Behavioral Health GRG

GRG: BG-BHG (ISC GRG)

MCG Health
General Recovery Care
30th Edition
Behavioral Health Case Management GRG GRG

Note: An appropriate Optimal Recovery Guideline (ORG) should be identified and used whenever possible. This General Recovery Guideline (GRG) is intended to aid only in situations in which no ORG appears applicable.

Care Planning - Inpatient Admission and Alternatives

Clinical Indications for Admission to Inpatient Care

- Hospital admission is needed for appropriate care of the patient because of **1 or more** of the following:
  - Admission to **Inpatient Level of Care for Adult** (LOCUS Level 6 - Medically Managed Residential Services, Composite Score 28 or more) is indicated due to **ALL** of the following[A][B][C][D]:
    - Patient risk or severity of behavioral health disorder is appropriate to proposed level of care, as indicated by **1 or more** of the following(1)(3)(4)(10)(11)(12):

- Imminent danger to self for adult is present due to **1 or more** of the following(1)(4)(13)(14):
  - Imminent risk for recurrence of Suicide attempt or act of serious Harm to self is present, as indicated by **ALL** of the following:
    - There has been a recent Suicide attempt or deliberate act of serious Harm to self.
    - There has not been Sufficient relief of the factors that precipitated attempt or act.
  - Current plan for suicide or serious Harm to self is present.
  - Command auditory hallucinations or paranoid delusions contributing to risk for suicide or serious Harm to self are present.
  - Patient has persistent Thoughts of suicide or serious Harm to self that cannot be adequately monitored or treated at lower level of care, as indicated by **1 or more** of the following[E]:
    - Necessary behavioral health care (such as required provider or lower level of care) not available or insufficient
    - Patient support system inadequate
    - Patient characteristics, such as extremely Impaired impulse control, judgment, or insight; severe Mania (adult), severe unreliability, or extreme agitation with desperation
    - Uncontrollable and overwhelming negative thoughts
    - Fatalistic conviction that life will not improve, along with oppressive sense of entrapment and doom
- Imminent danger to others for adult is present due to **1 or more** of the following(1)(4)(13)(15):
  - Imminent risk for recurrence of attempt to seriously Harm another is present, as indicated by **ALL** of the following:
    - There has been a recent attempt to seriously Harm another.
    - There has not been Sufficient relief of factors that precipitated the attempt.
  - Current plan for homicide or serious Harm to another is present.
  - Command auditory hallucinations or paranoid delusions contributing to risk for homicide or serious Harm to another are present.
  - Patient has persistent thoughts of homicide or violent acts that likely could result in serious Harm to another that cannot be adequately monitored or treated at lower level of care, as indicated by **1 or more** of the following[E]:
    - Necessary behavioral health care (such as required provider or lower level of care) not available or insufficient
    - Patient support system inadequate
    - Patient characteristics, such as extremely Impaired impulse control, judgment, or insight; severe Mania (adult), severe unreliability, or extreme agitation with desperation
    - Uncontrollable and overwhelming negative thoughts
    - Indication or report of repeated behavior, including physical or sexual aggression that is clearly injurious to others with history, plan or intent, and extremely Impaired impulse control, judgment, or insight

- Behavioral health disorder is present and appropriate for inpatient care with **ALL** of the following:
  - **Severe** psychiatric, behavioral, or other comorbid conditions are appropriate for management at proposed level of care, as indicated by **1 or more** of the following[F][G]:
    - Psychiatric symptoms, including **1 or more** of the following(12):
      - Hallucinations (adult), Delusions (adult), or other Positive symptoms (adult)
      - Negative symptoms (adult), including social or emotional withdrawal or lack of self-initiated behavior or movement
      - Mania (adult)
      - Depressive symptoms (adult)
      - Anxiety (adult)
      - Hyperactivity or inattention (adult)
      - Obsessions or compulsions (adult)
      - Personality disorders/maladaptive personality traits

- Other psychiatric symptoms related to underlying psychiatric disorder or underlying comorbid condition having a negative impact on primary psychiatric disorder

- Comorbid biomedical or developmental condition[H][I]
- Comorbid substance use disorder[J][K]
- Cognitive or memory impairment[L]
- Impaired impulse control, judgment, or insight
- Emotional or behavioral disturbances impacting symptoms or function, including **1 or more** of the following[M](35)(36)(37):
  - Externalizing symptoms (eg, angry outbursts, physical or verbal aggression, oppositional defiant traits, agitation, anxiety, or other disruptive behaviors)
  - Internalizing symptoms (eg, sulking, rumination, anhedonia, dysphoria, apathy)
  - Evidence of severely diminished ability to assess consequences of own actions (eg, acts of severe property damage)
  - High levels of family conflict or interpersonal conflict
  - Escalating relapse behaviors
  - Other emotional or behavioral disturbance relevant to clinical presentation
- **Severe** dysfunction in daily living for adult is present, as indicated by **1 or more** of the following(1)(8)(38)(39)(40)(41):
  - Incapacitation because of grave disability (eg, severe regression with inability to provide for self)
  - Extreme deterioration in social interactions (eg, threatening behaviors with little or no provocation)
  - Complete withdrawal from all social interactions
  - Complete neglect of self-care with associated impairment in physical status
  - Extreme disruption in vegetative function (eg, life-sustaining functions such as eating)
  - Complete inability to maintain any appropriate aspect of personal responsibility in any adult roles (eg, occupational, parental)
  - Other evidence of severe dysfunction

- Treatment services available at proposed level of care are necessary to meet patient needs and **1 or more** of the following[N]:
  - Specific condition related to admission diagnosis is present and judged likely to further improve at proposed level of care.
  - Specific condition related to admission diagnosis is present and judged likely to deteriorate in absence of treatment at proposed level of care.
  - Patient is receiving continuing care (eg, transition of care from less intensive level of care).
- Situation and expectations are appropriate for inpatient care for adult, as indicated by **1 or more** of the following(1)(4)(12)(15)(42):
  - Patient is unwilling to participate in treatment voluntarily and requires treatment (eg, legal commitment) in an involuntary unit.
  - Voluntary treatment at lower level of care is not feasible (eg, very short-term crisis intervention or residential care unavailable or insufficient for patient condition).
  - Need for physical restraint, seclusion, or other involuntary treatment intervention is present (eg, actively violent patient for whom treatment in an involuntary unit is deemed necessary in accordance with applicable medical and legal criteria).
  - Around-the-clock medical and nursing care to address symptoms and initiate intervention is required; specific need is identified.[K][O][P]
  - Treatment at a lower level of care is not feasible or appropriate due to severe biopsychosocial stressors[Q] (eg, persistent or traumatic environmental stressors, lack of material or emotional support, exposure to violence or substance use, inability to meet basic needs, or overwhelming demands), which have been assessed and found to be unmanageable without higher-level intervention.[R](1)(2)(3)(4)(5)(6)(7)(29)(36)
  - Treatment at a lower level of care is not feasible or appropriate due to the patient's persistent symptoms or limited response to prior interventions, even in highly structured environments.(1)(2)(3)(4)(5)(6)(7)(29)(36)
  - Treatment at a lower level of care is not feasible or appropriate due to the patient's minimal engagement, resistance to treatment, inability to accept their condition, lack of accountability or trust, and avoidance of recovery efforts.[S](1)(2)(3)(4)(5)(6)(7)(29)(36)

- Admission to **Inpatient Level of Care for Child or Adolescent** (CALOCUS-CASII Level 6 - Medically Managed Residence Based Services, Composite Score 28 or more) is indicated due to **ALL** of the following[T][U][V][W]:
  - Patient risk or severity of behavioral health disorder is appropriate to proposed level of care, as indicated by **1 or more** of the following(2)(5)(6)(12)(36)(37)(43)(44)(45)(46):
    - Imminent danger to self for child or adolescent is present due to **1 or more** of the following(2)(5)(6)(13)(14)(47)(48):
      - Imminent risk for recurrence of Suicide attempt or act of serious Harm to self is present, as indicated by **ALL** of the following:
        - There has been a recent Suicide attempt or deliberate act of serious Harm to self.
        - There has not been Sufficient relief of the factors that precipitated attempt or act.
      - Current plan for suicide or serious Harm to self is present.
      - Command auditory hallucinations or paranoid delusions contributing to risk for suicide or serious Harm to self are present.
      - Patient has persistent Thoughts of suicide or serious Harm to self that cannot be adequately monitored or treated at lower level of care, as indicated by **1 or more** of the following[X]:
        - Necessary child or adolescent behavioral health care (such as required provider or lower level of care) not available or insufficient
        - Severe conflict in family environment or other inadequacy in patient support system
        - Patient characteristics, such as extremely Impaired impulse control, judgment, or insight; severe Mania (child or adolescent), severe unreliability, or extreme agitation with desperation
        - Uncontrollable and overwhelming negative thoughts
        - Fatalistic conviction that life will not improve, along with oppressive sense of entrapment and doom
    - Imminent danger to others for child or adolescent is present due to **1 or more** of the following(2)(5)(6)(13)(15)(49):
      - Imminent risk for recurrence of attempt to seriously Harm another is present, as indicated by **ALL** of the following:
        - There has been a recent attempt to seriously Harm another.
        - There has not been Sufficient relief of factors that precipitated the attempt.
      - Current plan for homicide or serious Harm to another is present.
      - Command auditory hallucinations or paranoid delusions contributing to risk for homicide or serious Harm to another are present.
      - Patient has persistent thoughts of homicide or violent acts that likely could result in serious Harm to another that cannot be adequately monitored or treated at lower level of care, as indicated by **1 or more** of the following[X]:
        - Necessary child or adolescent behavioral health care (such as required provider or lower level of care) not available or insufficient
        - Severe conflict in family environment or other inadequacy in patient support system
        - Patient characteristics, such as extremely Impaired impulse control, judgment, or insight; severe Mania (child or adolescent), severe unreliability, or extreme agitation with desperation
        - Uncontrollable and overwhelming negative thoughts
        - Indication or report of repeated behavior, including physical or sexual aggression that is clearly injurious to others with history, plan or intent, and extremely Impaired impulse control, judgment, or insight
  - Behavioral health disorder is present and appropriate for inpatient care with **ALL** of the following:
    - **Severe** psychiatric, behavioral, or other comorbid conditions are appropriate for management at proposed level of care, as indicated by **1 or more** of the following[Y][Z]:
      - Psychiatric symptoms, including **1 or more** of the following(12):
        - Hallucinations (child or adolescent), Delusions (child or adolescent), or other Positive symptoms (child or adolescent)
        - Negative symptoms (child or adolescent), including social or emotional withdrawal or lack of self-initiated behavior or movement
        - Mania (child or adolescent)
        - Depressive symptoms (child or adolescent)
        - Anxiety (child or adolescent)

- Hyperactivity or inattention (child or adolescent)
- Obsessions or compulsions (child or adolescent)
- Personality disorders/maladaptive personality traits
- Other psychiatric symptoms related to underlying psychiatric disorder or underlying comorbid condition having a negative impact on primary psychiatric disorder

- Comorbid biomedical or developmental condition[AA][H]
- Comorbid substance use disorder[BB][CC]
- Cognitive or memory impairment[DD]
- Impaired impulse control, judgment, or insight

− Emotional or behavioral disturbances impacting symptoms or function, including **1 or more** of the following[M](35)(36)(37):

- Externalizing symptoms (eg, angry outbursts, physical or verbal aggression, oppositional defiant traits, agitation, anxiety, or other disruptive behaviors)
- Internalizing symptoms (eg, sulking, rumination, anhedonia, dysphoria, apathy)
- Evidence of severely diminished ability to assess consequences of own actions (eg, acts of severe property damage)
- High levels of family conflict or interpersonal conflict
- Escalating relapse behaviors
- Other emotional or behavioral disturbance relevant to clinical presentation

− **Severe** dysfunction in daily living for child or adolescent is present, as indicated by **1 or more** of the following(2)(5)(6)(7)(56)(57)(58):

- Incapacitation because of grave disability (eg, severe regression with inability to provide for self)
- Extreme deterioration in interactions with peers, adults, or family (eg, assaultive behaviors with no provocation, high levels of family conflict)
- Complete withdrawal from all social interactions
- Complete neglect of self-care with associated impairment in physical status
- Extreme disruption in vegetative function (eg, life-sustaining functions such as eating)
- Nearly complete inability to maintain any appropriate school behavior or academic achievement
- Severely diminished ability to assess consequences of own actions (eg, acts of severe property damage)
- Other evidence of severe dysfunction

− Treatment services available at proposed level of care are necessary to meet patient needs and **1 or more** of the following[EE]:

- Specific condition related to admission diagnosis is present and judged likely to further improve at proposed level of care.
- Specific condition related to admission diagnosis is present and judged likely to deteriorate in absence of treatment at proposed level of care.
- Patient is receiving continuing care (eg, transition of care from less intensive level of care).

