Psychiatric Rehabilitation Medical Necessity Criteria and Standards:

Guidelines for Reviewing Requests for Admission, Continued Stay and Discharge

These guidelines provide a tool to assist Managed Care Organizations and providers in assessing information needed to determine eligibility for admission, continued stay and discharge as part of the authorization process for psychiatric rehabilitation services (PRS). The guidelines are intended as an aid in making these decisions. Use of these guidelines is not a requirement for the review, authorization or provision of PRS. In making decisions about PRS, it is essential both the reviewer and the referrer have an understanding of psychiatric rehabilitation and how it differs from other services. Additional information about the Relationship of Psychiatric Rehabilitation to Other Services starts on page 14 and is summarized in a chart on page 19.

Before requesting authorization for admission for PRS from a managed care organization, the provider needs to determine with the person the following:

1. The person’s interest in participating in PRS including a specific domain in which the person wishes to make changes. One requirement for admission is that the person chooses to participate.
2. The presence as a result of the mental illness of a moderate or severe functional impairment. Providers may wish to use the Functional Assessment Tool to assist in this evaluation.

A diagnosis from a psychiatrist is also required.

It should be noted that the managed care organization (MCO) has an exception process which may be considered in the event the person does not meet the Admission Criteria for PRS but is deemed to have special circumstances which merits additional consideration and review of the request for PRS. Additionally, providers may request an exception to the maximum of six hours per week for Mobile Psychiatric Rehabilitation (MPR) services. It is the responsibility of the provider to present adequate information to justify approval of the request for an exception.

Eligibility for Admission to Psychiatric Rehabilitation Services

Admission Criteria:
(from the Psychiatric Rehabilitation Medical Necessity Criteria and Standards)

Admission criteria for psychiatric rehabilitation services are met as follows:

1. The person is 18 years or older and has the presence or history of a serious mental illness, based upon medical records, which includes a diagnosis by a psychiatrist, that includes: schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder or borderline personality disorder.

AND
2. As a result of the mental illness, the person has a moderate to severe functional impairment that interferes with or limits role performance in at least one (1) of the following domains: educational (i.e., obtaining a high school or college degree); social (i.e., developing a social support system); vocational (i.e., obtaining part time or full time employment); self maintenance (i.e., managing symptoms, understanding their illness, managing money, living more independently) relative to the person’s ethnic/cultural environment.

AND

3. The person chooses to participate in the program.

Assessing Eligibility for Admission to PRS
(This section contains questions concerning meeting PRS admission criteria which may be asked by the MCO reviewer.)

1. What is the person’s age?
   (If not age 18 or older, stop. Person is not eligible for PRS)

2. What is the person’s diagnosis?
   Qualifying Diagnoses: Schizophrenia, Major mood disorder, Schizoaffective disorder, Psychotic disorder NOS, or Borderline personality disorder
   (If diagnosis is on the qualifying list, go to Question 3. If not, stop. Person is not eligible for PRS unless the BHMCO approves another diagnosis through an exception process.)

3. Does the person want to receive PR services?
   (If no, stop. Person is not eligible for PRS. A yes answer must be based on an interview with the person and supported with identification of a specific domain in which the person wishes to make changes)

   Has a functional domain been identified with the person in which the person wants to make changes? Identify domain(s) which PRS will address.
   (If no, request referral source to identify with the person a proposed domain for change. If yes, continue to Question 4)

4. As a result of the mental illness, does the person have a moderate to severe functional impairment that interferes with role performance in one or more of the following domains:

   (See the Functional Assessment Tool for a description of the evaluation process which must include face-to-face discussion with the person. Also, see p.7 for Additional Questions about Specific Domains which may be helpful in assessing the degree of functional impairment(s) as well as the need for psychiatric rehabilitation and/or other services)
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<tr>
<th>Domain</th>
<th>Current Status</th>
<th>Functional Impairment(s)</th>
<th>Degree of Impairment</th>
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*(Does the person have a moderate to severe functional impairment in at least one domain as a result of mental illness? If yes, continue. If no, stop. Person is not eligible for PRS)*

**Treatment History and Clinical Issues:**
*(Psychiatric Rehabilitation Medical Necessity Criteria and Standards state PRS “should begin as soon as clinically possible, following diagnosis.” In assessing this standard, questions such as the following may be helpful. Also see Considerations in Assessing Individual Service Needs on p. 4.)*

1. Does the person have a history of alcohol and/or substance abuse? If yes, is person currently actively using alcohol or substances?

