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 member engages in the behavior, when the member is most likely to demonstrate the behavior, and situations in which the behavior is most likely and least likely to occur. Generally, members 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 member'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 member and their caregivers that can help the member acquire needed skills and reduce problematic behaviors.

1. 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.
      AND
    - 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.
      AND
    - 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.
      AND
    - 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.
      AND
    - The member presents with severe behaviors that cause significant impairments in all domains of the member's life and, without specialized behaviorally-focused assessment and treatment to address, will likely lead to disrupted placement in school and living environment.
      AND
    - The member'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.
      AND
    - The member 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.
2. 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 member functional behaviors to replace the maladaptive behaviors. As a result, the member will improve their ability to interact within the family, social, and educational constructs of their daily life.
3. Clinical Best Practices
    - 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, member 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 member'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 member.
- 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 members to gather relevant information about member 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 member's assessment and treatment.

INPATIENT TREATMENT

INPATIENT An Acute Inpatient program is designed to provide medically necessary, intensive assessment, psychiatric treatment and support to members with a DSM (current version) diagnosis and/or co-occurring disorder experiencing an acute exacerbation of a psychiatric condition. The Acute Inpatient setting is equipped to serve patients at high 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 member's acute psychiatric conditions.

1. Admission Criteria
    - The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
      AND

- The member 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.
  AND
- Due to the risk of medical instability the need for confinement beyond 23 hours with intensive medical and therapeutic intervention is clearly indicated.
  AND
- There is a clear and reasonable inference of imminent serious harm to self/others as evidenced by having any one of the following:
  - A 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; or
  - Violent unpredictable or uncontrolled behavior is related to the behavioral health disorder and represents an imminent risk of serious harm to self or others;

  AND
- 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.
  AND
- The member 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 member's general medical or mental health.

2. Continued Service Criteria
   - The member demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
     AND
   - The member 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.
     AND
   - Due to the risk of medical instability the need for confinement beyond 23 hours with intensive medical and therapeutic intervention is clearly indicated.
     AND
   - There is a clear and reasonable inference of imminent serious harm to self/others as evidenced by having any one of the following:
     - A 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; or
     - Violent unpredictable or uncontrolled behavior is related to the behavioral health disorder and represents an imminent risk of serious harm to self or others;

     AND
   - 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.
     AND
   - The member 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 member's general medical or mental health.
3. Discharge Criteria
   - Symptoms are stabilized and the member no longer meets clinical criteria for acute care.
     AND
   - Sufficient supports are in place and member can safely move to a less restrictive environment.
     AND
   - Treatment plan goals and objectives are substantially met.

4. Clinical Best Practices
    - Evaluation and Service Planning
        - The psychiatrist in conjunction with the treatment team completes the initial evaluation commensurate within 24 hours of admission.
        - 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.
        - Family members are encouraged to participate in the assessment/treatment of the member as appropriate and approved by the member, and their participation or lack of participation is documented in the member record.
        - Develop and implement a treatment plan with provisions for: resolution of acute medical problems; evaluation of, and needs assessment for, medications; protocol to ensure patient's safety; discharge plan initiated at the time of admission.
          The treatment plan must be reviewed weekly or as medically necessary.
    - Service Delivery
        - There is an intensive and comprehensive active treatment program provided that includes professional psychiatric, medical, surgical, nursing, social work, psychological, and activity therapies required to carry out a member treatment plan for each patient and their family.
        - Hospitals which provide inpatient psychiatric services must be staffed with the number of qualified professional, technical, and supporting personnel and consultants required to implement comprehensive assessments and treatment plans.
        - Face to face evaluation and treatment by a physician six out of seven days is required.
          Psychiatric nursing interventions are available to patients 24/7
    - Medication management
        - Member, group, and family therapy available and offered as tolerated and/or appropriate.
          Social Services to engage in discharge planning and help the member develop community supports and resources and consult with community agencies on behalf of the member
    - Discharge Planning
        - A number of days driven by the medical necessity for a patient to remain at this level of care.

INTENSIVE OUTPATIENT TREATMENT ADULT

INTENSIVE OUTPATIENT TREATMENT ADULTS Intensive Outpatient Services are non-residential, intensive, structured intervention consisting counseling and education regarding the needs of the targeted population. IOP interventions may include: ongoing assessment, individual, group, and family psychotherapy and psycho-educational services. Services are goal oriented interactions in preparing the youth to apply learned skills in "real world" environments.

1. Admission Criteria
    - The member is assessed and meets the diagnostic criteria for a Mental Health Disorder as defined in the most recent DSM.
      AND
    - 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.
      AND
    - Of all reasonable options for active psychiatric treatment available to the client, this program must be the best choice for expecting reduction in treatment.
      AND
    - For individuals who present with co-occurring mental health and substance use disorder symptoms and diagnoses, the provider must refer to the ASAM Criteria (current edition) Intensive Outpatient Level 2.1.

