

YALE UNIVERSITY

Medical Necessity Criteria 2011

Medical Necessity Criteria for Members Enrolled with Yale Health Plan

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Preamble- Principles of Medical Necessity Determinations

Individualized, Needs-Based, Least-Restrictive Treatment

Magellan Behavioral Health* is committed to the philosophy of providing treatment at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment and meet the individual patient's biopsychosocial needs. We see the continuum of care as a fluid treatment pathway, where patients may enter treatment at any level and be moved to more or less-intensive settings or levels of care as their changing clinical needs dictate.^{Q3} At any level of care, such treatment is individualized, active and takes into consideration the patient's stage of readiness to change/readiness to participate in treatment.^{Q1, Q2}

The level of care criteria that follow are guidelines for determining medical necessity for DSM-IV-TR disorders. Individuals may at times seek admission to clinical services for reasons other than medical necessity, e.g., to comply with a court order, to obtain shelter, to deter antisocial behavior, to deter runaway/truant behavior, to achieve family respite, etc. However, these factors do not alone determine a medical necessity decision. Further, coverage for services is subject to the limitations and conditions of the member benefit plan. Specific information in the member's contract and the benefit design for the plan dictate which Medical Necessity Criteria are applicable.

Although these Medical Necessity Criteria are divided into "psychiatric" and "substance-related" sets to address the patient's primary problem requiring each level of care, psychiatric and substance-related disorders are often co-morbid. Thus, it is very important for all treatment facilities and providers to be able to assess these co-morbidities and address them along with the primary problem.^{J4,R7,R15}

Clinical Judgment and Exceptions

The Magellan Behavioral Health Medical Necessity Criteria guide both providers and reviewers to the most appropriate level of care for a patient. While these criteria will assign the safest, most effective and least restrictive level of care in nearly all instances, an infrequent number of cases may fall beyond their definition and scope. Thorough and careful review of each case, including consultation with supervising clinicians, will identify these exceptions. As in the review of non-exceptional cases, clinical judgment consistent with the standards of good medical practice will be used to resolve these exceptional cases.

All medical necessity decisions about proposed admission and/or treatment, other than outpatient, are made by the reviewer after receiving a sufficient description of the current clinical features of the patient's condition that have been gathered from a face-to-face evaluation of the patient by a qualified clinician. Medical necessity decisions about each patient are based on the clinical features of the individual patient relative to the patient's socio-cultural environment, the medical necessity criteria, and the real resources available. We recognize that a full array of services is not available everywhere. When a medically necessary level does not exist (e.g., rural locations), we will support the patient through extra-contractual benefits, or we will authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the patient's essential needs for safe and effective treatment.

*Magellan Behavioral Health, Inc.; Magellan Behavioral Health Systems, LLC, f/k/a Human Affairs International; CMG Health, Inc.; Green Spring Health Services, Inc.; Merit Behavioral Care; Magellan Health Services of Arizona, Inc.; Magellan Health Services of California, Inc.-Employer Services; Human Affairs International of California; Magellan Behavioral Care of Iowa, Inc; Magellan Behavioral Health of Florida, Inc; Magellan Behavioral of Michigan, Inc.; Magellan Behavioral Health of New Jersey, LLC; Magellan Behavioral Health of Pennsylvania, Inc; Magellan Behavioral Health Providers of Texas, Inc.; and their respective affiliates and subsidiaries are affiliates of Magellan Health Services, Inc. (collectively "Magellan").

Medical Necessity Definition

Magellan reviews mental health and substance abuse treatment for medical necessity. Magellan defines medical necessity as:

"Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are:

- a. consistent with:*
 - (1) the diagnosis and treatment of a condition; and*
 - (2) the standards of good medical practice;*
- b. required for other than convenience; and*
- c. the most appropriate supply or level of service.*

When applied to inpatient care, the term means: the needed care can only be safely given on an inpatient basis."

Each criteria set, within each level of care category (see below) is a more detailed elaboration of the above definition for the purposes of establishing medical necessity for these health care services. Each set is characterized by admission and continued stay criteria. The admission criteria are further delineated by severity of need and intensity and quality of service.

Particular rules in each criteria set apply in guiding a provider or reviewer to a medically necessary level of care (please note the possibility and consideration of exceptional patient situations described in the preamble when these rules may not apply). For admission, both the severity of need and the intensity and quality of service criteria must be met. The continued stay of a patient at a particular level of care requires the continued stay criteria to be met (Note: this often requires that the admission criteria are still fulfilled). Specific rules for the admission and continued stay groupings are noted within the criteria sets.

Levels of Care & Service Definitions

Magellan believes that optimal, high-quality care is best delivered when patients receive care that meets their needs in the least-intensive, least-restrictive setting possible. Magellan's philosophy is to endorse care that is safe and effective, and that maximizes the patient's independence in daily activity and functioning.

Magellan has defined seven levels of care as detailed below. These levels of care may be further qualified by the distinct needs of certain populations who frequently require behavioral health services. Children, adolescents, geriatric adults and those with substance use and eating disorders often have special concerns not present in adults with mental health disorders alone. In particular, special issues related to family/support system involvement, physical symptoms, medical conditions and social supports may apply. More specific criteria sets in certain of the level of care definitions address these population issues.

The seven levels of care definitions are:

1. Hospitalization

Hospitalization describes the highest level of skilled psychiatric and substance abuse services provided in a facility. This could be a free-standing psychiatric hospital, a psychiatric unit of general hospital or a detoxification unit in a hospital. Settings that are eligible for this level of care are licensed at the hospital level and provide 24-hour medical and nursing care¹.

This definition also includes crisis beds, hospital-level rehabilitation beds for substance use disorders and 23-hour beds that provide a similar, if not greater, intensity of medical and nursing care*. For crisis and 23-hour programs, the psychiatric hospitalization criteria apply for medical necessity reviews. For hospital-level substance abuse rehabilitation, the Hospitalization, Rehabilitation Treatment, Substance Use Disorder criteria set applies. For subacute hospitalization, the Hospitalization, Subacute criteria set applies.

2. Subacute Hospitalization

The subacute hospital level of care is designed to meet the needs of a patient with mental health problems that require an inpatient setting due to potential for harm to self or to others or potential for harm to self due to an inability to adequately care for his/her personal needs without presenting an imminent threat to himself/herself or to others.

The purpose of subacute care programs is to provide rehabilitation and recovery services and to assist in a patient's return to baseline function and transition back into the community. Subacute care programs serve patients who require less-intensive care than traditional acute hospital care, but more intensive care than residential treatment. Typically, length of stay for subacute is longer than acute hospitalization, but shorter than residential. Twenty-four hour monitoring and supervision by a multidisciplinary behavioral health treatment team provide a safe and effective treatment environment.

Patients in this setting should have adequate impulse control and the ability to cooperate with staff to communicate effectively and accomplish the tasks of daily living with minimal support. Treatment includes daily psychiatric nursing evaluation and intervention, direct services at least three times weekly,

¹ Magellan Medical Necessity criteria do not supersede state or Federal law or regulation concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.

direct services by a psychiatrist (including medication management), psychotherapy and social interventions in a structured therapeutic setting. Psychiatric and medical services are available 24-hours a day, seven days a week in the case of emergencies. When indicated (and especially for children and adolescents), families and/or guardians are involved in the treatment process. Patients are ready for discharge from this level of care when they show good impulse control, medication compliance, effective communication and the ability to accomplish activities of daily living consistent with their developmental capabilities. Subacute is usually provided as a step-down from acute hospitalization.

3. 23-Hour Observation

The main objective of 23-hour observation is to promptly evaluate and stabilize individuals presenting in a crisis situation. This level of care provides up to 23 hours and 59 minutes of observation and crisis stabilization, as needed. Care occurs in a secure and protected environment staffed with appropriate medical and clinical personnel, including psychiatric supervision and 24-hour nursing coverage.

Aspects of care include a comprehensive assessment and the development and delivery of a treatment plan. The treatment plan should emphasize crisis intervention services intended to stabilize and restore the individual to a level of functioning that does not necessitate hospitalization. In addition, 23-hour observation may be used to complete an evaluation to determine diagnostic clarification to establish the appropriate level of care. As soon as the risk level is determined, diagnostic clarity is established, and/or crisis stabilization has been achieved, appropriate referral and linkage to follow-up services will occur.

If clinical history or initial presentation suggested that the individual required a secure and protected inpatient level of care for more than 23 hours and 59 minutes, this level of care would not be appropriate.

4. Residential Treatment

Residential Treatment is defined as a 24-hour level of care that provides persons with long-term or severe mental disorders and persons with substance-related disorders with residential care. This care is medically monitored, with 24-hour medical and nursing services availability. Residential care typically provides less intensive medical monitoring than subacute hospitalization care. Residential care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential care also includes training in the basic skills of living as determined necessary for each patient. Residential treatment for psychiatric conditions and residential rehabilitation treatment for alcohol and substance abuse are included in this level of care. Settings that are eligible for this level of care are licensed at the residential intermediate level or as an intermediate care facility (ICF). Licensure requirements for this level of care may vary by state.

5. Partial Hospitalization

These programs are defined as structured and medically supervised day, evening and/or night treatment programs. Program services are provided to patients at least 4 hours/day and are available at least 3 days/week. The services include medical and nursing², but at less intensity than that provided in a hospital setting. The patient is not considered a resident at the program. The range of services offered is

² Magellan Medical Necessity criteria do not supersede state or Federal law or regulation concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.

designed to address a mental health and/or substance-related disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team.

6. Intensive Outpatient Programs

Intensive outpatient programs are defined as having the capacity for planned, structured, service provision of at least 2 hours per day and 3 days per week, although some patients may need to attend less often. These encounters are usually comprised of coordinated and integrated multidisciplinary services. The range of services offered are designed to address a mental or a substance-related disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured “crisis intervention programs,” “psychiatric or psychosocial rehabilitation,” and some “day treatment.” (Although treatment for substance-related disorders typically includes involvement in a self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here excludes times spent in these self-help programs, which are offered by community volunteers without charge).

7. Outpatient Treatment

Outpatient treatment is typically individual, family and/or group psychotherapy, and consultative services (including nursing home consultation). Times for provision of these service episodes range from fifteen minutes (e.g., medication checks) to fifty minutes (e.g., individual, conjoint, family psychotherapy), and may last up to two hours (e.g., group psychotherapy).

Term Definitions

1. Family:

Individuals identified by **an adult** as part of his/her family or **identified by a legal guardian on behalf of children**. Examples would include parents/step-parents, children, siblings, extended family members, guardians, or other caregivers.

2. Support System:

A network of personal (natural) or professional contacts available to a person for practical, clinical, or moral support when needed. Examples of personal or natural contacts would include friends, church, school, work and neighbors. Professional contacts would include primary care physician, psychiatrist, psychotherapist, treatment programs (such as clubhouse, psychiatric rehabilitation), peer specialists, and community or state agencies.

3. Significant Improvement:

Services provided at any level of care must reasonably be expected to improve the patient's condition in a meaningful and measurable manner. The expectation is that the patient can accomplish the following in the current treatment setting:

- continue to make measurable progress, as demonstrated by a further reduction in psychiatric symptoms, or
- acquire requisite strengths in order to be discharged or move to a less restrictive level of care.

The treatment must, at a minimum, be designed to alleviate or manage the patient's psychiatric symptoms so as to prevent relapse or a move to a more restrictive level of care, while improving or maintaining the patient's level of functioning. "Significant Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require a move to a more restrictive level of care, this criterion would be met.

For most patients, the goal of therapy is restoration to the level of functioning exhibited prior to the onset of the illness. For other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable interpretation of "significant improvement."

Hospitalization, Psychiatric, Adult

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B and one of C, D or E must be met to satisfy the criteria for severity of need.

- A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).
- B. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:
 - 1) a current plan or intent to harm self with an available and lethal means, *or*
 - 2) a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, *or*
 - 3) an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, *or*
 - 4) other similarly clear and reasonable evidence of imminent serious harm to self.
- D. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:
 - 1) a current plan or intent to harm others with an available and lethal means, *or*
 - 2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*
 - 3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*
 - 4) other similarly clear and reasonable evidence of imminent serious harm to others.
- E. The patient's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient's general medical or mental health.^{H1}

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or other support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.^{W2} Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.
- C. If the patient is involved in treatment with another behavioral health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*
 - 4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician.
- B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and ongoing contact with the patient's family and/or other support systems, unless there is an identified, valid reason why it is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.^{H2, H39, H48}

- C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist.
- D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources. H3, H15

Hospitalization, Psychiatric, Child and Adolescent³

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B, and one of C, D or E must be met to satisfy the criteria for severity of need.

- A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).
- B. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:
 - 1) a current plan or intent to harm self with an available and lethal means, *or*
 - 2) a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, *or*
 - 3) an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, *or*
 - 4) other similarly clear and reasonable evidence of imminent serious harm to self.
- D. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:
 - 1) a current plan or intent to harm others with an available and lethal means, *or*
 - 2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*
 - 3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*
 - 4) other similarly clear and reasonable evidence of imminent serious harm to others.

³ Experts generally agree that no one chronological age defines the end of adolescence. Rather, it is determined by considering a number of factors including chronological age, maturity, school and social status, family relationships, and living situation. For purposes of consistency, it is suggested that child and adolescent criteria sets be applied to individuals 17 years of age or younger.

- E. The patient's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient's general medical or mental health.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or other support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions. Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.
- C. The individualized plan of treatment includes plans for at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- D. If the patient is involved in treatment with another behavioral health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
- 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*
 - 4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician.

- B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and intensive family and/or support system's involvement occurring at least once per week, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.^{W3} This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.^{L2}

- C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. The evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist.

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

Hospitalization, Psychiatric, Geriatric⁴

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and B, and one of C, D or E must be met to satisfy the criteria for severity of need.

- A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).
- B. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. The patient demonstrates a clear and reasonable inference of imminent serious harm to self. This is evidenced by having any one of the following:
 - 1) a current plan or intent to harm self with an available and lethal means, *or*
 - 2) a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety, *or*
 - 3) an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, *or*
 - 4) other similarly clear and reasonable evidence of imminent serious harm to self.
- D. The patient demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:
 - 1) a current plan or intent to harm others with an available and lethal means, *or*
 - 2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control and an inability to plan reliably for safety, *or*
 - 3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*
 - 4) other similarly clear and reasonable evidence of imminent serious harm to others.

⁴ These criteria apply to those individuals at or over the age of 65.

- E. The patient's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the patient's general medical or mental health.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Caretakers/guardians/family members should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric and nursing staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, fall precautions, ambulation with assistance, assistance with activities of daily living⁵, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions. Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.
- C. If the patient is involved in treatment with another behavioral health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*

⁵ Activities of daily living (ADLs) defined as those of self-care: feeding oneself, bathing, dressing, grooming

- 4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician.
- B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and ongoing contact with caretakers/guardians/family members, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.
 - C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist.
 - D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post-hospitalization treatment resources.^{G46}

Hospitalization, Eating Disorders⁶

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A and one of criteria B, C, D or E must be met to satisfy the criteria for severity of need.

- A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. The illness can be expected to improve and/or not worsen through medically necessary and appropriate therapy, by accepted medical standards. Patients hospitalized because of another primary psychiatric disorder who have a coexisting eating disorder may be considered for admission to an eating disorders hospital level of care based on severity of need relative to both the eating disorder and the other psychiatric disorder that requires active treatment at this level of care.
- B. One of the following:
- 1) the adult patient has physiologic instability that may include but is not limited to: disturbances in heart rate, blood pressure, glucose, potassium, electrolyte balance, temperature, and hydration; clinically significant compromise in liver, kidney, or cardiovascular function; and/or poorly controlled diabetes.^{E3}
 - 2) the child or adolescent patient has physiologic instability that may include but is not limited to: disturbances in heart rate or blood pressure, including orthostatic blood pressure changes; hypokalemia, hypophosphatemia, or hypomagnesemia.^{E3}
 - 3) while admission to this level of care is primarily based on presence of physiologic instability, generally, patients with a body weight significantly below ideal, e.g., 75% of Ideal Body Weight (IBW) or less, or Body Mass Index (BMI) of 16 or below, will have physiologic instability as described above. However, if body weight is significantly greater than 75% of IBW (or BMI significantly greater than 16), Criterion B can be met if there is evidence of any one of the following:
 - a) weight loss or fluctuation of >15% in one month, *or*
 - b) weight loss associated with physiologic instability unexplained by any other medical condition, *or*
 - c) the patient rapidly approaching a weight at which physiologic instability occurred in the past, *or*

⁶ Because of the severity of co-existing medical disorders, the principal or primary treatment of some eating disorders may be medical/surgical. In these instances, medical/surgical benefits and criteria for appropriateness of care will apply.

- d) a child or adolescent patient having a body weight <85% of IBW during a period of rapid growth.
- C. In anorexia, the patient's malnourished condition requires 24-hour medical/nursing intervention to provide immediate interruption of the food restriction, excessive exercise, purging and/or use of laxatives/diet pills/diuretics^{E13} to avoid imminent, serious harm due to medical consequences *or* to avoid imminent, serious complications to a co-morbid medical condition or psychiatric condition (e.g., severe depression with suicidal ideation).
- D. In patients with bulimia, the patient's condition requires 24-hour medical/nursing intervention to provide immediate interruption of the binge/purge cycle to avoid imminent, serious harm due to medical consequences *or* to avoid imminent, serious complications to a co-morbid medical condition (e.g., pregnancy, uncontrolled diabetes) or psychiatric condition (e.g., severe depression with suicidal ideation).^{E79}
- E. The patient's eating disordered behavior is not responding to an adequate therapeutic trial of treatment in a less-intensive setting (e.g., residential or partial hospital) or there is clinical evidence that the patient is not likely to respond in a less-intensive setting. If in treatment, the patient must:
- 1) be in treatment that, at a minimum, consists of treatment at least once per week with individual therapy, family and/or other support system involvement (unless there is a valid reason why it is not clinically appropriate or feasible), either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated, *and*
 - 2) have physiologic instability and/or significant weight loss (generally, <85% IBW), *and*
 - 3) have significant impairment in social or occupational functioning, *and*
 - 4) be uncooperative with treatment (or cooperative only in a highly structured environment), *and*
 - 5) require changes in the treatment plan that cannot be implemented in a less-intensive setting.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of the eating disorder diagnosis must take place in a face-to-face evaluation of the patient performed by an attending physician prior to, or within 24 hours following the admission. This psychiatric evaluation should also assess for co-morbid psychiatric disorders, and if present, these should be addressed in the treatment plan. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- B. This care must provide an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment including but not limited to medication monitoring and administration, nutritional services, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.^{E13} Admission to a psychiatric unit within a general hospital should be considered when the patient is reasonably

expected to require medical treatment for a co-morbid illness better provided by a full-service general hospital.

- C. If the patient is involved in treatment with another behavioral health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and either E or F must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*
 - 4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician.
- B. The current treatment plan includes documentation of diagnosis (DSM-IV-TR axes I-V), individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and intensive family and/or support system's involvement occurring at least once per week, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospitalization needs.
- C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by the psychiatrist.
- D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources.
- E. The patient's weight remains <85% of IBW and he or she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.
- F. There is evidence of a continued inability to adhere to a meal plan and maintain control over urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required.

Hospitalization, Substance Use Disorders, Detoxification⁷

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B and C must be met to satisfy the criteria for severity of need.

- A. The patient has a recent history of heavy and continuous use of substances that have withdrawal syndromes that can be potentially life threatening or cause serious physical harm, or cause physical withdrawal symptoms that are uncomfortable and disruptive enough to make it highly unlikely that the patient would be able to comply with outpatient treatment. This does not include the patient having mere physical or mental discomfort.
- B. Detoxification at a lesser intensive level of care would potentially be unsafe as evidenced by one of the following:
 - 1) the patient presents with either:
 - a) signs and symptoms of an impending withdrawal syndrome that has the imminent potential to be life threatening or produce serious physical harm *or*
 - b) a history of withdrawal seizures, delirium tremens, or other life threatening complications of withdrawal from substances.
 - or*
 - 2) the patient presents with co-morbid medical conditions that are likely to complicate the management of withdrawal to the degree that the patient's life would be endangered.
- C. Organized support system and/or less-intensive level of care services cannot be established at this time.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician prior to, or within 24 hours following the admission.

⁷ It is recognized that life threatening intoxication/poisoning (i.e. endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention but that attention is generally not considered detoxification. In such cases, general medical/surgical criteria are applied instead of these criteria for detoxification.

- B. This care must provide an individual plan of active medical treatment that includes 24-hour access to the full spectrum of physician and nurse staffing. This staffing must provide 24-hour services, including skilled observation and medication administration.
- C. Documentation of blood and/or urine drug screen is ordered upon admission.
- D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.
- E. Treatment interventions are guided by quantitative measures of withdrawal such as the CIWA-Ar or COWS.
- F. If the patient is involved in treatment with another behavioral health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

- A. Admission criteria continue to be met.
- B. There are physical signs and symptoms of acute withdrawal, and/or risk of signs and symptoms of acute withdrawal have not remitted to an extent that intensive nursing and medical interventions on a 24-hour basis are no longer required.
- C. Documentation of signs and symptoms must be noted at least three times daily, of which one such notation must be made by a physician.
- D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-hospitalization treatment needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent^{D2, D5}

Hospitalization Substance Use Disorders, Rehabilitation Treatment, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for severity of need.

- A. The patient has a substance use disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.
- B. The patient has sufficient cognitive stability to benefit from admission to an inpatient substance rehabilitation treatment program.
- C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.
- D. The patient's need for detoxification treatment is not of a severity to require a hospital level of detoxification care.
- E. One of the following must be met to satisfy this criterion:
 - 1) despite recent (i.e., the past 3 months) appropriate, professional outpatient intervention at a less-intensive level of care, the patient is continually unable to maintain abstinence and recovery, *or*
 - 2) the patient is residing in a severely dysfunctional living environment which would undermine effective outpatient rehabilitation treatment at a less-intense level of care, and alternative living situations are not available or clinically appropriate.
- F. One of the following must be met:
 - 1) due to continued abuse of substance(s), the patient is not able to adequately care for a substance-related, acute, co-morbid medical condition(s) that require(s) medical monitoring or treatment; *or*
 - 2) the patient is in need of substance use disorder rehabilitation treatment and has a substance-related, acute, co-morbid medical condition(s) that currently require(s) a hospital level of care that can be reasonably and safely delivered on a rehabilitation ward setting rather than requiring a medical/surgical ward setting.
- G. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of a DSM-IV-TR substance use disorder diagnosis must result from a face-to-face behavioral health evaluation. There must be the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-morbid medical conditions. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- B. The program must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services to monitor the co-morbid medical condition(s) and any ancillary detoxification needs, to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live substance-free outside of a hospital rehabilitation setting.
- C. An individualized plan of active behavioral health treatment is provided. This plan must include intensive individual, group and family education and therapy in a hospital rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- D. If the patient is involved in treatment with another behavioral health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued inpatient treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the physician at least on a daily basis. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospital treatment needs. This plan will include linkage to outpatient primary care.