− Situation and expectations are appropriate for inpatient care for child or adolescent, as indicated by **1 or more** of the following(2)(5)(6)(7)(12)(15)(36)(59):

- Patient is unwilling to participate voluntarily in treatment and requires treatment (eg, legal commitment or order by guardian) in an involuntary unit.
- Voluntary treatment at lower level of care is not feasible (eg, very short-term crisis intervention or residential care unavailable or insufficient for patient condition).
- Need for physical restraint, seclusion, or other involuntary treatment intervention is present (eg, actively violent patient for whom treatment in an involuntary unit is deemed necessary in accordance with applicable medical and legal criteria).
- Around-the-clock medical and nursing care to address symptoms and initiate intervention is required; specific need is identified.[CC][FF][GG]
- Treatment at a lower level of care is not feasible or appropriate due to severe biopsychosocial stressors[Q] (eg, persistent or traumatic environmental challenges, the absence or inadequacy of material and emotional support, exposure to violence or harmful activities (including

substance use), unfulfilled basic needs, or destabilizing life circumstances), which have been assessed and found to be unmanageable without higher-level intervention.[HH](1)(2)(4)(5)(6)(7)(29)(36)(37)
- Treatment at a lower level of care is not feasible or appropriate due to the patient's persistent symptoms, minimal or negligible resilience to stress and change, and limited or no sustained response to prior interventions, even when provided with intensive support in structured environments.(1)(2)(4)(5)(6)(7)(29)(36)(37)
- Treatment at a lower level of care is not feasible or appropriate due to limited or absent collaborative engagement and acceptance, characterized by resistance to treatment, an inability to establish or maintain a therapeutic relationship, refusal to acknowledge the problem or its impacts, and avoidance or obstruction of recovery efforts by the patient or their caregivers.[II](1)(2)(4)(5)(6)(7)(29)(36)(37)

- **Behavioral Health** condition, symptom, or finding for which observation care has failed or is not considered appropriate. See General Criteria: Observation Care ISC, General Admission Criteria GRG, or Pediatric General Admission Criteria GRG guidelines as appropriate.

Supplemental Medicare Criteria

Note: These criteria are to be considered for Medicare patients if none of the standard Clinical Indications for Admission to Inpatient Care apply.

- Patient with Medicare coverage requires inpatient admission, as indicated by **1 or more** of the following(60):
  - Admitting clinician expects patient to require hospital care for less than 2 midnights but, based on complex medical factors documented in medical record, judges that inpatient care is necessary (case-by-case exception). The medical record must contain sufficient documentation to make clear the rationale for the exception.
  - Patient has need for intubation and mechanical ventilation that is new (ie, did not present to hospital already on mechanical ventilation).
  - Treatment plan for hospital admission includes procedure designated by CMS as inpatient only (ie, on Inpatient Only List).
  - Patient has already received medically necessary hospital care that meets 2-midnight benchmark (excluding activities such as triage/intake, delays in provision of care, or time added due to patient or family convenience). The medical record must contain sufficient documentation to make clear the medical necessity for hospital care across 2 or more midnights.

Alternatives to Admission

- Alternatives include(1)(2)(3)(5)(6)(36)(37)(61)(62):
  - Outpatient care
  - Intensive outpatient program
  - Partial hospital program
  - Residential care
  - Crisis intervention
  - Observation behavioral health level of care
  - Medical setting (eg, general hospital) observation care (eg, if initial evaluation unclear). See General Criteria: Observation Care ISC.

For descriptions of these alternative levels of care, see Behavioral Health Levels of Care SR.

Hospitalization

General Recovery Course

Stage	Level of Care	Clinical Status	Interventions

1	• Floor care • Social Determinants of Health Assessment • Begin discharge planning. See Discharge Planning Tool SR.	• **Clinical Indications met[JJ]**	• Initial assessment[KK] • **Appropriate crisis management instituted or documented as not needed** • Possible continual observation or frequent safety checks • Medication and psychosocial interventions as appropriate
2	• Floor • Social Determinants of Health Assessment	• **Evaluation completed and reviewed** • **Symptom and functioning assessment at appropriate frequency documented** • **Physician evaluation of patient and progress at appropriate frequency (eg, daily) documented** • **Review of need for medication or adjustment at appropriate frequency documented**	• **Ongoing Care coordination** • **Close observation or regular safety checks done at appropriate frequency** • **Appropriate treatment plan review**
3	• Social Determinants of Health Assessment • Floor to discharge • Complete discharge planning	• **Risk status acceptable** • **Functional status acceptable** • **Symptom status acceptable** • **General Discharge Criteria met**	• **Treatment goals for level of care met** • **Medical needs absent or manageable/treatable at available lower level of care**

(12)(13)(15)(36)(48)(61)(63)(64)(65)(66)(67)(68)

Recovery Milestones are indicated in **bold**.

Benchmark Length of Stay (BLOS): Access diagnosis and procedure code-specific BLOS via Search functions.

Discharge Criteria

- Continued inpatient stay is necessary until **ALL** of the following conditions are met:
  - Risk status acceptable, as indicated by **ALL** of the following(1)(2)(3)(5)(7)(53):
    - Danger to self or others manageable/treatable, as indicated by **1 or more** of the following:
      - Absence of Thoughts of suicide, homicide, or serious Harm to self or to another
      - Thoughts of suicide, homicide, or serious Harm to self or to another present but manageable/treatable at available lower level of care
    - Patient and supports understand follow-up treatment and crisis plan.
    - Provider and supports are sufficiently available at lower level of care.
    - Patient, as appropriate, can participate as needed in monitoring at available lower level of care.
  - Functional status acceptable, as indicated by **1 or more** of the following:
    - No essential function[LL] is significantly impaired.
    - An essential function is impaired, but impairment is manageable/treatable at available lower level of care.

- Symptom status acceptable, as indicated by **ALL** of the following(1)(2)(3)(5)(7)(53):
  - Symptoms stabilized and may be appropriately treated at available lower level of care
  - No current plan for change in treatment or re-evaluation
- Medical needs absent or manageable/treatable at available lower level of care, as indicated by **ALL** of the following(1)(2)(3)(5)(7)(53):
  - Adverse medication effects absent or manageable/treatable
  - Medical comorbidity absent or manageable/treatable
  - Medical complications absent or manageable/treatable (eg, complications of eating disorder)
  - Substance-related disorder absent or manageable/treatable
- Treatment goals for level of care met
- General Discharge Criteria GRG met or Pediatric General Discharge Criteria GRG met (if either is relevant or necessary for patient's condition)

Case Management

See Behavioral Health Case Management GRG GRG for further information.

Discharge Destination

- Discharge destination levels of care may include:
  - Outpatient care
  - Intensive outpatient program
  - Partial hospital program
  - Residential care

See Behavioral Health Levels of Care SR for descriptions of the above levels of care. See Behavioral Health Home Care GRG HC for additional discharge planning recommendations.

Evidence Summary

Criteria

The evidence for the clinical indications found in this guideline includes 22 published peer reviewed articles, 2 specialty society or other evidence-based guidelines, and 22 book sections.

Rationale

Use of this MCG care guideline helps the clinician identify patient-specific complex clinical factors that make it reasonable to expect a necessity for hospital care across 2 or more midnights. The evidence-based clinical criteria assist the clinician in the decision to appropriately admit a patient to inpatient care. For Medicare enrollees, MCG care guidelines also support the clinician in the decision to appropriately admit a patient to inpatient care when there is not an expectation of 2 or more midnights of hospital care (eg, CMS' Two-Midnight Rule exceptions).

Use of these evidence-based clinical criteria to support decision making around the need for inpatient treatment is of clinical benefit to the patient and is crucial for quality patient care. Use of evidence-based clinical criteria ensures patients receive the most appropriate care for their specific condition, reduces unnecessary risks, promotes recovery, and provides a standard that can reduce disparities in care. Evidence-based clinical criteria not only help align treatment decisions with

best practice, but they can also help reduce unwarranted variation in care by fostering consistency and equality in healthcare provision across regions and facilities. Appropriate use of the evidence-based clinical criteria in conjunction with the Supplemental Medicare Criteria ensures Medicare patients receive full access to Medicare benefits (eg, inpatient care), without risk of delay or decreased access, based on variables such as clinical severity of illness, length of provision of medically necessary hospital-level care, or satisfaction of specified Medicare criteria as directed by CMS. Use of these criteria will help ensure that the patient receives necessary care in the appropriate setting.

Related CMS Coverage Guidance

This guideline supplements but does not replace, modify, or supersede existing Medicare regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs).

Code of Federal Regulations (CFR): 42 CFR 412.3(60); 42 CFR 419.22(69); 42 CFR 422.101(70)

Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A(71); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B(72); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services(73); CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6, Section 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment(74)

Medicare Coverage Determinations: Medicare Coverage Database(75)

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Footnotes

[A] Inpatient psychiatric units generally are locked, equipped to restrain or seclude patients for safety if necessary, and staffed by nurses around the clock. A covering physician is available to assess patients if indicated around the clock.(1) [A in Context Link 1]

[B] Symptoms or conditions used to determine the appropriate treatment intensity should be due to the underlying behavioral health diagnosis or represent factors that contribute to destabilization of the underlying diagnosis, and are acute in nature or represent a significant worsening over baseline.(1) [B in Context Link 1]

[C] The purpose of the care guidelines is to promote evidence-based care across the continuum of care to enhance the delivery of quality healthcare. Indications are presented for different levels of care. These indications help define the optimal level of care and can assist in developing alternatives to higher levels of care, tracking patient progress during treatment within a level of care, facilitating the progress of patients whose recovery is delayed, and preparing comprehensive plans for transition of patients from one level of care to another. Relevant professional society guidelines are foundational content for evaluation and treatment of behavioral health disorders at different levels of care and are complemented by the best available published evidence.(1)(2)(3)(4)(5)(6)(7)(8)(9) [C in Context Link 1]

[D] Composite score does not replace clinical judgment and is meant as a guide to assist in determining needed level of care. Extreme risk of harm, severe functional impairment, or severe comorbidity may independently necessitate placement at inpatient level of care.(1) [D in Context Link 1]

[E] Patients with persistent thoughts of suicide, homicide, or serious harm to self or another may need frequent monitoring for progression to planning or intention to act on their thoughts. Such monitoring can be safely conducted at an outpatient level of care if providers and supports are adequately available and the patient can reliably participate in the monitoring process.(4) [E in Context Link 1, 2]

[F] Determination of severity may be based on symptom severity alone (including intensity or frequency of symptoms and the extent to which they interfere with functioning), or may be due to other factors (eg, comorbid medical illness, developmental condition, cognitive impairment, substance use disorder, or other factors that contribute to destabilization or decreased ability to cope with the underlying behavioral health disorder). If the comorbidity affects the level of care appropriate to meet the patient's behavioral health needs, the manner in which it impacts the behavioral health condition (and how the comorbidity will be managed at the proposed level of care) should be documented in order to optimize comprehensive patient care. Assessment for comorbid conditions should take place at admission evaluation, and any identified conditions should be manageable by the program (either directly or through alternative arrangements). Co-occurring mental health and substance use conditions and co-occurring medical and behavioral health conditions are considered an expectation, not an exception, in all programs at all psychiatric and addiction service levels of care. Integrated care, with recovery-oriented and "co-occurring capable" services, is increasingly expected to be included

in the design of programs at all levels of care and in all settings. In programs without integrated care, comorbidities that require more active management or that currently distract the patient from treatment or have been associated with challenges in treatment follow-through in the past should prompt consideration of a program designed to provide treatment for both disorders (eg, a dual-diagnosis program).(1)(3)(4)(12) [F in Context Link 1]

