Adult Residential Treatment

Adult residential treatment services are delivered in a facility or a freestanding Residential Treatment Center that provides overnight mental health services to members who do not require 24-hour nursing care and monitoring offered in an acute inpatient setting but who do require 24-hour structure.

Any ONE of the following criteria must be met...

1. The member is experiencing a disturbance in mood, affect or cognition resulting in behavior that cannot be safely managed in a less restrictive setting; or
2. There is an imminent risk that severe, multiple and/or complex psychosocial stressors will produce significant enough distress or impairment in psychological, social, occupational, or other important areas of functioning to undermine treatment in a lower level of care; or
3. The member has a co-occurring medical disorder or substance use disorder which complicates treatment of the presenting mental health condition to the extent that treatment in a Residential Treatment Center is necessary.

And all of the following...

4. The member is not at imminent risk of serious harm to self or others.
5. Within 48 hours of admission, the following occurs:
    a. A psychiatrist completes a comprehensive evaluation of the member.
    b. The treating psychiatrist and, whenever possible, the member does the following:
        i. Develop a treatment plan;
        ii. Project a discharge date; and
        iii. Develop an initial discharge plan.
    c. With the member's documented consent, the treatment team contacts the member's family/social supports to discuss participating in treatment and discharge planning when such participation is essential and clinically appropriate. Participation in treatment should be at least weekly.
    d. With the member's documented consent, the treatment team contacts the member's outpatient provider to obtain information about the member's presenting condition and response to treatment.
6. Subsequent psychiatric evaluations and consultations are available 24 hours a day. Visits with the treating psychiatrist occur at least 2 times per week.
7. All relevant general medical services, including assessment and diagnostic, treatment, and consultative services are available as needed and provided with urgency commensurate with the member's medical need. Co-occurring medical conditions can be safely treated in this level of care.

8. The provider and, whenever possible, the member collaborate to update the treatment plan at least weekly in response to changes in the member's condition, or provide compelling evidence that continued treatment in the current level of care is required to prevent acute deterioration or exacerbation of the member's current condition.
    a. Treatment in a residential setting is not for the purpose of providing custodial care. Custodial care in a residential setting is the implementation of clinical or non-clinical services that do not seek to cure, or which are provided during periods when the member's mental health condition is not changing, or does not require trained clinical personnel to safely deliver services. Examples of custodial care include respite services, daily living skills instruction, days awaiting placement, activities that are social and recreational in nature and interventions that are solely to prevent legal problems. Custodial care is characterized by the following:
        i. The member's presenting signs and symptoms have been stabilized, resolved, or a baseline level of functioning has been achieved;
        ii. The member is not responding to treatment or otherwise is not improving;
        iii. The intensity of active treatment provided in a residential setting is no longer required or services can be safely provided in a less intensive setting.
    b. Treatment in a residential setting is for the active treatment of a mental health condition. Active treatment is a clinical process involving 24-hour care that includes assessment, diagnosis, intervention, evaluation of care, treatment and planning for discharge and aftercare. Active treatment is indicated by services that are all of the following:
        i. Supervised and evaluated by a physician;
        ii. Provided under an individualized treatment plan;
        iii. Reasonably expected to improve the member's condition or for the purpose of diagnosis;
        iv. Unable to be provided in a less restrictive setting; and are
        v. Focused on interventions that are based on generally accepted standards of medical practice and are known to address the critical presenting problem(s), psychosocial issues and stabilized the member's condition to the extent that the member can be safely treated in a lower level of care.
9. The provider and, whenever possible, the member collaborate to update the initial discharge plan ultimately ensuring that an appropriate discharge plan is in place prior to discharge. Whenever possible, the treatment team should review the discharge plan with the provider at the next level of care prior to discharge. The final discharge plan should be provided to the Care Advocate at least 24 hours prior to the anticipated date of discharge.
10. The discharge plan must include ALL of the following:
    a. The anticipated discharge date.
    b. The level and modalities of post-discharge care including the following:

i. The next level of care, its location, and the name(s) of the provider(s) who will deliver treatment;
ii. The rationale for the referral;
iii. The date and time of the first appointment for treatment as well as the first follow-up psychiatric assessment;
iv. The first appointment should be within 7 days of discharge;
v. The recommended modalities of post-discharge care and the frequency of each modality;
vi. The names, dosages and frequencies of each medication and a schedule for appropriate lab tests if pharmacotherapy is a modality of post-discharge care.
vii. Linkages with peer services and other community resources.

c. The plan to communicate all pertinent clinical information to the provider(s) responsible for post-discharge care, as well as to the member's primary care provider as appropriate.
d. The plan to coordinate discharge with agencies and programs such as the court system with which the member has been involved, when appropriate, and with the member's documented consent.
e. A prescription for a supply of medication sufficient to bridge the time between discharge and the scheduled follow-up psychiatric assessment.
f. Confirmation that the member or authorized representative understands the discharge plan.
g. Confirmation that the member was provided with written instruction for what to do in the event that a crisis arises prior to the first follow-up appointment.

Note: This guideline is intended to be used in conjunction with the Continued Service guideline when assessing the need for a continuing stay.