- C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- D. There is evidence of at least regular family and/or support system involvement as indicated to promote a successful continuum of less-intense services post discharge, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible.
- E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post-hospitalization treatment resources.

Hospitalization, Substance Use Disorders, Rehabilitation Treatment, Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for severity of need.

- A. The patient has a substance use disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.
- B. The patient has sufficient cognitive stability to benefit from admission to an inpatient substance rehabilitation treatment program.
- C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.
- D. The patient's need for detoxification treatment is not of a severity to require a hospital level of detoxification care.
- E. One of the following must be met to satisfy this criterion:
 - 1) despite recent (i.e., the past 3 months) appropriate, professional intervention at a less-intensive level of care, the patient is continually unable to maintain abstinence and recovery,
or
 - 2) the patient is residing in a severely dysfunctional living environment which would undermine effective rehabilitation treatment at a less-intense level of care, and alternative living situations are not available or clinically appropriate.
- F. One of the following must be met:
 - 1) due to continued abuse of substance(s), the patient is not able to adequately care for a substance-related, acute, co-morbid medical condition(s) that require(s) medical monitoring or treatment; *or*
 - 2) the patient is in need of substance use disorder rehabilitation treatment and has a substance-related, acute, co-morbid medical condition(s) that currently require(s) a hospital level of care that can be reasonably and safely delivered on a rehabilitation ward setting rather than requiring a medical/surgical ward setting.
- G. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of a DSM-IV-TR substance use disorder diagnosis must result from a face-to-face behavioral health evaluation. An appropriate initial medical assessment and ongoing medical management must be available to evaluate and manage co-morbid medical conditions. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- B. The program must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services to monitor the co-morbid medical condition(s), to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live substance-free outside of a hospital rehabilitation setting.
- C. An individualized plan of active behavioral health treatment is provided. This plan must include intensive individual, group and family education and therapy in a hospital rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why it is not clinically appropriate or feasible.
- D. If the patient is involved in treatment with another behavioral health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the substance-related disorder to the degree that would necessitate continued inpatient treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the physician at least on a daily basis. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-hospital treatment needs. This plan will include linkage to outpatient primary care.

- C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- D. There is evidence of regular family and/or support system involvement as indicated to promote a successful continuum of less-intense services post discharge, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible.
- E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-hospitalization treatment resources.

Subacute Hospitalization, Psychiatric, Adult

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

- A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.
- B. Either:
 - 1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*
 - 2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.
- C. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include, but is not limited to, medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a subacute hospital setting.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission.
- B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.

- C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:
- 1) at least weekly family and/or support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*
 - 2) at least three-times-a-week psychiatric reassessments, *and*
 - 3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*
 - 4) evaluation for current medical problems, *and*
 - 5) evaluation for concomitant substance use issues, *and*
 - 6) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.
- D. If the patient is involved in treatment with another behavioral health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
- 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.
- B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can be discharged from this level of care.
- C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

- D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the psychiatrist.
- E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate treatment resources after the subacute hospitalization.

Subacute Hospitalization, Psychiatric, Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

- A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.
- B. Either:
 - 1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*
 - 2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.
- C. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric and nursing staffing. This psychiatric and nursing staffing must provide 24-hour services in a controlled environment that may include, but is not limited to: medication monitoring and administration, fall precautions, ambulation with assistance, assistance with activities of daily living⁸, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a subacute hospital setting.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission.
- B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of

⁸ Activities of daily living (ADLs) defined as those of self-care: feeding oneself, bathing, dressing, grooming

the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.

- C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:
- 1) at least weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*
 - 2) at least three-times-a-week psychiatric reassessments, *and*
 - 3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*
 - 4) evaluation for current medical problems, *and*
 - 5) ongoing medical services to evaluate and manage co-morbid medical conditions, *and*
 - 6) evaluation for concomitant substance use issues, *and*
 - 7) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his or her regular social environment as soon as possible, unless contraindicated.
- D. If the patient is involved in treatment with another behavioral health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
- 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.
- B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can be discharged from this level of care.

- C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.
- D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the psychiatrist.
- E. There is evidence of at least weekly caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate treatment resources after the subacute hospitalization.

Subacute Hospitalization, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

- A. There is clinical evidence that the patient has a DSM-IV-TR disorder that is amenable to active psychiatric treatment and has a high degree of potential for leading to acute psychiatric hospitalization in the absence of subacute hospitalization treatment.
- B. Either:
 - 1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*
 - 2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.
- C. The patient requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include, but is not limited to, medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a subacute hospital setting.

II. Admission - Intensity and Quality of Service

Criteria A, B, C and D must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face psychiatric evaluation performed within 24 hours of admission.
- B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a subacute hospital setting.

- C. An individualized plan of active psychiatric treatment is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. This plan includes:
- 1) at least weekly family and/or other support system involvement, unless there is an identified, valid reason why it is not clinically appropriate or feasible, *and*
 - 2) at least three-times-a-week psychiatric reassessments, *and*
 - 3) psychotropic medications, when used, are to be used with specific target symptoms identified, *and*
 - 4) evaluation for current medical problems, *and*
 - 5) evaluation for concomitant substance use issues, *and*
 - 6) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated.
- D. If the patient is involved in treatment with another behavioral health provider then, with proper patient informed consent, this provider should be notified of the patient's current status to ensure care is coordinated.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D, E and F must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
- 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.
- B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can be discharged from this level of care.
- C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

- D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIIA, and this is documented in at least three-times-a-week progress notes, written and signed by the provider.
- E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate treatment resources after the subacute hospitalization.

23-Hour Observation

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

- A. The patient has a diagnosed or suspected psychiatric and/or substance use disorder. A psychiatric and/or substance use disorder is defined as a disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable Axes (I-V). There may be a lack of a primary definitive DSM-IV-TR diagnosis and/or an incomplete understanding of the patient's clinical needs due to a lack of clinical information or an evolving clinical condition (e.g., intoxication) in which an extended observation period is medically necessary in order to establish a primary, definitive DSM-IV-TR and subsequent treatment plan.
- B. Based on the potential risk to self or others, the patient requires an individual plan of extended observation, acute medical and therapeutic crisis intervention and continuity of care services in a facility setting with medical staffing, psychiatric supervision and continuing nursing evaluation. The 23-hour observation must provide immediate services in a facility setting that may include, but are not limited to, diagnostic clarification, assessment of needs, medication monitoring and administration, individual therapy, family and/or other support system involvement, and suicidal/homicidal observation and precautions as needed.
- C. Although there is evidence of a potential or current mental health or substance abuse emergency based on history or initial clinical presentation, the need for confinement beyond 23-hours with intensive medical and therapeutic intervention is not clearly indicated.
- D. The patient must be medically stable, or there must be appropriate medical services to monitor and treat any active medical condition.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

- A. Acute care nursing, medication management and monitoring are available, and all appropriate drug screens, laboratory studies, and medical testing are considered in accordance with accepted medical practice and clinical practice guidelines.
- B. A comprehensive evaluation administered by a psychiatrist, which includes a biopsychosocial assessment (based on the available information), mental status examination, physical examination, and screening for a history of physical, sexual or emotional abuse, is completed and appropriate treatment and disposition recommendations are developed.

- C. Clinical interventions emphasize crisis intervention, relapse prevention and motivational strategies with the intent to stabilize the patient and enhance motivation for change utilizing medication management, individual therapy and/or family or other support system involvement (the frequency of which will be determined by what the treatment team believes is needed to stabilize and re-evaluate the patient) with focus on proximal events in a brief solution-focused model.
- D. Consultation services are available for general medical, pharmacology and psychological services.
- E. Outpatient treatment providers and/or primary care physicians are consulted during the observation period as clinically indicated (and with the patient's documented consent).
- F. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms that resulted in the admission to a 23-hour observation bed, and this discharge plan begins to identify appropriate treatment resources following discharge. Reasonable attempts are made to coordinate the treatment and affect a timely disposition plan in collaboration with current treatment providers.

Criteria for Continued Stay

None

Criteria for Discharge

Criteria A or B must be met to satisfy criteria for discharge:

- A. The patient meets admission criteria for inpatient hospitalization.
- B. The patient no longer meets admission criteria and can be safely and effectively treated at a less-intensive and restrictive level of care.

Residential Treatment, Substance Use Disorders, Detoxification⁹

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

- A. The patient has a recent history of heavy and continuous use of substances that have withdrawal syndromes that can be potentially life threatening or cause serious physical harm, or cause physical withdrawal symptoms that are uncomfortable and disruptive enough to make it highly unlikely that the patient would be able to comply with outpatient treatment. This does not include the patient having mere physical or mental discomfort.
- B. Detoxification cannot be safely or effectively managed at a less-intensive level of care
- C. Detoxification at an acute inpatient level of care is not required because the patient does not present with:
 - 1) co-morbid medical conditions that are likely to complicate the management of withdrawal to the degree that the patient's life would be endangered, *or*
 - 2) signs and symptoms of an impending withdrawal syndrome that has the imminent potential to be life threatening or produce serious physical harm *or*
 - 3) a history of withdrawal seizures, delirium tremens, or other life threatening complications of withdrawal from substances
- D. Organized support system and/or less-intensive level of care services cannot be established at this time.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician prior to, or within 24 hours following the admission.
- B. This care must provide an individual plan of active medical treatment that includes 24-hour access to the full spectrum of physician and nurse staffing. This staffing must provide 24-hour services, including skilled observation and medication administration.

⁹ It is recognized that life threatening intoxication/poisoning (i.e. endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention but that attention is generally not considered detoxification. In such cases, general medical/surgical criteria are applied instead of these criteria for detoxification.

- C. Documentation of blood and/or urine drug screen is ordered upon admission.
- D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.
- E. Treatment interventions are guided by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, and D must be met to satisfy the criteria for continued stay.

- A. Admission criteria continue to be met.
- B. There are physical signs and symptoms of acute withdrawal, and/or risk of signs and symptoms of acute withdrawal have not remitted to an extent that intensive nursing and medical interventions on a 24-hour basis are no longer required.
- C. Documentation of signs and symptoms must be noted at least three times daily, of which one such notation must be made by a physician.
- D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission. The discharge plan receives regular review and revision that includes ongoing plans for timely access to community-based treatment resources that will meet the patient's post-residential treatment needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent.^{D2, D5}

Residential Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

- A. The patient has a substance-related disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.
- B. The patient has sufficient cognitive stability to benefit from admission to a residential treatment program.
- C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.
- D. One of the following must be met to satisfy criterion D:
 - 1) despite recent (i.e., the past 3 months) appropriate, professional outpatient intervention at a less-intensive level of care, the patient is continually unable to maintain abstinence and recovery, *or*
 - 2) the patient is residing in a severely dysfunctional living environment which would undermine effective rehabilitation treatment at a less-intensive level of care and alternative living situations are not available or clinically appropriate, *or*
 - 3) there is evidence for, or clear and reasonable inference of, serious, imminent physical harm to self or others directly attributable to the continued abuse of substances, which would prohibit treatment in a less-intensive setting.
- E. The patient's condition is appropriate for residential treatment, as there is not a need for detoxification treatment at an inpatient hospital level of care.
- F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face behavioral health evaluation.
- B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a

range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

- C. Additionally, there is sufficient availability of medical and nursing services to manage this patient's ancillary co-morbid medical conditions.
- D. The patient has the capability of developing skills to manage symptoms or make behavioral change, or demonstrates motivation for change as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- E. An individualized plan of active behavioral health treatment and residential living support is provided. This treatment must be medically monitored, with 24-hour medical and nursing services available. This plan must include intensive individual, group and family education and therapy in a residential rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued residential treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the provider at least three times per week. This plan receives regular reviews and revisions that include ongoing plans for timely access to treatment resources that will meet the patient's post-residential treatment needs.
- C. There is evidence of regular caretakers'/guardians'/family members' involvement unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

- E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

Residential Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

- A. The patient has a substance-related disorder as defined by DSM-IV-TR that is amenable to active behavioral health treatment.
- B. The patient has sufficient cognitive stability to benefit from admission to a residential treatment program.
- C. The patient exhibits a pattern of severe substance abuse/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.
- D. One of the following must be met to satisfy criterion D:
 - 1) despite recent (i.e., the past 3 months), appropriate, professional intervention, at a less-intensive level of care the patient is continually unable to maintain abstinence and recovery, *or*
 - 2) the patient is residing in a severely dysfunctional living environment which would undermine effective rehabilitation treatment and alternative living situations are not available or clinically appropriate, *or*
 - 3) there is actual evidence for, or clear and reasonable inference of serious, imminent physical harm to self or others directly attributable to the continued abuse of substances, which would prohibit treatment in an outpatient setting.
- E. The patient's condition is appropriate for residential treatment, as there is not a need for detoxification treatment at an inpatient hospital level of care.
- F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of a DSM-IV-TR diagnosis must result from a face-to-face behavioral health evaluation.

- B. The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.
- C. An individualized plan of active behavioral health treatment and residential living support is provided. This treatment must be medically monitored, with 24-hour medical and nursing services available. This plan must include intensive individual, group and family education and therapy in a residential rehabilitative setting. In addition, the plan must include regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued residential treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problem(s) meeting criterion IIIA, and the patient's progress is documented by the provider at least three times per week. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-residential treatment needs.
- C. The individual plan of active treatment includes regular family and/or support system involvement unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

Partial Hospitalization, Psychiatric, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

- A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).
- B. There is clinical evidence that the patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. In addition, safe and effective treatment cannot be provided in a less-intensive outpatient setting at this time, and a partial hospital program can safely substitute for, or shorten, a hospital stay.
- C. Either:
 - 1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a partial hospitalization program, *or*
 - 2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.
- D. Additionally; either:
 - 1) the patient can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time, *or*
 - 2) the patient is believed to be capable of controlling this behavior and/or seeking professional assistance or other support when not in the partial hospital setting.
- E. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.

- B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours, frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical.
- C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team and should include caretakers'/guardians'/family members' involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible. Telephonic family conferences may be appropriate when distance, travel time, participants' work schedules or other difficulties make face-to-face sessions impractical. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the patient to a lesser level of care.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued partial hospitalization treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.
- C. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

Partial Hospitalization, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

- A. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).
- B. There is clinical evidence that the patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. In addition, safe and effective treatment cannot be provided in a less-intensive outpatient setting at this time, and a partial hospital program can safely substitute for, or shorten, a hospital stay.
- C. Either:
 - 1) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a partial hospitalization program, *or*
 - 2) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.
- D. Additionally, either:
 - 1) the patient can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time, *or*
 - 2) the patient is believed to be capable of controlling this behavior and/or seeking professional assistance or other support when not in the partial hospital setting.
- E. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.^{W6}

- B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours and frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. This also includes plans for at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. A specific treatment goal of this team is improving symptoms and level of functioning enough to return the patient to a lesser level of care.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued partial hospitalization treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.
- C. The individual plan of active treatment includes at least weekly family therapy and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

Partial Hospitalization, Eating Disorders

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, and D must be met to satisfy the criteria for severity of need. Additionally if anorectic, criterion E must also be met to satisfy the criteria for severity of need.

- A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. There is clinical evidence that the patient's condition can be expected to improve and/or not worsen through medically necessary and appropriate therapy. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR codes on all applicable axes (I-V).
- B. The patient can reliably cooperate in a clinically supervised, structured environment for part of the day and has a suitable environment for the rest of the time, *and* the patient is believed to be capable of significantly controlling bingeing, excessive exercising, purging and overuse of laxatives/diet pills/diuretics outside program hours. Additionally, the patient appears reasonably able to seek professional assistance or other support when not in the partial hospital setting.
- C. The patient is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.
- D. The patient's eating disordered behavior is not responding to an adequate therapeutic trial of treatment in a less-intensive setting (e.g., outpatient or intensive outpatient) or there is clinical evidence that the patient is not likely to respond in a less-intensive setting. If in treatment, the patient must:
 - 1) be in treatment that, at a minimum, consists of treatment at least once per week with individual therapy, family and/or other support system involvement (unless there is a valid reason why it is not clinically appropriate or feasible), either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated, *or*
 - 2) be uncooperative with treatment (or cooperative only in a highly structured environment), *or*
 - 3) require changes in the treatment plan that cannot be implemented in a less-intensive setting.
- E. The patient has anorexia; he or she is between 75-85 percent of his or her ideal body weight (IBW) and clinical evidence indicates the patient requires a structured program—including medical monitoring and nursing supervision during and between two meals per day to gain weight and/or control eating disorder behaviors—that cannot be provided in a less-intensive outpatient setting.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.
- B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours, frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. This plan also includes plans for at least weekly family and/or support system involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).
- C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. If the patient has anorexia, a specific treatment goal of this team is to help the patient gain weight and develop the capability to continue this weight gain upon returning to a less-intensive level of care. If the patient has bulimia, the goal is to help the patient develop internal controls to limit bingeing and purging to a degree sufficient to allow the patient to transition to a less-intensive level of care.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the eating disorder to the degree that would necessitate continued partial hospitalization treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the physician. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.
- C. There is evidence of at least weekly family and/or support system therapeutic involvement (unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible).
- D. A discharge plan is formulated that is directly linked to the eating disorder behaviors that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

Partial Hospitalization, Substance Use Disorders, Rehabilitation Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

- A. The provider is able to document that the patient has a history of a substance-related disorder meeting DSM-IV-TR criteria and is cognitively stable enough to benefit from admission to a partial hospitalization program.
- B. The patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. Additionally, the patient requires more intensive multidisciplinary evaluation, treatment and support than can be provided in a traditional outpatient visit setting or an intensive outpatient program.
- C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.^{E11}
- D. The patient is able to seek professional and/or social supports outside of program hours as needed.
- E. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.
- B. There is a structured program with evaluation by a psychiatrist within 48 hours, frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. Additionally, there is sufficient availability of medical and/or nursing services to manage this patient's ancillary detoxification needs.
- C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. Caretakers/guardians/family members should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

Telephonic family conferences may be appropriate when distance, travel time, participants work schedule or other difficulties make face-to-face sessions impractical. A specific treatment goal of this team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to a less-intensive level of care.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued partial hospitalization treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.
- C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- D. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

Partial Hospitalization, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

- A. The provider is able to document that the patient has a history of a substance-related disorder meeting DSM-IV-TR criteria and is mentally competent and cognitively stable enough to benefit from admission to a partial hospitalization program.
- B. The patient's condition requires a structured program with frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. Additionally, the patient requires more intensive multidisciplinary evaluation, treatment and support than can be provided in a traditional outpatient visit setting or an intensive outpatient program.
- C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.
- D. The patient is able to seek professional and/or social supports outside of program hours as needed.
- E. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. In order for a partial hospital program to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.
- B. The individualized plan of treatment includes a structured program with evaluation by a psychiatrist within 48 hours and frequent nursing and/or medical supervision, active treatment each program day, and no less than 3 times weekly nursing or medical assessment, one of which must be medical. This also includes plans for regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- C. The individualized plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. Family and/or support systems should be included in the evaluation

process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. A specific treatment goal of this team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to a less-intensive level of care.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued partial hospitalization treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day of partial hospitalization, written and signed by the provider. This treatment plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-partial hospitalization needs.
- C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- D. The individual plan of active treatment includes regular family and/or support system involvement as clinically indicated and commensurate with the intensity of service, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.
- E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-partial hospitalization treatment resources.

Intensive Outpatient Treatment, Psychiatric, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment. The patient's disorder can be expected to improve significantly through medically necessary and appropriate therapy. The individual is behaviorally and cognitively stable, to benefit from admission to an intensive outpatient program.
- B. The impairment results in at least one of the following:
 - 1) a clear, current threat to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*
 - 2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*
 - 3) an emerging/impending risk to the safety or property of the patient or of others.
- C. Either:
 - 1) for patients with persistent or recurrent disorders, the patient's past history indicates that when the patient has experienced similar clinical circumstances, less-intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others, *or*
 - 2) for patients with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others.
- D. The patient requires an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services, and is capable of seeking professional support and/or support from caretakers/guardians/family members outside of program hours as needed.
- E. The patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social support and/or support from caretakers/guardians/family members must be identified and available to the patient outside of program hours.
- B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.
- C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.

Criteria for Continued Stay

III. Continued Stay

Criteria A and B must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

Intensive Outpatient Treatment, Psychiatric, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment. The patient's disorder can be expected to improve significantly through medically necessary and appropriate therapy. The individual is sufficiently competent, and behaviorally and cognitively stable, to benefit from admission to an intensive outpatient program.
- B. The impairment results in at least one of the following:
 - 1) a clear, current threat to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*
 - 2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*
 - 3) an emerging/impending risk to the safety or property of the patient or of others.
- C. Either:
 - 1) for patients with persistent or recurrent disorders, the patient's past history indicates that when the patient has experienced similar clinical circumstances, less-intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the patient or others, *or*
 - 2) for patients with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient or others.
- D. The patient requires an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services and is capable of seeking professional and/or social supports outside program hours as needed.
- E. The patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.
- B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.
- C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. Family and/or support systems should be included in the evaluation process, unless there is an identified, valid reason why it is not clinically appropriate or feasible. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.
- C. The individual plan of active treatment includes at least weekly family and/or support system involvement in therapy, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Intensive Outpatient Treatment, Eating Disorders

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need. Additionally if anorectic, criterion G must be met to satisfy the criteria for severity of need.

- A. The patient has a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. There is clinical evidence that the patient's condition can be expected to improve through medically necessary and appropriate therapy. The individual is sufficiently competent, and behaviorally and cognitively stable, to benefit from admission to an intensive outpatient program.
- B. The impairment from the eating disorder results in at least one of the following, which requires a more intensive and structured level of care than outpatient:
 - 1) a clear, current threat to the patient's ability to live in his/her customary setting for a patient who, without that setting and the supports of that setting, would then meet the criteria for a higher level of care, e.g., inpatient or supervised residential care, *and/or*
 - 2) a clear, current threat to the patient's ability to be employed or attend school, *and/or*
 - 3) an emerging/impending risk to the safety or property of the patient or of others.
- C. Either of the following:
 - 1) for patients with a persistent or recurrent eating disorder, the past history indicates that when the patient has experienced similar clinical circumstances, less-intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing threats to the patient's medical stability, *or*
 - 2) for patients with an acute eating disorder crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less-intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the eating disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the patient.
- D. The patient requires an integrated program of dietary counseling, rehabilitation counseling, education, therapeutic, and/or family/support system services and is capable of seeking professional and/or social supports outside program hours as needed.
- E. The patient can reliably cooperate in a clinically supervised, structured environment for part of the day and has a suitable environment for the rest of the time, *and* the patient appears able to seek professional assistance or other support when not in the intensive outpatient setting.