2. If the person has had a recent change to an atypical antipsychotic medication or other significant change in medications, is additional stabilization needed before the person participates in PRS?

3. If the person has been discharged recently from an inpatient psychiatric hospitalization, is additional stabilization needed before the person participates in PRS?

4. Does the person have a significant physical condition which requires treatment before the person can actively participate in PRS?

**Note:** If PRS is not clinically indicated at present, the person should be reconsidered for PRS as soon as clinically indicated.

**Summary of Recommendations and Rationale for PRS:**
*(This may include the person’s current functional status with regard to the domain(s)*
identified for PRS services, recommended type(s) of PRS and number of hours of service per week, and initial service plans.)

**Initial Authorization of PRS:**
If after initial review the person is approved for PRS, determine specific service type(s), average number of hours of service per week and length of time period to be approved:
(Consider referral source recommendations and rationales:
Mobile Psychiatric Rehabilitation can be authorized up to 6 hours week per week maximum. The MPR maximum may be exceeded in special situations and for limited time periods with justification under an exception process. See p.5 for site-based and mobile psychiatric rehabilitation characteristics and indicators.)

**Denial of Services:**
If service is not authorized, reason(s) for denial:

**Considerations in Assessing Individual Service Needs:**

1. The person must want to participate in PRS in order to be eligible. This is determined through a face-to-face interview with the person by the PRS referring agency. The interview must include identification of specific domains in which the person is interested in making changes.

2. If the person is experiencing acute symptoms requiring stabilization or has had a recent significant change of medication, consider if the person needs additional services for stabilization such as a partial hospitalization program or continuation in current treatment setting.

3. If the person is actively abusing alcohol and/or substances, consider treatment in this area.

4. If the person needs support services only to maintain self in the community or to access treatment-related services and decrease use of crisis services or inpatient services, consider case management services. Case management may also be considered when the person has support needs to maintain self in the community and/or avoid use of costly services and is not interested in active PRS interventions such as goal setting.
5. If the person has a significant physical condition which requires treatment for the person to be able to participate in PRS, refer for treatment of the physical condition.

6. If review of the treatment history and clinical issues indicates that it is clinically possible for the person to participate in PRS interventions, and a functional domain has been identified with the person in which the person wants to make changes, consider PRS. Determination of functional domains in which the person is interested in making changes is based on discussion with the person. This would typically be part of the initial interview process.

7. If the person meets eligibility criteria for PRS including choosing to participate in the service and does not have significant clinical issues which need to be addressed before engaging in PRS, approve for PRS. Determine if the person will receive site-based services, MPR or a combination of both. Use indicators for site-based services, MPR services or both services to assist in making this decision.

**Site-based and Mobile Psychiatric Rehabilitation Services:**

**Characteristics and Indicators**

**Site-based Psychiatric Rehabilitation Services:**

Site-based services are characterized by:

1. Services provided primarily at a specific program facility.
2. Many services provided in groups.

Indicators for site-based services:

1. Person is willing and able to participate in groups.
2. Person is interested in participating in a variety of site-based experiences as part of choosing a goal.
3. Specific skills, supports and experiences needed for the person to be able to accomplish his/her PR goals are available in the context of the site-based program.
4. Person chooses to participate in the program.

**Mobile Psychiatric Rehabilitation Services (MPR):**

MPR services are characterized by:

1. Service is generally designed to be a short-term intervention based upon individual goals.
2. Mobile services are generally provided on a weekly basis for a limited number of hours (up to six hours/week unless a greater number of hours is approved under an exception process).
3. Services are provided in the community such as at the person’s home, an educational setting or other community setting.
4. Community resources used rather than program-based resources.
5. Services are on an individual (1:1 basis) and are face-to-face. **Note:** On a case-by-case basis, a 2:1 staffing approach may be used in certain situations when two clients are working on similar goals. All services to be delivered on this basis must have approval from both clients involved in the service as well as from the county or managed care organization.

6. The use of community-based services and supports is expected to promote the person choosing, getting and keeping psychiatric rehabilitation goals.

**Indicators for MPR services:**

1. Person is currently unable to attend a site-based service, OR
2. Person is setting a goal which needs substantial community exploration or practice.
   Example: person is planning to live independently in his/her own house or apartment in the community, OR
3. The nature of the person’s goal indicates the preferred site for service delivery and supports is the community. Example: person is returning to college to complete a college degree, OR
4. Person is already in a role in a community site and needs MPR services to be successful and satisfied in this role.
5. Person chooses to participate in a mobile program.

