RESIDENTIAL SERVICES

Acute Treatment Units

I. Definition of Service:
An Acute Treatment Unit (ATU) is a 24-hour residential facility licensed by the Colorado Department of Public Health and Environment (CDPHE) and the Division of Behavioral Health (DBH). ATUs may serve as an alternative to inpatient hospitalization when it is determined the client can receive equal benefit at the ATU level of care. They provide a level of care for individuals who are in need of intensive psychiatric interventions for stabilization. An ATU must be capable of ensuring individual safety by qualifying as a secure facility under the provisions of Colorado Department of Public Health and Environment (CDPHE), Chapter VI 6 CCR 1011-1 Acute Treatment Units or by having restraint and seclusion capacity under 27-10 licensure. To receive Mental Health Services program approval as an ATU, each facility must have written protocols that include administrative functions, program description, services provided, and staffing.

ATUs provide 24-hour services in a facility setting for individuals with acute psychiatric needs. Including but not limited to suicidal, homicidal thoughts and behaviors, who are in need of stabilization in a secure setting. The ATU may also be used to provide ongoing 24 hour observation and therapies for individuals who require this setting for longer periods of time because it is determined that discharge would result in de-stabilization and/or exacerbation of symptoms. Individuals receive therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. The ATU program addresses identified problems through a wide range of diagnostic and treatment services. Life skills training in areas such as social skills and activities of daily living are provided in the context of a comprehensive, multidisciplinary treatment plan. At a minimum, ATU treatment includes weekly medication management sessions with a psychiatrist.

Secured Facility Designation: For an ATU to be approved as a secured facility, it must comply with the CDPHE’s Chapter VI 6 1011-1 Acute Treatment Units.

II. Admission Criteria:
   Any of the following criteria are necessary for admission:
   A. The individual demonstrates symptoms consistent with a DSM-IV-TR (AXES I-V) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
   B. The individual exhibits suicidal or homicidal ideation or acute mood symptoms/thought disorder that requires an intensive level of care.
   C. The individual is not sufficiently stable to be treated outside of a highly structured 24-hour therapeutic environment.

III. Exclusion Criteria:
   Any of the following criteria are sufficient for exclusion from this level of care:
A. The individual is imminently dangerous to self and others and cannot be safely maintained in an ATU level of care. In this case, a psychiatric inpatient hospital stay will be secured.

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.

D. The primary presenting problem is social, economic (i.e. housing, family, conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care.

E. The admission is intended for use as an alternative to incarceration.

IV. Continued Stay Criteria:
All of the following criteria are necessary for continuing treatment at this level of care:

A. The individual’s treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.

B. The individual continues to display symptoms that meet the admission criteria or have not completed treatment goals necessary for discharge.

C. Client does not need to transfer to a higher level of care to stabilize, and it is determined that the ATU level of care remains appropriate.

D. Client can not reduce the level of care to meet the stabilization goals.

E. The treating psychiatrist believes that continued stay is necessary to avoid de-stabilization and/or exacerbation of symptoms even though the client may have reached the “acute” stabilization goals on the ATU unit. In this event, the treating psychiatrist should identify a timeframe (i.e., in number of days) to continue to evaluate the client and assure discharge needs. This is considered a “necessary” transition period without which the client is likely to de-stabilize.

V. Discharge Criteria:
Any of the following criteria are sufficient for discharge from this level of care:

A. The individual’s documented treatment plan goals and objectives have been substantially met.

B. The individual meets criteria for an alternative level of care.

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

D. Support systems, which allow the individual to be maintained in a less restrictive treatment environment, have been thoroughly explored and/or secured.

E. The patient is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care. If the client
remains a danger to self or others, a transfer to a psychiatric inpatient facility will occur.

The following types of Residential Services encompass entities which are not limited to individuals with impaired functioning due to a covered DSM-IV-TR diagnosis. As such, they do not have associated Admission, Exclusion or Discharge Criteria.

(In Colorado, assisted living facilities and personal care boarding homes are referred to as assisted living residences.)

There are three types of assisted living residences in Colorado: private pay, alternative care facilities (assisted living residences that are Medicaid certified) and residential treatment facilities for persons with severe and persistent mental illness. There are about over 500 assisted living residences in Colorado. Any assisted living residence caring for 3 or more residents must be licensed.

Private pay assisted living residences are licensed. Alternative care facilities have Medicaid clients, and are licensed and certified. Residential treatment facilities are mental health facilities and are licensed. They are operated by the local mental health center.

Assisted living residences range in size from 3 to more than 200 beds. The most common reasons for admission to assisted living residences are medication management, bathing and dressing assistance, and the need for protective oversight and supervision.

Assisted living residences provide room, board and at least the following: personal services, protective oversight, social care and regular supervision available on a 24-hour basis.

Personal services include a physically safe environment, supervision, assistance with activities of daily living such as medication administration, bathing, dressing, eating, laundry, recreational activities and arrangements for transportation. Protective oversight includes monitoring the needs to ensure the residents receive the services and care necessary to protect their health, safety and well-being.

**ADULT FOSTER CARE (AFC):**

Adult Foster Care is care provided on a 24-hour basis for no more than sixteen residents in a non-medical facility. The certification is completed by the agency designated by the State for frail, elderly, physically or emotionally disabled adults, 18 years of age and over, who do not require 24-hour medical care. AFCs shall provide an environment that is sanitary and safe from physical harm; adequate sleeping and living areas; and adequate recreational areas. Eligibility for this program is based on financial need, the client’s need for 24-hour residential supervision and assistance with activities of daily living, appropriateness for the AFC program and available appropriations. Residents with a primary diagnosis of mental illness must be willing to comply with medications
prescribed by the physician and must be receiving on-going services from the local mental health center or other mental health professional. A ULTC 100 must be completed to determine functional eligibility for AFC.

**SUPPORTED INDEPENDENT LIVING:**

The category of Supported Independent Living includes individuals residing in private, residential housing who need occasional help with daily living skills. This assistance could come from the community mental health center or from home care providers.

**CONGREGATE LIVING:**

Congregate living is defined as several unrelated individuals living together in private residential housing. Any support or help would be derived from those in the shared space as opposed to community mental health center or home care assistance.

**SUBSIDIZED INDEPENDENT LIVING:**

The individual in this category meets all the criteria for independent living and is approved for Section 8 vouchers or certificates to offset a portion of the rent. This person would need to meet the criteria and possess the skills for living as required by HUD and the certifying entity.

**INDEPENDENT LIVING:**

Independent living is defined as private, residential housing that offers little or no supervision from staff of the community mental health center. The lease or rental agreement is between the owner and the resident. The individual residing in independent housing is capable of maintaining his/her home and possess the skills for meeting his/her daily needs.

Bibliography

Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 6 CCR 1011-1; Standards for Hospitals and Health Facilities, Chapter VI—Acute Treatment Units; Adopted 01/17/2007, Effective 04/01/2007
Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 6 CCR 1011-1; Standards for Hospitals and Health Facilities, Chapter XVIII—Psychiatric Hospitals; Amended 11/28/2007, Effective 01/30/2008