NORTHERN NEVADA ADULT MENTAL HEALTH
POLICY AND PROCEDURE

SUBJECT: HEARTS ADMISSION CRITERIA

NUMBER: NN-PC-PL-21

ORIGINAL DATE: 04/03/08

REVIEW/REVISE DATE: 1/20/11

APPROVAL: Rosalyne Reynolds {s}, Agency Director

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I. PURPOSE

The purpose of this policy is to document specific admission criteria to admit participants into the HEARTS Intensive Outpatient Program in a standardized manner.

II. POLICY

It is the policy of Northern Nevada Adult Mental Health Services (NNAMHS) HEARTS Intensive Outpatient Program to admit participants into the HEARTS Program who meets the criteria as set forth in this document.

III. REFERENCES

Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

HEARTS Referral Form
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IV. PROCEDURES

A. Criteria for Admission:

The HEARTS Program is designed to address the needs of consumers who are determined to meet the diagnostic criteria for a Mental Disorder and a Substance-Related Disorder, as defined in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

1. The consumer has been assessed by Psychiatric Evaluation Services and determined to be eligible for services at NNAMHS.
2. Group participants will have a suspected or known psychiatric disorder and a co-occurring suspected or known substance abuse disorder.
3. Group participants may be actively using drugs and/or alcohol, in early remission, or abstinent.
4. Group participants may be in denial of an addiction and/or mental illness.
5. Group participants may be resistant to treatment or may have failed other treatment attempts.
6. Consumers who are in acute substance abuse or psychiatric distress and in immediate need of a higher level of care, i.e. – psychiatric hospitalization, or detoxification, are not considered appropriate for HEARTS

B. Admission Procedure:

1. Referrals may be initiated by any clinical staff member of any inpatient or outpatient NNAMHS department by sending a HEARTS Referral Form to the HEARTS Program.

2. The referral form will be given to a HEARTS staff member. Within 10-days of receipt of the referral form, the assigned counselor will contact the consumer to schedule an appointment for intake/assessment.

3. If a waiting list exists, all attempts will be made to make suitable alternative referrals for co-occurring disorders treatment, i.e. – CORE Program, Stars, DRA, detoxification, and/or residential care.

4. Admissions to the HEARTS Program are based on a clinical priority need basis, not the length of time on the waiting list. Priority will be determined by program staff and referring parties.

A. APPENDICES

HEARTS Referral Form

HEARTS PROGRAM REFERRAL

DIRECTIONS: Complete this form. Submit to HEARTS Program: 480 Galletti Way, Building #2A, Sparks, NV 89431, 688-0419 (office #), 688-2192 (fax).

Participant Name_____Soc. Sec. _____D.O.B._____

Participant
Address_____
City/State Zip Code

Participant Phone #_____ Chart #_____Service Coord_____

DIAGNOSIS
Admission to HEARTS is limited to individuals who have a substance abuse disorder AND a co-occurring psychiatric disorder, as listed in the DSM-IV Manual, with one (or more) of the following classification codes:

A. Substance-Related Disorders (Must meet criteria for at least one of the following):

_____Alcohol Disorder (303.90, 305.00)

_____Amphetamine Disorder (304.40, 305.70)

_____Cannabis Disorder (304.30, 305.20)

_____Cocaine Disorder (304.20, 305.60)

_____Hallucinogen Disorder (304.50, 305.30)

_____Inhalant Disorder (304.60, 305.90)

_____Opiod Disorder (304.00) 305.50)

_____Phencyclidine Disorder (304.90, 305.90)

_____Sedative, Hypnotic or Anxiolytic Disorder (304.10, 305.40)

_____Polysubstance Disorder (304.80)
_____

_____Other Substance Disorder
_____

B. Psychiatric Disorders (Must meet criteria for at least one of the following):

_____Schizophrenia and Other Psychotic Disorder (295.xx, 295.70, 297.1, 298.9)

_____Mood Disorder (296.xx, 300.4, 311, 301.13, 293.83)

_____Anxiety Disorder (300.xx, 293.89)

____Other Disorder
_____
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_____ _____ _____
Referring Staff Department/Agency
Contact # Date of Referral

HEARTS PROGRAM USE ONLY

Date rec'd:_____ Date Assessed:_____

_____Accepted _____Denied _____Pending START DATE: _____

Reason for
Denial/pendingCalls_____

Signature: _____ Date: _____