- F. The patient is medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.
- G. If the patient has anorexia and there is clinical evidence that without the structure of an intensive outpatient program, there is a clear current threat to the patient's ability to maintain weight >80% of IBW and a consequent threat to the patient's current medical physiologic stability.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.
- B. The individualized plan of treatment includes an integrated program of dietary and exercise counseling, rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.
- C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff within a structured program of treatment. One specific treatment goal of this team is helping the patient internalize better control of urges to restrict food, exercise excessively, binge, purge and/or overuse laxatives/diet pills/diuretics. If anorectic, a related goal is further solidifying the stability of weight gain and/or maintenance sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), e.g., continued instability in food intake despite weight gain, *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.

- C. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Adult and Geriatric

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis(es) of a substance-related disorder meeting DSM-IV-TR criteria, and is sufficiently cognitively stable to benefit from admission to an intensive outpatient program.
- B. The patient requires more intensive treatment and support than can be provided in a traditional outpatient visit setting, i.e., an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. The patient's condition reflects a pattern of severe substance use as evidenced by periods of inability to maintain abstinence over a consistent period of time.
- C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.
- D. The patient is able to seek professional supports and/or support from caretakers/guardians/family members outside of program hours as needed.
- E. For patients with a history of repeated relapses and a treatment history involving multiple treatment attempts in intensive outpatient or partial hospital programs, there must be documentation of the restorative potential for the proposed program admission.
- F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission - Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional support and/or support from caretakers/guardians/family members must be identified and available to the patient outside of program hours.
- B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. Additionally, there is the provision of or coordination with medical and/or nursing services sufficient to manage this patient's ancillary co-morbid medical conditions.

- C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.^{L5}

Criteria for Continued Stay

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued intensive outpatient treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.
- C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.

Intensive Outpatient Treatment, Substance Use Disorders, Rehabilitation, Child and Adolescent

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis(es) of substance-related disorder meeting DSM-IV-TR criteria, and is sufficiently mentally competent and cognitively stable to benefit from admission to an intensive outpatient program.
- B. The patient requires more intensive treatment and support than can be provided in a traditional outpatient visit setting, i.e., an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day. The patient's condition reflects a pattern of severe substance use as evidenced by periods of inability to maintain abstinence over a consistent period of time.
- C. The patient's detoxification needs are not of a severity that requires an inpatient hospital level of care.
- D. The patient is able to seek professional and/or social supports outside of program hours as needed.
- E. For patients with a history of repeated relapses and a treatment history involving multiple treatment attempts in intensive outpatient or partial hospital programs, there must be documentation of the restorative potential for the proposed program admission.
- F. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Admission- Intensity and Quality of Service

Criteria A, B and C must be met to satisfy the criteria for intensity and quality of service.

- A. In order for intensive outpatient services to be safe and therapeutic for an individual patient, professional and/or social supports must be identified and available to the patient outside of program hours.
- B. The individualized plan of treatment includes an integrated program of rehabilitation counseling, education, therapeutic, and/or family/support system services for at least 2 hours per scheduled day.

- C. The individual treatment plan for intensive outpatient requires that the services are provided by a multidisciplinary team of professional and supervised support staff. A specific treatment goal of the treatment team is reduction in severity of symptoms and improvement in level of functioning sufficient to return the patient to outpatient treatment follow-up and/or self-help support groups.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

- A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:
 - 1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*
 - 3) that disposition planning and/or attempts at therapeutic re-entry into a less-intensive level of care have resulted in, or would result in exacerbation of the substance-related disorder to the degree that would necessitate continued intensive outpatient treatment.
- B. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the presenting or newly defined problem(s) meeting criterion IIIA, and this is documented by progress notes for each day the patient attends the intensive outpatient program, written and signed by the provider.
- C. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- D. The individual plan of active treatment includes at least weekly family/support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

Ambulatory, Substance Use Disorders, Detoxification¹⁰

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

Criteria A, B and C must be met to satisfy the criteria for severity of need.

- A. The patient has a recent history and pattern of continuous use of substances that have withdrawal syndromes and require medically supervised outpatient treatment to prevent complications. Withdrawal symptoms are such that do they not require 24-hour access to physician and/or nurse monitoring, nor a history of medically complicated withdrawal in the past
- B. Presence of mild to moderate withdrawal symptoms may be safely managed outside a residential or inpatient setting as evidenced by:
 - 1) an absence of a withdrawal history of delirium tremens, seizures, or other life-threatening reactions to long-term substance use, *and*
 - 2) an absence of complicating psychiatric or medical illness that would require 24-hour inpatient or residential treatment, *and*
 - 3) a CIWA-Ar score in the mild to moderate range or the equivalent on a standardized scale for assessment of withdrawal symptoms, *and*
 - 4) family and/or social support is available to assist the patient during detoxification.
- C. The patient has expressed a desire to enter or continue rehabilitation treatment or self-help recovery.

II. Admission - Intensity and Quality of Service

Criteria A, B, C, D and E must be met to satisfy the criteria for intensity and quality of service.

- A. The evaluation and assignment of the diagnosis must take place in a face-to-face evaluation of the patient performed and documented by an attending physician.
- B. This care must provide an individual plan of active medical treatment. Adequate arrangements should be made for treatment of withdrawal symptoms during the times when the treating physician is not available.

¹⁰ It is recognized that life threatening intoxication/poisoning (i.e. endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention but that attention is generally not considered detoxification. In such cases, general medical/surgical criteria are applied instead of these criteria for detoxification.

- C. Documentation of blood and/or urine drug screen is ordered upon commencement of treatment.
- D. Treatment includes an individualized treatment plan based on an evaluation of both mental health and substance abuse conditions and includes aftercare needs.
- E. Treatment interventions are guided by quantitative measures of withdrawal such as the CIWA-Ar or COWS.

Criteria for Continued Stay

III. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

- A. Admission criteria continue to be met.
- B. The patient's condition does not require a higher level of care.
- C. Documentation of signs, symptoms and improvement in withdrawal symptoms are noted, and the treatment plan is re-evaluated and modified as medically appropriate.
- D. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.
- E. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in treatment. The discharge plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the patient's post-detoxification needs. This plan includes attempts to link to outpatient primary care after obtaining patient consent.^{D2, D5}

Outpatient Treatment, Psychiatric and Substance Use Disorders, Rehabilitation

Criteria for Treatment Status Review

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for the treatment review.

I. Severity of Need

Criteria A, B, C, D and E must be met to satisfy the criteria for severity of need.

- A. The patient has, or is being evaluated for, a DSM-IV-TR diagnosis on Axis I and/or Axis II.
- B. The presenting behavioral, psychological, and/or biological dysfunctions and functional impairment (occupational, academic, social) are consistent and associated with the DSM-IV-TR psychiatric/substance-related disorder(s) on Axis I and/or Axis II.
- C. One of the following:
 - 1) the patient has at least mild symptomatic distress and demonstrates impaired functioning due to psychiatric symptoms and/or behavior in at least one of the three spheres of functioning (occupational, scholastic, or social), that are the direct result of an Axis I or Axis II disorder. This is evidenced by specific clinical description of the symptom(s) and specific measurable behavioral impairment(s) in occupational, academic or social areas consistent with a GAF (DSM-IV-TR Axis V) score of less than 71, *or*
 - 2) the patient has a persistent illness described in DSM-IV-TR with a history of repeated admissions to 24-hour treatment programs for which maintenance treatment is required to maintain community tenure, *or*
 - 3) there is clinical evidence that additional treatment sessions are required to support termination of therapy, although the patient no longer has at least mild symptomatic distress or impairment in functioning. The factors considered in making a determination about the continued medical necessity of treatment in this termination phase are the frequency and severity of previous relapse, level of current stressors, and other relevant clinical indicators. Additionally, the treatment plan should include clear goals needing to be achieved and methods to achieve them in order to support successful termination (such as increasing time between appointments, use of community resources, and supporting personal success).
- D. The patient does not require a higher level of care.
- E. The patient appears to be motivated and capable of developing skills to manage symptoms or make behavioral change.

II. Intensity and Quality of Service

Criteria A, B, C, D, E, F, G, H, I and J must be met to satisfy the criteria for intensity and quality of service.

- A. There is documentation of a DSM-IV-TR diagnosis on Axis I and/or Axis II, and there are completed assessments on Axes III, IV, and V. The assessment also includes the precipitating event/presenting issues, specific symptoms and functional impairments, community and natural resources, personal strengths, and the focus of treatment.
- B. There is a medically necessary and appropriate treatment plan, or its update, specific to the patient's behavioral, psychological, and/or biological dysfunctions associated with the DSM-IV-TR psychiatric/substance-related disorder(s) on Axis I and/or Axis II. The treatment plan is expected to be effective in reducing the patient's occupational, academic or social functional impairments and:
 - 1) alleviating the patient's distress and/or dysfunction in a timely manner, *or*
 - 2) achieving appropriate maintenance goals for a persistent illness, *or*
 - 3) supporting termination.
- C. The treatment plan must identify all of the following:
 - 1) treatment modality, treatment frequency and estimated duration;
 - 2) specific interventions that address the patient's presenting symptoms and issues;
 - 3) coordination of care with other health care services, e.g., PCP or other behavioral health practitioners;
 - 4) the status of active involvement and/or ongoing contact with patient's family and/or support system, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible;
 - 5) the status of inclusion and coordination, whenever possible, with appropriate community resources;
 - 6) consideration/referral/utilization of psychopharmacological interventions for diagnoses that are known to be responsive to medication;
 - 7) documentation of objective progress toward goals for occupational, academic or social functional impairments, target-specific behavioral, psychological, and/or biological dysfunctions associated with the DSM-IV-TR psychiatric/substance-related disorder(s) being treated. Additionally, specific measurable interim treatment goals and specific measurable end of treatment goals, or specific measurable maintenance treatment goals (if this is maintenance treatment), are identified. Appropriate changes in the treatment plan are made to address any difficulties in making measurable progress;
 - 8) the description of an alternative plan to be implemented if the patient does not make substantial progress toward the given goals in a specified period of time. Examples of an alternative plan are psychiatric evaluation if not yet obtained, a second opinion, or introduction of adjunctive or different therapies; and

- 9) the current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting Severity of Need Criteria (I above). This evolving clinical status is documented by written contact progress notes.
- D. The patient has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
- E. Patient is adhering to treatment recommendations, or non-adherence is addressed with the patient, and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.
- F. Although the patient has not yet obtained the treatment goals, progress as relevant to presenting symptoms and functional impairment is clearly evident and is documented in objective terms.
- G. Treatment is effective as evidenced by improvement in GAF, SF-BH, CHI, and/or other valid outcome measures.
- H. Requested services do not duplicate other provided services.
- I. Visits for this treatment modality are recommended to be no greater than one session per week, except for: (i) acute crisis stabilization, or (ii) situations where the treating provider demonstrates more than one visit per week is medically necessary.
- J. As the patient exhibits sustained improvement or stabilization of a persistent illness, frequency of visits should be decreased over time (e.g., once every two weeks or once per month) to reinforce and encourage self-efficacy, autonomy, and reliance on community and natural supports.

Outpatient Electroconvulsive Treatment

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT).

I. Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the patient has a DSM-IV-TR Axis I diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.^{DD1}
- B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor.
- C. One of the following:
 - 1) the patient has a history of inadequate response to multiple adequate trials of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*
 - 2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*
 - 3) the patient has a history of good response to ECT during an earlier episode of the illness, *or*
 - 4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.
- D. The patient's status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.
- E. All:
 - 1) the patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *and*

- 2) the patient has access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course, *and*
 - 3) the patient can be reasonably expected to comply with post-procedure recommendations that maintain the health and safety of the patient and others, e.g., prohibition from driving or operating machinery, complying with dietary, bladder, bowel, and medication instructions, and reporting adverse effects and/or negative changes in medical condition between treatments.
- F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for intensity and quality of service.

- A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:
- 1) psychiatric history, including past response to ECT, mental status and current functioning; *and*
 - 2) 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; *and*
- B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:
- 1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*
 - 2) required modifications in medications or standard anesthetic technique, if any.
- C. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions, that addresses:
- 1) specific medications to be administered during ECT, *and*
 - 2) choice of electrode placement during ECT, *and*
 - 3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
- D. There is continuous physiologic monitoring during ECT treatment, addressing:
- 1) seizure duration, including missed, brief, and/or prolonged seizures, *and*
 - 2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*

- 3) electrocardiographic activity, *and*
 - 4) vital signs, *and*
 - 5) oximetry, *and*
 - 6) other monitoring specific to the needs of the patient.
- E. There is monitoring for and management of adverse effects during the procedure, including:
- 1) cardiovascular effects, *and*
 - 2) prolonged seizures, *and*
 - 3) respiratory effects, including prolonged apnea, *and*
 - 4) headache, muscle soreness, and nausea.
- F. There are post-ECT stabilization and recovery services, including:
- 1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*
 - 2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.
- G. The patient is released in the care of a responsible adult who can monitor and provide supportive care and who is informed in writing of post-procedure behavioral limitations, signs of potentially adverse effects of treatment or deterioration in health or psychiatric status, and post-procedure recommendations for diet, medications, etc.

Criteria for Continued Treatment

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued treatment.

- A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
- 1) the persistence of problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I; *or*
 - 2) the emergence of additional problems that meet the outpatient electroconvulsive treatment Severity of Need criteria as outlined in I; *or*
 - 3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status.

- B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.
- C. The treatment plan meets the Intensity and Quality of Service Criteria (II above).

Inpatient Electroconvulsive Treatment

Criteria for Authorization

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for inpatient electroconvulsive therapy (ECT).

I. Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the patient has a DSM-IV-TR Axis I diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, major depression, bipolar disorder, mood disorder with psychotic features, catatonia, schizoaffective disorder, schizophrenia, acute mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions and medical disorders.^{DD1}
- B. The type and severity of the behavioral health symptoms are such that a rapid response is required, including, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor.
- C. One of the following:
 - 1) the patient has a history of inadequate response to multiple adequate trials of medications and/or combination treatments, including polypharmacy when indicated, for the diagnosis(es) and condition(s); *or*
 - 2) the patient is unable or unwilling to comply with or tolerate side effects of available medications, or has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; *or*
 - 3) the patient has a history of good response to ECT during an earlier episode of the illness, *or*
 - 4) the patient is pregnant and has severe mania or depression, and the risks of providing no treatment outweigh the risks of providing ECT.
- D. The patient's status and/or co-morbid medical conditions do not rule out ECT; for example; unstable or severe cardiovascular disease, aneurysm or vascular malformation, severe hypertension, increased intracranial pressure, cerebral infarction, cerebral lesions, pulmonary insufficiency, musculoskeletal injuries or abnormalities (e.g., spinal injury), severe osteoporosis, glaucoma, retinal detachment, and/or medical status rated as severe.
- E. All:

- 1) the patient is medically stable and requires the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care, *or*
 - 2) the patient does not have access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course.
- F. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E and F must be met to satisfy the criteria for intensity and quality of service.

- A. There is documentation of a clinical evaluation performed by a physician who is credentialed to provide ECT, to include:
- 1) psychiatric history, including past response to ECT, mental status and current functioning; *and*
 - 2) 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.
- B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:
- 1) the patient's response to prior anesthetic inductions and any current anesthesia complications or risks, *and*
 - 2) required modifications in medications or standard anesthetic technique, if any.
- C. There is documentation in the medical record specific to the patient's psychiatric and/or medical conditions, that addresses:
- 1) specific medications to be administered during ECT, *and*
 - 2) choice of electrode placement during ECT, *and*
 - 3) stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
- D. There is continuous physiologic monitoring during ECT treatment, addressing:
- 1) seizure duration, including missed, brief and/or prolonged seizures, *and*
 - 2) duration of observed peripheral motor activity and/or electroencephalographic activity, *and*
 - 3) electrocardiographic activity, *and*

- 4) vital signs, *and*
 - 5) oximetry, *and*
 - 6) other monitoring specific to the needs of the patient.
- E. There is monitoring for and management of adverse effects during the procedure, including:
- 1) cardiovascular effects, *and*
 - 2) prolonged seizures, *and*
 - 3) respiratory effects, including prolonged apnea, *and*
 - 4) headache, muscle soreness and nausea.
- F. There are post-ECT stabilization and recovery services, including:
- 1) medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, *and*
 - 2) recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.

Criteria for Continued Treatment

III. Continued Stay

Criteria A, B and C must be met to satisfy the criteria for continued treatment.

- A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
- 1) the persistence of problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; *or*
 - 2) the emergence of additional problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; *or*
 - 3) that attempts to discharge to a less-intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status.
- B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.
- C. The treatment plan meets the Intensity and Quality of Service Criteria (II above).

Bibliography¹¹

A. Child & Adolescent Issues, General

1. Akoff, H., Vitiello, B., Riddle, M., Cunningham, C., Greenhill, L., Swanson, J., et al. (2007). Methylphenidate effects on functional outcomes in the Preschoolers with Attention-Deficit/Hyperactivity Disorder Treatment Study (PATs). *Journal Of Child And Adolescent Psychopharmacology*, 17(5), 581-592.
2. Asarnow JR, Jaycox LH, Tang L, Duan N, LaBorde AP, Zeledon LR, Anderson M, Murray PJ, Landon C, Rea MM, Wells KB. (2009). Long-term benefits of short-term quality improvement interventions for depressed youths in primary care. *Am J Psychiatry*. 2009 Sep;166(9):1002-10
3. Baroni, A.; Lunsford, JR.; Luckenbaugh, DA.; Towbin, KE; Leibenluft, E. (2009). Practitioner Review: The assessment of bipolar disorder in children and adolescents. *Journal of Child Psychology & Psychiatry*; Mar2009, Vol. 50 Issue 3, p203-215
4. Davis LL, Wisniewski SR, Howland RH, Trivedi MH, Husain MM, Fava M, McGrath PJ, Balasubramani GK, Warden D, Rush AJ. (2010). Does comorbid substance use disorder impair recovery from major depression with SSRI treatment? An analysis of the STAR*D level one treatment outcomes. *Drug Alcohol Depend*. 2010 Mar 1; 107(2-3):161-70.
5. Furnier, M., & Levy, S. (2006). Recent trends in adolescent substance use, primary care screening, and updates in treatment options. *Current Opinion In Pediatrics*, 18(4), 352-358.
6. Garrison, D., & Daigler, G. (2006). Treatment settings for adolescent psychiatric conditions. *Adolescent Medicine Clinics*, 17(1), 233-250.
7. Ghuman, J., Riddle, M., Vitiello, B., Greenhill, L., Chuang, S., Wigal, S., et al. (2007). Comorbidity moderates response to methylphenidate in the Preschoolers with Attention-Deficit/Hyperactivity Disorder Treatment Study (PATs). *Journal Of Child And Adolescent Psychopharmacology*, 17(5), 563-580.
8. Gray, K., Upadhyaya, H., Deas, D., & Brady, K. (2006). Advances in diagnosis of adolescent substance abuse. *Adolescent Medicine Clinics*, 17(2), 411-425.
9. Hoagwood, K. (2005). Family-based services in children's mental health: a research review and synthesis. *Journal Of Child Psychology And Psychiatry, And Allied Disciplines*, 46(7), 690-713.
10. Matson JL; Wilkins J; Fodstad JC. (2010) Children with autism spectrum disorders: a comparison of those who regress vs. those who do not. *Developmental Neurorehabilitation [Dev Neurorehabil]* 2010 Oct; Vol. 13 (1), pp. 37-45.
11. Mensinger, JL; Diamond, GS; Kaminer, Y; Wintersteen, MB. (2006). Adolescent and Therapist Perception of Barriers to Outpatient Substance Abuse Treatment. *American Journal on Addictions*; Dec2006 Supplement, Vol. 15, p16-25
12. Posner, K., Melvin, G., Murray, D., Gugga, S., Fisher, P., Skrobala, A., et al. (2007). Clinical presentation of attention-deficit/hyperactivity disorder in preschool children: the Preschoolers

¹¹ This is a selected bibliography from all the literature reviewed.

- with Attention-Deficit/Hyperactivity Disorder Treatment Study (PATs). *Journal Of Child And Adolescent Psychopharmacology*, 17(5), 547-562.
13. Steiner, H. (1997). Practice parameters for the assessment and treatment of children and adolescents with conduct disorder. American Academy of Child and Adolescent Psychiatry. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 36(10 Suppl), 122S-139S.
 14. Josephson, A. (2007). Practice parameter for the assessment of the family. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 46(7), 922-937.
 15. Winters, N., & Pumariga, A. (2007). Practice parameter on child and adolescent mental health care in community systems of care. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 46(2), 284-299.
 16. Vitiello, B., Abikoff, H., Chuang, S., Kollins, S., McCracken, J., Riddle, M., et al. (2007). Effectiveness of methylphenidate in the 10-month continuation phase of the Preschoolers with Attention-Deficit/Hyperactivity Disorder Treatment Study (PATs). *Journal Of Child And Adolescent Psychopharmacology*, 17(5), 593-604.

B. Consultation-Liaison Psychiatry

1. Antonowicz, J. (1998). Missed diagnoses in consultation liaison psychiatry. *The Psychiatric Clinics Of North America*, 21(3), 705-14.
2. Caughman, B., & Dickens, J. (1993). Diagnostic dilemmas in psychiatric consultation/liaison: the problem of depression. *Southern Medical Journal*, 86(7), 757.
3. Collins, D., Dimsdale, J., & Wilkins, D. (1992). Consultation/liaison psychiatry utilization patterns in different cultural groups. *Psychosomatic Medicine*, 54(2), 240-245.
4. Cremens, M., Calabrese, L., Shuster, J., & Stern, T. (1995). The Massachusetts General Hospital annotated bibliography. For residents training in consultation-liaison psychiatry. *Psychosomatics*, 36(3), 217-235.
5. Klein, D., Saravay, S., & Pollack, S. (1996). The attitudes of medical inpatients toward psychiatric consultation: a re-examination. *International Journal Of Psychiatry In Medicine*, 26(3), 287-293.
6. Knapp, P., & Harris, E. (1998). Consultation-liaison in child psychiatry: a review of the past 10 years. Part I: Clinical findings. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 37(1), 17-25.
7. Knapp, P., & Harris, E. (1998). Consultation-liaison in child psychiatry: a review of the past 10 years. Part II: Research on treatment approaches and outcomes. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 37(2), 139-146.
8. Lederberg, M. (1997). Making a situational diagnosis. Psychiatrists at the interface of psychiatry and ethics in the consultation-liaison setting. *Psychosomatics*, 38(4), 327-338.
9. Lipowski, Z. (1992). Consultation-liaison psychiatry at century's end. *Psychosomatics*, 33(2), 128-133.
10. McKegney, F., Schwartz, B., & O'Dowd, M. (1992). Reducing unnecessary psychiatric consultations for informed consent by liaison with administration. *General Hospital Psychiatry*, 14(1), 15-19.
11. Muskin, P., Kunkel, E., Worley, L., McCarty, T., Bagiella, E., Wallack, J., et al. (1997). The multisite field trial of the consultation-liaison psychiatry assessment instrument. *General Hospital Psychiatry*, 19(1), 16-23.