[G] The diagnosis and severity of depressive disorders may be confirmed and documented by the use of standardized rating scales that reliably measure depressive symptoms in adults, including the Beck Depression Inventory (BDI), the Hamilton Depression Rating Scale (HDRS), the Patient Health Questionnaire-9 (PHQ-9) in the primary care setting, the Montgomery-Asberg Depression Rating Scale (MADRS), and the Geriatric Depression Scale (GDS) for older adults.(16)(17)(18) As an example, the PHQ-9 asks the patient to describe the frequency of 9 symptoms over the past 2 weeks on a scale of 0 to 3 (0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day), and depression severity is scored as follows: 0 to 4 none, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe, and 20 to 27 severe.(19) In addition to screening, rating scales are often administered throughout treatment to measure changes in symptoms. An approximate 50% decrease in scores on the BDI, HDRS, PHQ-9, and/or MADRS has been found to be clinically significant when reassessing an individual for interval improvement.(17)(20)(21) [G in Context Link 1]

[H] A significant comorbid biomedical or developmental condition has the potential to prolong the course of illness, or necessitate admission to a higher level of care or closer monitoring of patients requiring psychiatric care.(1)(2)(5)(6)(22) [H in Context Link 1, 2]

[I] Assessment and treatment of co-occurring medical and/or developmental conditions through services and treatment settings capable of rendering integrated care is recommended.(1)(2)(4)(5)(6)(7) A "whole person care" approach that coordinates care across physical health, behavioral health, and social service sectors may bridge the gap of physical and mental health.(23)(24)(25)(26) The level that comorbid medical and/or developmental conditions are present may be described on a continuum (none/absent, low, moderate, and severe) and may impact determination of the appropriate level of care for treatment (ie, admission to a higher level of care).(1)(2)(3)(5)(6) [I in Context Link 1]

[J] A significant comorbid substance use disorder (either reflecting comorbidity in a patient whose primary diagnosis is a psychiatric disorder, such as an affective disorder, or is present in a patient with a polysubstance use disorder) has the potential to impact the appropriate level of care in which the underlying condition is managed, or require consideration of a program with structures in place to treat multiple conditions, such as a dual-diagnosis program. The risk for problems with substance use is increased with the presence of many types of behavioral disturbance (eg, impulse control disorders, or self-medication of depression or anxiety symptoms). The severity of the substance use disorder as it relates to the underlying psychiatric condition includes the frequency and chronicity of use, ability to control use, intensity of other symptoms (eg, cravings, withdrawal), or other negative impact on the underlying condition.(1)(2)(3)(5)(6)(27) [J in Context Link 1]

[K] Evaluation/assessment and treatment of co-occurring substance use disorders through services and treatment settings capable of rendering integrated care is recommended.(1)(2)(4)(5)(6) A "whole person care" approach that coordinates care across physical health, behavioral health, and social service sectors may bridge the gap of physical and mental health.(23)(24)(25)(26) The level that comorbid substance use disorders contribute to the primary presenting condition may be described on a continuum (none/absent, low, moderate, and severe) and may impact determination of the appropriate level of care for treatment (ie, admission to a higher level of care or specialty dual-diagnosis program).(1)(2)(3)(5)(6) [K in Context Link 1, 2]

[L] Intake and assessment should include a mental status examination and memory assessment. If cognitive impairments are identified, they may require modifying the intensity or pace of planned interventions to allow the patient to participate in the program, or using an enhanced program designed to address co-occurring cognitive disorders.(27)(28)(29)(30)(31)(32) [L in Context Link 1]

[M] Symptoms may be circumscribed (eg, attention-seeking behaviors) or may be seen in the context of one or more major psychiatric disorders, including depression; anxiety disorders; obsessive-compulsive disorder; posttraumatic stress disorder; eating disorders; attention-deficit hyperactivity disorders; bipolar disorders; schizophrenia; personality disorders; autism spectrum disorder; and other disruptive, impulse-control, and conduct disorders.(33)(34)(35) [M in Context Link 1, 2]

[N] Assessment of the likelihood of benefit at the proposed level of care may help identify subgroups of patients more likely to respond to particular treatments and help optimize the care plan to increase the likelihood of successful recovery. It may also help determine if a specialized treatment setting (eg, dual-diagnosis program) or a different level of service intensity would be more appropriate to address the patient's needs.(1)(3) [N in Context Link 1]

[O] Examples of medical conditions appropriate for inpatient care include conditions that require intensive, around-the-clock medical monitoring and daily nursing interventions, or patients with significant metabolic or ECG abnormalities related to vomiting.(1) [O in Context Link 1]

[P] Comorbid conditions may directly impact the experience of psychiatric symptoms (eg, COPD and anxiety), or may indirectly impact determination of the appropriate venue for care (eg, routine blood sugar and insulin management in people with diabetes). If clinically appropriate, testing related to diagnosis or management (eg, screening for liver and kidney function, hepatitis, HIV, syphilis, tuberculosis) may be performed off-site.(1)(2)(5)(6) Assessment and treatment of co-occurring medical and/or developmental conditions through services and treatment settings capable of rendering integrated care is recommended.(1)(2)(4)(5)(6)(7) A "whole person care" approach that coordinates care across physical health, behavioral health, and social service sectors may bridge the gap of physical and mental health.(23)(24)(25)(26) The level that comorbid medical and/or developmental conditions are present may be described on a continuum (none/absent, low, moderate, and severe) and may impact determination of the appropriate level of care for treatment (ie, admission to a higher level of care).(1)(2)(3)(5)(6) [P in Context Link 1]

[Q] Biopsychosocial stressors may impact the level of care necessary to manage a psychiatric or behavioral condition, including the ability of the program to meet comprehensive patient needs, ensure treatment adherence, enhance motivation, or prevent relapse (ie, comorbidities, environmental factors, or other barriers may prevent effective treatment at a less intensive level of care than might otherwise be appropriate to the patient's condition). Biopsychosocial assessment factors should be incorporated into care planning, including planned treatment goals, and intensity and duration of interventions. A "whole person care" approach that coordinates care across physical health, behavioral health, and social service sectors may bridge the gap of physical and mental health.(23)(24)(25)(26) Any identified deficits should be manageable by the program directly or through alternative arrangements.(1)(2)(5)(6) [Q in Context Link 1, 2]

[R] The degree of environmental stressors and amount of support in the patient recovery environment should be considered in the context of the clinical presentation in determining the appropriate level of care for treatment. The level of environmental stressors may be low, mild, moderate, high, or extreme. The level of support in the environment may range from absent or minimal to limited to supportive or highly supportive.(1)(2)(3)(4)(5)(6)(7) [R in Context Link 1]

[S] Participation motivated by a wish to avoid negative consequences rather than accept the need to work toward recovery may require more intense monitoring and follow-up.(3)(27) The patient's level of engagement may be described on a continuum: optimal, positive, limited, minimal, or unengaged. Readiness to change may range from actively and willingly engaged to unable to follow treatment recommendations due to clinical condition.(1)(2)(3)(5)(6) [S in Context Link 1]

[T] Inpatient psychiatric units generally are locked, equipped to restrain or seclude patients for safety if necessary, and staffed by nurses around the clock. A covering physician is available to assess patients if indicated around the clock.(2)(5)(6)(36) [T in Context Link 1]

[U] Symptoms or conditions used to determine the appropriate treatment intensity should be due to the underlying behavioral health diagnosis or represent factors that contribute to destabilization of the underlying diagnosis, and are acute in nature or represent a significant worsening over baseline.(2)(5)(6) [U in Context Link 1]

[V] The purpose of the care guidelines is to promote evidence-based care across the continuum of care to enhance the delivery of quality healthcare. Indications are presented for different levels of care. These indications help define the optimal level of care and can assist in developing alternatives to higher levels of care, tracking patient progress during treatment within a level of care, facilitating the progress of patients whose recovery is delayed, and preparing comprehensive plans for transition of patients from one level of care to another. Relevant professional society guidelines are foundational content for evaluation and treatment of behavioral health disorders at different levels of care and are complemented by the best available published evidence.(1)(2)(4)(5)(6)(7)(8)(9)(37) [V in Context Link 1]

[W] Composite score does not replace clinical judgment and is meant as a guide to assist in determining needed level of care. Extreme risk of harm, severe functional impairment, or severe comorbidity may independently necessitate placement at inpatient level of care.(2)(5)(6) [W in Context Link 1]

[X] Patients with persistent thoughts of suicide, homicide, or serious harm to self or another may need frequent monitoring for progression to planning or intention to act on their thoughts. Such monitoring can be safely conducted at an outpatient level of care if providers and supports are adequately available and the patient can reliably participate in the monitoring process.(47) [X in Context Link 1, 2]

[Y] Determination of severity may be based on symptom severity alone (including intensity or frequency of symptoms and the extent to which they interfere with functioning), or may be due to other factors (eg, comorbid medical illness, developmental condition, cognitive impairment, substance use disorder, or other factors that contribute to destabilization or decreased ability to cope with the underlying behavioral health disorder). If the comorbidity affects the level of care appropriate to meet the patient's behavioral health needs, the manner in which it impacts the behavioral health condition (and how the comorbidity will be managed at the proposed level of care) should be documented in order to optimize comprehensive patient care. Assessment for comorbid conditions should take place at admission evaluation, and any identified conditions should be manageable by the program (either directly or through alternative arrangements). Co-occurring mental health and substance use conditions and co-occurring medical and behavioral health conditions are considered an expectation, not an exception, in all programs at all psychiatric and addiction service levels of care. Integrated care, with recovery-oriented and "co-occurring capable" services, is increasingly expected to be included in the design of programs at all levels of care and in all settings. In programs without integrated care, comorbidities that require more active management or that currently distract the patient from treatment or have been associated with challenges in treatment follow-through in the past should prompt consideration of a program designed to provide treatment for both disorders (eg, a dual-diagnosis program).(2)(5)(6)(12)(37) [Y in Context Link 1]

[Z] The diagnosis and severity of depressive disorders may be confirmed and documented by the use of standardized rating scales that reliably measure depressive symptoms in children and adolescents, including the Beck Depression Inventory (BDI), the Children's Depression Inventory (CDI), and the Patient Health Questionnaire-9 (PHQ-9) modified for adolescents (PHQ-A) in the primary care setting.(50)(51)(52) As an example, the PHQ-9 asks the patient to describe the frequency of 9 symptoms over the past 2 weeks on a scale of 0 to 3 (0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day), and depression severity is scored as follows: 0 to 4 none, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe, and 20 to 27 severe.(19) In addition to screening, rating scales are often administered throughout treatment to measure changes in symptoms. An approximate 50% decrease in scores on the BDI and PHQ-A has been found to be clinically significant when reassessing an individual for interval improvement.(17)(20)(21)(50) [Z in Context Link 1]

[AA] Assessment and treatment of co-occurring medical and/or developmental conditions through services and treatment settings capable of rendering integrated care is recommended.(1)(2)(4)(5)(6)(7) A "whole person care" approach that coordinates care across physical health, behavioral health, and social service sectors may bridge the gap of physical and mental health.(23)(24)(25)(26) The level that comorbid medical and/or developmental conditions are present may be described on a continuum (none/absent, low, moderate, and severe) and may impact determination of the appropriate level of care for treatment (ie, admission to a higher level of care).(1)(2)(5)(6)(53) [AA in Context Link 1]