**Indicators for concurrent use of site-based and mobile services:**

Mobile and site-based psychiatric rehabilitation can be provided concurrently under certain limited circumstances as follows:

1. Person is transitioning to a site-based service and needs assistance in the transition.
2. Person is transitioning from site-based to mobile and needs assistance in the transition.
3. Specific issues have been identified which require both services.

**Note:** Examples are illustrations of possible services and are not meant to limit psychiatric rehabilitation goals to these services.
Additional Questions about Specific Domains
(These questions may be helpful in eliciting more information about specific domains for making decisions regarding eligibility, continued stay or discharge)

Functional Domains:

1. **Education**
   a. Does the individual want to complete or continue his/her education?
   b. What is the person’s current level of education?
   c. Has the person identified a self-determined goal for education?
   d. Have potential community resources for education been identified?
   e. What skills and supports would the person need to use the identified community resource with success and satisfaction?
   f. Is the person currently in an educational environment and experiencing difficulties which might be addressed by psychiatric rehabilitation services?

2. **Work**
   a. Does the individual want to work?
   b. Has the person worked in the past? (The best predictor of future employment according to Anthony)
   c. What is the person’s level of knowledge about potential work environments?
   d. What is the person’s level of knowledge about self (preferences, values, experience in decision making) regarding potential work environments?
   e. Would the person benefit and is he/she interested in participating in an experience involving the work-ordered day (Clubhouse)?
   f. What skills and supports would the person need to access and utilize vocational resources in the community such as the Office of Vocational Rehabilitation or job coaches?
   g. What skills and supports might the person need to gain and maintain employment?
   h. Has the person made any decisions about what he/she might want to do including possibility of full-time, part-time or volunteer work?
   i. What effects will working have on the person’s benefits including Section 8 housing? Is the person aware of these effects and agreeable to them?
   j. Is the person currently in a work environment where he/she is experiencing difficulties? What skills and supports might help alleviate these difficulties?

3. **Social (Enhancing social networks)**
   a. Is the person satisfied with his/her social network in the community?
   b. What community resources might the person access or improve his/her ability to utilize in order to improve or expand his/her social network?
   c. What skills and supports does the person need in order to improve or expand the social network?
   d. Does the person want a significant other or seek to improve a relationship with a current significant other?
   e. Is the person a parent, either with or without custody?
   f. Is the person satisfied with current parenting knowledge and skills?
   g. What skills and supports are needed to address parenting issues?
4. **Living (Housing)**
   a. What level or type of housing is the person living in now?
   b. Does the person want to live in a more independent level or type of housing?
   c. What level of housing does the person prefer?
   d. Are there external barriers to the person living in a more independent level of housing?
   e. What is the person’s level of knowledge regarding community housing resources?
   f. What skills and supports would the person need to live in the preferred environment with success and satisfaction?

5. **Illness and Wellness Management**
   a. Can the person state and describe the major symptoms of his/her illness including prodromal and relapse symptoms?
   b. Can the person identify triggers to symptoms including prodromal and relapse symptoms?
   c. Can the person describe strategies he/she can use for symptom management in the target environment (work, school, housing, social situations)?
   d. Can the person name medications prescribed, dosage, common side effects, and indicate those which require immediate notification of the psychiatrist?
   e. What skills and supports does the person need to access and utilize community resources for treatment of mental illness including self-help and support groups?
   f. Does the person need to make a transition between a partial hospital program and an outpatient setting?
   g. If the person has a history of substance abuse in addition to mental illness, is he/she able to access and use effectively community resources such as AA, NA or Double Trouble groups?
   h. What skills and supports would the person need to access community resources for substance abuse?
   i. Does the person have a physical illness or disability which affects management of the mental illness?
   j. Can the person describe treatment required including medications prescribed by the M.D?
   k. If the process for recovery requires lifestyle changes, can the person identify these changes?
   l. What lifestyle changes is the person willing to implement?
   m. What strategies does the person use regularly to promote wellness?
   n. Does the person want to learn or improve strategies to manage the illness and promote wellness?
Eligibility for Continued Stay

Continued Stay Criteria:
(from the Psychiatric Rehabilitation Medical Necessity Criteria and Standards)

1. An assessment appropriate to the model of PRS as specified in the standards, indicates at least one (1) of the following:

   A. As a result of the mental illness, there are or continue to be functional impairments and skill deficits which are effectively addressed in the Psychiatric Rehabilitation Plan. In the event that earlier efforts have not achieved the intended objectives, the revised plan indicates service modifications to address these issues.