12. Norwood, S. (1998). Psychiatric consultation-liaison nursing: revisiting the role. *Clinical Nurse Specialist CNS*, 12(4), 153-156.
13. Ormont, M., Weisman, H., Heller, S., Najara, J., & Shindlecker, R. (1997). The timing of psychiatric consultation requests. Utilization, liaison, and diagnostic considerations. *Psychosomatics*, 38(1), 38-44.
14. Pajarillo, E., Sers, A., Ryan, R., Headley, B., & Nalven, C. (1997). Consultation-liaison psychiatric nursing in long-term care. *Journal Of Psychosocial Nursing And Mental Health Services*, 35(8), 24-30.
15. Powell, T. (1997). Consultation-liaison psychiatry and clinical ethics. Representative cases. *Psychosomatics*, 38(4), 321-326.
16. Ramchandani, D., Lamdan, R., O'Dowd, M., Boland, R., Hails, K., Ball, S., et al. (1997). What, why, and how of consultation-liaison psychiatry. An analysis of the consultation process in the 1990s at five urban teaching hospitals. *Psychosomatics*, 38(4), 349-355.
17. Stoudemire, A., Bronheim, H., & Wise, T. (1998). Why guidelines for consultation-liaison psychiatry? *Psychosomatics*, 39(4), S3-S7.
18. Subramaniam GA; Lewis LL; Stitzer ML; Fishman MJ. (2004). Depressive symptoms in adolescents during residential treatment for substance use disorders. *The American Journal On Addictions / American Academy Of Psychiatrists In Alcoholism And Addictions [Am J Addict]* 2004 May-Jun; Vol. 13 (3), pp. 256-67.
19. Swenson, J., Abbey, S., & Stewart, D. (1993). Consultation-liaison psychiatry as a subspecialty. A Canadian survey. *General Hospital Psychiatry*, 15(6), 386-391.
20. Swigar, M., Sanguinetti, V., & Piscatelli, R. (1992). A retrospective study on the perceived need for and actual use of psychiatric consultations in older medical patients. *International Journal Of Psychiatry In Medicine*, 22(3), 239-249.
21. Templeton, B., & Selarnick, H. (1994). Evaluating consultation psychiatry residents. *General Hospital Psychiatry*, 16(5), 326-334.
22. Viinamäki, H., Tienari, P., Niskanen, L., Niskanen, M., Leppävuori, A., Hiltunen, P., et al. (1998). Factors predictive of referral to psychiatric hospital among general hospital psychiatric consultations. *Acta Psychiatrica Scandinavica*, 97(1), 47-54.
23. Worley, L., Kunkel, E., & Hilty, D. (1998). How C-L services can comply with new HCFA guidelines. *General Hospital Psychiatry*, 20(3), 160-169.
24. Youngner, S. (1997). Consultation-liaison psychiatry and clinical ethics. Historical parallels and diversions. *Psychosomatics*, 38(4), 309-312.
25. Zigun, J. (1990). The Psychiatric Consultation Checklist: a structured form to improve the clarity of psychiatric consultation requests. *General Hospital Psychiatry*, 12(1), 36-44.

C. Crisis Services

1. Ash, D., & Galletly, C. (1997). Crisis beds: the interface between the hospital and the community. *The International Journal Of Social Psychiatry*, 43(3), 193-198.
2. Ashcraft L; Anthony W. (2008). Eliminating seclusion and restraint in recovery-oriented crisis services. *Psychiatric Services (Washington, D.C.) [Psychiatr Serv]* 2008 Oct; Vol. 59 (10), pp. 1198-1202.

3. Breslow, R., Klinger, B., & Erickson, B. (1995). Crisis hospitalization in a psychiatric emergency service. *New Directions For Mental Health Services*, (67), 5-12.
4. Breslow, R., Klinger, B., & Erickson, B. (1993). Crisis hospitalization on a psychiatric emergency service. *General Hospital Psychiatry*, 15(5), 307-315.
5. Guo, S., Biegel, D., Johnsen, J., & Dyches, H. (2001). Assessing the impact of community-based mobile crisis services on preventing hospitalization. *Psychiatric Services (Washington, D.C.)*, 52(2), 223-228.
6. Henggeler, S., Rowland, M., Halliday-Boykins, C., Sheidow, A., Ward, D., Randall, J., et al. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 42(5), 543-551.
7. Joy, C., Adams, C., & Rice, K. (2006). Crisis intervention for people with severe mental illnesses. *Cochrane Database Of Systematic Reviews (Online)*, (4), CD001087.
8. Schweitzer, R., & Dubey, D. (1994). Scattered-site crisis beds: an alternative to hospitalization for children and adolescents. *Hospital & Community Psychiatry*, 45(4), 351-354.
9. Stelzer, J., & Elliott, C. (1990). A continuous-care model of crisis intervention for children and adolescents. *Hospital & Community Psychiatry*, 41(5), 562-564.
10. Wasylenki, D., Gehrs, M., Goering, P., & Toner, B. (1997). A home-based program for the treatment of acute psychosis. *Community Mental Health Journal*, 33(2), 151-162.

D. Detoxification, Hospital

1. Collins, E., Kleber, H., Whittington, R., & Heitler, N. (2005). Anesthesia-assisted vs buprenorphine- or clonidine-assisted heroin detoxification and naltrexone induction: a randomized trial. *JAMA: The Journal Of The American Medical Association*, 294(8), 903-913.
2. Hättenschwiler, J., Rüesch, P., & Hell, D. (2000). Effectiveness of inpatient drug detoxification: links between process and outcome variables. *European Addiction Research*, 6(3), 123-131.
3. Kleber, HD. (2007). Pharmacologic treatments for opioid dependence: detoxification and maintenance options. *Dialogues In Clinical Neuroscience [Dialogues Clin Neurosci] 2007; Vol. 9 (4)*, pp. 455-70.
4. Madlung-Kratzer, E., Spitzer, B., Brosch, R., Dunkel, D., & Haring, C. (2009). A double-blind, randomized, parallel group study to compare the efficacy, safety and tolerability of slow-release oral morphine versus methadone in opioid-dependent in-patients willing to undergo detoxification. *Addiction (Abingdon, England)*, 104(9), 1549-1557.
5. Saitz, R., Larson, M., Horton, N., Winter, M., & Samet, J. (2004). Linkage with primary medical care in a prospective cohort of adults with addictions in inpatient detoxification: room for improvement. *Health Services Research*, 39(3), 587-606.
6. Stein BD; Kogan JN; Sorbero M. (2009). Substance abuse detoxification and residential treatment among Medicaid-enrolled adults: rates and duration of subsequent treatment. *Drug And Alcohol Dependence [Drug Alcohol Depend] 2009 Sep 1; Vol. 104 (1-2)*, pp. 100-6.
7. Sweeney, L., Samet, J., Larson, M., & Saitz, R. (2004). Establishment of a multidisciplinary Health Evaluation and Linkage to Primary care (HELP) clinic in a detoxification unit. *Journal Of Addictive Diseases*, 23(2), 33-45.

8. Carroll, C., Triplett, P., & Mondimore, F. (2009). The Intensive Treatment Unit: A brief inpatient detoxification facility demonstrating good postdetoxification treatment entry. *Journal Of Substance Abuse Treatment*, 37(2), 111-119.

E. Detoxification, Ambulatory

1. Albright, J., Ciaverelli, R., Essex, A., Tkacz, J., Ruetsch, C. (2010). Psychiatrist Characteristics that Influence Use of Buprenorphine Medication-Assisted Treatment. *Journal of Addiction Medicine*. 21 January 2010. 10.1097
2. Boothby, L., & Doering, P. (2007). Buprenorphine for the treatment of opioid dependence. *American Journal Of Health-System Pharmacy: AJHP: Official Journal Of The American Society Of Health-System Pharmacists*, 64(3), 266-272.
3. Caldiero, RM; Parran, TV Jr; Adelman, CL; Piche, B. (2006) Inpatient initiation of buprenorphine maintenance vs. detoxification: can retention of opioid-dependent patients in outpatient counseling be improved? *The American Journal On Addictions / American Academy Of Psychiatrists In Alcoholism And Addictions [Am J Addict]* 2006 Jan-Feb; Vol. 15 (1), pp. 1-7.
4. Fiellin, D., Kleber, H., Trumble-Hejduk, J., McLellan, A., & Kosten, T. (2004). Consensus statement on office-based treatment of opioid dependence using buprenorphine. *Journal Of Substance Abuse Treatment*, 27(2), 153-159.
5. Francis E; Marchand, W; Hart, M.; Carter, A.; Schinka, J.; Feldman, A.; Ordorica, P. (2000). Utilization and Outcome in an Overnight Psychiatric Observation Program at a Veterans Affairs Medical Center. *Psychiatr Serv*, January 2000, 51:92-95.
6. Gandhi, D., Jaffe, J., McNary, S., Kavanagh, G., Hayes, M., & Currens, M. (2003). Short-term outcomes after brief ambulatory opioid detoxification with buprenorphine in young heroin users. *Addiction (Abingdon, England)*, 98(4), 453-462.
7. Horspool, MJ; Seivewright, N; Armitage, CJ; Mathers, N. (2008). Post-Treatment Outcomes of Buprenorphine Detoxification in Community Settings: A Systematic Review. *European Addiction Research*; 2008, Vol. 14 Issue 4, p179-185.
8. Kampman, KM; Pettinati, HM; Lynch, KG; Xie, H; Dackis, C; Oslin, DW; Sparkman, T; Sharkoski, T; O'Brien, CP. (2009) Initiating acamprosate within-detoxification versus post-detoxification in the treatment of alcohol dependence. *Addictive Behaviors [Addict Behav]* 2009 Jun-Jul; Vol. 34 (6-7), pp. 581-6.
9. Katz EC; Schwartz RP; King S; Highfield DA; O'Grady KE; Billings T; Gandhi D; Weintraub E; Glovinsky D; Barksdale W; Brown BS. (2009). Brief vs. extended buprenorphine detoxification in a community treatment program: engagement and short-term outcomes. *The American Journal Of Drug And Alcohol Abuse [Am J Drug Alcohol Abuse]* 2009; Vol. 35 (2), pp. 63-7.
10. Kleber, HD. (2007). Pharmacologic treatments for opioid dependence: detoxification and maintenance options. *Dialogues In Clinical Neuroscience [Dialogues Clin Neurosci]* 2007; Vol. 9 (4), pp. 455-70.
11. Krantz, M., & Mehler, P. (2004). Treating opioid dependence. Growing implications for primary care. *Archives Of Internal Medicine*, 164(3), 277-288.

12. Malcolm, R., Roberts, J., Wang, W., Myrick, H., & Anton, R. (2000). Multiple previous detoxifications are associated with less responsive treatment and heavier drinking during an index outpatient detoxification. *Alcohol (Fayetteville, N.Y.)*, 22(3), 159-164.
13. Marsch, L., Bickel, W., Badger, G., Stothart, M., Quesnel, K., Stanger, C., et al. (2005). Comparison of pharmacological treatments for opioid-dependent adolescents: a randomized controlled trial. *Archives Of General Psychiatry*, 62(10), 1157-1164.
14. Myrick, H., & Anton, R. (2000). Clinical management of alcohol withdrawal. *CNS Spectrums*, 5(2), 22-32.
15. Soyka, M., & Horak, M. (2004). Outpatient Alcohol Detoxification: Implementation Efficacy and Outcome Effectiveness of a Model Project. *European Addiction Research*, 10(4), 180-187.
16. Woody GE, Poole SA, Subramaniam G, Dugosh K, Bogenschutz M, Abbott P, Patkar A, Publicker M, McCain K, Potter JS, Forman R, Vetter V, McNicholas L, Blaine J, Lynch KG, Fudala P. (2008). Extended vs. short-term buprenorphine-naloxone for treatment of opioid-addicted youth: a randomized trial. *JAMA*. 2008 Nov 5; 300 (17):2003-11.

F. Eating Disorders

1. American Psychiatric Association. (2006). 'Practice Guideline for the Treatment of Patients With Eating Disorders, Third Edition': Erratum. *The American Journal of Psychiatry*, 163(9), 4-54.
2. Anderson, D., Williamson, D., Duchmann, E., Gleaves, D., & Barbin, J. (1999). Development and validation of a multifactorial treatment outcome measure for eating disorders. *Assessment*, 6(1), 7-20.
3. Ash, J., Piazza, E., & Anderson, J. (1998). Light therapy in the clinical management of an eating-disordered adolescent with winter exacerbation. *The International Journal Of Eating Disorders*, 23(1), 93-97.
4. Attia, E., & Walsh, B. (2007). Anorexia nervosa. *The American Journal Of Psychiatry*, 164(12), 1805-1810.
5. Baran, S., Weltzin, T., & Kaye, W. (1995). Low discharge weight and outcome in anorexia nervosa. *The American Journal Of Psychiatry*, 152(7), 1070-1072.
6. Becker, A. (2003). Outpatient management of eating disorders in adults. *Current Women's Health Reports*, 3(3), 221-229.
7. Beumont, P., Hay, P., Beumont, D., Birmingham, L., Derham, H., Jordan, A., et al. (2004). Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa. *The Australian And New Zealand Journal Of Psychiatry*, 38(9), 659-670.
8. Braun, D., Sunday, S., Huang, A., & Halmi, K. (1999). More males seek treatment for eating disorders. *The International Journal Of Eating Disorders*, 25(4), 415-424.
9. Bravender, T., Robertson, L., Woods, E., Gordon, C., & Forman, S. (1999). Is there an increased clinical severity of patients with eating disorders under managed care?. *The Journal Of Adolescent Health: Official Publication Of The Society For Adolescent Medicine*, 24(6), 422-426.
10. Bulik, C., Klump, K., Thornton, L., Kaplan, A., Devlin, B., Fichter, M., et al. (2004). Alcohol use disorder comorbidity in eating disorders: a multicenter study. *The Journal Of Clinical Psychiatry*, 65(7), 1000-1006.

11. Bulik, C., Sullivan, P., Tozzi, F., Furberg, H., Lichtenstein, P., & Pedersen, N. (2006). Prevalence, heritability, and prospective risk factors for anorexia nervosa. *Archives Of General Psychiatry*, *63*(3), 305-312.
12. Cachelin, F., & Maher, B. (1998). Is amenorrhea a critical criterion for anorexia nervosa?. *Journal Of Psychosomatic Research*, *44*(3-4), 435-440.
13. Cachelin, F., Striegel-Moore, R., Elder, K., Pike, K., Wilfley, D., & Fairburn, C. (1999). Natural course of a community sample of women with binge eating disorder. *The International Journal Of Eating Disorders*, *25*(1), 45-54.
14. Caruso, D., & Klein, H. (1998). Diagnosis and treatment of bulimia nervosa. *Seminars In Gastrointestinal Disease*, *9*(4), 176-182.
15. Casper, R. (1998). Depression and eating disorders. *Depression & Anxiety (1091-4269)*, 896-104.
16. Castro, J., Gila, A., Puig, J., Rodriguez, S., & Toro, J. (2004). Predictors of rehospitalization after total weight recovery in adolescents with anorexia nervosa. *The International Journal Of Eating Disorders*, *36*(1), 22-30.
17. Colton, P., Woodside, D., & Kaplan, A. (1999). Laxative withdrawal in eating disorders: treatment protocol and 3 to 20-month follow-up. *The International Journal Of Eating Disorders*, *25*(3), 311-317.
18. Crow, S. (2006). Fluoxetine treatment of anorexia nervosa: important but disappointing results. *JAMA: The Journal Of The American Medical Association*, *295*(22), 2659-2660.
19. Dancyger, I., & Fornari, V. (2005). A review of eating disorders and suicide risk in adolescence. *The scientific world journal*, 5803-811.
20. Dawe, S., & Staiger, P. (1998). Case report: treatment of a woman with alcohol and binge eating problems. *Journal Of Behavior Therapy And Experimental Psychiatry*, *29*(3), 249-260.
21. de Groot, J., & Rodin, G. (1998). Coming alive: the psychotherapeutic treatment of patients with eating disorders. *Canadian Journal Of Psychiatry. Revue Canadienne De Psychiatrie*, *43*(4), 359-356.
22. Fairburn, C., Stice, E., Cooper, Z., Doll, H., Norman, P., & O'Connor, M. (2003). Understanding persistence in bulimia nervosa: a 5-year naturalistic study. *Journal Of Consulting And Clinical Psychology*, *71*(1), 103-109.
23. Fisher, M. (2003). The course and outcome of eating disorders in adults and in adolescents: a review. *Adolescent Medicine (Philadelphia, Pa.)*, *14*(1), 149-158.
24. Franko, D., Keel, P., Dorer, D., Blais, M., Delinsky, S., Eddy, K., et al. (2004). What predicts suicide attempts in women with eating disorders?. *Psychological Medicine*, *34*(5), 843-853.
25. Guarda, A., Pinto, A., Coughlin, J., Hussain, S., Haug, N., & Heinberg, L. (2007). Perceived coercion and change in perceived need for admission in patients hospitalized for eating disorders. *The American Journal Of Psychiatry*, *164*(1), 108-114.
26. Geary, N. (1998). The effect of estrogen on appetite. *Medscape Women's Health*, *3*(6), 3.
27. Geller, J., Drab-Hudson, D., Whisenhunt, B., & Srikameswaran, S. (2004). Readiness to Change Dietary Restriction Predicts Outcomes in the Eating Disorders. *Eating Disorders*, *12*(3), 209-224.
28. Godart, N., Perdereau, F., Rein, Z., Berthoz, S., Wallier, J., Jeammet, P., et al. (2007). Comorbidity studies of eating disorders and mood disorders. Critical review of the literature. *Journal Of Affective Disorders*, *97*(1-3), 37-49.

29. Gowers, S., & Bryant-Waugh, R. (2004). Management of child and adolescent eating disorders: the current evidence base and future directions. *Journal Of Child Psychology And Psychiatry, And Allied Disciplines*, 45(1), 63-83.
30. Halmi, K., Agras, W., Crow, S., Mitchell, J., Wilson, G., Bryson, S., et al. (2005). Predictors of treatment acceptance and completion in anorexia nervosa: implications for future study designs. *Archives Of General Psychiatry*, 62(7), 776-781.
31. Jordan, P., Redding, C., Troop, N., Treasure, J., & Serpell, L. (2003). Developing a stage of change measure for assessing recovery from anorexia nervosa. *Eating Behaviors*, 3(4), 365-385.
32. Kaplan, A., Olmsted, M., Carter, J., & Woodside, B. (2001). Matching patient variables to treatment intensity. The continuum of care. *The Psychiatric Clinics Of North America*, 24(2), 281-292.
33. Kaye, W., Bulik, C., Thornton, L., Barbarich, N., & Masters, K. (2004). Comorbidity of anxiety disorders with anorexia and bulimia nervosa. *The American Journal Of Psychiatry*, 161(12), 2215-2221.
34. Kaye, W., Strober, M., Stein, D., & Gendall, K. (1999). New directions in treatment research of anorexia and bulimia nervosa. *Biological Psychiatry*, 45(10), 1285-1292.
35. Keel, P., Dorer, D., Eddy, K., Franko, D., Charatan, D., & Herzog, D. (2003). Predictors of mortality in eating disorders. *Archives Of General Psychiatry*, 60(2), 179-183.
36. Keel, P., Dorer, D., Franko, D., Jackson, S., & Herzog, D. (2005). Postremission predictors of relapse in women with eating disorders. *The American Journal Of Psychiatry*, 162(12), 2263-2268.
37. Le Grange, D., Binford, R., & Loeb, K. (2005). Manualized family-based treatment for anorexia nervosa: a case series. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 44(1), 41-46.
38. Le Grange, D., Crosby, R., Rathouz, P., & Leventhal, B. (2007). A randomized controlled comparison of family-based treatment and supportive psychotherapy for adolescent bulimia nervosa. *Archives Of General Psychiatry*, 64(9), 1049-1056.
39. Luce, K., & Crowther, J. (1999). The Reliability of the Eating Disorder Examination--Self-Report Questionnaire Version (EDE-Q). *International Journal Of Eating Disorders*, 25(3), 349-351.
40. Maddox, R., & Long, M. (1999). Eating disorders: current concepts. *Journal Of The American Pharmaceutical Association (Washington, D.C.: 1996)*, 39(3), 378-387.
41. Marcus, M., & Kalarchian, M. (2003). Binge eating in children and adolescents. *The International Journal Of Eating Disorders*, 34 SupplS47-S57.
42. Mehler, P., Crews, C., & Weiner, K. (2004). Bulimia: medical complications. *Journal Of Women's Health (2002)*, 13(6), 668-675.
43. Miller, K., Grinspoon, S., Ciampa, J., Hier, J., Herzog, D., & Klibanski, A. (2005). Medical findings in outpatients with anorexia nervosa. *Archives Of Internal Medicine*, 165(5), 561-566.
44. Misra, M., Aggarwal, A., Miller, K., Almazan, C., Worley, M., Soyka, L., et al. (2004). Effects of anorexia nervosa on clinical, hematologic, biochemical, and bone density parameters in community-dwelling adolescent girls. *Pediatrics*, 114(6), 1574-1583.
45. Mizes, J. (1998). Neglected topics in eating disorders: guidelines for clinicians and researchers. *Clinical Psychology Review*, 18(4), 387-390.
46. Modan-Moses, D., Yaroslavsky, A., Novikov, I., Segev, S., Toledano, A., Miterany, E., et al. (2003). Stunting of Growth as a Major Feature of Anorexia Nervosa in Male Adolescents. *Pediatrics*, 111(2), 270.

