Brattleboro Retreat
COMPREHENSIVE MENTAL HEALTH SERVICES SINCE 1834

September 9, 2024

Ms. Donna Jerry
Senior Health Policy Analyst
Green Mountain Care Board
144 State St.
Montpelier VT 05602

Re: Docket No. GMCB 015-23con Brattleboro Retreat, Re-opening Paused Adolescent Residential Treatment Beds.

Dear Ms. Jerry:

Thank you for your questions sent to the Brattleboro Retreat on August 28, 2024. The Retreat's answers are below.

1. **Explain in detail the Retreat's policy for the admission of voluntary and involuntary patients in the residential program that was paused in 2021 and to policy for voluntary and involuntary admissions for the PRTF.**

In the paused residential program, the Retreat only admitted residents who agreed to attend the program, that is voluntary residents. The PRTF will also only admit voluntary residents.

2. **Explain in detail whether the residential program that was paused in 2021 was a locked or unlocked program and whether PRTF will be a locked or unlocked program.**

The paused residential program was unlocked. The PRTF will also be unlocked. In both cases, all the doors that lead outside have a 30 second delay before they open, and an alarm that sounds, so that staff are alerted when a resident leaves the building.

3. **Explain in more detail why the Retreat does not believe that the overall acuity of the resident population of the residential program that was paused in 2021 will be different in the PRTF program.**

The Brattleboro Retreat believes that the overall acuity of the resident population will not be materially different from the population of the paused program because the admission and exclusion criteria are not materially different. We have included the 2021 policy (Attachment 1,

pages 9-12), and the proposed policy submitted with the PRTF RFP (Attachment 2) so that you may compare them. Admission decisions are always based on a combination of the resident's presentation, the milieu in the program, and the availability of staff. While there may be individual residents that the PRTF can accept whose presentation is more acute than the average in the milieu, decisions to admit each individual resident are carefully considered based on the admission criteria, and the milieu and staffing available at the time the admission is requested.

4. **In your response to questions dated August 8, 2024, it is stated, "The Retreat maintains that because of this provision, the Retreat's PRTF program can and should be licensed under the current Hospital Licensing Rule. However, the Retreat noted in its previous letter it remains unclear as to whether the Department of Health will determine that a separate licensure category is necessary." Please provide an update regarding CMS's requirements for licensure and the licensure decision made by the Vermont Department of Health regarding the PRTF.**

The CMS licensure requirement has not changed and states that PRTF services must be provided by:

i. A psychiatric hospital that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital as specified in § 482.60 of this chapter, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS; or a hospital with an inpatient psychiatric program that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, as specified in part 482 of this chapter, or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.

ii. A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of healthcare organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council of Accreditation Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.

42 C.F.R. § 441.151 (a)(2). The Brattleboro Retreat meets the first criterion, and therefore, is eligible to provide PRTF services.

We understand that the Department of Health is considering rulemaking related to this type of facility, but we have no further information to provide at this time. Based on the Retreat's best information and knowledge as of today, the PRTF beds will not change the number of licensed beds at the Retreat. The Retreat once again thanks the Board for the care that it has taken in reviewing this jurisdictional request and looks forward to resuming this longstanding program.

Sincerely,

Elizabeth R. Wohl
General Counsel

Attachment 1

Title: **ADMISSION, DISCHARGE, CONTINUING CARE AND TRANSFER CRITERIA**

Replaces:

Section:	Provision of Care	Date Last Reviewed	2022/11
Source:	Patient Care Services	Date Last Revised	2019/07
		Replaces	2019/07
Approval:	Administration	Date Last Approved	2022/11
	Medical Affairs	Date Last Approved	2022/11
	Patient Care Services	Date Last Approved	2022/11
		NEXT POLICY REVIEW	2025/11

PURPOSE:

To assure appropriate criteria is met for admissions to the Retreat's inpatient, residential and ambulatory services programs.

POLICY:

The goal of acute inpatient mental health care is to stabilize individuals who display acute psychiatric conditions associated with a relatively sudden onset and a short severe course. Typically, the individual poses a significant danger to self or others, displays severe psychosocial dysfunction or mental instability. Acute inpatient care represents the most intensive level of psychiatric treatment. Treatment encompasses multidisciplinary assessments and multimodal interventions. Twenty-four-hour skilled nursing care, daily medical care and a structured treatment milieu are required.

Patients may be admitted to inpatient programs at the Brattleboro Retreat only by providers and other practitioners who have been granted admitting privileges by the Governing Body. All practitioners shall be governed by this official admitting policy of the Hospital as adopted by the Medical Staff and approved by the Governing Body.

PROCEDURE:

I. INPATIENT PROGRAMS

A. Patient, provider, or referring party contacts Central Intake (24 hours day/7-days week). An admissions coordinator or nursing supervisor conducts an initial screening to determine level of care and behavioral treatment options utilizing admission screening criteria as outlined below

B. Patients may be evaluated by external evaluators/crisis teams in local emergency departments or crisis centers, who perform managed care gate keeping functions. Evaluators contact Central Intake for clinical presentation and bed management.

