

Chapter: **CLINICAL PRACTICE**  
Title: **ASSESSMENT SERVICES**

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Chief Executive Officer Date

Approved by: Al Lorenzo 01/18/2026  
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## **I. ABSTRACT**

This policy establishes the standards and procedures of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, to ensure that level of care authorization and the individualized plan of service development are based on thorough assessments appropriate to the needs of MCCMH persons served.

## **II. APPLICATION**

This policy shall apply to all directly-operated and contracted network providers of MCCMH.

## **III. POLICY**

It is the policy of MCCMH that assessments appropriate to the needs of each MCCMH person served be conducted and that level of care authorization and the individualized plan of service development be consistent with the findings of conducted assessments.

## **IV. DEFINITIONS**

### **A. Alcohol Use Disorder Identification Test (AUDIT)**

A 10-item screening tool developed by the World Health Organization to assess alcohol consumption, drinking behaviors, and alcohol related problems. The tool has been validated across genders and in a wide range of racial/ethnic groups, making it an ideal screening tool for behavioral healthcare settings as well as primary care settings.

It is best practice to use the AUDIT at initial intake and annually thereafter. A score of 8 or higher indicates dangerous alcohol use and should prompt further assessment of the appropriate level of care for the person served based on their identified alcohol use and other presenting needs.

B. American Society of Addiction Medicine (ASAM) Patient Placement Criteria

A widely used, evidence-based, comprehensive set of standards for placement, continued service, and transfer of persons served with addiction and co-occurring conditions. The ASAM provides outcome-oriented and results-based care standards for the treatment of addiction. When preliminary screening tools, such as the AUDIT and/or the UNCOPE result in a score indicating substance or alcohol use that is dangerous, hazardous, or above the threshold for educating on the potential for addiction due to repeated, excessive, or uncontrolled use is present, the ASAM should be administered by clinicians trained in the use of the criteria to assess the appropriate level of care recommendations. ASAM criteria re-assessment is based on the person served and their current level of care, if applicable. ASAM criteria provides re-assessment frequency information. For example, levels 2.1, 2.5, 3.1 and 3.5 recommend monthly reassessments.

C. Assessments

Generally accepted professional evaluations that integrate knowledge, clinical judgement, reliable collateral information (e.g. observation, semi-structured or structured interviews, third-party report) and expertise in an area of professional practice or application. Assessments can include health assessments, psychiatric evaluations, biopsychosocial assessments, psychological testing, and other assessments and testing conducted by appropriately qualified and licensed health care professionals within their scope of practice for the purposes of determining eligibility for services decision-making and recommendations of the treatment needs for the person served. An initial assessment is provided upon entry into the system, and a re-assessment is provided annually thereafter, unless clinically indicated to complete more frequently.

D. Beck Depression Inventory (BDI)

A 21-item self-report rating scale that evaluates key symptoms of depression in adults, including mood, pessimism, guilt, self-dissatisfaction, suicidal ideas, crying, irritability, social withdrawal, fatigue, loss of appetite and other core symptoms to measure the severity of depression. The BDI is used in a variety of clinical settings to support diagnostic formulation and determine the level of treatment need. The BDI can be used to further support treatment needs and may be used in conjunction with other depression screening and assessment tools, such as the PHQ-9.

E. Child and Adolescent Functional Assessment Scale (CAFAS) / Preschool & Early Childhood Functional Assessment Scale (PECFAS)

Tools used for the assessment of children requesting to be enrolled in the Serious Emotional Disturbance (SED) Waiver performed by staff trained in the implementation of CAFAS and PECFAS. The PECFAS is used to assess children between 3 to 7 years of age and the CAFAS is used to assess children between 7 and 17 years of age. The CAFAS/PECFAS is required at initial intake, annual reassessment, and discharge. Children enrolled in SEDW will also be assessed by the Michigan Child and Adolescent Needs and Strengths Tool (MichiCANS).

F. Children's Depression Rating Scale- Revised (CDRS-R)

A clinician-rated 17-item scale, which uses a semi-structured interview with children and/or their caregivers to assess the severity of depression in children and adolescents

between 6 and 12 years of age. Individual items are summed to create a total score, which can be interpreted based on the sum. The CDRS-R can be administered in about 20 minutes and is widely used in clinical settings. This tool is recommended to be used for youth between 6 and 11 years of age to assess for the presence of depression.

G. Columbia Suicide Severity Rating Scale (C-SSRS)

A short questionnaire used to screen for risk of suicide. The scale is evidence-supported, available in 103 different languages, and is intended to help establish a person's immediate risk of suicide. It can be administered quickly in the field by clinical and non-clinical staff. The scale is relevant in a wide range of settings such as schools, primary care settings, justice systems, clinical settings, and can be used for individuals of all ages. The C-SSRS is required at initial intake, preplanning/preliminary plan of service, individual plan of service, and ongoing at every service contact (e.g., case management, psychiatric, therapy, etc.).