   OR

   B. There is a reasonable expectation that the withdrawal of services may result in loss of rehabilitation gains or goals attained by the consumer.

   OR

   C. A change in program or level of service is indicated and a transition plan is in place reflecting the proposed change.

2. The person chooses to continue participation in the program.

Assessing Eligibility for Continued Stay:
((Information for this section is based on the person’s progress toward choosing, attaining and keeping rehabilitation goals including review and discussion with the person about the PRS plan and the required assessment for continued stay. See p. 7 for Additional Questions about Specific Domains which may be helpful in assessing current functional status.)

1. Has an assessment appropriate to the model of PRS been completed including face-to-face discussion with the person about progress and the person’s needs/desire for additional services?

2. Summary of PRS services delivered since the last authorization:
   a. What domain is the person working on? Has the domain changed?
   b. What active PR services have been delivered?
   c. What supports have been delivered?
   d. Is the person making progress toward the goal? Describe.
   e. What additional services are requested with average number of hours per week and length of time period needed?
3. Are there or do there continue to be functional impairments and skill deficits which are expected to be effectively addressed by the PRS Plan? Identify specific functional impairments and skill deficits.

4. If services are withdrawn, is there a reasonable expectation that the withdrawal of services may result in loss of rehabilitation gains or goals attained by the person?

5. Is a change in type of PRS program or level of services indicated? If so, describe indicated changes. Is there a transition plan in place reflecting the proposed changes?

6. Does the person choose to continue in PRS?

7. Which functional domain(s) will PRS address during the continued stay? Identify specific domain(s) and the person’s current functional status with regard to that domain(s)?

8. If the person is receiving both mobile psychiatric rehabilitation services (MPR) and site-based services, can the person now receive services in only one type of program?

Clinical Issues and Other Considerations:

(Requests for continued stay in PRS need to be considered in the context of all services the person is receiving. See p. 11 regarding Considerations in Assessing Eligibility for Continued Stay)

1. Has the person been attending program or keeping appointments regularly? If not, what are reasons for this? Has this been discussed with the person with plans developed to resolve any issues? Are there special circumstances which have interfered? What is being done to follow up to resolve these circumstances?

2. What behavioral outcomes have been accomplished to date as a result of PR services? What additional services are needed during this authorization period for the person to complete: Choosing a rehabilitation goal including functional assessment of skills and supports needed to accomplish the goal, OR Attaining the goal, OR Maintaining the goal?

3. Has the person received support services only? What plans are there for active PRS services to identify and transition support to other community-based resources? What is the rationale for support-only services?

4. Have there been treatment crises or active use of alcohol and/or substances which is negatively affecting the person’s ability to engage in PRS? If so, what steps are planned to resolve these issues?
Summary of Recommendations and Rationale for PRS Continued Stay:
(This may include the person’s current functional status with regard to the domain(s) identified for PRS services, revised service plans, and recommended type(s) of PRS and number of hours of service per week during the continued stay)

Authorization of Continued Stay for PRS:
If, after review, the person is approved for PRS, determine specific service type(s), average number of hours of service per week to be approved and length of time period approved:
(Consider referral source recommendations and rationale for service. For MPR, services may be approved up to 6 hours per week. Requests for MPR services above 6 hours per week may be approved under an exception process.)

Denial of Services:
If continued stay is not authorized, reason(s) for denial:
(If continued stay for PRS is denied, consider referrals to other services as needed.)

Considerations in Assessing Eligibility for Continued Stay:

1. If the person is not attending regularly or keeping appointments, it is essential that the agency implement follow-up procedures to identify and resolve issues which may interfere with participating in PRS. If issues around attendance cannot be resolved, consider other services such as case management which may better meet the person’s needs and preferences. If PRS services are not authorized for continuing stay, the referring agency should discuss with the person the possibility of return to PRS when the person’s circumstances change.

2. If the person is experiencing clinical/treatment issues which interfere with participation in PRS, consider referral for case management and/or a more intensive treatment setting with possible discontinuation of PRS until it is clinically indicated that the person is able to participate regularly in PRS. If the person is actively using alcohol and/or substances and participation in PRS is not clinically indicated at present, consider referral for substance abuse treatment with discontinuation of PRS until re-referral to PRS is clinically possible.

3. If PRS is providing only support services, consider if there are plans for transition to other community-based resources and the additional time PRS services may be needed and desired. Factors to consider in this decision are the length of time support only has been provided and if there is a history of regression without supports. Individuals who have attained a goal and are keeping it may need an extended period of support-only services to assure there is an adequate level of skill use, and other community supports are available and effective. Consider referral for case management if the person needs only support to maintain self in the community or to access treatment-related services and decrease use of crisis services or
inpatient services When support-only PR services are discontinued, there may need to be a transitional period to phase out services.