[BB] A significant comorbid substance use disorder (either reflecting comorbidity in a patient whose primary diagnosis is a psychiatric disorder, such as an affective disorder, or is present in a patient with a polysubstance use disorder) has the potential to impact the appropriate level of care in which the underlying condition is managed, or require consideration of a program with structures in place to treat multiple conditions, such as a dual-diagnosis program. The risk for problems with substance use is increased with the presence of many types of behavioral disturbance (eg, impulse control disorders, or self-medication of depression or anxiety symptoms). The severity of the substance use disorder as it relates to the underlying psychiatric condition includes the frequency and chronicity of use, ability to control use, intensity of other symptoms (eg, cravings, withdrawal), or other negative impact on the underlying condition.(1)(2)(5)(6)(37)(54) [BB in Context Link 1]

[CC] Evaluation/assessment and treatment of co-occurring substance use disorders through services and treatment settings capable of rendering integrated care is recommended.(1)(2)(4)(5)(6) A "whole person care" approach that coordinates care across physical health, behavioral health, and social service sectors may bridge the gap of physical and mental health.(23)(24)(25)(26) The level that comorbid substance use disorders contribute to the primary presenting condition may be described on a continuum (none/absent, low, moderate, and severe) and may impact determination of the appropriate level of care for treatment (ie, admission to a higher level of care or specialty dual-diagnosis program).(1)(2)(5)(6)(53) [CC in Context Link 1, 2]

[DD] Intake and assessment should include a mental status examination and memory assessment. If cognitive impairments are identified, they may require modifying the intensity or pace of planned interventions to allow the patient to participate in the program, or using an enhanced program designed to address co-occurring cognitive disorders.(29)(30)(31)(32)(54)(55) [DD in Context Link 1]

[EE] Assessment of the likelihood of benefit at the proposed level of care may help identify subgroups of patients more likely to respond to particular treatments and help optimize the care plan to increase the likelihood of successful recovery. It may also help determine if a specialized treatment setting (eg, dual-diagnosis program) or a different level of service intensity would be more appropriate to address the patient's needs.(2)(5)(6)(37) [EE in Context Link 1]

[FF] Examples of medical conditions appropriate for inpatient care include conditions that require intensive, around-the-clock medical monitoring and daily nursing interventions, or patients with significant metabolic or ECG abnormalities related to vomiting.(2)(5)(6) [FF in Context Link 1]

[GG] Comorbid conditions may directly impact the experience of psychiatric symptoms (eg, COPD and anxiety), or may indirectly impact determination of the appropriate venue for care (eg, routine blood sugar and insulin management in people with diabetes). If clinically appropriate, testing related to diagnosis or management (eg, screening for liver and kidney function, hepatitis, HIV, syphilis, tuberculosis) may be performed off-site.(1)(2)(5)(6) Assessment and treatment of co-occurring medical and/or developmental conditions through services and treatment settings capable of rendering integrated care is recommended.(1)(2)(4)(5)(6)(7) A "whole person care" approach that coordinates care across physical health, behavioral health, and social service sectors may bridge the gap of physical and mental health.(23)(24)(25)(26) The level that comorbid medical and/or developmental conditions are present may be described on a continuum (none/absent, low, moderate, and severe) and may impact determination of the appropriate level of care for treatment (ie, admission to a higher level of care).(1)(2)(5)(6)(53) [GG in Context Link 1]

[HH] The degree of environmental stressors and amount of support in the patient recovery environment should be considered in the context of the clinical presentation in determining the appropriate level of care for treatment. The level of environmental stressors may be low, mild, moderate, high, or extreme. The level of support in the environment may range from absent or minimal to limited to supportive or highly supportive.(1)(2)(4)(5)(6)(7)(53) [HH in Context Link 1]

[II] Participation motivated by a wish to avoid negative consequences rather than accept the need to work toward recovery may require more intense monitoring and follow-up.(37)(53)(54) The patient's level of engagement may be described on a continuum: optimal, positive, limited, minimal, or unengaged. Readiness to change may range from actively and willingly engaged to unable to follow treatment recommendations due to clinical condition.(1)(2)(5)(6)(53) [II in Context Link 1]

[JJ] See Clinical Indications for Admission to Inpatient Care in this guideline. [JJ in Context Link 1]

[KK] Initial assessment should include at a minimum: admission precipitants; psychiatric, social, medical, and substance use histories; and mental status and physical examinations. Appropriateness of laboratory tests is best determined on a case-by-case basis.(4) [KK in Context Link 1]

[LL] Essential functions are those that are necessary to sustain life, such as feeding and hydrating oneself.(1)(2)(5)(6) [LL in Context Link 1]

Definitions

Anxiety (adult)

- Multiple instruments are available to assess anxiety severity. The General Anxiety Disorder-7 (GAD-7) asks the patient to describe the frequency of 7 symptoms over the past 2 weeks on a scale of 0 to 3 (0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day). A score of 5 to 9 suggests mild anxiety; 10 to 14, moderate anxiety; and 15 or greater, severe anxiety.(1) Examples of anxiety symptoms include(2):
    - Feeling nervous, anxious, or on edge
    - Not being able to stop or control worrying
    - Worrying too much about different things

- Trouble relaxing
- Being so restless that it is hard to sit still
- Becoming easily annoyed or irritable
- Feeling afraid, as if something awful might happen

References

1. Spitzer RL, Kroenke K, Williams JB, Lowe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of Internal Medicine 2006;166(10):1092-7. DOI: 10.1001/archinte.166.10.1092.
2. Anxiety disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:215-261.

Anxiety (child or adolescent)

- Multiple instruments are available to assess anxiety severity, including the Multidimensional Anxiety Scale for Children-2nd Edition (MASC 2), the Screen for Child Anxiety-Related Emotional Disorders (SCARED), and the Spence Children's Anxiety Scale (SCAS).(1)(2)(3)(4)(5) Examples of anxiety symptoms include(6):
  - Nervousness
  - Feeling on edge
  - Inability to stop worrying or excessive worrying
  - Being told by others that one worries too much
  - Trouble relaxing
  - Inability to sit still due to restlessness
  - Easily irritable or annoyed
  - Feeling afraid that something awful might happen
  - Feeling frightened for no reason
  - Feeling afraid to be alone in the house
  - Feeling scared to go to school

References

1. Walter HJ, et al. Clinical practice guideline for the assessment and treatment of children and adolescents with anxiety disorders. Journal of the American Academy of Child and Adolescent Psychiatry 2020;59(10):1107-1124. DOI: 10.1016/j.jaac.2020.05.005. (Reaffirmed 2025 Apr)
2. March JS, Parker JD, Sullivan K, Stallings P, Conners CK. The Multidimensional Anxiety Scale for Children (MASC): factor structure, reliability, and validity. Journal of the American Academy of Child and Adolescent Psychiatry 1997;36(4):554-65. DOI: 10.1097/00004583-199704000-00019.
3. Fraccaro RL, Stelnicki AM, Nordstokke DW. Test review: Multidimensional Anxiety Scale for Children by J. S. March. Canadian Journal of School Psychology 2015;30(1):70-77. DOI: 10.1177/0829573514542924.
4. Birmaher B, Brent DA, Chiappetta L, Bridge J, Monga S, Baugher M. Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. Journal of the American Academy of Child and Adolescent Psychiatry 1999;38(10):1230-6. DOI: 10.1097/00004583-199910000-00011.
5. Spence SH. A measure of anxiety symptoms among children. Behaviour Research and Therapy 1998;36(5):545-66.
6. Anxiety disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:215-261.

Appropriate treatment plan review

- Appropriate treatment plan review and outcome includes **1 or more** of the following(1):
  - Maintenance of current plan under which patient is making substantial progress
  - Review and modification based on inadequate progress
  - No review deemed needed as patient has progressed and is transitioning to new level of care plan

References

1. Taylor E. The role of the hospital in the care of persons with mental illness. In: Boland R, Verduin ML, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 11th ed. Wolters Kluwer; 2025:4477-4585.

Care coordination

- Care coordination includes communication with **ALL** of the following(1)(2):
  - Outside psychiatrist, other therapists, and medical care providers as appropriate
  - Patient, family, guardian, and other supports as appropriate
  - All team members in other disciplines involved in ongoing patient care

References

1. Taylor E. The role of the hospital in the care of persons with mental illness. In: Boland R, Verduin ML, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 11th ed. Wolters Kluwer; 2025:4477-4585.
2. Wilson C, Martin A. Inpatient psychiatric, partial hospitalization, and residential treatment for children and adolescents. In: Boland R, Verduin ML, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 11th ed. Wolters Kluwer; 2025:3935-3939.

Command auditory hallucinations

- An auditory hallucination is a "false perception of sound." This is the most common type of hallucination in psychiatric disorders and typically consists of voices but also may consist of any type of sound. A command auditory hallucination is a false perception of a voice giving orders to the patient that they may feel compelled to obey. Likely adherence to a command auditory hallucination is indicated by **1 or more** of the following(1)(2)(3)(4)(5):
  - Perceived familiar or benevolent source
  - No belief by patient in their ability to control the voices
  - History of frequent response to such hallucinations with unquestioning obedience

References

1. Lewis SF, Escalona R, Keith SJ. Phenomenology of schizophrenia. In: Boland R, Verduin ML, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 11th ed. Wolters Kluwer; 2025:1448-1466.
2. Dugre JR, West ML. Disentangling compliance with command hallucinations: Heterogeneity of voice intents and their clinical correlates. Schizophrenia Research 2019;212:33-39. DOI: 10.1016/j.schres.2019.08.016.
3. Matorin AA, Avellaneda Ojeda AA, Shah AA, Ruiz P. Clinical manifestations of psychiatric disorders. In: Boland R, Verduin ML, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 11th ed. Wolters Kluwer; 2025:1161-1197.
4. Clementz B. Phenotypes of psychosis. In: Boland R, Verduin ML, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 11th ed. Wolters Kluwer; 2025:1566-1573.

5. DeVylder J, et al. Attributes of auditory hallucinations that are associated with self-harm: A prospective cohort study. Schizophrenia Research 2023;251:30-36. DOI: 10.1016/j.schres.2022.12.008.

Current plan

- Determining the existence of current plan for suicide, homicide, or serious harm to self or another involves clinical judgment regarding multiple factors. Higher risk may be indicated by a combination of factors including explicit or implicit evidence of **1 or more** of the following(1)(2)(3)(4):
  - Identification and/or availability of severe or lethal method (eg, using a gun)
  - Preparatory acts (eg, writing suicide note)
  - Intention that act will have severe or fatal outcome evidenced by planning where and when action will be taken (eg, act unlikely to be discovered and likely to be fatal)

References

1. Rufino KA. Suicide treatment. In: Boland R, Verduin ML, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 11th ed. Wolters Kluwer; 2025:2715-2718.
2. Cobb RT, Camfield K. Other psychiatric emergencies. In: Boland R, Verduin ML, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 11th ed. Wolters Kluwer; 2025:2719-2734.
3. Giles LL, Martini DR. Psychiatric emergencies. In: Dulcan MK, editor. Dulcan's Textbook of Child and Adolescent Psychiatry. 3rd ed. American Psychiatric Association Publishing; 2022:605-620.
4. APA Work Group on Psychiatric Evaluation. The American Psychiatric Association practice Guidelines for the Psychiatric Evaluation of Adults. 3rd edition [Internet] American Psychiatric Association. 2016 Accessed at: https://psychiatryonline.org/. [accessed 2025 Sep 05] DOI: 10.1176/appi.books.9780890426760.