H. Devereux Early Childhood Assessment (DECA)

A series of assessments for assessing protective factors, potential social and emotional developmental risks, and evaluating behaviors related to social and emotional resilience and social and emotional concerns in preschool children 24 months to 6 years of age.

The DECA is required at intake and during treatment planning, based on the results of the MichiCANS screener, for infants, toddlers, and children 1 month of age to 5 years of age who have a serious emotional disturbance (SED) or SED and intellectual/developmental disabilities. The DECA for infants is used for children 1 to 18 months of age. The DECA for Toddlers (DECA-T) is used for children 18 months to 36 months of age. The DECA Clinical (DECA-C) is used for children 2 years to 5 years of age.

I. Life Events Checklist (LEC)

A brief, self-report screening used to assess traumatic events in the lifetime of the respondent. The LEC assesses exposure to 16 events known to potentially result in PTSD or distress and includes an item to assess for any other potentially significant stressful or distressing event that is not captured in the previous 16 items. The Life Events Checklist is to be completed at initial intake and annually thereafter, or as clinically indicated in the event of a significant life event and/or in the event of a proposed plan of service or behavior treatment plan which includes a request for emergency physical management as outlined in MCCMH Policy 8-008, "Behavior Treatment Plans."

J. Level Of Care Utilization System (LOCUS)

An assessment tool from the American Association for Community Psychiatry which helps clinicians, insurers, and those in need of behavioral health services to make decisions about the level of care based on identified needs, support available, past treatment and response to treatment to provide clear, consistent and easy to understand options for care that is person focused. The LOCUS is a tool to inform and support treatment planning and service recommendation. The LOCUS is used for adults 18 years of age or older who have a mental health, and/or substance use disorder. The LOCUS

is not used for individuals with intellectual or developmental disabilities. The LOCUS is done at the time of intake, treatment planning and periodic review.

**K. Michigan Child and Adolescent Needs and Strengths (MichiCANS) Tool**

A multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The MichiCANS is used to identify the needs and strengths of a child/youth or young adult and their families. MichiCANS is comprised of the Screener and the Comprehensive. The Screener, used at the point of access, is a standardized format for recording key areas of functioning and intensity of specific needs. The Comprehensive is used at initial assessment, treatment planning, treatment plan reviews, and at a child and family's functioning and circumstances change. The Comprehensive is used by clinical and care coordination providers, therapist, case managers, wraparound facilitators, and others. All children and youth aged 0 through 20 years of age receiving services will require a MichiCANS Screener at point of access and Comprehensive at intake, initial individual plan of service, and annually at treatment planning. Young adults 18-20 years of age can be transitioned to adult services, where clinically indicated. The MichiCANS is not used to assess individuals in adult services.

**L. Patient Health Questionnaire (PHQ-9)/ Patient Health Questionnaire modified for Adolescents (PHQ-A)**

The PHQ-9 is a diagnostic tool used to screen adults in primary and behavioral healthcare settings for the presence and severity of depression. It is a 9-item self-report screener that asks about frequency of symptoms over the past two weeks. A score of 5 or higher on the PHQ-9 indicates the presence of major depression. The PHQ-A is a modified version of the PHQ-9 specifically for children and adolescents 11 to 17 years of age and like the PHQ-9 contains 9-items that screen for the frequency of depressive symptoms and the presence of a depressive disorder as described in the DSM-V. The PHQ-9 and the PHQ-A are required at initial intake, at least quarterly thereafter, or sooner as clinically indicated based on the person's needs.

**M. UNCOPE**

The UNCOPE is a brief, six-question screener used for identifying risk for abuse or dependence on alcohol or other substances when neither is clearly identified as a problem. The UNCOPE assesses the unintended use of substances in the past 12 months, neglect of usual responsibilities as result of substance use, the person's desire to cut down on their use, the objections of others in the person's life related to their substance use, the person's possible preoccupation with wanting to use substances and the use of substances to relieve emotional distress or boredom. The UNCOPE is a first line screening, to determine if additional and further assessment is indicated. When the score is 2 or higher, additional screening (including the AUDIT) is completed. The UNCOPE is completed at initial intake and annually thereafter, unless there is an identified Alcohol Use Disorder or Substance Use Disorder at which point more appropriate assessments shall be completed as detailed in this policy.