4. PRS is characterized by improved levels of functioning and other behavioral outcomes. To authorize continued stay, there must be plans which include identified behavioral outcomes as a result of PR services and interventions. If the person has an extended period of no progress toward the goal in terms of behavioral outcomes, there should be reconsideration of the plan. The PRS provider should discuss the lack of progress with the person and develop revised plans with the person to address this issue or develop alternative rehabilitation plans with the person. PRS should be continued while revised or alternative plans are implemented. If PRS is terminated, the referring agency should offer the person an opportunity to return to PRS in the future should circumstances change.

5. If the person is attending both MPR and site-based PRS, there must be a specific rationale and justification for continued stay in both types of PRS.

6. In every continued stay review, consideration should be given in reauthorizing services to the person’s needs and preferences for site-based or MPR services. Consider referral to site-based services if there is not a need for 1:1, community-based services, and the person can participate in site-based PRS. See p. 5 for site-based and mobile psychiatric rehabilitation characteristics and indicators.

7. If continued stay is not approved, the person is to be reconsidered for PRS should there be a change in the person’s situation. Referrals to other services as needed must be considered. When PRS services are discontinued, the referring agency has the responsibility to discuss this with the person and offer opportunities to return to PRS should circumstances change. The referring agency should discuss alternative services with the person, assist the person in accessing them, and discuss with the person the process for appeal as well as the person’s rights.

**Eligibility for Discharge**

**Discharge Criteria**
(from the Psychiatric Rehabilitation Medical Necessity Criteria and Standards)

Discharge may be considered when the person meets criteria 1 and 2, or 3, or 4:

1. The person is not expected to receive additional rehabilitative benefit from the program.

   AND

2. There is a reasonable expectation that the withdrawal of services will not result in loss of rehabilitation gains or goals attained by the consumer.

   OR
3. The person has successfully achieved rehabilitation goals and sustained them for a period of time as designated in the rehabilitation plan.

OR

4. The person voluntarily terminates from the program.

AND

5. Upon discharge or termination the person is informed of his/her rights and the process for appeal.

**Assessing Eligibility for Discharge:**

1. Has the person voluntarily ended participation in the program? Include indicators that the termination is voluntary and efforts at follow-up, if appropriate.  
   *(If person voluntarily terminates PRS, has the person been informed of rights and process for appeal?)*

2. Has the person successfully achieved the rehabilitation goal(s) in one or more functional domains and sustained them for a period of time per the rehabilitation plan?  
   Note domains in which goals were achieved and specific goal(s) achieved.  
   *(If yes, go to Question 3. If no, go to Eligibility for Continued Stay on p. 9 to assess need for additional PRS services)*

3. Is the person interested in selecting and attaining rehabilitation goal(s) in another domain?  
   *(If no, the person may be considered for discharge if the withdrawal of services is not expected to result in loss of rehabilitation goals. **Note:** Persons may need a sustained period of minimal ongoing support to maintain rehabilitation goals. Example: weekly participation in a Job Club for a person who is currently employed.)*

4. Is the person expected to achieve additional rehabilitative benefits from participation in PRS?  
   If so, what specific rehabilitative benefits are expected?  
   *(If additional rehabilitative benefits are expected, consider for additional PRS under Eligibility for Continued Stay. If no additional rehabilitative benefits are expected, go to Question 5.)*

5. Is withdrawal of PRS likely to result in loss of attained rehabilitation gains or goals?  
   *(If yes, consider additional authorization of PRS. If no, consider person for discharge from PRS)*

**Approval for Discharge from PRS:**

*(Document the rationale for discharge from PRS. If the person is not discharged, go to Eligibility for Continued Stay on p. 9 to assess the need for additional PRS.  
*Note:* All individuals who are discharged must be notified of their rights and the process for appeal)*
Introduction:

Recovery from serious mental illness involves more than diminishing symptoms and alleviating distress from the illness. It also involves finding new purpose and meaning in life. As individuals recover, their illness is no longer the main focus of their lives. Individuals in recovery are interested in gaining or regaining roles that they value in the community. Among the roles individuals are interested in attaining and maintaining are worker, independent community resident, student, and member of a social network.