Delusions (adult)

- Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence. Common themes include persecutory, grandiose, erotomanic, nihilistic, and somatic. Delusions are considered bizarre if they are clearly implausible, not understandable to peers of the same culture, and do not derive from ordinary life experiences. Thought withdrawal, thought insertion, and delusions of control are examples of bizarre delusions.(1) Delusion severity may be described as(2)(3)(4):
  - Minimal (subtle symptoms that may rarely bother the patient, and are not associated with pressure to act on beliefs or interference with daily functioning (may represent extreme end of normal range))
  - Mild (symptoms may not be very bothersome to the patient, are only occasionally present, are associated with little pressure to act on beliefs, and contribute to **Mild** dysfunction in daily living for adult)
  - Mild to moderate (symptoms may not be very bothersome to the patient, are established (eg, present up to half of each week), are associated with little pressure to act on beliefs, and contribute to **Mild to moderate** dysfunction in daily living for adult)
  - Moderate (symptoms may be somewhat bothersome to the patient, are clearly established (eg, present more than half of each week, but not daily or near daily), are associated with pressure to act on beliefs, and contribute to **Moderate** dysfunction in daily living for adult)
  - Moderately severe (symptoms may be bothersome to the patient, are associated with pressure to act on beliefs, are present more than half of each week (but not daily or near daily), and contribute to **Serious** dysfunction in daily living for adult, but are not all-consuming and usually can be contained at will)
  - Severe (symptoms may be very bothersome to the patient, are present daily (or near daily), are associated with strong pressure to act on beliefs, and contribute to **Severe** dysfunction in daily living for adult (eg, symptoms may be all-consuming or cannot be contained at will, and often require close supervision))

- Extreme (symptoms may be highly disturbing to the patient, are present on an almost constant basis, are associated with intense pressure to act on beliefs, and contribute to **Severe** dysfunction in daily living for adult (condition usually requires close supervision))

References

1. Schizophrenia spectrum and other psychotic disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:101-138.
2. Assessment measures. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:841-857.
3. Kay SR, Fiszbein A, Opler LA. The positive and negative syndrome scale (PANSS) for schizophrenia. Schizophrenia Bulletin 1987;13(2):261-276.
4. The PANSS Institute. [Internet] The PANSS Institute. Accessed at: http://www.panss.org/. Updated 2024 [accessed 2024 Oct 02]

Delusions (child or adolescent)

- Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence. Common themes include persecutory, grandiose, erotomanic, nihilistic, and somatic. Delusions are considered bizarre if they are clearly implausible, not understandable to peers of the same culture, and do not derive from ordinary life experiences. Thought withdrawal, thought insertion, and delusions of control are examples of bizarre delusions. Instruments are available for assessing severity of symptoms in young people, including versions of the Positive and Negative Syndrome Scale (PANSS) modified for pediatric populations. Delusion severity may be described as(1)(2)(3):
  - Minimal (subtle symptoms that may rarely bother the patient, and are not associated with pressure to act on beliefs or interference with daily functioning (may represent extreme end of normal range))
  - Mild (symptoms may not be very bothersome to the patient, are only occasionally present, are associated with little pressure to act on beliefs, and contribute to **Mild** dysfunction in daily living for child or adolescent)
  - Mild to moderate (symptoms may not be very bothersome to the patient, are established (eg, present up to half of each week), are associated with little pressure to act on beliefs, and contribute to **Mild to moderate** dysfunction in daily living for child or adolescent)
  - Moderate (symptoms may be somewhat bothersome to the patient, are clearly established (eg, present more than half of each week, but not daily or near daily), are associated with pressure to act on beliefs, and contribute to **Moderate** dysfunction in daily living for child or adolescent)
  - Moderately severe (symptoms may be bothersome to the patient, are associated with pressure to act on beliefs, are present more than half of each week (but not daily or near daily), and contribute to **Serious** dysfunction in daily living for child or adolescent, but are not all-consuming and usually can be contained at will)
  - Severe (symptoms may be very bothersome to the patient, are present daily (or near daily), are associated with strong pressure to act on beliefs, and contribute to **Severe** dysfunction in daily living for child or adolescent (eg, symptoms may be all-consuming or cannot be contained at will, and often require close supervision))
  - Extreme (symptoms may be highly disturbing to the patient, are present on an almost constant basis, are associated with intense pressure to act on beliefs, and contribute to **Severe** dysfunction in daily living for child or adolescent (condition usually requires close supervision))

References

1. Schizophrenia spectrum and other psychotic disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:101-138.
2. Findling RL, et al. An optimized version of the positive and negative symptoms scale (PANSS) for pediatric trials. Journal of the American Academy of Child and Adolescent Psychiatry 2023;62(4):427-434. DOI: 10.1016/j.jaac.2022.07.864.
3. Fields JH, et al. Assessing positive and negative symptoms in children and adolescents. American Journal of Psychiatry 1994;151(2):249-53.

Depressive symptoms (adult)

- Multiple instruments are available to assess depression severity and may be used to measure changes in depressive symptoms throughout treatment. For example, the Patient Health Questionnaire-9 (PHQ-9) for adults, used in the primary care setting, assesses how frequently the patient experienced the following symptoms over the past 2 weeks[A](1)(2)(3)(4)(5):
  - Interest in activities
  - Depressed mood/hopelessness
  - Disturbed sleep
  - Decreased energy
  - Change in appetite
  - Self-loathing
  - Difficulty concentrating
  - Psychomotor retardation
  - Suicidal thoughts

References

1. Bukumiric Z, et al. Meta-analysis of the changes in correlations between depression instruments used in longitudinal studies. Journal of Affective Disorders 2016;190:733-743. DOI: 10.1016/j.jad.2015.10.054.
2. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. Journal of General Internal Medicine 2001;16(9):606-13.
3. Maurer DM, Raymond TJ, Davis BN. Depression: screening and diagnosis. American Family Physician 2018;98(8):508-515.
4. Spitzer RL, Williams JB, Kroenke K. Patient Health Questionnaire-9 (PHQ-9). [Internet] Pfizer, Inc. Accessed at: https://www.phqscreeners.com/. [accessed 2025 Sep 16]
5. Riedel M, et al. Response and remission criteria in major depression--a validation of current practice. Journal of Psychiatric Research 2010;44(15):1063-8. DOI: 10.1016/j.jpsychires.2010.03.006.

Footnotes

A. The diagnosis and severity of depressive disorders may be confirmed and documented by the use of standardized rating scales that reliably measure depressive symptoms in adults, including the Beck Depression Inventory (BDI), the Hamilton Depression Rating Scale (HDRS), the Patient Health Questionnaire-9 (PHQ-9) in the primary care setting, the Montgomery-Asberg Depression Rating Scale (MADRS), and the Geriatric Depression Scale (GDS) for older adults.(1)(2)(3) As an example, the PHQ-9 asks the patient to describe the frequency of 9 symptoms over the past 2 weeks on a scale of 0 to 3 (0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day), and depression severity is scored as follows: 0 to 4 none, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe, and 20 to 27 severe.(4) In addition to screening, rating scales are often administered throughout treatment to measure changes in symptoms. An approximate 50% decrease in scores on the BDI, HDRS, PHQ-9, and/or MADRS has been found to be clinically significant when reassessing an individual for interval improvement.(2)(5)

Depressive symptoms (child or adolescent)

- Multiple instruments are available to assess depression severity and may be used to measure changes in depressive symptoms throughout treatment. For example, the Patient Health Questionnaire-9 (PHQ-9) modified for adolescents (PHQ-A), used in the primary care setting, assesses how frequently the patient experienced symptoms over the past 2 weeks. Of note, the PHQ-A has been validated for use with adolescents, but has not been validated for use with children younger than 11 years of age. Symptoms assessed include[A](1)(2)(3)(4)(5)(6)(7):
  - Interest in activities

- Depressed mood/hopelessness
- Disturbed sleep
- Decreased energy
- Change in appetite
- Self-loathing
- Difficulty concentrating
- Psychomotor retardation
- Suicidal thoughts

References

1. US Preventive Services Task Force, et al. Screening for depression and suicide risk in children and adolescents: US Preventive Services Task Force recommendation statement. Journal of the American Medical Association 2022;328(15):1534-1542. DOI: 10.1001/jama.2022.16946. (Reaffirmed 2025 May)
2. Richardson LP, et al. Evaluation of the Patient Health Questionnaire-9 Item for detecting major depression among adolescents. Pediatrics 2010;126(6):1117-23. DOI: 10.1542/peds.2010-0852.
3. Allgaier AK, Pietsch K, Fruhe B, Sigl-Glockner J, Schulte-Korne G. Screening for depression in adolescents: validity of the patient health questionnaire in pediatric care. Depression and Anxiety 2012;29(10):906-13. DOI: 10.1002/da.21971.
4. Spitzer RL, Williams JB, Kroenke K. Patient Health Questionnaire-9 (PHQ-9). [Internet] Pfizer, Inc. Accessed at: https://www.phqscreeners.com/. [accessed 2025 Sep 16]
5. Riedel M, et al. Response and remission criteria in major depression--a validation of current practice. Journal of Psychiatric Research 2010;44(15):1063-8. DOI: 10.1016/j.jpsychires.2010.03.006.
6. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. Journal of General Internal Medicine 2001;16(9):606-13.
7. Davis M, et al. Adolescent depression screening in primary care: Who is screened and who is at risk? Journal of Affective Disorders 2022;299:318-325. DOI: 10.1016/j.jad.2021.12.022.

Footnotes

A. The diagnosis and severity of depressive disorders may be confirmed and documented by the use of standardized rating scales that reliably measure depressive symptoms in children and adolescents, including the Beck Depression Inventory (BDI), the Children's Depression Inventory (CDI), and the Patient Health Questionnaire-9 (PHQ-9) modified for adolescents (PHQ-A) in the primary care setting.(1)(2)(3) As an example, the PHQ-9 asks the patient to describe the frequency of 9 symptoms over the past 2 weeks on a scale of 0 to 3 (0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day), and depression severity is scored as follows: 0 to 4 none, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe, and 20 to 27 severe.(4) In addition to screening, rating scales are often administered throughout treatment to measure changes in symptoms. An approximate 50% decrease in scores on the BDI and PHQ-A has been found to be clinically significant when reassessing an individual for interval improvement.(1)(5)(6)

Evaluation completed and reviewed

- Completion of appropriate evaluation includes **ALL** of the following(1)(2)(3):
  - Psychiatric history and evaluation
  - Mental status examination
  - Evaluation of precipitants
  - Observation and symptom assessment completed or not needed
  - Physical examination completed or not indicated for level of care

References

1. APA Work Group on Psychiatric Evaluation. The American Psychiatric Association practice Guidelines for the Psychiatric Evaluation of Adults. 3rd edition [Internet] American Psychiatric Association. 2016 Accessed at: https://psychiatryonline.org/. [accessed 2025 Sep 05] DOI: 10.1176/appi.books.9780890426760.
2. Egger HL, Pataki CS. Psychiatric assessment of preschool children. In: Boland R, Verduin ML, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 11th ed. Wolters Kluwer; 2025:3553-3557.
3. Hua LL, et al. Suicide and suicide risk in adolescents. Pediatrics 2024;153(1):Online. DOI: 10.1542/peds.2023-064800.

Functional status acceptable

- Functional status acceptable, as indicated by **1 or more** of the following:
  - No essential function[A] is significantly impaired.
  - An essential function is impaired, but impairment is manageable/treatable at available lower level of care.

References

1. American Association of Community Psychiatrists. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS). Adult version 20 [Internet] American Association of Community Psychiatrists. 2016 Dec Accessed at: https://www.communitypsychiatry.org/keystone-programs/locus. [accessed 2025 Sep 04]
2. American Association of Community Psychiatrists. CALOCUS/CASII: Child and Adolescent Level of Care Utilization System. Child and Adolescent Version 20 [Internet] American Association of Community Psychiatrists. 2019 Jul Accessed at: https://www.aacap.org/AACAP/Member_Resources/Practice_Information/CALOCUS_CASII.aspx. [accessed 2025 Sep 04]
3. CASII. Child and Adolescent Service Intensity Instrument [Internet] American Academy of Child and Adolescent Psychiatry. Accessed at: https://www.aacap.org/aacap/Member_Resources/Practice_Information/CASII.aspx. Updated 2024 [accessed 2024 Sep 20]
4. Child & Adolescent Service Intensity Instrument (CASII) User's Manual version 4.0. American Academy of Child and Adolescent Psychiatry 2014 Oct.