2. Continued Service Criteria
    - For adults:
        - The persistence of problems that caused the admission
        AND
        - The emergence of additional problems that meet the admission criteria.
        AND
        - Reasonable improvement in the client's psychiatric condition.
        AND
        - 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.
3. Discharge Criteria
    - The member has met the treatment plan goals and objectives.
    AND
    - The precipitating condition and relapse potential is stabilized such that member's condition can be managed without professional external supports and intervention.
    AND
    - The member is able to remain stable a less intensive level of treatment or support.
    AND
    - The member has support systems secure to help them maintain stability
4. Clinical Best Practices
    - Evaluation and Service Planning
        - An Initial Diagnostic Assessment (IDI) and a Substance Use Disorder Assessment by a licensed clinician prior to the beginning of treatment.
            - The IDI shall 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 the first 2 appointments with the provider.
    - Service Delivery
        - Therapies/interventions should include individual, family, and group psychotherapy, educational groups, motivational, enhancement and engagement strategies.
        - Provision of 9 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.
        - 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.
        - Other services could include 24 hours crisis management, family education, self-help group and support group orientation.
        - Therapists of members with more than one mental health/substance use disorder provider must communicate with and document coordinated services with any other mental health/substance provider for the family or individual family members.
        - Monitoring stabilized comorbid medical and psychiatric conditions.
        - Consultation and/or referral for general medical, psychiatric, needs.
    - Discharge Planning
        - Length of service is individualized and based on clinical criteria for admission and continuing stay. The frequency and duration varies according to the individual needs of the client and the client's response to the day-to-day treatment intervention.

INTENSIVE OUTPATIENT TREATMENT YOUTH

INTENSIVE OUTPATIENT TREATMENT YOUTH
Intensive Outpatient Services are non-residential, intensive, structured intervention consisting counseling and education regarding the needs of the targeted population.

For youth, Intensive Outpatient Services consist of services to improve the mental health, sexually harmful behavior, substance use disorder and /or eating disorder symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). IOP interventions may include: ongoing assessment, individual, group, and family psychotherapy and psycho-educational services. Services are goal oriented interactions in preparing the youth to apply learned skills in "real world" environments.

1. Admission Criteria
    - The youth is assessed and meets the diagnostic criteria for a Mental Health or Substance Use Disorder as defined in the most recent DSM.
      AND
    - 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.
      AND
    - Of all reasonable options for active psychiatric or substance abuse treatment available to the client, this program must be the best choice for expecting reduction in treatment.
      AND
    - For individuals who present with co-occurring mental health and substance use disorder symptoms and diagnoses, the provider must refer to the ASAM Criteria (current edition) Intensive Outpatient Level 2.1.
2. Continued Service Criteria
        - The member 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 member to continue to work toward his or her treatment goals.
          OR
        - The member is not yet making progress, but has the capacity to resolve his or her problems. The member 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 member 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 member's new problems can be addressed effectively.
3. Discharge Criteria
    - The individual has met the treatment plan goals and objectives.
      AND
    - The precipitating condition and relapse potential is stabilized such that individual's condition can be managed without professional external supports and intervention.
      AND
    - Individual is able to remain stable a less intensive level of treatment or support.
      AND
    - Individual has support t systems secure to help them maintain stability
4. Clinical Best Practices
    - Evaluation and Service Planning
        - If indicated, an Initial Diagnostic Assessment (IDI) and a Substance Use Disorder Assessment is completed by a licensed clinician prior to the beginning of treatment.
        - The IDI should be completed for youth exhibiting Eating Disorders or sexually harmful behaviors.
        - The IDI may 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.

- 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.

- Service Delivery
  - Therapies/interventions should include individual, family, and group psychotherapy, educational groups, motivational, enhancement and engagement strategies.
  - Provision of 9 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.
  - 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.
  - Other services could include 24 hours crisis management, family education, self-help group and support group orientation.
  - Therapists of members with more than one mental health/substance use disorder provider must communicate with and document coordinated services with any other mental health/substance provider for the family or individual family members.
  - Monitoring stabilized comorbid medical and psychiatric conditions.
  - Consultation and/or referral for general medical, psychiatric, needs.
- Discharge Planning
  - Length of service is individualized and based on clinical criteria for admission and continuing stay. The frequency and duration varies according to the individual needs of the client and the client's response to the day-to-day treatment intervention.

MULTISYSTEMIC THERAPY

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.

1. Admission Criteria
   - The member is not in imminent or current risk of harm to self, others, and/or property.
     AND
   - The target age of the member is 12-17 years old.
     AND
   - The member exhibits significant externalizing behavior, such as chronic or violent juvenile offenses.
     AND