Individuals generally benefit from a variety of services to facilitate recovery. Two essential services to promote recovery are treatment and psychiatric rehabilitation. The focus of treatment is to reduce the frequency and discomfort of symptoms of the illness and to reduce emotional distress. Examples of treatment services are medication evaluation and management and psychotherapy, either individually or in groups. Psychiatric rehabilitation has as its mission helping individuals to gain or regain valued roles in the community. Examples of psychiatric rehabilitation services including choosing goals about future roles such as going to school or getting a job, functional assessment to determine the specific skills and supports to attain and maintain goals individuals have chosen, teaching skills either directly or indirectly, and arranging supports to assist individuals to get and keep goals.

**Psychiatric rehabilitation service interventions should occur concurrently with necessary treatment services and should begin as soon as clinically possible.**

Relationships among psychiatric rehabilitation services and other types of services are summarized below:

**Psychiatric Rehabilitation and Partial Hospitalization:** The primary mission of partial hospitalization is treatment-oriented. Partial hospitalization aims to stabilize the person’s symptoms and reduce distress from these symptoms. Partial hospital programs use various treatment modalities such as medication and psychotherapy to impact on the individual’s symptomatology and experience of the illness. Services offered in partial hospital programs frequently include 1) individual psychotherapy, 2) group psychotherapy, 3) medication evaluation and management, and 4) biopsychosocial assessment.

Psychiatric rehabilitation services focus on planning for the future for the person to select, attain and maintain goals of personal choice such as obtaining employment, enrolling in and completing an educational program, or moving from a supervised community residence to living independently in an apartment or house. Psychiatric rehabilitation services have as their mission assisting the person to identify individualized, personally satisfying rehabilitation goals, developing plans with the person to get and keep the chosen goal, and providing critical skills and supports to facilitate the person accomplishing the goal.

Partial hospital programs have specific requirements for services provided by a psychiatrist as well as other requirements for mental health professional staffing. While individuals must have
a diagnosis from a psychiatrist to enroll in psychiatric rehabilitation services, there are no services offered by a psychiatrist as part of a psychiatric rehabilitation program or service. Individuals enrolled in psychiatric rehabilitation services must also be enrolled in a separate mental health treatment program to receive necessary treatment services such as antipsychotic medication or verbal therapy.

A person may be enrolled concurrently in a partial hospital program and a psychiatric rehabilitation program. While one provider agency may offer both of these services, each service must be offered in a distinct manner including having separate program space.

**Relationship of Psychiatric Rehabilitation to Intensive Case Management:**

The mission of intensive case management is to assist individuals to obtain needed resources and services. Intensive case managers do not provide services directly. Instead, they link individuals with other providers of service and assure these services are delivered. Intensive case management is often used to facilitate transitions from the hospital to the community and to decrease the use of expensive services such as psychiatric hospitalization. Traditionally, it has been directed toward individuals who are heavy users of these expensive services. Examples would be individuals who experience frequent crises and emergency room admissions and individuals who have repeated psychiatric hospitalizations. Intensive case management assures service linkages are made and maintained in order to increase the person’s stability in the community, increase cooperation with treatment interventions, and decrease use of crisis services and psychiatric hospitalization. Often, intensive case management services are made available to the person on a 24-hour, 7-day a week basis, if needed.

Psychiatric rehabilitation services are directed toward individuals who are interested in finding new meaning and focus in their lives. Generally, the person enrolling in psychiatric rehabilitation services has benefited from treatment services although the person may still experience significant symptoms. While the job of the intensive case manager is to link individuals with services, the psychiatric rehabilitation provider works directly with the person in a process of determining goals of interest to the person with regard to choosing, getting and keeping roles the person values in community environments such as work, school, independent living settings and social settings. As part of goal attainment, the psychiatric rehabilitation provider may personally engage in skill teaching and providing other supports to help the person obtain and maintain the desired goal. Psychiatric rehabilitation services are typically not offered on an around the clock basis.

Intensive case management has been described as an intermediate service in a mental health system. It does not have the intensity of acute services such as crisis intervention or psychiatric hospitalization, which often have as a mission to stabilize the person’s symptoms. Intensive case management generally offers high support to the person and linkages to services in the community to maintain stability and to keep the person in the community. In contrast, psychiatric rehabilitation services are directed toward accomplishing complex future-directed goals such as enrolling in college, securing paid employment or expanding one’s social network.
Intensive case managers may refer individuals for psychiatric rehabilitation services. However, psychiatric rehabilitation services and intensive case management must be provided by different staff.