Footnotes

A. Essential functions are those that are necessary to sustain life, such as feeding and hydrating oneself.(1)(2)(3)(4)

General Discharge Criteria met

- General Discharge Criteria met or Pediatric General Discharge Criteria met (if either is relevant or necessary for patient's condition)

Hallucinations (adult)

- Hallucinations are perceptions that occur without an external stimulus (eg, hearing, seeing, tasting, smelling, or feeling things that are not present). They may occur in any sensory modality, but auditory hallucinations are the most common in schizophrenia and related disorders.(1) Hallucination severity may be described as(2)(3)(4):
  - Minimal (subtle symptoms that may rarely bother the patient, and are not associated with pressure to act on beliefs or interference with daily functioning (may represent extreme end of normal range))
  - Mild (symptoms may not be very bothersome to the patient, are only occasionally present, are associated with little pressure to act on beliefs, and contribute to **Mild** dysfunction in daily living for adult)
  - Mild to moderate (symptoms may not be very bothersome to the patient, are established (eg, present up to half of each week), are associated with little pressure to act on beliefs, and contribute to **Mild to moderate** dysfunction in daily living for adult)

- Moderate (symptoms may be somewhat bothersome to the patient, are clearly established (eg, present more than half of each week, but not daily or near daily), are associated with pressure to act on beliefs, and contribute to **Moderate** dysfunction in daily living for adult)
- Moderately severe (symptoms may be bothersome to the patient, are associated with pressure to act on beliefs, are present more than half of each week (but not daily or near daily), and contribute to **Serious** dysfunction in daily living for adult, but are not all-consuming and usually can be contained at will)
- Severe (symptoms may be very bothersome to the patient, are present daily (or near daily), are associated with strong pressure to act on beliefs, and contribute to **Severe** dysfunction in daily living for adult (eg, symptoms may be all-consuming or cannot be contained at will, and often require close supervision))
- Extreme (symptoms may be highly disturbing to the patient, are present on an almost constant basis, are associated with intense pressure to act on beliefs, and contribute to **Severe** dysfunction in daily living for adult (condition usually requires close supervision))

References

1. Schizophrenia spectrum and other psychotic disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:101-138.
2. Assessment measures. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:841-857.
3. Kay SR, Fiszbein A, Opler LA. The positive and negative syndrome scale (PANSS) for schizophrenia. Schizophrenia Bulletin 1987;13(2):261-276.
4. The PANSS Institute. [Internet] The PANSS Institute. Accessed at: http://www.panss.org/. Updated 2024 [accessed 2024 Oct 02]

Hallucinations (child or adolescent)

- Hallucinations are perceptions that occur without an external stimulus (eg, hearing, seeing, tasting, smelling, or feeling things that are not present). They may occur in any sensory modality, but auditory hallucinations are the most common in schizophrenia and related disorders. Instruments are available for assessing the severity of symptoms in young people, including versions of the Positive and Negative Syndrome Scale (PANSS) modified for pediatric populations.(1)(2)(3)

References

1. Schizophrenia spectrum and other psychotic disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:101-138.
2. Findling RL, et al. An optimized version of the positive and negative symptoms scale (PANSS) for pediatric trials. Journal of the American Academy of Child and Adolescent Psychiatry 2023;62(4):427-434. DOI: 10.1016/j.jaac.2022.07.864.
3. Fields JH, et al. Assessing positive and negative symptoms in children and adolescents. American Journal of Psychiatry 1994;151(2):249-53.

Harm

- Harm to self or another is considered serious if it has a substantial likelihood of causing death, disability, or major disfigurement.(1)(2)(3)(4)(5)

References

1. American Association of Community Psychiatrists. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS). Adult version 20 [Internet] American Association of Community Psychiatrists. 2016 Dec Accessed at: https://www.communitypsychiatry.org/keystone-programs/locus. [accessed 2025 Sep 04]
2. American Association of Community Psychiatrists. CALOCUS/CASII: Child and Adolescent Level of Care Utilization System. Child and Adolescent Version 20 [Internet] American Association of Community Psychiatrists. 2019 Jul Accessed at: https://www.aacap.org/AACAP/Member_Resources/Practice_Information/CALOCUS_CASII.aspx. [accessed 2025 Sep 04]

3. CASII. Child and Adolescent Service Intensity Instrument [Internet] American Academy of Child and Adolescent Psychiatry. Accessed at: https://www.aacap.org/aacap/Member_Resources/Practice_Information/CASII.aspx. Updated 2024 [accessed 2024 Sep 20]
4. Child & Adolescent Service Intensity Instrument (CASII) User's Manual version 4.0. American Academy of Child and Adolescent Psychiatry 2014 Oct.
5. APA Work Group on Psychiatric Evaluation. The American Psychiatric Association practice Guidelines for the Psychiatric Evaluation of Adults. 3rd edition [Internet] American Psychiatric Association. 2016 Accessed at: https://psychiatryonline.org/. [accessed 2025 Sep 05] DOI: 10.1176/appi.books.9780890426760.

Hyperactivity or inattention (adult)

- Hyperactivity refers to increased movement, impulsive actions, excessive talking, and difficulty sitting still. Inattention refers to easy distractibility and deficits in the ability to focus or stay on task. Determining severity includes the number of hyperactive or inattentive symptoms present, the frequency and duration of symptom presentation, and the impact that symptoms have on function and development. Levels of severity may be described as(1)(2):
    - Minimal (subtle symptoms that may rarely bother the patient, and are not associated with interference with daily functioning (may represent extreme end of normal range))
    - Mild (symptoms may not be very bothersome to the patient, are only occasionally present, and contribute to **Mild** dysfunction in daily living for adult)
    - Mild to moderate (symptoms may not be very bothersome to the patient, are established (eg, present up to half of each week), and contribute to **Mild to moderate** dysfunction in daily living for adult)
    - Moderate (symptoms may be somewhat bothersome to the patient, are clearly established (eg, present more than half of each week, but not daily or near daily), and contribute to **Moderate** dysfunction in daily living for adult)
    - Moderately severe (symptoms may be bothersome to the patient, are present more than half of each week (but not daily or near daily), and contribute to **Serious** dysfunction in daily living for adult, but are not all-consuming and usually can be contained at will)
    - Severe (symptoms may be very bothersome to the patient, are present daily (or near daily), and contribute to **Severe** dysfunction in daily living for adult (eg, symptoms may be all-consuming or cannot be contained at will, and often require close supervision))
    - Extreme (symptoms may be highly disturbing to the patient, are present on an almost constant basis, and contribute to **Severe** dysfunction in daily living for adult (condition usually requires close supervision))

References

1. Neurodevelopmental disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:35-99.
2. Kessler RC, et al. The World Health Organization Adult ADHD Self-Report Scale (ASRS): a short screening scale for use in the general population. Psychological Medicine 2005;35(2):245-56.

Hyperactivity or inattention (child or adolescent)

- Hyperactivity refers to increased movement, impulsive actions, excessive talking, and difficulty sitting still. Inattention refers to easy distractibility and deficits in the ability to focus or stay on task. Determining severity includes the number of hyperactive or inattentive symptoms present, the frequency and duration of symptom presentation, and the impact that symptoms have on function and development. Levels of severity may be described as(1):
    - Minimal (subtle symptoms that may rarely bother the patient, and are not associated with interference with daily functioning (may represent extreme end of normal range))
    - Mild (symptoms may not be very bothersome to the patient, are only occasionally present, and contribute to **Mild** dysfunction in daily living for child or adolescent)
    - Mild to moderate (symptoms may not be very bothersome to the patient, are established (eg, present up to half of each week), and contribute to **Mild to moderate** dysfunction in daily living for child or adolescent)

- Moderate (symptoms may be somewhat bothersome to the patient, are clearly established (eg, present more than half of each week, but not daily or near daily), and contribute to **Moderate** dysfunction in daily living for child or adolescent)
- Moderately severe (symptoms may be bothersome to the patient, are present more than half of each week (but not daily or near daily), and contribute to **Serious** dysfunction in daily living for child or adolescent, but are not all-consuming and usually can be contained at will)
- Severe (symptoms may be very bothersome to the patient, are present daily (or near daily), and contribute to **Severe** dysfunction in daily living for child or adolescent (eg, symptoms may be all-consuming or cannot be contained at will, and often require close supervision))
- Extreme (symptoms may be highly disturbing to the patient, are present on an almost constant basis, and contribute to **Severe** dysfunction in daily living for child or adolescent (condition usually requires close supervision))

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1. Neurodevelopmental disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:35-99.

Impaired impulse control, judgment, or insight

- Impaired impulse control describes a lack of control or ability to regulate actions related to inner urges. Impaired judgment and insight may include a lack of recognition of current or past symptoms, denial of need for treatment, or lack of recognition of consequences of actions. Levels of severity may be described as(1)(2)(3)(4)(5)(6):
  - Minimal (subtle symptoms that may rarely bother the patient and are not associated with interference with daily functioning (may represent extreme end of normal range))
  - Mild (symptoms may not be very bothersome to the patient, are only occasionally present, and contribute to **Mild** dysfunction in daily living for adult or **Mild** dysfunction in daily living for child or adolescent)
  - Mild to moderate (symptoms may not be very bothersome to the patient, are established (eg, present up to half of each week), and contribute to **Mild to moderate** dysfunction in daily living for adult or **Mild to moderate** dysfunction in daily living for child or adolescent)
  - Moderate (symptoms may be somewhat bothersome to the patient, are clearly established (eg, present more than half of each week, but not daily or near daily), and contribute to **Moderate** dysfunction in daily living for adult or **Moderate** dysfunction in daily living for child or adolescent)
  - Moderately severe (symptoms may be bothersome to the patient, are present more than half of each week (but not daily or near daily), and contribute to **Serious** dysfunction in daily living for adult or **Serious** dysfunction in daily living for child or adolescent but are not all-consuming and usually can be contained at will)
  - Severe (symptoms may be very bothersome to the patient, are present daily (or near daily), and contribute to **Severe** dysfunction in daily living for adult or **Severe** dysfunction in daily living for child or adolescent (eg, symptoms may be all-consuming or cannot be contained at will, and often require close supervision))
  - Extreme (symptoms may be highly disturbing to the patient, are present on an almost constant basis, and contribute to **Severe** dysfunction in daily living for adult or **Severe** dysfunction in daily living for child or adolescent (condition usually requires close supervision))

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Mania (adult)

- Mania symptoms may include elated/irritable mood, grandiosity, decreased need for sleep (eg, feeling rested after only a few hours of sleep), hyperverbal or rapid pressured speech, flight of ideas, racing thoughts, distractibility (ie, attention too easily drawn to unimportant or irrelevant external stimuli), increase in goal-directed activity (either socially, at work, or at school), hypersexuality, excessive energy, psychomotor agitation, or excessive involvement in pleasurable activities that have a high potential for negative consequences (eg, engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments). Symptoms do not have an alternative explanation (eg, intoxication, delirium, or other medical condition). Symptom severity may be described as(1)(2)(3)(4)(5)(6):
    - Mild (periods of somewhat elevated, expansive, or irritable mood, or other manic symptoms that are occasionally present)
    - Mild to moderate (periods of somewhat elevated, expansive, or irritable mood, or other manic symptoms that are present up to half the days of each week)
    - Moderate (periods of extensively elevated, expansive, or irritable mood or restlessness, or other manic symptoms that are present more than half the days of each week)
    - Moderately severe (frequent, but not daily, periods of extensively elevated, expansive, or irritable mood or restlessness, or other manic symptoms)
    - Severe (daily periods of extensively elevated, expansive, or irritable mood or restlessness, or other manic symptoms)

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Mania (child or adolescent)

- Mania symptoms may include elated/irritable mood, grandiosity, decreased need for sleep (eg, feeling rested after only a few hours of sleep), hyperverbal or rapid pressured speech, flight of ideas, racing thoughts, distractibility (ie, attention too easily drawn to unimportant or irrelevant external stimuli), increase in goal-directed activity (eg, socially or at school), hypersexuality, excessive energy, psychomotor agitation, or excessive involvement in pleasurable activities that have a high potential for negative consequences. Symptoms do not have an alternative explanation (eg, intoxication, delirium, or other medical condition).(1)(2)(3)

References

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3. Bipolar and related disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:139-175.