**V. STANDARDS**

- A. Prior to entry into service, each person served shall receive a comprehensive Biopsychosocial Assessment, also referred to as an Initial Assessment or Intake, to identify treatment needs and clinical recommendations.
  - 1. Clinical recommendations inform the planning process, propose service possibilities, and determine medical necessity.
  - 2. An Initial Assessment shall be completed within fourteen (14) calendar days of a non-emergent request for services or within seven (7) calendar days of discharge from a psychiatric inpatient unit.
- B. Medically necessary ongoing services, including any specialized assessments, must begin within fourteen (14) calendar days of completing a non-emergent Biopsychosocial Assessment.
- C. Additional discipline-specific assessments provided by appropriately privileged clinicians may be conducted to clarify diagnosis, levels of functioning, and need for services. Additional assessments shall be completed within thirty (30) days of the referral unless there is a clearly documented reason for the delay.
- D. A physician's prescription or referral order is required for the provision of an Occupational Therapy Assessment, Psychological Testing, Physical Therapy Assessment, Speech and Language Assessment, Neurological Evaluation, and laboratory tests. See MCCMH MCO Policy 2-020, "Specialized Health Care Services," for standards regarding referral of MCCMH persons served to specialized health care services when those service needs are identified during the provision of services.
- E. A Re-Assessment, also referred to as an Annual Assessment, shall be completed prior to the expiration of the Individual Plan of Service (IPOS) and at least annually.
- F. A Periodic Review shall be conducted within seven (7) days post discharge from a psychiatric hospitalization where an established MCCMH person served was inpatient for fourteen (14) calendar days or more.
  - 1. The Periodic Review will note any significant changes in activities of daily living, as applicable, and update treatment goals, as appropriate.
  - 2. The LOCUS or MichiCANS will be completed to guide the most appropriate level of care.
- G. Each type of assessment described herein is accessible to MCCMH persons served according to need.
- H. Assessments provided within a particular MCCMH service program shall be repeated at intervals as specified in this policy and at any other time, as clinically necessary.

## **VI. PROCEDURES**

- A. Initial Assessment

1. An Initial Assessment shall include gathering and reviewing relevant information to clarify presenting concerns and information that contributes to case conceptualization and informs treatment planning.
2. The Initial Assessment shall identify characteristics of the person served; their goals and preferences relevant to the treatment process; a brief pertinent life history including family origin, composition, and relationships among family and community members; and information pertaining to the developmental history and significant familial health and behavioral health conditions of the person served.
3. The Initial Assessment shall review the person's current environment; functioning at home, work, and in the community; significant relationships; educational and vocational experiences; relevant medical and social histories; lifestyle; cultural and ethnic identity leisure pursuits; involvement with law enforcement; substance use; and military service, as applicable.
4. The initial assessment shall include, at a minimum, information within the categories outlined below:
  - a. General Information (identifying information, demographics, contacts and emergency contacts, etc.)
  - b. Medical History (including current medical services providers and specialty providers, where applicable)
  - c. Financial Information (Salary and wages, state benefit information, etc.)
  - d. Guardianship / Parent Information / Family Information
  - e. Education
  - f. Employment Status
  - g. Legal Information (corrections related status, arrest history, etc.)
  - h. Presenting Problem and Clinical History
  - i. Bio-Psycho-Social Development and History
  - j. Risk Assessment, including suicide (Columbia Suicide Severity Rating Scale) and homicide screening, insight and judgement, and perception assessments
  - k. Assessment of social determinants of health, in the domains of economic stability, education access and quality, health care access and quality, neighborhood and built environment and social and community context (Accountable Health Communities Health-Related Social Needs Screening Tool (AHC HRSN))

- l. Support Needs Worksheet (self-care, receptive and expressive language, mobility, self-direction, capacity for independent living, economic self-sufficiency). *\*This section captures information on symptom and/or condition impact to areas of daily living and instrumental daily living and is not specific to any population or diagnostic profile.*
  - m. Cultural, ethnic, spiritual, religious considerations
  - n. Person's strengths
  - o. Barriers to engagement and/or access to services
  - p. Mental status exam
  - q. Psychiatric history
  - r. Family history of mental illness and substance use
  - s. Brief trauma history and screening (Life Events Checklist, review of potential traumatic experiences throughout the lifetime)
  - t. Depression screening/assessment (PHQ9, PHQ-A, Beck Depression Inventory, Children's Depression Rating Scale or CDRS, etc.)
  - u. Substance use history
  - v. UNCOPE substance use screening
  - w. AUDIT/AUDIT-C
  - x. American Society of Addiction Medicine (ASAM) Patient Placement Criteria
  - y. Substance use chart
  - z. Moods and emotions
  - aa. Diagnosis and treatment readiness
  - bb. Service Eligibility Criteria (Adults with Serious Mental Illness, Children / Adolescents with Serious Emotional Disturbance, Persons with Intellectual and/or Developmental Disabilities, Infant Mental Health)
  - cc. DD Proxy Measures, where applicable, include ability to make self-understood; support needs with mobility, personal care, or other functional needs; support system availability; challenging behavior needs; and use of medication for behavioral control
  - dd. Challenging behaviors

