ADULT RESIDENTIAL TREATMENT SERVICES (RTS)

I. Definition of Service:

Residential Treatment Services (RTS) are provided to individuals who require 24-hour treatment and supervision in a safe therapeutic environment. RTS is a 24-hour a day/7 day a week, facility-based level of care. Residential treatment provides individuals with severe and persistent psychiatric disorders therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. RTS addresses the identified problems through a wide range of diagnostic and treatment services as well as through training in basic skills such as social skills and activities of daily living that are needed in order to transition to community living. The services are provided in the context of a comprehensive, multi-disciplinary and individualized treatment plan that is regularly reviewed and updated based on the individual's clinical status and response to treatment. This treatment provides social, psychosocial rehabilitative training and a focus on family or caregiver support. Active family involvement is a key element of treatment and is strongly recommended.

II. Admission Criteria:

***All** of the following criteria are necessary for admission:*

A. The individual demonstrates symptoms consistent with a DSM-IV-TR diagnoses that is covered by the BHO Medicaid Program. Typically, though not exclusively, the individual has been diagnosed with one or more mental health conditions that result in severe and persistent mental illness (SPMI).

B. The individual's symptoms require intensive therapeutic intervention and can reasonably be expected to respond to Residential Treatment Services.

C. The individual is experiencing emotional or behavioral problems in the home, community and/or treatment setting and is not sufficiently stable, either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment.

D. The individual demonstrates a capacity to respond favorably to rehabilitative counseling and training and independent or semi-independent living.

E. The individual has a history of multiple hospitalizations or other treatment episodes at other levels of care and/or a recent inpatient stay with a history of poor treatment adherence or outcome.

F. The individual lacks community/primary supports sufficient to maintain him/her in the community with treatment at a lower level.

Psychosocial, Occupational, and Cultural and Linguistic Factors

These factors may change the risk assessment and should be considered when making level of care decisions.

III. Exclusion Criteria:

***Any** of the following criteria are sufficient for exclusion from this service:*

A. The individual exhibits severe suicidal, homicidal or acute mood symptoms/thought disorder, which requires a more intensive level of care.
B. The individual can be safely maintained and effectively treated at a less intensive level of care.
C. The individual has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications.
D. The primary problem is social, legal, economic (e.g., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.
E. The primary problem requiring treatment is a substance abuse or dependency issue without a concurrent mental health diagnosis.

IV. Continued Stay Criteria:

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

A. The individual's condition continues to meet admission criteria for this level of care.
B. The individual's treatment does not require a more intensive level of care and no less intensive level of care would be appropriate.
C. Treatment planning is documented and individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family or other support system involvement, unless contraindicated. The expected benefits from all relevant treatment modalities are documented.
D. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
E. If treatment progress is not documented, then there is documentation of treatment plan adjustments to address such lack of progress.
F. Care is rendered in a clinically appropriate manner and focused on the individual's behavior and functional outcomes.
G. Individual is actively participating in treatment to the extent possible, consistent with his or her condition, or there are active efforts being made that can reasonably be expected to lead to the individual's engagement in treatment.
H. Unless contraindicated, family, guardian, and/or custodian is actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.
I. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
J. An individualized discharge plan has been documented and developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.

K. There is a documented active attempt at coordination of care with relevant outpatient providers and community supports, when appropriate.

V. Discharge Criteria:

Criteria A, B, C, D or E, in addition to criteria F and G are sufficient for discharge from this level of care:

A. The individual's documented treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at an alternate level of care.

B. The individual no longer meets admission criteria, or meets criteria for a less or more intensive level of care.

C. The individual, family, guardian and/or custodian are competent but non-participatory in treatment or in following the program rules or regulations. The is non-participation of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple documented attempts to address non-participation issues.

D. The individual is not making progress toward treatment goals despite persistent efforts to engage him or her, and there is no reasonable expectation of progress at this level of care, nor is treatment at this level of care required to maintain the current level of functioning.

E. Consent for treatment is withdrawn, and it is determined that the individual has the capacity to make an informed decision and does not meet criteria for an inpatient level of care. Support systems, which allow the individual to be maintained in a less restrictive treatment environment, have been thoroughly explored and/or secured.

F. The individual can be safely treated at an alternative level of care.

G. An individualized discharge plan is documented with appropriate, realistic and timely follow-up care is in place.

VI. Frequency of Review:

Concurrent reviews must occur every 30 days, or more often, as appropriate.

VII. Clinical Resources:

ValueOptions National Guideline "*Residential Treatment Services (Adult)*" (2.301), revised 11/18/09.

See related BHO guideline for Residential Treatment—Children/Adolescents.