Medical needs absent or manageable/treatable at available lower level of care

- Medical needs absent or manageable/treatable at available lower level of care, as indicated by **ALL** of the following(1)(2)(3)(4)(5)(6):
  - Adverse medication effects absent or manageable/treatable
  - Medical comorbidity absent or manageable/treatable
  - Medical complications absent or manageable/treatable (eg, complications of eating disorder)
  - Substance-related disorder absent or manageable/treatable

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1. American Association of Community Psychiatrists. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS). Adult version 20 [Internet] American Association of Community Psychiatrists. 2016 Dec Accessed at: https://www.communitypsychiatry.org/keystone-programs/locus. [accessed 2025 Sep 04]
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Mild dysfunction in daily living for adult

- **Mild** dysfunction in daily living for adult is present, as indicated by **1 or more** of the following(1)(2)(3)(4)(5)(6):
  - Some deterioration in interpersonal interactions (eg, increased conflict), but able to maintain some meaningful relationships
  - Some recent minor disruptions in self-care
  - Minor but consistent disruptions in social role functioning and meeting obligations, but still able to maintain these roles
  - Self-neglect with at least some minor limitation in ability to provide for basic needs (by self or others) in maintenance care
  - Other evidence of mild dysfunction

References

1. American Association of Community Psychiatrists. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS). Adult version 20 [Internet] American Association of Community Psychiatrists. 2016 Dec Accessed at: https://www.communitypsychiatry.org/keystone-programs/locus. [accessed 2025 Sep 04]
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Mild dysfunction in daily living for child or adolescent

- **Mild** dysfunction in daily living for child or adolescent is present, as indicated by **1 or more** of the following(1)(2)(3)(4)(5)(6)(7):
  - Minor deterioration or episodic failure in relationships with peers, family, or adults (eg, defiance, lying, provocative behavior)
  - Self-care sporadically below usual or expected standards
  - Impairments in function characterized by ability to show improvements following episodes of deterioration
  - Diminished ability to assess consequences of own actions (eg, acts of severe property damage) that therapeutic intervention can remediate
  - Self-neglect with at least some minor limitation in ability to provide for basic needs (by self or others) in maintenance care
  - Other evidence of mild dysfunction

References

1. American Association of Community Psychiatrists. CALOCUS/CASII: Child and Adolescent Level of Care Utilization System. Child and Adolescent Version 20 [Internet] American Association of Community Psychiatrists. 2019 Jul Accessed at: https://www.aacap.org/AACAP/Member_Resources/Practice_Information/CALOCUS_CASII.aspx. [accessed 2025 Sep 04]
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7. Early Childhood Service Intensity Instrument (ECSII) for Infants, Toddlers, and Preschool-aged Children Ages 0-5 version 1. American Academy of Child and Adolescent Psychiatry 2009 Sep.

Mild to moderate dysfunction in daily living for adult

- **Mild to moderate** dysfunction in daily living for adult is present, as indicated by **1 or more** of the following(1)(2)(3)(4)(5)(6):

- Some recent deterioration in interpersonal interactions (eg, conflicted, withdrawn), but maintains control of impulsive or abusive behaviors and maintains some meaningful relationships
- Some recent disruptions in self-care below usual or expected standards
- Disturbance in vegetative status (eg, eating, sleeping habits) that does not pose serious threat to health
- Some deterioration in social role functioning and meeting obligations (eg, avoiding responsibilities on some occasions), but still can maintain roles overall
- Other evidence of mild to moderate dysfunction

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Mild to moderate dysfunction in daily living for child or adolescent

- **Mild to moderate** dysfunction in daily living for child or adolescent is present, as indicated by **1 or more** of the following(1)(2)(3)(4)(5)(6)(7):
  - Some difficulty in relationships with peers, family, or adults (eg, defiance, lying), but without physical aggression
  - Self-care sometimes below usual or expected standards
  - Disturbance in vegetative status (eg, eating, sleeping habits) that does not pose serious threat to health
  - Deteriorating school behavior such that disruption in school is threatened (eg, threat of expulsion)
  - Diminished ability to assess consequences of own actions (eg, acts of severe property damage) that therapeutic intervention can remediate
  - Other evidence of mild to moderate dysfunction

References

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7. Early Childhood Service Intensity Instrument (ECSII) for Infants, Toddlers, and Preschool-aged Children Ages 0-5 version 1. American Academy of Child and Adolescent Psychiatry 2009 Sep.

Moderate dysfunction in daily living for adult

- **Moderate** dysfunction in daily living for adult is present, as indicated by **1 or more** of the following(1)(2)(3)(4)(5)(6):
  - Recent conflicted, withdrawn, or troubled relationships, but maintains control of impulsive, aggressive, or abusive behaviors
  - Self-care frequently below usual or expected standards
  - Significant disturbance in vegetative status (eg, eating, sleeping habits), but not posing serious threat to health
  - Significant deterioration in ability to fulfill responsibilities (eg, work, commitments to significant others), including neglect or avoidance of these responsibilities on some occasions
  - Ongoing and variably severe deficits in interpersonal relationships and ability to engage socially in constructive manner
  - Other evidence of moderate dysfunction

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Moderate dysfunction in daily living for child or adolescent

- **Moderate** dysfunction in daily living for child or adolescent is present, as indicated by **1 or more** of the following(1)(2)(3)(4)(5)(6)(7):
  - Troubled relationships with peers, family, or adults (eg, conflicted, withdrawn), but without physical aggression
  - Self-care frequently below usual or expected standards
  - Significant disturbance in vegetative status (eg, eating, sleeping habits), but not posing serious threat to health
  - Deteriorated school behavior such that disruption in school has occurred (eg, suspension, expulsion), and child is at risk for placement in alternative school setting or repeating grade
  - Diminished ability to assess consequences of own actions (eg, acts of severe property damage)
  - Other evidence of moderate dysfunction

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7. Early Childhood Service Intensity Instrument (ECSII) for Infants, Toddlers, and Preschool-aged Children Ages 0-5 version 1. American Academy of Child and Adolescent Psychiatry 2009 Sep.

Negative symptoms (adult)

- Negative symptoms represent thoughts, feelings, or behaviors that normally would be present, but are absent or diminished in relation to a psychiatric disorder.

They may include apathy, anhedonia, poverty of speech, motor behavior that is diminished or signs or symptoms of psychomotor retardation.(1)(2)(3)(4) Levels of severity may be described as:

- Minimal (subtle symptoms that may rarely bother the patient, and are not associated with interference with daily functioning (may represent extreme end of normal range))
- Mild (symptoms may not be very bothersome to the patient, are only occasionally present, and contribute to **Mild** dysfunction in daily living for adult)
- Mild to moderate (symptoms may not be very bothersome to the patient, are established (eg, present up to half of each week), and contribute to **Mild to moderate** dysfunction in daily living for adult)
- Moderate (symptoms may be somewhat bothersome to the patient, are clearly established (eg, present more than half of each week, but not daily or near daily), and contribute to **Moderate** dysfunction in daily living for adult)
- Moderately severe (symptoms may be bothersome to the patient, are present more than half of each week (but not daily or near daily), and contribute to **Serious** dysfunction in daily living for adult, but are not all-consuming and usually can be contained at will)
- Severe (symptoms may be very bothersome to the patient, are present daily (or near daily), and contribute to **Severe** dysfunction in daily living for adult (eg, symptoms may be all-consuming or cannot be contained at will, and often require close supervision))
- Extreme (symptoms may be highly disturbing to the patient, are present on an almost constant basis, and contribute to **Severe** dysfunction in daily living for adult (condition usually requires close supervision))

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4. Schizophrenia spectrum and other psychotic disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:101-138.

Negative symptoms (child or adolescent)

- Negative symptoms represent thoughts, feelings, or behaviors that normally would be present, but are absent or diminished in relation to a psychiatric disorder. They may include apathy, anhedonia, poverty of speech, motor behavior that is diminished or signs or symptoms of psychomotor retardation. Instruments are available for assessing severity of symptoms in young people, including versions of the Positive and Negative Syndrome Scale (PANSS) modified for pediatric populations.(1)(2)(3) Levels of severity may be described as:
  - Minimal (subtle symptoms that may rarely bother the patient, and are not associated with interference with daily functioning (may represent extreme end of normal range))
  - Mild (symptoms may not be very bothersome to the patient, are only occasionally present, and contribute to **Mild** dysfunction in daily living for child or adolescent)
  - Mild to moderate (symptoms may not be very bothersome to the patient, are established (eg, present up to half of each week), and contribute to **Mild to moderate** dysfunction in daily living for child or adolescent)
  - Moderate (symptoms may be somewhat bothersome to the patient, are clearly established (eg, present more than half of each week, but not daily or near daily), and contribute to **Moderate** dysfunction in daily living for child or adolescent)
  - Moderately severe (symptoms may be bothersome to the patient, are present more than half of each week (but not daily or near daily), and contribute to **Serious** dysfunction in daily living for child or adolescent, but are not all-consuming and usually can be contained at will)
  - Severe (symptoms may be very bothersome to the patient, are present daily (or near daily), and contribute to **Severe** dysfunction in daily living for child or adolescent (eg, symptoms may be all-consuming or cannot be contained at will, and often require close supervision))
  - Extreme (symptoms may be highly disturbing to the patient, are present on an almost constant basis, and contribute to **Severe** dysfunction in daily living for child or adolescent (condition usually requires close supervision))

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Obsessions or compulsions (adult)

- Obsessions are recurrent and persistent thoughts, urges, or images that are intrusive and unwanted, which often cause marked anxiety or distress, and are associated with attempts to ignore, suppress, or neutralize these experiences.(1)(2) Compulsions are repetitive behaviors that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly; the behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation, but are not connected in a realistic way with what they are designed to neutralize or prevent (or are clearly excessive).(1)(2)

References

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2. Goodman WK, et al. The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. Archives of General Psychiatry 1989;46(11):1006-11.

Obsessions or compulsions (child or adolescent)

- Obsessions are recurrent and persistent thoughts, urges, or images that are intrusive and unwanted, which often cause marked anxiety or distress, and are associated with attempts to ignore, suppress, or neutralize these experiences.(1)(2) Compulsions are repetitive behaviors that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly; the behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation, but are not connected in a realistic way with what they are designed to neutralize or prevent (or are clearly excessive). Young children may not be able to articulate the aims of these behaviors or mental acts.(1)(2)(3)

References

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2. Goodman WK, et al. The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. Archives of General Psychiatry 1989;46(11):1006-11.
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Positive symptoms (adult)

- Positive symptoms are feelings, thoughts, perceptions, or behaviors that usually are not based on a shared reality. They may include hallucinations, delusions, or other symptoms that are abnormal or bizarre. Levels of severity may be described as(1)(2)(3)(4):
  - Minimal (subtle symptoms that may rarely bother the patient, and are not associated with pressure to act on beliefs or interference with daily functioning (may represent extreme end of normal range))
  - Mild (symptoms may not be very bothersome to the patient, are only occasionally present, are associated with little pressure to act on beliefs, and contribute to **Mild** dysfunction in daily living for adult)
  - Mild to moderate (symptoms may not be very bothersome to the patient, are established (eg, present up to half of each week), are associated with little pressure to act on beliefs, and contribute to **Mild to moderate** dysfunction in daily living for adult)
  - Moderate (symptoms may be somewhat bothersome to the patient, are clearly established (eg, present more than half of each week, but not daily or near daily), are associated with pressure to act on beliefs, and contribute to **Moderate** dysfunction in daily living for adult)
  - Moderately severe (symptoms may be bothersome to the patient, are associated with pressure to act on beliefs, are present more than half of each week (but not daily or near daily), and contribute to **Serious** dysfunction in daily living for adult, but are not all-consuming and usually can be contained at will)
  - Severe (symptoms may be very bothersome to the patient, are present daily (or near daily), are associated with strong pressure to act on beliefs, and contribute to **Severe** dysfunction in daily living for adult (eg, symptoms may be all-consuming or cannot be contained at will, and often require close supervision))
  - Extreme (symptoms may be highly disturbing to the patient, are present on an almost constant basis, are associated with intense pressure to act on beliefs, and contribute to **Severe** dysfunction in daily living for adult (condition usually requires close supervision))

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3. Assessment measures. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:841-857.
4. Schizophrenia spectrum and other psychotic disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:101-138.