47. Mont, L., Castro, J., Herreros, B., Paré, C., Azqueta, M., Magriña, J., et al. (2003). Reversibility of cardiac abnormalities in adolescents with anorexia nervosa after weight recovery. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 42(7), 808-813.
48. Myers, T., Swan-Kremeier, L., Wonderlich, S., Lancaster, K., & Mitchell, J. (2004). The use of alternative delivery systems and new technologies in the treatment of patients with eating disorders. *The International Journal Of Eating Disorders*, 36(2), 123-143.
49. Olmsted, M., Kaplan, A., & Rockert, W. (2003). Relative Efficacy of a 4-Day Versus a 5-Day Day Hospital Program. *International Journal of Eating Disorders*, 34(4), 441-449.
50. Ornstein, R., Golden, N., Jacobson, M., & Shenker, I. (2003). Hypophosphatemia during nutritional rehabilitation in anorexia nervosa: implications for refeeding and monitoring. *The Journal Of Adolescent Health: Official Publication Of The Society For Adolescent Medicine*, 32(1), 83-88.
51. Paul, T., Schroeter, K., Dahme, B., & Nutzinger, D. (2002). Self-injurious behavior in women with eating disorders. *The American Journal Of Psychiatry*, 159(3), 408-411.
52. Peterson, C., Mitchell, J., Engbloom, S., Nugent, S., Mussell, M., Crow, S., et al. (1998). Binge eating disorder with and without a history of purging symptoms. *International Journal of Eating Disorders*, 24(3), 251-257.
53. Peterson, C., & Mitchell, J. (1999). Psychosocial and pharmacological treatment of eating disorders: A review of research findings. *Journal of Clinical Psychology*, 55(6), 685-697.
54. Pike, K. (1998). Long-term course of anorexia nervosa: response, relapse, remission, and recovery. *Clinical Psychology Review*, 18(4), 447-475.
55. Pike KM, Roberto CA, and Marcus MD. (2007). Evidence Based and Innovative Psychological Treatments in Gabbard's Treatments of Psychiatric Disorders, 4th Edition. Arlington, VA. American Psychiatric Publishing, Inc.
56. Pike, K., Walsh, B., Vitousek, K., Wilson, G., & Bauer, J. (2003). Cognitive behavior therapy in the posthospitalization treatment of anorexia nervosa. *The American Journal Of Psychiatry*, 160(11), 2046-2049.
57. Pompili, M., Girardi, P., Tatarelli, G., Ruberto, A., & Tatarelli, R. (2006). Suicide and attempted suicide in eating disorders, obesity and weight-image concern. *Eating Behaviors*, 7(4), 384-394.
58. Pompili, M., Mancinefli, I., Girardi, P., Ruberto, A., & Tatarefli, R. (2004). Suicide in anorexia nervosa: A meta-analysis. *International Journal of Eating Disorders*, 36(1), 99-103.
59. Quadflieg, N., & Fichter, M. (2003). The course and outcome of bulimia nervosa. *European Child & Adolescent Psychiatry*, 12:99.
60. Reas, D., & Williamson, D. (2000). Duration of Illness Predicts Outcome for Bulimia Nervosa: A Long-Term Follow-Up Study. *International Journal of Eating Disorders*, 27(4), 428-434.
61. Ressler, A. (1998). "A body to die for": eating disorders and body-image distortion in women. *International Journal Of Fertility And Women's Medicine*, 43(3), 133-138.
62. Riva, G., Bacchetta, M., Cesa, G., Conti, S., & Molinari, E. (2003). Six-Month Follow-Up of In-Patient Experiential Cognitive Therapy for Binge Eating Disorders. *CyberPsychology & Behavior*, 6(3), 251-258.
63. Robin, A., Gilroy, M., & Dennis, A. (1998). Treatment of eating disorders in children and adolescents. *Clinical Psychology Review*, 18(4), 421-446.

-
64. Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., et al. (2007). A randomized controlled trial of family therapy and cognitive behavior therapy guided self-care for adolescents with bulimia nervosa and related disorders. *The American Journal Of Psychiatry*, 164(4), 591-598.
 65. Schmidt, U., & Troop, N. (1999). Events and the Onset of Eating Disorders: Correcting an 'Age Old' Myth. *International Journal of Eating Disorders*, 25(1), 83-88.
 66. Schwitzer, A., Bergholz, K., Dore, T., & Salimi, L. (1998). Eating disorders among college women: Prevention, education, and treatment responses. *Journal of American College Health*, 46(5), 199.
 67. Segal, A., Kinoshita Kusunoki, D., & Larino, M. (2004). Post-surgical refusal to eat: anorexia nervosa, bulimia nervosa or a new eating disorder? A case series. *Obesity Surgery*, 14(3), 353-360.
 68. Signorini, A., De Filippo, E., Panico, S., De Caprio, C., Pasanisi, F., & Contaldo, F. (2007). Long-term mortality in anorexia nervosa: a report after an 8-year follow-up and a review of the most recent literature. *European Journal Of Clinical Nutrition*, 61(1), 119-122.
 69. Silber, T. (1994). Eating disorders and health insurance. *Archives Of Pediatrics & Adolescent Medicine*, 148(8), 785-788.
 70. Solano, R., Fernández-Aranda, F., Aitken, A., López, C., & Vallejo, J. (2005). Self-injurious behaviour in people with eating disorders. *European Eating Disorders Review*, 13(1), 3-10.
 71. Spangler, D. (1999). Cognitive-behavioral therapy for bulimia nervosa: an illustration. *Journal Of Clinical Psychology*, 55(6), 699-713.
 72. Spindler, A., & Milos, G. (2004). Psychiatric comorbidity and inpatient treatment history in bulimic subjects. *General Hospital Psychiatry*, 26(1), 18-23.
 73. Stashwick, C. When you suspect an eating disorder. Contemporary Pediatrics (Archive) November 1996. www.contemporarypediatrics.com.
 74. Steiner, H., & Lock, J. (1998). Anorexia nervosa and bulimia nervosa in children and adolescents: a review of the past 10 years. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 37(4), 352-359.
 75. Stewart, T., & Williamson, D. (2004). Multidisciplinary treatment of eating disorders--Part 1: Structure and costs of treatment. *Behavior Modification*, 28(6), 812-830.
 76. Striegel-Moore, R., Garvin, V., Dohm, F., & Rosenheck, R. (1999). Psychiatric comorbidity of eating disorders in men: a national study of hospitalized veterans. *The International Journal Of Eating Disorders*, 25(4), 399-404.
 77. Strober, M. (2004). Managing the chronic, treatment-resistant patient with anorexia nervosa. *International Journal of Eating Disorders*, 36(3), 245-255.
 78. Sullivan, P., Bulik, C., Fear, J., & Pickering, A. (1998). Outcome of anorexia nervosa: a case-control study. *The American Journal Of Psychiatry*, 155(7), 939-946.
 79. Takii, M., Uchigata, Y., Komaki, G., Nozaki, T., Kawai, H., Iwamoto, Y., et al. (2003). An integrated inpatient therapy for type 1 diabetic females with bulimia nervosa: a 3-year follow-up study. *Journal Of Psychosomatic Research*, 55(4), 349-356.
 80. Vitousek, K., Watson, S., & Wilson, G. (1998). Enhancing motivation for change in treatment-resistant eating disorders. *Clinical Psychology Review*, 18(4), 391-420.
 81. Walsh, B., & Devlin, M. (1998). Eating disorders: Progress and problems. (cover story). *Science*, 280(5368), 1387.
-

82. Walsh, B., Kaplan, A., Attia, E., Olmsted, M., Parides, M., Carter, J., et al. (2006). Fluoxetine after weight restoration in anorexia nervosa: a randomized controlled trial. *JAMA: The Journal Of The American Medical Association*, 295(22), 2605-2612.
83. Watson, T., & Andersen, A. (2003). A critical examination of the amenorrhea and weight criteria for diagnosing anorexia nervosa. *Acta Psychiatrica Scandinavica*, 108(3), 175-182.
84. White, J., & Litovitz, G. (1998). A comparison of inpatient and outpatient women with eating disorders. *Archives Of Psychiatric Nursing*, 12(4), 181-194.
85. Wildman, P., Lilenfeld, L., & Marcus, M. (2004). Axis I comorbidity onset and parasuicide in women with eating disorders. *International Journal of Eating Disorders*, 35(2), 190-197.
86. Wildman, P., Lilenfeld, L., & Marcus, M. (2004). Axis I comorbidity onset and parasuicide in women with eating disorders. *International Journal of Eating Disorders*, 35(2), 190-197.
87. Wilson, G. (1999). Cognitive behavior therapy for eating disorders: progress and problems. *Behaviour Research And Therapy*, 37 Suppl 1S79-S95.
88. Winzelberg, A., & Taylor, C. (1998). Evaluation of a Computer-Mediated Eating Disorder Intervention Program. *International Journal of Eating Disorders*, 24(4), 339-349.
89. Wiseman, C., Sunday, S., Klapper, F., Harris, W., & Halmi, K. (2001). Changing patterns of hospitalization in eating disorder patients. *The International Journal Of Eating Disorders*, 30(1), 69-74.
90. Wisner, S., & Telch, C. (1999). Dialectical behavior therapy for binge-eating disorder. *Journal of Clinical Psychology*, 55(6), 755-768.
91. Wolfe, B., & Gimby, L. (2003). Caring for the hospitalized patient with an eating disorder. *The Nursing Clinics Of North America*, 38(1), 75-99.
92. Wolk, S., Loeb, K., & Walsh, B. (2005). Assessment of patients with anorexia nervosa: Interview versus self-report. *International Journal of Eating Disorders*, 37(2), 92-99.

G. Geriatric Issues

1. Ancill, R., & Holliday, S. (1990). Treatment of depression in the elderly: a Canadian view. *Progress In Neuro-Psychopharmacology & Biological Psychiatry*, 14(5), 655-661.
2. Bakey, A., Kunik, M., Orengo, C., Molinari, V., Workman, R., & Hamilton, J. (1997). Outcome of psychiatric hospitalization for very low-functioning demented patients. *Journal Of Geriatric Psychiatry And Neurology*, 10(2), 55-57.
3. Balkrishnan, R. (1998). Predictors of medication adherence in the elderly. *Clinical Therapeutics*, 20(4), 764-771.
4. Blake, L. (1991). Somatic therapies in geriatric psychiatry. *Psychiatric Medicine*, 9(2), 263-273.
5. Borja, B; Borja, CS; Gade, S. (2007). Psychiatric emergencies in the geriatric population. *Clinics in Geriatric Medicine [Clin Geriatr Med]* 2007 May; Vol. 23 (2), pp. 391-400, vii.
6. Brandt, B., & Ugarriza, D. (1996). Electroconvulsive therapy and the elderly client. *Journal Of Gerontological Nursing*, 22(12), 14-20.
7. Burd, J., & Kettl, P. (1998). Incidence of asystole in electroconvulsive therapy in elderly patients. *The American Journal Of Geriatric Psychiatry: Official Journal Of The American Association For Geriatric Psychiatry*, 6(3), 203-211.

8. Busse EW, Blazer DG. (2004). Mood Disorders: Depression and Medical Illness, in Textbook of Geriatric Psychiatry 3rd Edition. Arlington, VA. American Psychiatric Press.
9. Casey, D., & Davis, M. (1996). Electroconvulsive therapy in the very old. *General Hospital Psychiatry*, 18(6), 436-439.
10. Choi S, Rozario P, Morrow-Howell N, Proctor E. (2009). Elders with first psychiatric hospitalization for depression. *Int J Geriatr Psychiatry*. 2009 Jan; 24(1):33-40.
11. Clark, C., Alexopoulos, G., & Kaplan, J. (1995). Prolactin release and clinical response to electroconvulsive therapy in depressed geriatric inpatients: a preliminary report. *Convulsive Therapy*, 11(1), 24-31.
12. Clark, W., & Vorst, V. (1994). Group therapy with chronically depressed geriatric patients. *Journal Of Psychosocial Nursing And Mental Health Services*, 32(5), 9-13.
13. Cole, M., Fenton, F., Engelsmann, F., & Mansouri, I. (1991). Effectiveness of geriatric psychiatry consultation in an acute care hospital: a randomized clinical trial. *Journal Of The American Geriatrics Society*, 39(12), 1183-1188.
14. Cole, M., Primeau, F., Bailey, R., Bonnycastle, M., Masciarelli, F., Engelsmann, F., et al. (1994). Systematic intervention for elderly inpatients with delirium: a randomized trial. *CMAJ: Canadian Medical Association Journal = Journal De L'association Medicale Canadienne*, 151(7), 965-970.
15. Colenda, C., Streim, J., Greene, J., Meyers, N., Beckwith, E., & Rabins, P. (1999). The impact of OBRA '87 on psychiatric services in nursing homes. Joint testimony of the American Psychiatric Association and the American Association for Geriatric Psychiatry. *The American Journal Of Geriatric Psychiatry: Official Journal Of The American Association For Geriatric Psychiatry*, 7(1), 12-17.
16. Ennis, K., & Reichard, R. (1997). Maximizing drug compliance in the elderly. Tips for staying on top of your patients' medication use. *Postgraduate Medicine*, 102(3), 211.
17. Ettner, S., & Hermann, R. (1998). Inpatient psychiatric treatment of elderly Medicare beneficiaries. *Psychiatric Services (Washington, D.C.)*, 49(9), 1173-1179.
18. Fillit, H., & Miller, M. (1993). The geriatric evaluation and treatment unit: a model site for acute care of the frail elderly, education, and research. *The Mount Sinai Journal Of Medicine, New York*, 60(6), 475-481.
19. Finlayson, R., & Davis, L. (1994). Prescription drug dependence in the elderly population: demographic and clinical features of 100 inpatients. *Mayo Clinic Proceedings. Mayo Clinic*, 69(12), 1137-1145.
20. Flint, A., & Rifat, S. (1997). Anxious depression in elderly patients. Response to antidepressant treatment. *The American Journal Of Geriatric Psychiatry: Official Journal Of The American Association For Geriatric Psychiatry*, 5(2), 107-115.
21. Ganzini, L., Lee, M., Heintz, R., Bloom, J., & Fenn, D. (1994). The effect of depression treatment on elderly patients' preferences for life-sustaining medical therapy. *The American Journal Of Psychiatry*, 151(11), 1631-1636.
22. Goldman, L., & Klugman, A. (1990). Psychiatric consultation in a teaching nursing home. *Psychosomatics*, 31(3), 277-281.
23. Grant, R., & Casey, D. (1995). Adapting cognitive behavioral therapy for the frail elderly. *International Psychogeriatrics / IPA*, 7(4), 561-571.

24. Greene, J., Stone, M., & Johnson, W. (1994). Evaluation of a multidisciplinary treatment approach in an inpatient geropsychiatric unit. *Journal Of The Tennessee Medical Association*, 87(10), 421-424.
25. Heeren, O., Dixon, L., Gavirneni, S., & Regenold, W. (2002). The association between decreasing length of stay and readmission rate on a psychogeriatric unit. *Psychiatric Services (Washington, D.C.)*, 53(1), 76-79.
26. Hinrichsen, G. (1992). Recovery and relapse from major depressive disorder in the elderly. *The American Journal Of Psychiatry*, 149(11), 1575-1579.
27. Holroyd, S., & Duryee, J. (1997). Characteristics of persons utilizing a geriatric psychiatry outpatient clinic. *Journal Of Geriatric Psychiatry And Neurology*, 10(4), 136-141.
28. Joseph, C., Goldsmith, S., Rooney, A., McWhorter, K., & Ganzini, L. (1995). An interdisciplinary mental health consultation team in a nursing home. *The Gerontologist*, 35(6), 836-839.
29. Kalunian, D., Binder, R., & McNeil, D. (1990). Violence by geriatric patients who need psychiatric hospitalization. *The Journal Of Clinical Psychiatry*, 51(8), 340-343.
30. Koenig, H., George, L., & Meador, K. (1997). Use of antidepressants by nonpsychiatrists in the treatment of medically ill hospitalized depressed elderly patients. *The American Journal Of Psychiatry*, 154(10), 1369-1375.
31. Kunik, M., Benton, C., Snow-Turek, A., Molinari, V., Orengo, C., & Workman, R. (1998). The contribution of cognitive impairment, medical burden, and psychopathology to the functional status of geriatric psychiatric inpatients. *General Hospital Psychiatry*, 20(3), 183-188.
32. Kunik, M., Edwards, M., Molinari, V., Hale, D., & Orengo, C. (2001). Outcomes of decreased length of hospital stay among geriatric patients with dementia. *Psychiatric Services (Washington, D.C.)*, 52(3), 376-378.
33. Kunik, M., Mulsant, B., Rifai, A., Sweet, R., Pasternak, R., & Zubenko, G. (1994). Diagnostic rate of comorbid personality disorder in elderly psychiatric inpatients. *The American Journal Of Psychiatry*, 151(4), 603-605.
34. Kunik, M., Ponce, H., Molinari, V., Orengo, C., Emenaha, I., & Workman, R. (1996). The benefits of psychiatric hospitalization for older nursing home residents. *Journal Of The American Geriatrics Society*, 44(9), 1062-1065.
35. Lee MJ, Proctor E, Morrow-Howell N. (2006). Depression outcomes and quality of post-discharge care of elders hospitalized for major depression. *Psychiatr Serv.* 2006 Oct; 57(10):1446-51.
36. Lichtenberg, P., Kimbarow, M., MacKinnon, D., Morris, P., & Bush, J. (1995). An interdisciplinary behavioral treatment program for depressed geriatric rehabilitation inpatients. *The Gerontologist*, 35(5), 688-690.
37. Little, J., Reynolds, C., Dew, M., Frank, E., Begley, A., Miller, M., et al. (1998). How common is resistance to treatment in recurrent, nonpsychotic geriatric depression?. *The American Journal Of Psychiatry*, 155(8), 1035-1038.
38. Lyness, J., Conwell, Y., & Nelson, J. (1992). Suicide attempts in elderly psychiatric inpatients. *Journal Of The American Geriatrics Society*, 40(4), 320-324.

39. Moos, R., & Mertens, J. (1996). Patterns of diagnoses, comorbidities, and treatment in late-middle-aged and older affective disorder patients: comparison of mental health and medical sectors. *Journal Of The American Geriatrics Society*, 44(6), 682-688.
40. Nahas, Z., Kunik, M., Orengo, C., Molinari, V., & Workman, R. (1997). Depression in male geropsychiatric inpatients with and without dementia: a naturalistic study. *Journal Of Affective Disorders*, 46(3), 243-246.
41. Neville, P., Boyle, A., & Baillon, S. (1999). A descriptive survey of acute bed usage for dementia care in old age psychiatry. *International Journal of Geriatric Psychiatry*, 14(5), 348-354.
42. Nobler, M., Devanand, D., Kim, M., Fitzsimons, L., Singer, T., Turret, N., et al. (1996). Fluoxetine treatment of dysthymia in the elderly. *The Journal Of Clinical Psychiatry*, 57(6), 254-256.
43. Orengo, C., Kunik, M., Molinari, V., & Workman, R. (1996). The use and tolerability of fluoxetine in geropsychiatric inpatients. *The Journal Of Clinical Psychiatry*, 57(1), 12-16.
44. Oxman, T. (1996). Geriatric psychiatry at the interface of consultation-liaison psychiatry and primary care. *International Journal Of Psychiatry In Medicine*, 26(2), 145-153.
45. Pasternak, R., Rosenweig, A., Booth, B., Fox, A., Morycz, R., Mulsant, B., et al. (1998). Morbidity of homebound versus inpatient elderly psychiatric patients. *International Psychogeriatrics / IPA*, 10(2), 117-125.
46. Paton, J., Fahy, M., & Livingston, G. (2004). Delayed discharge--a solvable problem? The place of intermediate care in mental health care of older people. *Aging & Mental Health*, 8(1), 34-39.
47. Proctor, E., Morrow-Howell, N., Rubin, E., & Ringenberg, M. (1999). Service use by elderly patients after psychiatric hospitalization. *Psychiatric Services (Washington, D.C.)*, 50(4), 553-555.
48. Rabins, P., & Nicholson, M. (1991). Acute psychiatric hospitalization for patients with irreversible dementia. *International Journal of Geriatric Psychiatry*, 6(4), 209-211.
49. Ramchandani D, Lamdan RM, O'Dowd MA, Boland R, Hails K, Ball S, Schindler BA, Reichman WE, Coyne AC, Borson S, Negron AE, Rovner BW, Pelchat RJ, Sakauye KM, Katz P, Cantillon M, Hamer RM. Psychiatric consultation in the nursing home. A survey of six states. *Am J Geriatr Psychiatry* 6(4):320-7 (Fall 1998).
50. Rosen, J., Sweet, R., Mulsant, B., Rifai, A., Pasternak, R., & Zubenko, G. (1994). The Delirium Rating Scale in a psychogeriatric inpatient setting. *The Journal Of Neuropsychiatry And Clinical Neurosciences*, 6(1), 30-35.
51. Rothschild, B. (1994). Fluoxetine-nortriptyline therapy of treatment-resistant major depression in a geriatric patient. *Journal Of Geriatric Psychiatry And Neurology*, 7(3), 137-138.
52. Sajatovic, M., Jaskiw, G., Konicki, P., Jurjus, G., Kwon, K., & Ramirez, L. (1997). Outcome of clozapine therapy for elderly patients with refractory primary psychosis. *International Journal Of Geriatric Psychiatry*, 12(5), 553-558.
53. Sajatovic, M., Ramirez, L., Garver, D., Thompson, P., Ripper, G., & Lehmann, L. (1998). Clozapine therapy for older veterans. *Psychiatric Services (Washington, D.C.)*, 49(3), 340-344.
54. Sajatovic, M., Ramirez, L., Vernon, L., Brescan, D., Simon, M., & Jurjus, G. (1996). Outcome of risperidone therapy in elderly patients with chronic psychosis. *International Journal Of Psychiatry In Medicine*, 26(3), 309-317.

55. Sakauye, K., & Camp, C. (1992). Introducing psychiatric care into nursing homes. *The Gerontologist*, 32(6), 849-852.
56. Schiller, A. (1992). [Psychotherapy with elderly patients. Experiences from a psychiatric psychotherapeutic consultation service]. *Zeitschrift Für Psychosomatische Medizin Und Psychoanalyse*, 38(4), 371-380.
57. Schmid, H., Manjee, K., & Shah, T. (1994). On the distinction of suicide ideation versus attempt in elderly psychiatric inpatients. *The Gerontologist*, 34(3), 332-339.
58. Schweizer, E., Rickels, K., Hassman, H., & Garcia-España, F. (1998). Buspirone and imipramine for the treatment of major depression in the elderly. *The Journal Of Clinical Psychiatry*, 59(4), 175-183.
59. Sheline, Y. (1990). Quantifying undiagnosed organic mental disorder in geriatric inpatients. *Hospital & Community Psychiatry*, 41(9), 1004-1008.
60. Small, G., Rabins, P., Barry, P., Buckholtz, N., DeKosky, S., Ferris, S., et al. (1997). Diagnosis and treatment of Alzheimer disease and related disorders. Consensus statement of the American Association for Geriatric Psychiatry, the Alzheimer's Association, and the American Geriatrics Society. *JAMA: The Journal Of The American Medical Association*, 278(16), 1363-1371.
61. Smith, M., Mitchell, S., Buckwalter, K., & Garand, L. (1994). Geropsychiatric nursing consultation: a valuable resource in rural long-term care. *Archives Of Psychiatric Nursing*, 8(4), 272-279.
62. Steffens, DC. (2008). Separating mood disturbance from mild cognitive impairment in geriatric depression. *International Review Of Psychiatry (Abingdon, England) [Int Rev Psychiatry]* 2008 Aug; Vol. 20 (4), pp. 374-81.
63. Steffens, DC; Potter, GG. (2007). Geriatric depression and cognitive impairment. *Psychological Medicine [Psychol Med]* 2008 Feb; Vol. 38 (2), pp. 163-75. *Date of Electronic Publication:* 2007 Jun 22.
64. Stolee, P., Le Clair, J., & Kessler, L. (1994). Geriatric psychiatry consultation in the community. *Canadian Journal Of Psychiatry. Revue Canadienne De Psychiatrie*, 39(8 Suppl 1), S27-S33.
65. Stoudemire, A., Hill, C., Dalton, S., & Marquardt, M. (1994). Rehospitalization rates in older depressed adults after antidepressant and electroconvulsive therapy treatment. *Journal Of The American Geriatrics Society*, 42(12), 1282-1285.
66. Stoudemire, A., Hill, C., Morris, R., & Lewison, B. (1993). Long-term outcome of treatment-resistant depression in older adults. *The American Journal Of Psychiatry*, 150(10), 1539-1540.
67. Stoudemire, A., Hill, C., Morris, R., Martino-Saltzman, D., Markwalter, H., & Lewison, B. (1991). Cognitive outcome following tricyclic and electroconvulsive treatment of major depression in the elderly. *The American Journal Of Psychiatry*, 148(10), 1336-1340.
68. Sweet, R., Mulsant, B., Rifai, A., & Zubenko, G. (1992). Dyskinesia and neuroleptic exposure in elderly psychiatric inpatients. *Journal Of Geriatric Psychiatry And Neurology*, 5(3), 156-161.
69. Sweet, R., Pollock, B., Rosen, J., Mulsant, B., Altieri, L., & Perel, J. (1994). Early detection of neuroleptic-induced parkinsonism in elderly patients with dementia. *Journal Of Geriatric Psychiatry And Neurology*, 7(4), 251-253.