**Relationship of Psychiatric Rehabilitation to Mobile Crisis Services:**

Mobile crisis services are an outreach response to an unplanned emergency in a person’s life which might otherwise result in psychiatric hospitalization. Mobile crisis services generally deal with distress related to the illness and its symptoms. Psychiatric rehabilitation is not a crisis service and is not equipped either through mission or staffing to address treatment emergencies. For example, there are no services from a psychiatrist as part of a psychiatric rehabilitation service. Persons enrolled in psychiatric rehabilitation services would be enrolled in a separate treatment program to receive any necessary clinical services such as medication therapy or psychotherapy.

Psychiatric rehabilitation is a service designed to assist individuals to achieve specific rehabilitation goals related to living, learning, working and socializing environments. While psychiatric rehabilitation providers attempt to assist individuals to resolve issues related to getting and keeping identified goals in these community environments, it is not the mission of the psychiatric rehabilitation service to address treatment-related emergencies. It is expected psychiatric rehabilitation providers would notify treatment providers and crisis service providers of the person’s needs for crisis intervention services.

**Relationship of Psychiatric Rehabilitation to Supported Living:**

Certain portions of the services provided in supported living may be considered psychiatric rehabilitation services. Examples of psychiatric rehabilitation services in a living environment include identifying skills and supports necessary for success and satisfaction in the living environment, teaching identified skills, and working with individuals to choose, get and keep more independent living arrangements such as their own apartments. Certain housing support services are clearly not psychiatric rehabilitation services eligible for Medicaid reimbursement. Examples of services which are not Medicaid reimbursable include landlord assistance, rental management, and developing housing stock.

**Relationship of Psychiatric Rehabilitation and Vocational Rehabilitation Services:**

Both psychiatric rehabilitation services and vocational rehabilitation services can assist a person to choose, get and keep employment. An individual may receive both psychiatric rehabilitation services, which are Medicaid reimbursable, and vocational rehabilitation services, which are not Medicaid reimbursable, at the same time. Vocational services such as transitional employment, vocational and on-the-job training programs, as well as supported and competitive employment are not Medicaid reimbursable even though they may be an integral part of attaining the person’s employment goal. These services must be paid for through Office of Vocational Rehabilitation (OVR) funds, 100% state funds or other non-Medicaid funding streams.
Psychiatric rehabilitation services which are Medicaid reimbursable would include a variety of prevocational services as well as services that enable the person to access vocational rehabilitation services. Pre-vocational services may be directed at assisting the individual to develop a general vocational direction such as deciding whether to enroll in transitional employment or apply for a formal vocational training program. Pre-vocational services can also be aimed at improving the overall functioning of the person in preparation for vocational rehabilitation services. Examples of such improvements might include learning to work as part of a team, learning to ask for assistance, and learning skills to be able to report to assignments on time. Additionally, psychiatric rehabilitation services may assist the person to learn skills and use supports to be able to participate in a vocational rehabilitation program or to gain and maintain employment. Examples of such services are learning to take transportation to the job site, improving coping skills for job-related stress, learning how to negotiate with a supervisor, and learning how to navigate the vocational rehabilitation system including working with agencies such as OVR and the Social Security Administration.

Case Examples: Attending a work-ordered day in a Clubhouse is a psychiatric rehabilitation service if it is directed towards goals such as learning to work as part of a team, learning to follow directions or deciding whether to pursue competitive employment. A Transitional Employment Placement (TEP) in which a person is employed through the Clubhouse at a competitive job placement with support from a Clubhouse staff generalist is a vocational rehabilitation service. It is a type of supported employment and is not a psychiatric rehabilitation service.

A person attends a vocational training school to learn to be a computer technician. This is a vocational training program and is considered to be a vocational rehabilitation service. The person is experiencing difficulty at the school in asking for assistance from the instructor and does not know how to socialize with other students at the lunch hour. The psychiatric rehabilitation practitioner meets with the person in the community to teach the person how to ask for help so that the person can be more successful in class. The psychiatric rehabilitation practitioner also teaches the person the skill of discussing impersonal topics so that the person can be more satisfied in social relationships with other students. This is considered psychiatric rehabilitation because it assists the person to be able to participate in the vocational training program. It does not provide vocational skills directly but does enable the person to benefit from vocational rehabilitation services paid for by another funding source such as OVR.

Relationship of Psychiatric Rehabilitation and Education:

Medicaid will not pay for the cost of educational programs and services such as vocational schools, GED services and tuition for postsecondary education. However, some services which are currently referred to as “supported education” may be Medicaid reimbursable. Supported education refers to the provision of a variety of services that assist individuals to be successful and satisfied in a formal educational program in the community such as a college or other postsecondary program. Services provided in supported education frequently include counseling to help individuals to develop educational and career choices, assisting individuals to coordinate community services and campus-based services, teaching skills such as asking for help or
participating in class discussions that individuals need to be successful and satisfied as students, and assisting in problem solving if any difficulties arise.