Positive symptoms (child or adolescent)

- Positive symptoms are feelings, thoughts, perceptions, or behaviors that usually are not based on a shared reality. They may include hallucinations, delusions, or other symptoms that are abnormal or bizarre. Instruments are available for assessing severity of symptoms in young people, including versions of the Positive and Negative Syndrome Scale (PANSS) modified for pediatric populations.(1)(2)(3) Levels of severity may be described as:
  - Minimal (subtle symptoms that may rarely bother the patient, and are not associated with pressure to act on beliefs or interference with daily functioning (may represent extreme end of normal range))
  - Mild (symptoms may not be very bothersome to the patient, are only occasionally present, are associated with little pressure to act on beliefs, and contribute to **Mild** dysfunction in daily living for child or adolescent)
  - Mild to moderate (symptoms may not be very bothersome to the patient, are established (eg, present up to half of each week), are associated with little pressure to act on beliefs, and contribute to **Mild to moderate** dysfunction in daily living for child or adolescent)
  - Moderate (symptoms may be somewhat bothersome to the patient, are clearly established (eg, present more than half of each week, but not daily or near daily), are associated with pressure to act on beliefs, and contribute to **Moderate** dysfunction in daily living for child or adolescent)
  - Moderately severe (symptoms may be bothersome to the patient, are associated with pressure to act on beliefs, are present more than half of each week (but not daily or near daily), and contribute to **Serious** dysfunction in daily living for child or adolescent, but are not all-consuming and usually can be contained at will)
  - Severe (symptoms may be very bothersome to the patient, are present daily (or near daily), are associated with strong pressure to act on beliefs, and contribute to **Severe** dysfunction in daily living for child or adolescent (eg, symptoms may be all-consuming or cannot be contained at will, and often require close supervision))
  - Extreme (symptoms may be highly disturbing to the patient, are present on an almost constant basis, are associated with intense pressure to act on beliefs, and contribute to **Severe** dysfunction in daily living for child or adolescent (condition usually requires close supervision))

References

1. Schizophrenia spectrum and other psychotic disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:101-138.
2. Findling RL, et al. An optimized version of the positive and negative symptoms scale (PANSS) for pediatric trials. Journal of the American Academy of Child and Adolescent Psychiatry 2023;62(4):427-434. DOI: 10.1016/j.jaac.2022.07.864.
3. Fields JH, et al. Assessing positive and negative symptoms in children and adolescents. American Journal of Psychiatry 1994;151(2):249-53.

Risk status acceptable

- Risk status acceptable, as indicated by **ALL** of the following(1)(2)(3)(4)(5)(6):
  - Danger to self or others manageable/treatable, as indicated by **1 or more** of the following:
    - Absence of Thoughts of suicide, homicide, or serious Harm to self or to another
    - Thoughts of suicide, homicide, or serious Harm to self or to another present but manageable/treatable at available lower level of care
  - Patient and supports understand follow-up treatment and crisis plan.
  - Provider and supports are sufficiently available at lower level of care.
  - Patient, as appropriate, can participate as needed in monitoring at available lower level of care.

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Serious dysfunction in daily living for adult

- **Serious** dysfunction in daily living for adult is present, as indicated by **1 or more** of the following(1)(2)(3)(4)(5)(6):
  - Serious deterioration in quality of interpersonal interactions (eg, impulsive or abusive behaviors)
  - Significant withdrawal and avoidance of almost all social interaction
  - Consistent failure to achieve self-care (eg, personal hygiene, appearance) to usual standards
  - Serious disturbance in vegetative status (eg, weight change, sleep disruption) threatening physical function
  - Inability to perform close to usual standards in adult obligations (eg, work, parenting) and neglecting these responsibilities frequently or over extended period of time
  - Other evidence of serious dysfunction

References

1. American Association of Community Psychiatrists. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS). Adult version 20 [Internet] American Association of Community Psychiatrists. 2016 Dec Accessed at: https://www.communitypsychiatry.org/keystone-programs/locus. [accessed 2025 Sep 04]
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Serious dysfunction in daily living for child or adolescent

- **Serious** dysfunction in daily living for child or adolescent is present, as indicated by **1 or more** of the following(1)(2)(3)(4)(5)(6)(7):
  - Serious deterioration in interpersonal interactions (eg, impulsive or abusive behaviors)

- Significant withdrawal and avoidance of almost all social interaction
- Consistent failure to achieve self-care as appropriate to age or developmental level
- Serious disturbance in vegetative status (eg, weight change, sleep disruption) threatening physical function
- Inability to perform adequately in school (including specialized setting) due to disruptive or aggressive behavior
- Severely diminished ability to assess consequences of own actions (eg, acts of severe property damage)
- Other evidence of serious dysfunction

References

1. American Association of Community Psychiatrists. CALOCUS/CASII: Child and Adolescent Level of Care Utilization System. Child and Adolescent Version 20 [Internet] American Association of Community Psychiatrists. 2019 Jul Accessed at: https://www.aacap.org/AACAP/Member_Resources/Practice_Information/CALOCUS_CASII.aspx. [accessed 2025 Sep 04]
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3. Child & Adolescent Service Intensity Instrument (CASII) User's Manual version 4.0. American Academy of Child and Adolescent Psychiatry 2014 Oct.
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7. Early Childhood Service Intensity Instrument (ECSII) for Infants, Toddlers, and Preschool-aged Children Ages 0-5 version 1. American Academy of Child and Adolescent Psychiatry 2009 Sep.

Severe dysfunction in daily living for adult

- **Severe** dysfunction in daily living for adult is present, as indicated by **1 or more** of the following(1)(2)(3)(4)(5)(6):
  - Incapacitation because of grave disability (eg, severe regression with inability to provide for self)
  - Extreme deterioration in social interactions (eg, threatening behaviors with little or no provocation)
  - Complete withdrawal from all social interactions
  - Complete neglect of self-care with associated impairment in physical status
  - Extreme disruption in vegetative function (eg, life-sustaining functions such as eating)
  - Complete inability to maintain any appropriate aspect of personal responsibility in any adult roles (eg, occupational, parental)
  - Other evidence of severe dysfunction

References

1. American Association of Community Psychiatrists. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS). Adult version 20 [Internet] American Association of Community Psychiatrists. 2016 Dec Accessed at: https://www.communitypsychiatry.org/keystone-programs/locus. [accessed 2025 Sep 04]
2. Assessment measures. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:841-857.
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4. WHO Disability Assessment Schedule 2.0 (WHODAS 2,0). 12-Item Instrument Scoring Sheet [Internet] World Health Organization. 2014 Nov Accessed at: https://www.who.int/. [accessed 2025 Sep 17]
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Severe dysfunction in daily living for child or adolescent

- **Severe** dysfunction in daily living for child or adolescent is present, as indicated by **1 or more** of the following(1)(2)(3)(4)(5)(6)(7):
  - Incapacitation because of grave disability (eg, severe regression with inability to provide for self)
  - Extreme deterioration in interactions with peers, adults, or family (eg, assaultive behaviors with no provocation, high levels of family conflict)
  - Complete withdrawal from all social interactions
  - Complete neglect of self-care with associated impairment in physical status
  - Extreme disruption in vegetative function (eg, life-sustaining functions such as eating)
  - Nearly complete inability to maintain any appropriate school behavior or academic achievement
  - Severely diminished ability to assess consequences of own actions (eg, acts of severe property damage)
  - Other evidence of severe dysfunction

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5. Shaffer D, et al. A children's global assessment scale (CGAS). Archives of General Psychiatry 1983;40(11):1228-31.
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7. Early Childhood Service Intensity Instrument (ECSII) for Infants, Toddlers, and Preschool-aged Children Ages 0-5 version 1. American Academy of Child and Adolescent Psychiatry 2009 Sep.

Social Determinants of Health Assessment

- Risk of poor health outcomes may be increased by the presence of **1 or more** of the following social determinants of health(1)(2)(3):
  - Housing insecurity, as indicated by **1 or more** of the following:
    - Individual or caregiver's current living situation is **1 or more** of the following(4):
      - Does not have own housing (eg, staying in a hotel, shelter, or with others)
      - Has own housing (eg, house, apartment), but at risk of losing it in the future (ie, behind on rent or mortgage)
      - Has own housing (eg, house, apartment), but has lived in 3 or more places in past year
    - Current housing has **1 or more** of the following:

    - Electrical appliances (eg, stove, refrigerator) not working or unavailable
    - Insufficient heating or cooling
    - Insufficient ventilation
    - Lead paint or pipes
    - Mold
    - Pests (eg, bugs) or rodents
    - Smoke detectors not working or unavailable
- Food insecurity, as indicated by **1 or more** of the following(5):
    - In the past year, individual or caregiver ran out of food and did not have money to buy more food.
    - In the past year, individual or caregiver worried that they would run out of food before they received money to buy more food.
- Insufficient transportation, as indicated by **1 or more** of the following(6):
    - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of transportation.
    - In the past year, individual or caregiver missed nonmedical activities, work, or could not get things needed for daily living due to lack of transportation.
- Insufficient utilities, as indicated by **1 or more** of the following(7):
    - Utilities (eg, electricity, water, gas, or oil) are currently shut off or unavailable.
    - In the past year, electric, water, gas, or oil company threatened to shut off services.
- Personal safety risk, as indicated by **2 or more** of the following(5):
    - Individual is sometimes or frequently physically hurt by another person (including family member).
    - Individual is sometimes or frequently insulted or talked down to by another person (including family member).
    - Individual is sometimes or frequently threatened with physical harm by another person (including family member).
    - Individual is sometimes or frequently screamed or cursed at by another person (including family member).
- Insufficient dependent care, as indicated by **1 or more** of the following:
    - In the past year, individual or caregiver was unable to work due to lack of dependent care.
    - In the past year, individual or caregiver was unable to work more (additional) hours due to lack of dependent care.
    - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of dependent care.
    - In the past year, individual or caregiver missed nonmedical activities (eg, school, church, social activity) due to lack of dependent care.
- Depression risk, as indicated by **ALL** of the following(8):
    - In the past 2 weeks, individual had little interest or pleasure in normal activities on at least several days.
    - In the past 2 weeks, individual felt down, depressed, or hopeless on at least several days.

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Sufficient relief

- Sufficient relief is that which is adequate to alleviate the immediate impetus for recurrence of suicide attempt or act of harm to self or another.(1)(2)(3)(4)(5)

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Suicide attempt

- A suicide attempt may be identified by an actual, interrupted, or aborted act of self-injurious behavior accompanied by **1 or more** of the following(1)(2)(3):
  - Explicit or implicit evidence that the person believed the act would be lethal (eg, gaining access to gun, carbon monoxide inhalation)
  - Explicit or implicit evidence that the person intended to die (eg, act that was unlikely to be discovered in time for rescue, writing suicide note)

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Symptom status acceptable

- Symptom status acceptable, as indicated by **ALL** of the following(1)(2)(3)(4)(5)(6):
  - Symptoms stabilized and may be appropriately treated at available lower level of care
  - No current plan for change in treatment or re-evaluation

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1. American Association of Community Psychiatrists. Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS). Adult version 20 [Internet] American Association of Community Psychiatrists. 2016 Dec Accessed at: https://www.communitypsychiatry.org/keystone-programs/locus. [accessed 2025 Sep 04]
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Thoughts of suicide

- Thoughts of suicide or suicidal ideations are defined as "thoughts of serving as the agent of one's own death," to be distinguished from thoughts of death that do not involve actively bringing death about.(1)(2)(3)

References

1. Rufino KA. Suicide treatment. In: Boland R, Verduin ML, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 11th ed. Wolters Kluwer; 2025:2715-2718.
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