70. Thobaben, M., & Kozlak, J. (1990). Home health care's unique role in serving the elderly mentally ill. *Home Healthcare Nurse*, 8(4), 37-39.
71. Tillman-Jones, T. (1990). How to work with elderly patients on a general psychiatric unit. *Journal Of Psychosocial Nursing And Mental Health Services*, 28(5), 27-31.
72. Tomac, T., Rummans, T., Pileggi, T., & Li, H. (1997). Safety and efficacy of electroconvulsive therapy in patients over age 85. *The American Journal Of Geriatric Psychiatry: Official Journal Of The American Association For Geriatric Psychiatry*, 5(2), 126-130.
73. Trace, S., & Howell, T. (1991). Occupational therapy in geriatric mental health. *The American Journal Of Occupational Therapy.: Official Publication Of The American Occupational Therapy Association*, 45(9), 833-838.
74. Unutzer, J., & Katon, W. (1999). Treating depressed older adults in primary care: Narrowing the gap between efficacy and.. *Milbank Quarterly*, 77(2), 225.
75. Wells, K., Rogers, W., Davis, L., Benjamin, B., Norquist, G., Kahn, K., et al. (1994). Quality of care for depressed elderly pre-post prospective payment system: differences in response across treatment settings. *Medical Care*, 32(3), 257-276.
76. Wylie, M., Mulsant, B., Pollock, B., Sweet, R., Zubenko, G., Begley, A., et al. (1999). Age at onset in geriatric bipolar disorder. Effects on clinical presentation and treatment outcomes in an inpatient sample. *The American Journal Of Geriatric Psychiatry: Official Journal Of The American Association For Geriatric Psychiatry*, 7(1), 77-83.
77. Zisselman, M., Rovner, B., Shmueli, Y., & Ferrie, P. (1996). A pet therapy intervention with geriatric psychiatry inpatients. *The American Journal Of Occupational Therapy.: Official Publication Of The American Occupational Therapy Association*, 50(1), 47-51.
78. Zisselman, M., Rovner, B., & Shmueli, Y. (1996). Benzodiazepine use in the elderly prior to psychiatric hospitalization. *Psychosomatics*, 37(1), 38-42.
79. Zubenko, G., Rosen, J., Sweet, R., Mulsant, B., & Rifai, A. (1992). Impact of psychiatric hospitalization on behavioral complications of Alzheimer's disease. *The American Journal Of Psychiatry*, 149(11), 1484-1491.

H. Hospitalization, Psychiatric, Adult

1. Appelbaum, B., Appelbaum, P., & Grisso, T. (1998). *Competence to consent to voluntary psychiatric hospitalization: a test of a standard proposed by APA*. American Psychiatric Association. *Psychiatric Services (Washington, D.C.)*, 49(9), 1193-1196.
2. Bloom, J., Williams, M., Land, C., McFarland, B., & Reichlin, S. (1998). Changes in public psychiatric hospitalization in Oregon over the past two decades. *Psychiatric Services (Washington, D.C.)*, 49(3), 366-369.
3. Browne, G., Courtney, M., & Meehan, T. (2004). Type of housing predicts rate of readmission to hospital but not length of stay in people with schizophrenia on the Gold Coast in Queensland. *Australian Health Review: A Publication Of The Australian Hospital Association*, 27(1), 65-72.
4. Bruffaerts, R., Sabbe, M., & Demyttenaere, K. (2004). Effects of patient and health-system characteristics on community tenure of discharged psychiatric inpatients. *Psychiatric Services (Washington, D.C.)*, 55(6), 685-690.

5. Buchanan, J., Dixon, D., & Thyer, B. (1997). A preliminary evaluation of treatment outcomes at a veterans' hospital's inpatient psychiatry unit. *Journal Of Clinical Psychology, 53*(8), 853-858.
6. Burgess, A., Douglas, J., Burgess, A., Baker, T., Sauve, H., & Gariti, K. (1997). Hospital communication threats and intervention. *Journal Of Psychosocial Nursing And Mental Health Services, 35*(8), 9-16.
7. Capp, H., Thyer, B., & Bordnick, P. (1997). Evaluating improvement over the course of adult psychiatric hospitalization. *Social Work In Health Care, 25*(4), 55-66.
8. Cascardi, M., Poythress, N., & Ritterband, L. (1997). Stability of psychiatric patients' perceptions of their admission experience. *Journal Of Clinical Psychology, 53*(8), 833-839.
9. Claassen, C., Hughes, C., Gilfillan, S., McIntire, D., Roose, A., Lumpkin, M., et al. (2000). Toward a redefinition of psychiatric emergency. *Health Services Research, 35*(3), 735-754.
10. Cohen, N., Gantt, A., & Sainz, A. (1997). Influences on fit between psychiatric patients' psychosocial needs and their hospital discharge plan. *Psychiatric Services (Washington, D.C.), 48*(4), 518-523.
11. Davidson, L., Tebes, J., Rakfeldt, J., & Sledge, W. (1996). Differences in social environment between inpatient and day hospital-crisis respite settings. *Psychiatric Services (Washington, D.C.), 47*(7), 714-720.
12. Dew, R., & McCall, W. (2004). Efficiency of outpatient ECT. *The Journal Of ECT, 20*(1), 24-25.
13. Dilonardo, J., Connelly, C., Gurel, L., Seifert, R., Kendrick, K., & Deutsch, S. (1998). Scheduled intermittent hospitalization for psychiatric patients. *Psychiatric Services (Washington, D.C.), 49*(4), 504-509.
14. Engleman, N., Jobes, D., Berman, A., & Langbein, L. (1998). Clinicians' decision making about involuntary commitment. *Psychiatric Services (Washington, D.C.), 49*(7), 941-945.
15. Evenson, R., Holland, R., & Cho, D. (1994). A psychiatric hospital 100 years ago: I. A comparative study of treatment outcomes then and now. *Hospital & Community Psychiatry, 45*(10), 1021-1025.
16. Figueroa, R., Harman, J., & Engberg, J. (2004). Use of claims data to examine the impact of length of inpatient psychiatric stay on readmission rate. *Psychiatric Services (Washington, D.C.), 55*(5), 560-565.
17. Gabbard, G., Coyne, L., Allen, J., Spohn, H., Colson, D., & Vary, M. (2000). Evaluation of intensive inpatient treatment of patients with severe personality disorders. *Psychiatric Services (Washington, D.C.), 51*(7), 893-898.
18. Garbrick, L., Levitt, M., Barrett, M., & Graham, L. (1996). Agreement between emergency physicians and psychiatrists regarding admission decisions. *Academic Emergency Medicine: Official Journal Of The Society For Academic Emergency Medicine, 3*(11), 1027-1030.
19. Gardner, W., Lidz, C., Hoge, S., Monahan, J., Eisenberg, M., Bennett, N., et al. (1999). Patients' revisions of their beliefs about the need for hospitalization. *The American Journal Of Psychiatry, 156*(9), 1385-1391.
20. Garritson, S. (1999). Availability and performance of psychiatric acute care facilities in California from 1992 to 1996. *Psychiatric Services (Washington, D.C.), 50*(11), 1453-1460.

21. Goethe, J., Dornelas, E., & Gruman, C. (1999). Predicting service utilization after psychiatric hospitalization. *Comprehensive Psychiatry*, 40(3), 192-197.
22. Green, J., & Grindel, C. (1996). Supervision of suicidal patients in adult inpatient psychiatric units in general hospitals. *Psychiatric Services (Washington, D.C.)*, 47(8), 859-863.
23. Harbin H. (1994). Inpatient services. In R Schreter, S Sharfstein, and C Schreter (eds), *Allies and Adversaries*. Washington DC, American Psychiatric Press.
24. Harman, J., Cuffel, B., & Kelleher, K. (2004). Profiling hospitals for length of stay for treatment of psychiatric disorders. *The Journal Of Behavioral Health Services & Research*, 31(1), 66-74.
25. Hirschfeld, R. (2001). When to hospitalize patients at risk for suicide. *Annals Of The New York Academy Of Sciences*, 932188-196.
26. Isohanni, I., Jones, P., Järvelin, M., Nieminen, P., Rantakallio, P., Jokelainen, J., et al. (2001). Educational consequences of mental disorders treated in hospital. A 31-year follow-up of the Northern Finland 1966 Birth Cohort.
27. Katz S. Hospitalization and the mental health service system. In H Kaplan and B Saddock (Eds.). (2009). *Comprehensive Textbook of Psychiatry* (9th ed). Baltimore, MD: Lippincott, Williams and Wilkins
28. King, E., Baldwin, D., Sinclair, J., Baker, N., Campbell, M., & Thompson, C. (2001). The Wessex Recent In-Patient Suicide Study, 1. Case-control study of 234 recently discharged psychiatric patient suicides. *The British Journal Of Psychiatry: The Journal Of Mental Science*, 178531-536.
29. Klinkenberg, W., & Calsyn, R. (1998). Gender differences in the receipt of aftercare and psychiatric hospitalization among adults with severe mental illness. *Comprehensive Psychiatry*, 39(3), 137-142.
30. Klinkenberg, W., & Calsyn, R. (1997). Race as a moderator of the prediction of receipt of aftercare and psychiatric hospitalization. *The International Journal Of Social Psychiatry*, 43(4), 276-284.
31. Lesage, A., Bonsack, C., Clerc, D., Vanier, C., Charron, M., Sasseville, M., et al. (2002). Alternatives to acute hospital psychiatric care in east-end Montreal. *Canadian Journal Of Psychiatry. Revue Canadienne De Psychiatrie*, 47(1), 49-55.
32. Lesage, A., Morissette, R., Fortier, L., Reinharz, D., & Contandriopoulos, A. (2000). Downsizing psychiatric hospitals: needs for care and services of current and discharged long-stay inpatients. *Canadian Journal Of Psychiatry. Revue Canadienne De Psychiatrie*, 45(6), 526-532.
33. Lieberman, P., McPhetres, E., Elliott, B., Egerter, E., & Wiitala, S. (1993). Dimensions and predictors of change during brief psychiatric hospitalization. *General Hospital Psychiatry*, 15(5), 316-24.
34. Lieberman, P., Wiitala, S., Elliott, B., McCormick, S., & Goyette, S. (1998). Decreasing length of stay: are there effects on outcomes of psychiatric hospitalization? *The American Journal Of Psychiatry*, 155(7), 905-909.
35. Lyons, J., O'Mahoney, M., Miller, S., Neme, J., Kabat, J., & Miller, F. (1997). Predicting readmission to the psychiatric hospital in a managed care environment: implications for quality indicators. *The American Journal Of Psychiatry*, 154(3), 337-340.
36. Maden, A. (1996). Risk assessment in psychiatry. *British Journal Of Hospital Medicine*, 56(2-3), 78-82.

37. McDonagh, M., Smith, D., & Goddard, M. (2000). Measuring appropriate use of acute beds. A systematic review of methods and results. *Health Policy (Amsterdam, Netherlands)*, 53(3), 157-184.
38. Nelson, E., Maruish, M., & Axler, J. (2000). Effects of discharge planning and compliance with outpatient appointments on readmission rates. *Psychiatric Services (Washington, D.C.)*, 51(7), 885-889.
39. Pfeiffer, S., O'Malley, D., & Shott, S. (1996). Factors associated with the outcome of adults treated in psychiatric hospitals: a synthesis of findings. *Psychiatric Services (Washington, D.C.)*, 47(3), 263-269.
40. Prince JD, Akincigil A, Hoover DR, Walkup JT, Bilder S, Crystal S. (2009). Substance abuse and hospitalization for mood disorder among Medicaid beneficiaries. *The American Journal of Public Health*, 99(1), 160-167.
41. Reynolds, W., Lauder, W., Sharkey, S., Maciver, S., Veitch, T., & Cameron, D. (2004). The effects of a transitional discharge model for psychiatric patients. *Journal Of Psychiatric And Mental Health Nursing*, 11(1), 82-88.
42. Rissmiller, D., Steer, R., Friedman, M., & DeMercurio, R. (1999). Prevalence of malingering in suicidal psychiatric inpatients: a replication. *Psychological Reports*, 84(3 Pt 1), 726-730.
43. Shaner, A., Eckman, T., Roberts, L., Wilkins, J., Tucker, D., Tsuang, J., et al. (1995). Disability income, cocaine use, and repeated hospitalization among schizophrenic cocaine abusers--a government-sponsored revolving door?. *The New England Journal Of Medicine*, 333(12), 777-783.
44. Sloan, D., Yokley, J., Gottesman, H., & Schubert, D. (1999). A five-year study on the interactive effects of depression and physical illness on psychiatric unit length of stay. *Psychosomatic Medicine*, 61(1), 21-25.
45. Strakowski, S., Keck, P., McElroy, S., West, S., Sax, K., Hawkins, J., et al. (1998). Twelve-month outcome after a first hospitalization for affective psychosis. *Archives Of General Psychiatry*, 55(1), 49-55.
46. Thomas, M., Rosenberg, S., Giese, A., Fryer, G., Dubovsky, S., & Shore, J. (1996). Shortening length of stay without increasing recidivism on a university-affiliated inpatient unit. *Psychiatric Services (Washington, D.C.)*, 47(9), 996-998.
47. Tyrer, P., Evans, K., Gandhi, N., Lamont, A., Harrison-Read, P., & Johnson, T. (1998). Randomised controlled trial of two models of care for discharged psychiatric patients. *BMJ (Clinical Research Ed.)*, 316(7125), 106-109.
48. Varner, R., Chen, Y., Swann, A., & Moeller, F. (2000). The Brief Psychiatric Rating Scale as an acute inpatient outcome measurement tool: a pilot study. *The Journal Of Clinical Psychiatry*, 61(6), 418-421.
49. Yeaman, C., Gambach, J., Bach, B., Manker, J., Diwan, S., & Corrigan, P. (2003). What happens to people receiving inpatient psychiatric services in mixed rural and urban communities?. *Administration And Policy In Mental Health*, 30(3), 247-253.

I. Hospitalization, Psychiatric, Child & Adolescent

1. Becker, D., & Grilo, C. (2007). Prediction of suicidality and violence in hospitalized adolescents: comparisons by sex. *Canadian Journal Of Psychiatry. Revue Canadienne De Psychiatrie*, 52(9), 572-580.
2. Case, B., Olfson, M., Marcus, S., & Siegel, C. (2007). Trends in the inpatient mental health treatment of children and adolescents in US community hospitals between 1990 and 2000. *Archives Of General Psychiatry*, 64(1), 89-96.
3. Cropsey, K., Weaver, M., & Dupre, M. (2008). Predictors of involvement in the juvenile justice system among psychiatric hospitalized adolescents. *Addictive Behaviors*, 33(7), 942-948.
4. Daniel, S., Goldston, D., Harris, A., Kelley, A., & Palmes, G. (2004). Review of literature on aftercare services among children and adolescents. *Psychiatric Services (Washington, D.C.)*, 55(8), 901-912.
5. Foster, E. (1999). Do aftercare services reduce inpatient psychiatric readmissions?. *Health Services Research*, 34(3), 715-736.
6. Gold, J., Shera, D., & Clarkson, B. (1993). Private psychiatric hospitalization of children: predictors of length of stay. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 32(1), 135-143.
7. Flanders, S., Findling, R., Youngstrom, E., Pandina, G., Rupnow, M., Jensik, S., et al. (2007). Observed clinical and health services outcomes in pediatric inpatients treated with atypical antipsychotics: 1999-2003. *Journal Of Child And Adolescent Psychopharmacology*, 17(3), 312-327.
8. Gutterman, E. (1998). Is diagnosis relevant in the hospitalization of potentially dangerous children and adolescents?. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 37(10), 1030-1037.
9. Patel, N., Hariparsad, M., Matias-Akthar, M., Sorter, M., Barzman, D., Morrison, J., et al. (2007). Body mass indexes and lipid profiles in hospitalized children and adolescents exposed to atypical antipsychotics. *Journal Of Child And Adolescent Psychopharmacology*, 17(3), 303-311.
10. Santiago, L., Tunik, M., Foltin, G., & Mojica, M. (2006). Children requiring psychiatric consultation in the pediatric emergency department: epidemiology, resource utilization, and complications. *Pediatric Emergency Care*, 22(2), 85-89.
11. Stellwagen, K., Kerig, P. (2010). Relation of callous-unemotional traits to length of stay among youth hospitalized at a state psychiatric inpatient facility. *Child Psychiatry & Human Development*; Jun2010, Vol. 41 Issue 3, p251-261
12. Swadi, H., & Bobier, C. (2005). Hospital admission in adolescents with acute psychiatric disorder: how long should it be?. *Australasian Psychiatry: Bulletin Of Royal Australian And New Zealand College Of Psychiatrists*, 13(2), 165-168.
13. Warner, L., Fontanella, C., & Pottick, K. (2007). Initiation and change of psychotropic medication regimens among adolescents in inpatient care. *Journal Of Child And Adolescent Psychopharmacology*, 17(5), 701-712.

J. Hospitalization, Substance-Induced Disorders

1. Alford, D., Compton, P., & Samet, J. (2006). Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. *Annals Of Internal Medicine*, 144(2), 127-134.

2. Barker, S., Knisely, J., & Dawson, K. (1999). The evaluation of a consultation service for delivery of substance abuse services in a hospital setting. *Journal Of Addictive Diseases*, 18(1), 73-82.
3. Dijkgraaf, M., van der Zanden, B., de Borgie, C., Blanken, P., van Ree, J., & van den Brink, W. (2005). Cost utility analysis of co-prescribed heroin compared with methadone maintenance treatment in heroin addicts in two randomised trials. *BMJ (Clinical Research Ed.)*, 330(7503), 1297.
4. Donaher, P., & Welsh, C. (2006). Managing opioid addiction with buprenorphine. *American Family Physician*, 73(9), 1573-1578.
5. Fløvig, J., Vaaler, A., & Morken, G. (2009). Substance use at admission to an acute psychiatric department. *Nordic Journal Of Psychiatry*, 63(2), 113-119.
6. Kakko, J., Grönbladh, L., Svanborg, K., von Wachenfeldt, J., Rück, C., Rawlings, B., et al. (2007). A stepped care strategy using buprenorphine and methadone versus conventional methadone maintenance in heroin dependence: a randomized controlled trial. *The American Journal Of Psychiatry*, 164(5), 797-803.
7. Kaskutas, L., Witbrodt, J., & French, M. (2004). Outcomes and costs of day hospital treatment and nonmedical day treatment for chemical dependency. *Journal Of Studies On Alcohol*, 65(3), 371-382.
8. Mojtabai, R., & Zivin, J. (2003). Effectiveness and cost-effectiveness of four treatment modalities for substance disorders: a propensity score analysis. *Health Services Research*, 38(1 Pt 1), 233-259.
9. Montoya, I., Gorelick, D., Preston, K., Schroeder, J., Umbricht, A., Cheskin, L., et al. (2004). Randomized trial of buprenorphine for treatment of concurrent opiate and cocaine dependence. *Clinical Pharmacology And Therapeutics*, 75(1), 34-48.
10. Mowbray, C., Solomon, M., Ribisl, K., Ebejer, M., Deiz, N., Brown, W., et al. (1995). Treatment for mental illness and substance abuse in a public psychiatric hospital. Successful strategies and challenging problems. *Journal Of Substance Abuse Treatment*, 12(2), 129-139.
11. Schwartz, R., Highfield, D., Jaffe, J., Brady, J., Butler, C., Rouse, C., et al. (2006). A randomized controlled trial of interim methadone maintenance. *Archives Of General Psychiatry*, 63(1), 102-109.
12. Vocci, F., Acri, J., & Elkashef, A. (2005). Medication development for addictive disorders: the state of the science. *The American Journal Of Psychiatry*, 162(8), 1432-1440.
13. Zweben, J., Cohen, J., Christian, D., Galloway, G., Salinardi, M., Parent, D., et al. (2004). Psychiatric symptoms in methamphetamine users. *The American Journal On Addictions / American Academy Of Psychiatrists In Alcoholism And Addictions*, 13(2), 181-190.

K. Intensive Outpatient, Psychiatric

1. Holden P; Neff JA. (2000). Intensive outpatient treatment of persons with mental retardation and psychiatric disorder: a preliminary study. *Mental Retardation [Ment Retard]* 2000 Feb; Vol. 38 (1), pp. 27-32.
2. Lenior, M., Dingemans, P., Linszen, D., de Haan, L., & Schene, A. (2001). Social functioning and the course of early-onset schizophrenia: five-year follow-up of a psychosocial intervention. *The British Journal Of Psychiatry: The Journal Of Mental Science*, 17953-58.

3. McQuillan, A., Nicastro, R., Guenot, F., Girard, M., Lissner, C., & Ferrero, F. (2005). Intensive dialectical behavior therapy for outpatients with borderline personality disorder who are in crisis. *Psychiatric Services (Washington, D.C.)*, *56*(2), 193-197.
4. Raskin, R., Novacek, J., Bahlinger, D., & Firth, L. (1996). A model for evaluating intensive outpatient behavioral health care programs. *Psychiatric Services (Washington, D.C.)*, *47*(11), 1227-1232. Retrieved from MEDLINE database.
5. Washton, A. (1997). Evolution of intensive outpatient treatment (IOP) as a "legitimate" treatment modality. *Journal Of Addictive Diseases*, *16*(2), xxi-xxvii.
6. Wise EA. (2003). Empirical validation of a mental health intensive outpatient program in a private practice setting. *The American Journal Of Orthopsychiatry [Am J Orthopsychiatry]* 2003 Oct; Vol. 73 (4), pp. 405-10.