- ee. Diagnostic formulation including specific criteria observed and/or reported to support the clinical formulation.
- ff. Summary of findings and recommendations, which includes the clinical formulation and summary of the assessment from the clinician
- gg. Disposition designation, indicating what recommendations are based on the summary of findings and include information on level of care, provider amount/scope/durations of services
- hh. Preliminary Plan of Service

B. Additional assessments are performed as needed. These may include:

- 1. Psychological Testing
- 2. Assessment mandated under the Omnibus Budget Reconciliation Act of 1987
- 3. Emergency Psychiatric Pre-Admission Screening / Continued Stay Review
- 4. Specialty Assessments, which may include but are not limited to:
  - a. Occupational Therapy Assessment
  - b. Physical Therapy Assessment
  - c. Speech / Language / Hearing Assessment
  - e. Neurological Evaluation
- 5. Functional Behavioral Assessment
- 6. Psychosocial Rehabilitation Assessment
- 7. Health Assessment, which may include but is not limited to:
  - a. Nutritional Assessment
  - b. Specialized Nursing Assessment
  - c. Personal Health Review

C. Re-Assessment

- 1. A Re-Assessment shall be completed annually, or as clinically indicated, prior to the expiration of the current Individual Plan of Service (IPOS).
- 2. Re-Assessment shall be completed in preparation for review of, updates to, and/or development of a new IPOS as clinically appropriate and in accordance with the choices and preferences of the person served. This may include, as

needed, a Preliminary Plan of Service to provide necessary services and supports for up to sixty (60) days while the full plan is developed.

3. The Re-Assessment shall:

- a. Review the Initial Assessment, updating and documenting where appropriate all current information within the categories as outlined in this policy. The Re-Assessment will confirm current demographic information, household composition, financial, employment and any necessary updates to legal involvement. The Re-Assessment does not require repetition of historical information, nor does it require recapturing developmental or historical information as documented in the Initial Intake.
- b. The Re-Assessment shall review the progress made or lack thereof in the past year, noting as appropriate any areas of engagement or treatment that were effective as well as any that were ineffective.
- c. Document the current needs, symptoms, presenting areas of concern, strengths, and clinical case conceptualization. This includes medically necessary level of care and recommended service array, and any services or supports outside of the MCCMH provider network (e.g. social services, educational services, community services).
- d. Document status changes from previous Intake/Annual Assessments, or the changes in treatment needs in conjunction with the recommended follow-up from hospital discharge.
- e. Document status at discharge and current barriers, as applicable.
- f. Amend the Individual Plan of Service (IPOS) through a person-centered process.

## VII. REFERENCES / LEGAL AUTHORITY

- A. American Psychological Association. (2021). Professional Practice Guidelines for Evidence-Based Psychological Practice in Health Care. Retrieved from <https://www.apa.org/about/policy/evidence-based-psychological-practice-health-care.pdf>
- B. American Psychological Association, APA Task Force on Psychological Assessment and Evaluation Guidelines. (2020). APA Guidelines for Psychological Assessment and Evaluation. Retrieved from <https://www.apa.org/about/policy/guidelines-psychological-assessment-evaluation.pdf>
- C. MCL 330.1712
- D. Michigan Department of Health and Human Services (MDHHS) Administrative Rules, R 330.7199, “Plan of Service”

- E. Michigan Department of Health and Human Services (MDHHS) Final Bulletin MMP-25-37-BCCHPS, August 29, 2025.
- F. Michigan Department of Health and Human Services (MDHHS) Numbered Letter-L-25-13-BCCHPS, March 14, 2025.
- G. Commission on Accreditation of Rehabilitation Facilities (CARF) 2022 Standards Manual, §2. B., “Screening and Access to Service,” pp. 138-146
- H. MCCMH MCO Policy 2-010, “Clinical Service Documentation”
- I. MCCMH MCO Policy 2-032, “Person-Centered Planning Practice Guidelines”
- J. MCCMH MCO Policy 12-001, “Access, Eligibility, and Discharge”
- K. MDHHS Medicaid Provider Manual
- L. MDHHS/MCCMH Medicaid Managed Specialty Supports and Services Contract, in effect and as amended.

## **VIII. EXHIBITS**

None.