

ACUTE INPATIENT TREATMENT

I. Definition of Service:

Acute inpatient hospitalization represents the most intensive level of psychiatric care. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour secure and protected, medically staffed and psychiatrically supervised treatment environment. This level of service is typically administered on a locked unit. Twenty-four hour skilled psychiatric nursing care, daily medical care, and a structured treatment milieu under the direction of a psychiatrist, or for children/adolescents, a board certified child and adolescent psychiatrist is required. The goal of acute inpatient hospitalization is to stabilize individuals who display acute psychiatric conditions associated with a relatively sudden onset and a short, severe course, or a marked exacerbation of symptoms associated with a more persistent, recurring disorder. Typically, the individual poses a significant danger to self or others, or displays severe psychosocial dysfunction. Special treatment may include physical and mechanical restraint and/or seclusion. Impulsive behavior increases the need for consideration of this level of care. However, 23-hour observation may be used initially.

II. Admission Criteria:

The following criteria are necessary for admission:

Individual has been evaluated by a licensed clinician and demonstrates symptomatology consistent with a Medicaid covered DSM-IV-TR (AXIS I-V) diagnosis that requires and can reasonably be expected to respond to therapeutic intervention, and the individual presents with at least one of the following:

- a. At imminent risk for self-injury with an inability to guarantee safety as evidenced by **at least one** of the following:
 - A recent suicide attempt that is serious by degree of lethality and intentionality or
 - Current suicidal ideation with a plan and means.
 - Recent self mutilation that is severe and dangerous
 - Recent statements and/or behavior indicating a high risk for severe injury
 - Command hallucinations directing harm to self
- b. At imminent risk for injury to others as evidenced by any of the following:
 - Active plan, means and lethal intent to seriously injure others
 - Current assaultive threats or behaviors with a clear risk for escalation or future repetition

- Recent history of self-mutilation, significant risk-taking or loss of impulse control resulting in danger to self or others.
 - Command hallucinations directing harm to others
- c. Disordered/bizarre behavior or psychomotor agitation or retardation that interferes with the activities of daily living to such a degree that the individual cannot function at a less intensive level of care.
- d. Imminent risk for acute medical status deterioration due to the presence of a psychiatric disorder because either:
- Psychiatric symptoms or behaviors prevent the accurate diagnosis or treatment of a serious medical condition requiring inpatient medical care
 - Providing the needed acute psychiatric intervention will likely result in deterioration of medical condition and/or mental health.

Assessment of individuals with suicidal or homicidal behaviors should include:

- A thorough psychiatric evaluation and inquiry about thoughts, plans and behaviors and estimation of suicidal or homicidal risk.
- The presence of continued feelings of helplessness and/or hopelessness, severely depressed mood, and/or recent significant losses.
- Availability of responsible support systems, including recovery based community services.
- Assessment of the person's strengths, vulnerabilities and needs in relation to risk and development of the treatment plan.

III. Continued Stay Criteria:

All of the following criteria are necessary for continuing treatment at this level of care:

1. The individual's condition continues to meet admission criteria for inpatient care and no other less intensive level of care would be adequate.
2. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family or other support systems, social, occupational, and interpersonal assessment with involvement when indicated.
3. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice.
4. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress and/or psychiatric/medical complications are evident.

5. Care is rendered in a clinically appropriate manner and focused on the individual's behavioral and functional outcomes as described in the discharge plan.
6. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
7. There is documented active Discharge Planning.
8. There is documented active attempt at coordination of care with the Behavioral Health Provider and the PCP (primary care physician) when appropriate.
9. The patient is currently involved and cooperating in treatment process or, they are not cooperating/involved but there are measurable indicators the patient is progressing towards active involvement in treatment.

IV. Exclusion Criteria:

Any of the following criteria are sufficient for exclusion from this level of care:

1. The individual can be safely maintained and effectively treated at a less intensive level of care.
2. Symptoms result from a medical condition, which warrants a medical/surgical setting for treatment.
3. The individual exhibits serious and persistent mental illness and is not in an acute exacerbation of the illness.
4. The primary problem is social, economic (e.g., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care or admission is being used as an alternative to incarceration.

V. Discharge Criteria:

1. No longer meets admission criteria or meets criteria for a less intensive level of care.
2. Plan for continuation of services at a lower level of care has been implemented.
3. The client decides that he/she wishes to be discharged and is not on a 27-10 hold for this level of care.

VI. Frequency of Review:

1. Review for medical necessity will occur at least every seven days (as of 5/1/08)

V. Clinical Resources:

1. "Criteria for Short-Term Treatment of Acute Psychiatric Illness", American Academy of Child & Adolescent Psychiatry and the American Psychiatric Association, available at:
http://www.psych.org/psych_pract/criteria121503.pdf

2. “Assessing and Treating Suicidal Behaviors: A Quick Reference Guide, American Psychiatric Association available at:
[http://www.psych.org/psych_pract/treatg/quick_ref_guide/
Suibehavs.QRG.pdf](http://www.psych.org/psych_pract/treatg/quick_ref_guide/Suibehavs.QRG.pdf)