L. Intensive Outpatient, Substance-Related Disorder

1. Campbell, J., Gabrielli, W., Laster, L., & Liskow, B. (1997). Efficacy of outpatient intensive treatment for drug abuse. *Journal Of Addictive Diseases*, *16*(2), 15-25.
2. Coviello, D., Alterman, A., Rutherford, M., Cacciola, J., McKay, J., & Zanis, D. (2001). The effectiveness of two intensities of psychosocial treatment for cocaine dependence. *Drug And Alcohol Dependence*, *61*(2), 145-154.
3. Fiellin, D., Kleber, H., Trumble-Hejduk, J., McLellan, A., & Kosten, T. (2004). Consensus statement on office-based treatment of opioid dependence using buprenorphine. *Journal Of Substance Abuse Treatment*, *27*(2), 153-159.
4. Fiellin, D., Pantalon, M., Chawarski, M., Moore, B., Sullivan, L., O'Connor, P., et al. (2006). Counseling plus buprenorphine-naloxone maintenance therapy for opioid dependence. *The New England Journal Of Medicine*, *355*(4), 365-374.
5. Fudala, P., Bridge, T., Herbert, S., Williford, W., Chiang, C., Jones, K., et al. (2003). Office-based treatment of opiate addiction with a sublingual-tablet formulation of buprenorphine and naloxone. *The New England Journal Of Medicine*, *349*(10), 949-958.
6. Goldman, C., Hicks, P., Bennett, M., & Leggett, R. (1994). Treating patients with mental illness and chemical dependency: an intensive outpatient program. *Journal Of The South Carolina Medical Association (1975)*, *90*(3), 105-108.
7. Manlandro, J. (2007). Using buprenorphine for outpatient opioid detoxification. *The Journal Of The American Osteopathic Association*, *107*(9 Suppl 5), ES11-ES16.
8. McLellan, A., Hagan, T., Meyers, K., Randall, M., & Durell, J. (1997). "Intensive" outpatient substance abuse treatment: comparisons with "traditional" outpatient treatment. *Journal Of Addictive Diseases*, *16*(2), 57-84.
9. Robinson, S. (2006). Buprenorphine-containing treatments: place in the management of opioid addiction. *CNS Drugs*, *20*(9), 697-712.
10. Schottenfeld, R., Chawarski, M., Pakes, J., Pantalon, M., Carroll, K., & Kosten, T. (2005). Methadone versus buprenorphine with contingency management or performance feedback for cocaine and opioid dependence. *The American Journal Of Psychiatry*, *162*(2), 340-349.
11. Weinstein, S., Gottheil, E., & Sterling, R. (1997). Randomized comparison of intensive outpatient vs. individual therapy for cocaine abusers. *Journal Of Addictive Diseases*, *16*(2), 41-56.

M. Medical Necessity and Medical Necessity Criteria

1. American Association of Community Psychiatrists: Level of Care Utilization System for Psychiatric and Addiction Services, Adult Version. March 20, 2009.
2. American Society of Addiction Medicine. (2001) Patient Placement Criteria for the Treatment of Substance-Related Disorders (2nd ed. - Revised). Chevy Chase, MD.
3. Bergthold, L. (1995). Medical necessity: do we need it?. *Health Affairs (Project Hope)*, 14(4), 180-190.
4. Book J, Harbin H, Marques C, Silverman C, Lizanich-Aro S, Lazarus A. (1995) The ASAM and Green Spring alcohol and drug detoxification and rehabilitation criteria for utilization review. *Am J of Addict* 4:187-197.
5. Criteria for Short-Term Treatment of Acute Psychiatric Illness. A Joint Publication of the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association. (1998).
6. Klein, C., di Menza, S., Arfken, C., & Schuster, C. (2002). Interaction effects of treatment setting and client characteristics on retention and completion. *Journal Of Psychoactive Drugs*, 34(1), 39-50.
7. Kosanke, N., Magura, S., Staines, G., Foote, J., & DeLuca, A. (2002). Feasibility of matching alcohol patients to ASAM levels of care. *The American Journal On Addictions / American Academy Of Psychiatrists In Alcoholism And Addictions*, 11(2), 124-134.
8. Munetz, M., & Geller, J. (1993). The least restrictive alternative in the postinstitutional era. *Hospital & Community Psychiatry*, 44(10), 967-973.
9. Medicare national coverage determinations manual. Centers for Medicare and Medicaid Services (CMS) Coverage Issues Manual Medical Procedures, Chapter 2, Part 2 (Sections 160.14-160.26).
10. Nyman, G., Harbin, H., Book, J., Wiegand, D., Lizanich-Aro, S., Krajewski, T., et al. (1992). Green Spring criteria for medical necessity of outpatient treatment and its use in a mental health utilization review program. *Quality Assurance And Utilization Review: Official Journal Of The American College Of Utilization Review Physicians*, 7(2), 65-69.
11. Rosenbaum S, Kamoie B, Mauery DR, Walitt B. (2003) *Medical necessity in private health plans: implications for behavioral health care*. DHHS Pub No (SMA) 03-3790. 2003 SAMHSA Rockville, MD.
12. Roy-Byrne, P., Russo, J., Rabin, L., Fuller, K., Jaffe, C., Ries, R., et al. (1998). A brief medical necessity scale for mental disorders: reliability, validity, and clinical utility. *The Journal Of Behavioral Health Services & Research*, 25(4), 412-424.
13. Tischler, G. (1990). Utilization management of mental health services by private third parties. *The American Journal Of Psychiatry*, 147(8), 967-973.
14. Wells, K. (1991). Placement of emotionally disturbed children in residential treatment: a review of placement criteria. *The American Journal Of Orthopsychiatry*, 61(3), 339-347.

N. Miscellaneous

1. Allen, M. (1996). Definitive treatment in the psychiatric emergency service. *The Psychiatric Quarterly*, 67(4), 247-262.

2. Bellavia, C., & Toro, P. (1999). Mental disorder among homeless and poor people: a comparison of assessment methods. *Community Mental Health Journal*, 35(1), 57-67.
3. Bennett, M. (1996). Is psychotherapy ever medically necessary?. *Psychiatric Services (Washington, D.C.)*, 47(9), 966-970.
4. Borenstein, D. (1996). Does managed care permit appropriate use of psychotherapy?. *Psychiatric Services (Washington, D.C.)*, 47(9), 971-974.
5. Burns, T., Knapp, M., Catty, J., Healey, A., Henderson, J., Watt, H., et al. (2001). Home treatment for mental health problems: a systematic review. *Health Technology Assessment (Winchester, England)*, 5(15), 1-139.
6. Davis, J., & Kutter, C. (1998). Independent living skills and posttraumatic stress disorder in women who are homeless: implications for future practice. *The American Journal Of Occupational Therapy.: Official Publication Of The American Occupational Therapy Association*, 52(1), 39-44.
7. DiCataldo, F. (1999). A typology of patients admitted to a forensic psychiatric hospital from correctional settings. *The Journal Of The American Academy Of Psychiatry And The Law*, 27(2), 259-271.
8. Dolinar, L. (1993). A historical review of outpatient consultation-liaison psychiatry. *General Hospital Psychiatry*, 15(6), 363-368.
9. Evans, M., Boothroyd, R., Greenbaum, P., Brown, E., Armstrong, M., & Kuppinger, A. (2001). Outcomes associated with clinical profiles of children in psychiatric crisis enrolled in intensive, in-home interventions. *Mental Health Services Research*, 3(1), 35-44.
10. Greenfield, D., & Brown, J. (1993). What to expect from a psychiatric consultation. *New Jersey Medicine: The Journal Of The Medical Society Of New Jersey*, 90(2), 139-141.
11. Grella, C. (1996). Background and overview of mental health and substance abuse treatment systems: meeting the needs of women who are pregnant or parenting. *Journal Of Psychoactive Drugs*, 28(4), 319-343.
12. Hales RE, Yudofsky SC, Talbott JA. Textbook of Psychiatry, fifth edition, American Psychiatric Press, Eating Disorders (2008).
13. Hersh, K., & Borum, R. (1998). Command hallucinations, compliance, and risk assessment. *The Journal Of The American Academy Of Psychiatry And The Law*, 26(3), 353-359.
14. Hoge, M., Davidson, L., Griffith, E., Sledge, W., & Howenstine, R. (1994). Defining managed care in public-sector psychiatry. *Hospital & Community Psychiatry*, 45(11), 1085-1089.
15. Hopper, K., Jost, J., Hay, T., Welber, S., & Haugland, G. (1997). Homelessness, severe mental illness, and the institutional circuit. *Psychiatric Services (Washington, D.C.)*, 48(5), 659-665.
16. Howard, K., Cornille, T., Lyons, J., Vessey, J., Lueger, R., & Saunders, S. (1996). Patterns of mental health service utilization. *Archives Of General Psychiatry*, 53(8), 696-703.
17. Klinkenberg, W., & Calsyn, R. (1997). The moderating effects of race on return visits to the psychiatric emergency room. *Psychiatric Services (Washington, D.C.)*, 48(7), 942-945.
18. Moos, R., Schaefer, J., Andrassy, J., & Moos, B. (2001). Outpatient mental health care, self-help groups, and patients' one-year treatment outcomes. *Journal Of Clinical Psychology*, 57(3), 273-287.

19. Mueser, K., Rosenberg, S., Drake, R., Miles, K., Wolford, G., Vidaver, R., et al. (1999). Conduct disorder, antisocial personality disorder and substance use disorders in schizophrenia and major affective disorders. *Journal Of Studies On Alcohol*, 60(2), 278-284.
20. Nicholson, J., Young, S., Simon, L., Bateman, A., & Fisher, W. (1996). Impact of Medicaid managed care on child and adolescent emergency mental health screening in Massachusetts. *Psychiatric Services (Washington, D.C.)*, 47(12), 1344-1350.
21. Noak, J. (1997). Assessment of the risks posed by people with mental illness. *Nursing Times*, 93(1), 34-36.
22. Olfson, M., & Pincus, H. (1994). Outpatient psychotherapy in the United States, I: Volume, costs, and user characteristics. *The American Journal Of Psychiatry*, 151(9), 1281-1288.
23. Olfson, M., & Pincus, H. (1994). Outpatient psychotherapy in the United States, II: Patterns of utilization. *The American Journal Of Psychiatry*, 151(9), 1289-1294.
24. Olfson, M., Weissman, M., & Gottlieb, J. (1997). Essential roles for psychiatry in the era of managed care. *Archives Of General Psychiatry*, 54(3), 206-208.
25. Piersma, H., & Boes, J. (1997). The GAF and psychiatric outcome: a descriptive report. *Community Mental Health Journal*, 33(1), 35-41.
26. Quinlivan, R., & McWhirter, D. (1996). Designing a comprehensive care program for high-cost clients in a managed care environment. *Psychiatric Services (Washington, D.C.)*, 47(8), 813-815.
27. Regier, D., Kaelber, C., Rae, D., Farmer, M., Knauper, B., Kessler, R., et al. (1998). Limitations of diagnostic criteria and assessment instruments for mental disorders. Implications for research and policy. *Archives Of General Psychiatry*, 55(2), 109-115.
28. Reinhartz, D., Lesage, A., & Contandriopoulos, A. (2000). Cost-effectiveness analysis of psychiatric deinstitutionalization. *Canadian Journal Of Psychiatry. Revue Canadienne De Psychiatrie*, 45(6), 533-538.
29. Ryan, T. (1998). Perceived risks associated with mental illness: beyond homicide and suicide. *Social Science & Medicine (1982)*, 46(2), 287-297.
30. Scheller-Gilkey, G., Lewine, R., Caudle, J., & Brown, F. (1999). Schizophrenia, substance use, and brain morphology. *Schizophrenia Research*, 35(2), 113-120.
31. Schreter R. Essential skills for managed behavioral care. *Psychiatr Serv* 48:653-658 (1997).
32. Schreter, R. (1997). Psychiatric care for the 21st century. *Psychiatric Services (Washington, D.C.)*, 48(10), 1245-1246.
33. Schreter, R. (1998). Reorganizing departments of psychiatry, hospitals, and medical centers for the 21st century. *Psychiatric Services (Washington, D.C.)*, 49(11), 1429-1433.
34. Schreter, R. (1993). Ten trends in managed care and their impact on the biopsychosocial model. *Hospital & Community Psychiatry*, 44(4), 325-327.
35. Shearer, S., Peters, C., Quaytman, M., & Ogden, R. (1990). Frequency and correlates of childhood sexual and physical abuse histories in adult female borderline inpatients. *The American Journal Of Psychiatry*, 147(2), 214-216.

O. Partial Hospitalization, Psychiatric, Child/Adolescent and Adult

1. Bateman, A., & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *The American Journal Of Psychiatry*, 158(1), 36-42.
2. Black, D. (1997). Emergency day hospital assessments. *Clinical Rehabilitation*, 11(4), 344-346.
3. Budson, R. (1994). Community residential and partial hospital care: low-cost alternative systems in the spectrum of care. *The Psychiatric Quarterly*, 65(3), 209-220.
4. Creed, F., Mbaya, P., Lancashire, S., Tomenson, B., Williams, B., & Holme, S. (1997). Cost effectiveness of day and inpatient psychiatric treatment: results of a randomised controlled trial. *BMJ (Clinical Research Ed.)*, 314(7091), 1381-1385.
5. Freed, P., & Rudolph, S. (1998). Protecting partial-hospitalization patients from suicide. *Perspectives In Psychiatric Care*, 34(2), 14-23.
6. Granello, D., Granello, P., & Lee, F. (1999). Measuring treatment outcomes and client satisfaction in a partial hospitalization program. *The Journal Of Behavioral Health Services & Research*, 26(1), 50-63.
7. Granello, D., Granello, P., & Lee, F. (2000). Measuring treatment outcome in a child and adolescent partial hospitalization program. *Administration And Policy In Mental Health*, 27(6), 409-422.
8. Horvitz-Lennon, M., Normand, S., Gaccione, P., & Frank, R. (2001). Partial versus full hospitalization for adults in psychiatric distress: a systematic review of the published literature (1957-1997). *The American Journal Of Psychiatry*, 158(5), 676-685.
9. Kallert, T., Priebe, S., McCabe, R., Kiejna, A., Rymaszewska, J., Nawka, P., et al. (2007). Are day hospitals effective for acutely ill psychiatric patients? A European multicenter randomized controlled trial. *The Journal Of Clinical Psychiatry*, 68(2), 278-287.
10. Kiser LJ, Heston JD, Pruitt DB. Partial Hospitalization and Ambulatory Behavioral Health Services. In H Kaplan and B Saddock (Eds.). (2009). *Comprehensive Textbook of Psychiatry* (9th ed). Baltimore, MD: Lippincott, Williams and Wilkins
11. Marshall, M., Crowther, R., Almaraz-Serrano, A., Creed, F., Sledge, W., Kluiters, H., et al. (2001). Systematic reviews of the effectiveness of day care for people with severe mental disorders: (1) acute day hospital versus admission; (2) vocational rehabilitation; (3) day hospital versus outpatient care. *Health Technology Assessment (Winchester, England)*, 5(21), 1-75.
12. Marshall, M., Crowther, R., Almaraz-Serrano, A., Creed, F., Sledge, W., Kluiters, H., et al. (2003). Day hospital versus admission for acute psychiatric disorders. *Cochrane Database Of Systematic Reviews (Online)*, (1), CD004026.
13. Mackenzie, C., Rosenberg, M., & Major, M. (2006). Evaluation of a psychiatric day hospital program for elderly patients with mood disorders. *International Psychogeriatrics / IPA*, 18(4), 631-641.
14. Mazza, M., Barbarino, E., Capitani, S., Sarchiapone, M., & De Risio, S. (2004). Day hospital treatment for mood disorders. *Psychiatric Services (Washington, D.C.)*, 55(4), 436-438.
15. Neuhaus, Edmund C. (2006). Fixed Values and a Flexible Partial Hospital Program Model. *Harvard Review of Psychiatry*; Jan2006, Vol. 14 Issue 1, p1-14, 14.
16. Piper, W., Rosie, J., Azim, H., & Joyce, A. (1993). A randomized trial of psychiatric day treatment for patients with affective and personality disorders. *Hospital & Community Psychiatry*, 44(8), 757-763.

17. Priebe, S., Jones, G., McCabe, R., Briscoe, J., Wright, D., Slead, M., et al. (2006). Effectiveness and costs of acute day hospital treatment compared with conventional in-patient care: randomised controlled trial. *The British Journal Of Psychiatry: The Journal Of Mental Science*, 188(243-249).
18. Russell, V., Mai, F., Busby, K., Attwood, D., Davis, M., & Brown, M. (1996). Acute day hospitalization as an alternative to inpatient treatment. *Canadian Journal Of Psychiatry. Revue Canadienne De Psychiatrie*, 41(10), 629-637.
19. Simpson, E., Pistorello, J., Begin, A., Costello, E., Levinson, J., Mulberry, S., et al. (1998). Use of dialectical behavior therapy in a partial hospital program for women with borderline personality disorder. *Psychiatric Services (Washington, D.C.)*, 49(5), 669-673.
20. Sledge, W., Tebes, J., Rakfeldt, J., Davidson, L., Lyons, L., & Druss, B. (1996). Day hospital/crisis respite care versus inpatient care, Part I: Clinical outcomes. *The American Journal Of Psychiatry*, 153(8), 1065-1073.
21. Sledge, W., Tebes, J., Wolff, N., & Helminiak, T. (1996). Day hospital/crisis respite care versus inpatient care, Part II: Service utilization and costs. *The American Journal Of Psychiatry*, 153(8), 1074-1083.
22. Weinberg, A., Greaves, J., Creed, F., & Tomenson, B. (1998). Severity of psychiatric disorder in day hospital and in-patient admissions. *Acta Psychiatrica Scandinavica*, 98(3), 250-253.

P. Partial Hospitalization, Substance-Related Disorder

1. Greenwood, G., Woods, W., Guydish, J., & Bein, E. (2001). Relapse outcomes in a randomized trial of residential and day drug abuse treatment. *Journal Of Substance Abuse Treatment*, 20(1), 15-23.
2. Reymann, G., & Danziger, H. (2001). Replacing the last week of a motivational inpatient alcohol withdrawal programme by a day-clinic setting. *European Addiction Research*, 7(2), 56-60.

Q. Preamble

1. Gregoire, T., & Burke, A. (2004). The relationship of legal coercion to readiness to change among adults with alcohol and other drug problems. *Journal Of Substance Abuse Treatment*, 26(1), 337-343.
2. Hasler, G., Delsignore, A., Milos, G., Buddeberg, C., & Schnyder, U. (2004). Application of Prochaska's transtheoretical model of change to patients with eating disorders. *Journal Of Psychosomatic Research*, 57(1), 67-72.
3. Timko, C., & Sempel, J. (2004). Short-term outcomes of matching dual diagnosis patients' symptom severity to treatment intensity. *Journal Of Substance Abuse Treatment*, 26(3), 209-218.

R. Psychiatric/Substance-Related Disorder Comorbidity

1. Biederman, J., Wilens, T., Mick, E., Milberger, S., Spencer, T., & Faraone, S. (1995). Psychoactive substance use disorders in adults with attention deficit hyperactivity disorder (ADHD): effects of ADHD and psychiatric comorbidity. *The American Journal Of Psychiatry*, 152(11), 1652-1658.
2. Brizer, D. (1993). Religiosity and drug abuse among psychiatric inpatients. *The American Journal Of Drug And Alcohol Abuse*, 19(3), 337-345.
3. Davis LL, Wisniewski SR, Howland RH, Trivedi MH, Husain MM, Fava M, McGrath PJ, Balasubramani GK, Warden D, Rush AJ. (2010). Does comorbid substance use disorder

- impair recovery from major depression with SSRI treatment? An analysis of the STAR*D level one treatment outcomes. *Drug Alcohol Depend.* 2010 Mar 1; 107 (2-3):161-70.
4. Dickey, B., & Azeni, H. (1996). Persons with dual diagnoses of substance abuse and major mental illness: their excess costs of psychiatric care. *American Journal Of Public Health, 86*(7), 973-977.
 5. Gil-Rivas V; Prause J; Grella CE. (2009). Substance use after residential treatment among individuals with co-occurring disorders: the role of anxiety/depressive symptoms and trauma exposure. *Psychology Of Addictive Behaviors: Journal Of The Society Of Psychologists In Addictive Behaviors [Psychol Addict Behav]* 2009 Jun; Vol. 23 (2), pp. 303-14.
 6. Grilo, C., Martino, S., Walker, M., Becker, D., Edell, W., & McGlashan, T. (1997). Psychiatric comorbidity differences in male and female adult psychiatric inpatients with substance use disorders. *Comprehensive Psychiatry, 38*(3), 155-159.
 7. Grilo, C., Martino, S., Walker, M., Becker, D., Edell, W., & McGlashan, T. (1997). Controlled study of psychiatric comorbidity in psychiatrically hospitalized young adults with substance use disorders. *The American Journal Of Psychiatry, 154*(9), 1305-1307.
 8. Jackson, C., Fein, D., Essock, S., & Mueser, K. (2001). The effects of cognitive impairment and substance abuse on psychiatric hospitalizations. *Community Mental Health Journal, 37*(4), 303-312.
 9. Jaycox, L., Morral, A., & Juvonen, J. (2003). Mental health and medical problems and service use among adolescent substance users. *Journal Of The American Academy Of Child And Adolescent Psychiatry, 42*(6), 701-709.
 10. Kosten, T., & Ziedonis, D. (1997). Substance abuse and schizophrenia: editors' introduction. *Schizophrenia Bulletin, 23*(2), 181-186.
 11. Lambert, M., Griffith, J., & Hendrickse, W. (1996). Characteristics of patients with substance abuse diagnoses on a general psychiatry unit in a VA Medical Center. *Psychiatric Services (Washington, D.C.), 47*(10), 1104-1107.
 12. Lehman, A., Myers, C., Corty, E., & Thompson, J. (1994). Prevalence and patterns of "dual diagnosis" among psychiatric inpatients. *Comprehensive Psychiatry, 35*(2), 106-112.
 13. Leon, S., Lyons, J., Christopher, N., & Miller, S. (1998). Psychiatric hospital outcomes of dual diagnosis patients under managed care. *The American Journal On Addictions / American Academy Of Psychiatrists In Alcoholism And Addictions, 7*(1), 81-86.
 14. Maynard, C., & Cox, G. (1998). Psychiatric hospitalization of persons with dual diagnoses: estimates from two national surveys. *Psychiatric Services (Washington, D.C.), 49*(12), 1615-1617.
 15. Prince JD, Akincigil A, Hoover DR, Walkup JT, Bilder S, Crystal S. (2009). Substance abuse and hospitalization for mood disorder among Medicaid beneficiaries. *The American Journal of Public Health, 99*(1), 160-167.
 16. RachBeisel, J., Dixon, L., & Gearon, J. (1999). Awareness of substance abuse problems among dually-diagnosed psychiatric inpatients. *Journal Of Psychoactive Drugs, 31*(1), 53-57.
 17. Timko, C., Sempel, J., & Moos, R. (2003). Models of standard and intensive outpatient care in substance abuse and psychiatric treatment. *Administration And Policy In Mental Health, 30*(5), 417-436.
 18. Timko, C., Lesar, M., Calvi, N., & Moos, R. (2003). Trends in acute mental health care: comparing psychiatric and substance abuse treatment programs. *The Journal Of Behavioral Health Services & Research, 30*(2), 145-160.