Individuals may also benefit from psychoeducational services to learn more about managing their illnesses and developing strategies to cope with symptoms in target environments such as school or work. Psychoeducational services are considered to be a psychiatric rehabilitation service and are reimbursable under Medicaid.

Relationship of Psychiatric Rehabilitation and Recreational/Leisure and Social Activities:

Individuals may choose to develop and implement specific goals related to increasing their social network and making other changes in their social roles and environments such as socializing with others in drug-free activities. When recreation, leisure and social activities are part of an individualized rehabilitation plan, they are psychiatric rehabilitation services and are eligible for Medicaid reimbursement. In addition to helping individuals to identify goals related to social environments, psychiatric rehabilitation services may include skill teaching to increase the person’s success and satisfaction in target social environments. Examples of skills which may be taught depending upon the person’s needs and interests are introducing yourself to others, inviting others to activities, and discussing topics other than yourself.

Recreation, leisure and social activities not related to a rehabilitation plan are not eligible for Medicaid reimbursement. Such activities are considered to be enrichment activities in that they are not expected to have specific, identifiable outcomes related to setting and accomplishing rehabilitation goals in social environments.

Relationship of Psychiatric Rehabilitation and Personal Care Services:

The mission of personal care services is to provide services for another person or assist with services that the person cannot perform independently. Examples of personal care services include preparing meals, assisting the person to take medications, and assisting with grooming and personal hygiene tasks. Personal care is distinguished from psychiatric rehabilitation in that the personal care provider does not work with the individual to improve ability to perform these tasks independently, and the services are not part of a plan to attain and maintain an individualized rehabilitation goal. In psychiatric rehabilitation, the practitioner works with the person to increase independence and self-sufficiency as part of accomplishing an identified individualized rehabilitation goal.

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## Psychiatric Services for Recovery

<table>
<thead>
<tr>
<th>Service</th>
<th>Purpose</th>
<th>Outcome</th>
<th>Examples of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>Reduce symptoms and distress of the illness</td>
<td>Symptoms and emotional distress of illness decreased</td>
<td>Medication, Psychotherapy</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>Increase success and satisfaction in roles and environments of personal choice.</td>
<td>Individuals gain or regain roles they value</td>
<td>Goal setting, Skills teaching; Work-ordered day</td>
</tr>
<tr>
<td>Basic Support</td>
<td>Provide essentials for survival</td>
<td>Personal survival assured</td>
<td>Physical health care; Financial support; Providing meals, shelter, clothing</td>
</tr>
<tr>
<td>Case Management</td>
<td>Obtain services to solve problems and maintain gains (often used to facilitate transition to the community)</td>
<td>Individuals access services they need and want</td>
<td>Linking to services; Advocacy for service improvements</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>Stabilize and resolve critical or dangerous events</td>
<td>Personal safety assured</td>
<td>Medication evaluation, Crisis counseling</td>
</tr>
<tr>
<td>Self-help</td>
<td>Self-led recovery</td>
<td>Personal empowerment</td>
<td>Consumer-run support groups</td>
</tr>
<tr>
<td>Rights protection</td>
<td>Advocacy to assure legal protections</td>
<td>Equal opportunity and access</td>
<td>Advocacy services</td>
</tr>
<tr>
<td>Enrichment</td>
<td>Engage in satisfying activities to increase quality of life</td>
<td>Self-development and enjoyment</td>
<td>Leisure activities; Socializing; Community trips</td>
</tr>
<tr>
<td>Vocational Rehabilitation</td>
<td>Choose, get and keep paid employment</td>
<td>Obtain and maintain employment</td>
<td>Vocational training, job development and placement</td>
</tr>
<tr>
<td>Supported Education</td>
<td>Participate in a structured learning program, often postsecondary</td>
<td>Completion of an educational degree or certificate</td>
<td>Skill and support development: Career counseling</td>
</tr>
<tr>
<td>Leisure, Social and Recreation Activities</td>
<td>Develop an expanded social network.</td>
<td>Use of leisure time is satisfying and constructive.</td>
<td>Varies depending on purpose: psychiatric rehabilitation or enrichment</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>Provide activities of daily living services</td>
<td>Care of personal needs assured</td>
<td>Perform cooking, personal hygiene services for the person</td>
</tr>
</tbody>
</table>