19. Wong J, Besett T. (1999) Sex differences on the MMPI-2 substance abuse scales in psychiatric inpatients. *Psychological Reports*. Apr. 84(2):582-84
20. Xafenias, A., Diakogiannis, I., Iacovides, A., Fokas, K., & Kaprinis, G. (2008). Factors affecting hospital length of stay: is substance use disorder one of them? A study in a Greek public psychiatric hospital. *The American Journal On Addictions / American Academy Of Psychiatrists In Alcoholism And Addictions*, 17(5), 447-451.

S. Residential, Child & Adolescent

1. Byrnes, E., Hansen, K., Malloy, T., Carter, C., & Curry, D. (1999). Reductions in criminality subsequent to group, individual, and family therapy in adolescent residential and day treatment settings. *International Journal Of Group Psychotherapy*, 49(3), 307-322.
2. Connor, D., Ozbayrak, K., Harrison, R., & Melloni, R. (1998). Prevalence and patterns of psychotropic and anticonvulsant medication use in children and adolescents referred to residential treatment. *Journal Of Child And Adolescent Psychopharmacology*, 8(1), 27-38.
3. Connor, D., Ozbayrak, K., Kusiak, K., Caponi, A., & Melloni, R. (1997). Combined pharmacotherapy in children and adolescents in a residential treatment center. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 36(2), 248-254.
4. Curry, J. (2004). Future directions in residential treatment outcome research. *Child And Adolescent Psychiatric Clinics Of North America*, 13(2), 429-440.
5. Epstein, R. (2004). Inpatient and residential treatment effects for children and adolescents: a review and critique. *Child And Adolescent Psychiatric Clinics Of North America*, 13(2), 411-428.
6. Hussey, D., & Guo, S. (2005). Forecasting length of stay in child residential treatment. *Child Psychiatry And Human Development*, 36(1), 95-111.
7. Joshi, P., & Rosenberg, L. (1997). Children's behavioral response to residential treatment. *Journal Of Clinical Psychology*, 53(6), 567-573.
8. Leichtman, M. (2006). Residential treatment of children and adolescents: past, present, and future. *The American Journal Of Orthopsychiatry*, 76(3), 285-294.
9. Matthys, W. (1997). Residential behavior therapy for children with conduct disorders. *Behavior Modification*, 21(4), 512-532.
10. O'Malley, F. (2004). Contemporary issues in the psychiatric residential treatment of disturbed adolescents. *Child And Adolescent Psychiatric Clinics Of North America*, 13(2), 255-266.
11. Shoaf, T. (2004). Pediatric psychopharmacology for the major psychiatric disorders found in the residential treatment setting. *Child And Adolescent Psychiatric Clinics Of North America*, 13(2), 327-345.
12. Weiner, D., Abraham, M., & Lyons, J. (2001). Clinical characteristics of youths with substance use problems and implications for residential treatment. *Psychiatric Services (Washington, D.C.)*, 52(6), 793-799.

T. Residential, General

1. Bachrach, L. (1994). Residential planning: concepts and themes. *Hospital & Community Psychiatry*, 45(3), 202-203.

2. Davis, K., Devitt, T., Rollins, A., O'Neill, S., Pavick, D., & Harding, B. (2006). Integrated residential treatment for persons with severe and persistent mental illness: lessons in recovery. *Journal Of Psychoactive Drugs*, 38(3), 263-272.
3. Fenton, W., Hoch, J., Herrell, J., Mosher, L., & Dixon, L. (2002). Cost and cost-effectiveness of hospital vs residential crisis care for patients who have serious mental illness. *Archives Of General Psychiatry*, 59(4), 357-364.
4. Fenton, W., Mosher, L., Herrell, J., & Blyler, C. (1998). Randomized trial of general hospital and residential alternative care for patients with severe and persistent mental illness. *The American Journal Of Psychiatry*, 155(4), 516-522.
5. Gil-Rivas V; Prause J; Grella CE. (2009). Substance use after residential treatment among individuals with co-occurring disorders: the role of anxiety/depressive symptoms and trauma exposure. *Psychology Of Addictive Behaviors: Journal Of The Society Of Psychologists In Addictive Behaviors [Psychol Addict Behav]* 2009 Jun; Vol. 23 (2), pp. 303-14.
6. Gruber-Baldini, A., Boustani, M., Sloane, P., & Zimmerman, S. (2004). Behavioral symptoms in residential care/assisted living facilities: prevalence, risk factors, and medication management. *Journal Of The American Geriatrics Society*, 52(10), 1610-1617.
7. Hawthorne, W., Green, E., Gilmer, T., Garcia, P., Hough, R., Lee, M., et al. (2005). A randomized trial of short-term acute residential treatment for veterans. *Psychiatric Services (Washington, D.C.)*, 56(11), 1379-1386.
8. Hawthorne, W., Green, E., Lohr, J., Hough, R., & Smith, P. (1999). Comparison of outcomes of acute care in short-term residential treatment and psychiatric hospital settings. *Psychiatric Services (Washington, D.C.)*, 50(3), 401-406.
9. Hiller, M., Rowan-Szal, G., Bartholomew, N., & Simpson, D. (1996). Effectiveness of a specialized women's intervention in a residential treatment program. *Substance Use & Misuse*, 31(6), 771-783.
10. Kashubeck, S., Pottebaum, S., & Read, N. (1994). Predicting elopement from residential treatment centers. *The American Journal Of Orthopsychiatry*, 64(1), 126-135.
11. Subramaniam GA; Lewis LL; Stitzer ML; Fishman MJ. (2004). Depressive symptoms in adolescents during residential treatment for substance use disorders. *The American Journal On Addictions / American Academy Of Psychiatrists In Alcoholism And Addictions [Am J Addict]* 2004 May-Jun; Vol. 13 (3), pp. 256-67.
12. Timko, C. (1996). Physical characteristics of residential psychiatric and substance abuse programs: organizational determinants and patients outcomes. *American Journal Of Community Psychology*, 24(1), 173-192.
13. Vandevooren, J., Miller, L., & O'Reilly, R. (2007). Outcomes in community-based residential treatment and rehabilitation for individuals with psychiatric disabilities: a retrospective study. *Psychiatric Rehabilitation Journal*, 30(3), 215-217.

U. Residential, Substance-Related Disorder

1. Allen, M., & Phillips, K. (1993). Utilization review of treatment for chemical dependence. *Hospital & Community Psychiatry*, 44(8), 752-756.
2. Amodeo, M., Chassler, D., Oettinger, C., Labiosa, W., & Lundgren, L. (2008). Client retention in residential drug treatment for Latinos. *Evaluation And Program Planning*, 31(1), 102-112.

3. Davis, K., Devitt, T., Rollins, A., O'Neill, S., Pavick, D., & Harding, B. (2006). Integrated residential treatment for persons with severe and persistent mental illness: lessons in recovery. *Journal Of Psychoactive Drugs*, 38(3), 263-272.
4. Hiller, M., Knight, K., Devereux, J., & Hathcoat, M. (1996). Posttreatment outcomes for substance-abusing probationers mandated to residential treatment. *Journal Of Psychoactive Drugs*, 28(3), 291-296.
5. Kaspro, W., Rosenheck, R., Frisman, L., & DiLella, D. (1999). Residential treatment for dually diagnosed homeless veterans: a comparison of program types. *The American Journal On Addictions / American Academy Of Psychiatrists In Alcoholism And Addictions*, 8(1), 34-43.
6. McCusker, J., Vickers-Lahti, M., Stoddard, A., Hindin, R., Bigelow, C., Zorn, M., et al. (1995). The effectiveness of alternative planned durations of residential drug abuse treatment. *American Journal Of Public Health*, 85(10), 1426-1429.
7. Moos, R., Moos, B., & Andrassy, J. (1999). Outcomes of four treatment approaches in community residential programs for patients with substance use disorders. *Psychiatric Services (Washington, D.C.)*, 50(12), 1577-1583.
8. Stack, K., Cortina, J., Samples, C., Zapata, M., & Arcand, L. (2000). Race, age, and back pain as factors in completion of residential substance abuse treatment by veterans. *Psychiatric Services (Washington, D.C.)*, 51(9), 1157-1161.
9. Laffaye, C., McKellar, J., Ilgen, M., & Moos, R. (2008). Predictors of 4-year outcome of community residential treatment for patients with substance use disorders. *Addiction (Abingdon, England)*, 103(4), 671-680.
10. Subramaniam GA; Lewis LL; Stitzer ML; Fishman MJ. (2004). Depressive symptoms in adolescents during residential treatment for substance use disorders. *The American Journal On Addictions / American Academy Of Psychiatrists In Alcoholism And Addictions [Am J Addict]* 2004 May-Jun; Vol. 13 (3), pp. 256-67.
11. Weiner DA; Abraham ME; Lyons J. (2001). Clinical characteristics of youths with substance use problems and implications for residential treatment. *Psychiatric Services (Washington, D.C.) [Psychiatr Serv]* 2001 Jun; Vol. 52 (6), pp. 793-9.

V. Substance-Related Disorders, General

1. Cherubin, C., & Sapira, J. (1993). The medical complications of drug addiction and the medical assessment of the intravenous drug user: 25 years later. *Annals Of Internal Medicine*, 119(10), 1017-1028.
2. Corsino, B., Morrow, D., & Wallace, C. (1996). Quality improvement and substance abuse: rethinking impaired provider policies. *American Journal Of Medical Quality: The Official Journal Of The American College Of Medical Quality*, 11(2), 94-99.
3. Del Toro, I., Thom, D., Beam, H., & Horst, T. (1996). Chemically dependent patients in recovery: roles for the family physician. *American Family Physician*, 53(5), 1667-1681.
4. Farkas, K., & Parran, T. (1993). Treatment of cocaine addiction during pregnancy. *Clinics In Perinatology*, 20(1), 29-45.
5. French, M., Mauskopf, J., Teague, J., & Roland, E. (1996). Estimating the dollar value of health outcomes from drug-abuse interventions. *Medical Care*, 34(9), 890-910.

6. French, M. (2001). Economic evaluation of alcohol treatment services. *Recent Developments In Alcoholism: An Official Publication Of The American Medical Society On Alcoholism, The Research Society On Alcoholism, And The National Council On Alcoholism*, 15209-228.
7. Garcia, S. (1997). Ethical and legal issues associated with substance abuse by pregnant and parenting women. *Journal Of Psychoactive Drugs*, 29(1), 101-111.
8. Harrison, P., & Asche, S. (1999). Comparison of substance abuse treatment outcomes for inpatients and outpatients. *Journal Of Substance Abuse Treatment*, 17(3), 207-220.
9. Howell, E., Heiser, N., & Harrington, M. (1999). A review of recent findings on substance abuse treatment for pregnant women. *Journal Of Substance Abuse Treatment*, 16(3), 195-219.
10. Langenbucher, J., Chung, T., Morgenstern, J., Labouvie, E., Nathan, P., & Bavy, L. (1997). Physiological alcohol dependence as a "specifier" of risk for medical problems and relapse liability in DSM-IV. *Journal Of Studies On Alcohol*, 58(4), 341-350.
11. Liebschutz, J., Mulvey, K., & Samet, J. (1997). Victimization among substance-abusing women. Worse health outcomes. *Archives Of Internal Medicine*, 157(10), 1093-1097.
12. Marques, P., Zaloshjna, E., Miller, T., Wachrer, G., Danseco, E., Levy, D., et al. (2001). Financial risk, plan types, and authorizations for managed alcohol treatment services. *The American Journal Of Managed Care*, 7(12), 1151-1161.
13. McAvay, G., Nunes, E., Zaider, T., Goldstein, R., & Weissman, M. (1999). Physical health problems in depressed and nondepressed children and adolescents of parents with opiate dependence. *Depression And Anxiety*, 9(2), 61-69.
14. McCarty, D., & Argeriou, M. (2003). The Iowa Managed Substance Abuse Care Plan: access, utilization, and expenditures for Medicaid recipients. *The Journal Of Behavioral Health Services & Research*, 30(1), 18-25.
15. McCrady, B., & Langenbucher, J. (1996). Alcohol treatment and health care system reform. *Archives Of General Psychiatry*, 53(8), 737-746.
16. O'Neill, J. (1997). Primary care of the HIV-seropositive chemically dependent patient. *Primary Care*, 24(3), 667-676.
17. Sandlow, L., & Dos Santos, S. (1997). Addiction medicine and continuing medical education. *Journal Of Psychoactive Drugs*, 29(3), 275-284.
18. Winters, K., Stinchfield, R., Opland, E., Weller, C., & Latimer, W. (2000). The effectiveness of the Minnesota Model approach in the treatment of adolescent drug abusers. *Addiction (Abingdon, England)*, 95(4), 601-612.
19. Frydrych, L., Greene, B., Blondell, R., & Purdy, C. (2009). Self-help program components and linkage to aftercare following inpatient detoxification. *Journal Of Addictive Diseases*, 28(1), 21-27.

W. Suicide

1. Bhatia, S., Rezac, A., Vitiello, B., Sitorius, M., Buehler, B., & Kratochvil, C. (2008). Antidepressant prescribing practices for the treatment of children and adolescents. *Journal Of Child And Adolescent Psychopharmacology*, 18(1), 70-80.
2. Blader, J. (2006). Pharmacotherapy and postdischarge outcomes of child inpatients admitted for aggressive behavior. *Journal Of Clinical Psychopharmacology*, 26(4), 419-425.

3. Bridge, J., Iyengar, S., Salary, C., Barbe, R., Birmaher, B., Pincus, H., et al. (2007). Clinical response and risk for reported suicidal ideation and suicide attempts in pediatric antidepressant treatment: a meta-analysis of randomized controlled trials. *JAMA: The Journal Of The American Medical Association*, 297(15), 1683-1696.
4. Emslie, G., Kratochvil, C., Vitiello, B., Silva, S., Mayes, T., McNulty, S., et al. (2006). Treatment for Adolescents with Depression Study (TADS): safety results. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 45(12), 1440-1455.
5. Fawcet, J, Clark, DC, Busch, KA. Assessing and treating the patient at risk for suicide. *Psychiatric Annals* 23:244-255 (1993).
6. Friedman, R., & Leon, A. (2007). Expanding the black box - depression, antidepressants, and the risk of suicide. *The New England Journal Of Medicine*, 356(23), 2343-2346.
7. Gibbons, R., Hur, K., Bhaumik, D., & Mann, J. (2006). The relationship between antidepressant prescription rates and rate of early adolescent suicide. *The American Journal Of Psychiatry*, 163(11), 1898-1904.
8. Hammad, T., Laughren, T., & Racoosin, J. (2006). Suicidality in pediatric patients treated with antidepressant drugs. *Archives Of General Psychiatry*, 63(3), 332-339.
9. Høyer, E., Olesen, A., & Mortensen, P. (2004). Suicide risk in patients hospitalised because of an affective disorder: a follow-up study, 1973-1993. *Journal Of Affective Disorders*, 78(3), 209-217.
10. Huey, S., Henggeler, S., Rowland, M., Halliday-Boykins, C., Cunningham, P., Pickrel, S., et al. (2004). Multisystemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 43(2), 183-190.
11. Huth-Bocks, A., Kerr, D., Ivey, A., Kramer, A., & King, C. (2007). Assessment of psychiatrically hospitalized suicidal adolescents: self-report instruments as predictors of suicidal thoughts and behavior. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 46(3), 387-395.
12. Kennedy, S., Baraff, L., Suddath, R., & Asarnow, J. (2004). Emergency department management of suicidal adolescents. *Annals Of Emergency Medicine*, 43(4), 452-460.
13. Leon, A., Marzuk, P., Tardiff, K., Bucciarelli, A., Markham Piper, T., & Galea, S. (2006). Antidepressants and youth suicide in New York City, 1999-2002. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 45(9), 1054-1058.
14. Nemeroff, C., Kalali, A., Keller, M., Charney, D., Lenderts, S., Cascade, E., et al. (2007). Impact of publicity concerning pediatric suicidality data on physician practice patterns in the United States. *Archives Of General Psychiatry*, 64(4), 466-472.
15. Oxley STI, Van Meter S. (1996). The assessment and management of the suicidal patient. *J Prac Psych Behav Health*. Nov., vol. 2, issue 6. 327-335
16. Posner, K., Oquendo, M., Gould, M., Stanley, B., & Davies, M. (2007). Columbia Classification Algorithm of Suicide Assessment (C-CASA): classification of suicidal events in the FDA's pediatric suicidal risk analysis of antidepressants. *The American Journal Of Psychiatry*, 164(7), 1035-1043.
17. Ries, R., Yuodelis-Flores, C., Comtois, K., Roy-Byrne, P., & Russo, J. (2008). Substance-induced suicidal admissions to an acute psychiatric service: characteristics and outcomes. *Journal Of Substance Abuse Treatment*, 34(1), 72-79.

18. Safer, D. (1997). Adolescent/adult differences in suicidal behavior and outcome. *Annals Of Clinical Psychiatry: Official Journal Of The American Academy Of Clinical Psychiatrists*, 9(1), 61-66.
19. Simon, G., Savarino, J., Operskalski, B., & Wang, P. (2006). Suicide risk during antidepressant treatment. *The American Journal Of Psychiatry*, 163(1), 41-47.

X. Violence & Aggression

1. Edwards DW; Scott CL; Yarvis RM; Paizis CL; Panizzon MS. (2003). Violence And Victims [Violence Vict] 2003 Feb; Vol. 18 (1), pp. 3-14.
2. Fox, G. (1998). Risk assessment: a systematic approach to violence. *Nursing Standard (Royal College Of Nursing (Great Britain): 1987)*, 12(32), 44-47.
3. Menninger, W. (1993). Management of the aggressive and dangerous patient. *Bulletin Of The Menninger Clinic*, 57(2), 208-217.
4. Sandberg, D., McNiel, D., & Binder, R. (1998). Characteristics of psychiatric inpatients who stalk, threaten, or harass hospital staff after discharge. *The American Journal Of Psychiatry*, 155(8), 1102-1105.
5. Saner, H., & Ellickson, P. (1996). Concurrent risk factors for adolescent violence. *The Journal Of Adolescent Health: Official Publication Of The Society For Adolescent Medicine*, 19(2), 94-103.
6. Shaffer, C., Waters, W., & Adams, S. (1994). Dangerousness: assessing the risk of violent behavior. *Journal Of Consulting And Clinical Psychology*, 62(5), 1064-1068.
7. Steadman, H., Mulvey, E., Monahan, J., Robbins, P., Appelbaum, P., Grisso, T., et al. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives Of General Psychiatry*, 55(5), 393-401.
8. Stuart GL; Moore TM; Ramsey SE; Kahler CW. (2003). Relationship aggression and substance use among women court-referred to domestic violence intervention programs. *Addictive Behaviors* [Addict Behav] 2003 Dec; Vol. 28 (9), pp. 1603-10.

Y. Outpatient Treatment

1. Fontana, A., & Rosenheck, R. (1996). Improving the efficiency of outpatient treatment for post-traumatic stress disorders. *Administration and Policy in Mental Health*, 23, 197-210.
2. Fossum, S., Handegård, B., Martinussen, M., Mørch, W. (2008). Psychosocial interventions for disruptive and aggressive behaviour in children and adolescents. *European Child & Adolescent Psychiatry*; Oct2008, Vol. 17 Issue 7, p438-45.
3. Mensinger, JL; Diamond, GS; Kaminer, Y; Wintersteen, MB. (2006). Adolescent and Therapist Perception of Barriers to Outpatient Substance Abuse Treatment. *American Journal on Addictions*; Dec2006 Supplement, Vol. 15, p16-25
4. Moos, R., Schaefer, J., Andrassy, J., & Moos, B. (2001). Outpatient mental health care, self-help groups, and patients' one-year treatment outcomes. *Journal Of Clinical Psychology*, 57(3), 273-287.
5. Ouimette, P., Moos, R., & Finney, J. (1998). Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes. *Journal Of Studies On Alcohol*, 59(5), 513-522.
6. Steenbarger, B.N. (1994). Duration and outcome in psychotherapy: An integrative review. *Professional Psychology: Research and Practice*, 25, 111-119.

Z. Electroconvulsive Therapy

1. American Psychiatry Association. (2001). *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging*. Arlington, VA: American Psychiatric Press.
2. Dew, R., & McCall, W. (2004). Efficiency of outpatient ECT. *The Journal Of ECT*, 20(1), 24-25.
3. Fink, M. (2002) *The practice of electroconvulsive therapy: recommendations for treatment, training, and privileging*, second edition. Book Review. *Psychiatr Serv* 53(8):1040-1041.
4. Frederikse, M., Petrides, G., & Kellner, C. (2006). Continuation and maintenance electroconvulsive therapy for the treatment of depressive illness: a response to the National Institute for Clinical Excellence report. *The Journal Of ECT*, 22(1), 13-17.
5. Irvin SM 1997. Treatment of depression with outpatient electroconvulsive therapy. *AORN J*. 65(3):537-8, 581-2.
6. Kellner, C., Fink, M., Knapp, R., Petrides, G., Husain, M., Rummans, T., et al. (2005). Relief of expressed suicidal intent by ECT: a consortium for research in ECT study. *The American Journal Of Psychiatry*, 162(5), 977-982.
7. New York State Office of Mental Health. *Electroconvulsive Therapy Review Guidelines*. <http://www.omh.state.ny.us/omhweb/resources/>. Last modified 9/16/2008.
8. Rasmussen, K., Mueller, M., Kellner, C., Knapp, R., Petrides, G., Rummans, T., et al. (2006). Patterns of psychotropic medication use among patients with severe depression referred for electroconvulsive therapy: data from the Consortium for Research on Electroconvulsive Therapy. *The Journal Of ECT*, 22(2), 116-123.
9. Sackeim HA, Dillingham EM, Prudic J, Cooper T, McCall WV, Rosenquist P, Isenberg K, Garcia K, Mulsant BH, Haskett RF. (2009). Effect of concomitant pharmacotherapy on electroconvulsive therapy outcomes: short-term efficacy and adverse effects. *Arch Gen Psychiatry*. 2009 Jul; 66(7):729-37.
10. Silver JM, Yudofsky SC, Hurowitz GI. 2008. *Psychopharmacology and electroconvulsive therapy*. In *Textbook of Psychiatry*, second edition. Arlington, VA: American Psychiatric Press.

AA. 23-Hour Observation

1. Clinical Guidelines for the State of Nebraska Medicaid Managed Care Plan. (Revised 10/2003). 23-Hour Crisis Observation
https://www.magellanprovider.com/MHS/MGL/about/handbooks/supplements/ne_medic_aid/ne_appc_clinguide.pdf
2. Francis, E., Marchand, W., Hart, M., Carter, A., Schinka, J., Feldman, A., et al. (2000). Utilization and outcome in an overnight psychiatric observation program at a Veterans Affairs Medical Center. *Psychiatric Services (Washington, D.C.)*, 51(1), 92-95.