C. An Advanced Practice Provider (APP) conducts a face-to-face evaluation with patient and/or family at the Retreat campus. The APP and/or RN quickly assesses for levels of risk and security prior to conducting the face-to-face evaluation. The clinician will complete the Comprehensive Intake Evaluation (CIE), and whenever possible will complete the physical while the patient is in the Admissions area.

D. The APP presents the case to the admitting provider, or delegate, who determines admission status. Patients will be admitted on either voluntary or involuntary status.

E. Patients receive a nursing assessment for inpatient substance abuse prior to MD admitting order.

F. No patient shall be admitted to any inpatient service until a provisional diagnosis for admission has been stated and the patient has been deemed to meet criteria for an inpatient level of care as defined in the Utilization Management Plan.

Admission Criteria (Intensity of Service):

The patient must require intensive, comprehensive, multimodal treatment - including 24 hours-per-day of medical supervision and coordination because of a mental disorder. The need for 24 hours of supervision may be due to the need for patient safety, psychiatric diagnostic evaluation, potential severe side effects of psychotropic medication associated with medical or psychiatric co-morbidities, or evaluation of behaviors consistent with an acute psychiatric disorder for which a medical cause has not been ruled out.

The acute psychiatric condition being evaluated or treated by inpatient psychiatric hospitalization must require active treatment, including a combination of services such as intensive nursing and medical intervention, psychotherapy, occupational and activity therapy. Patients must require inpatient psychiatric hospitalization services at levels of intensity and frequency exceeding what may be rendered in an outpatient setting, including intensive outpatient or psychiatric partial hospitalization. There must be evidence of failure at inability to benefit from or unacceptable risk in an outpatient treatment setting.

For all diagnoses, the severity and acuity of symptoms and the likelihood of response to treatment, combined with the requirement for an intensive, 24-hour level of care are the significant factors in determining the necessity of inpatient psychiatric treatment.

Admission Criteria:

1. Both of the following criteria are necessary for admission:

   a) Individual demonstrates symptomatology consistent with the current version of the DSM (AXES I-V) diagnosis, which requires and will respond to therapeutic intervention.
   b) Individual is free from any physical conditions which require acute primary medical care and has been cleared for treatment in a non-medical surgical treatment environment.

2. In addition to the above, one of the following must be present:

   a) There is an indication of actual or potential danger to others or to self as evidenced by at least one of the following:

      - A serious suicide attempt with plan and means available
      - Command hallucinations
      - Persecutory delusions
      - Documented recent history of violence

   b) There is an indication of actual or potential danger to others as evidenced by at least one of the following:

      - Documented current threat to kill or injure an identified person known to individual.
      - Documented current threat to kill or injure someone not directly associated with the individual.
      - Documented threat with plans and means available to kill or injure someone, but no specific target identified.

   c) A recent serious suicide/homicide attempt within the past 72 hours, and continued significant suicidal/homicidal intent as indicated by the circumstances of the attempt, the method used, the statements of the individual, or continuing feelings of helplessness and/or hopelessness.

   d) A suicidal/homicidal gesture within the past 72 hours without the above indicators with a history of previous significant attempts, accompanied by a severely depressed mood, occurrence of significant losses, or with continuing significant suicidal/homicidal intent.

   e) The presence of suicidal/homicidal ideation when associated with suicide/homicide plan, means, and intent, command hallucinations, delusions of guilt, prolonged

intractable pain, fantasies of impending death, feelings of desperation or hopelessness, or other indicators of suicidal/homicidal intent.

f) Loss of impulse control resulting in life threatening behavior, significant weight loss within the past three months, or self-mutilation that could lead to permanent disability.

g) Individual is impaired to the degree that he/she manifests major disability in social, interpersonal, occupational, and/or educational function and is not responsive to treatment and/or management efforts at a less intensive level of care.

h) There is evidence of severe disorders of cognition, memory or judgment with attendant psychological impairment and family/community support cannot be relied on to provide essential care.

i) There is an indication of actual or potential danger to property as evidenced by at least one of the following:

- Documented recent history of violent, dangerous or destructive acts; or
- Documented recent Threats of violent, dangerous or destructive acts.

3. Failure of outpatient psychiatric treatment so that the beneficiary requires 24-hour professional observation and care. Reasons for the failure of outpatient treatment include:

a) Increasing severity of psychiatric symptoms;

b) Noncompliance with medication regimen due to the severity of psychiatric symptoms;

c) Inadequate clinical response to psychotropic medications;

d) Due to the severity of psychiatric symptoms, the patient is unable to participate in an outpatient psychiatric treatment program.

4. In the case of detox admissions, the individual must have a history of current alcohol and/or substance abuse at a level and with a frequency to have developed dependency and/or tolerance and to be at medical risk of life-threatening consequences if the substance is removed without medical supervision. The individual must be at medical risk for life-threatening consequences due to acute intoxication from alcohol or other substances of abuse.

In addition, at least one of the following conditions must exist:

a) **Alcohol**

- Patient is at risk of developing severe or complicated alcohol withdrawal.
- Patient whose underlying medical or psychiatric co-morbid condition will be significantly exacerbated by the withdrawal symptomatology;

- Patients with a recent history of seizures when withdrawing from alcohol. Patients with a recent history of delirium tremors when withdrawing from alcohol.

b) **Sedative/Hypnotics**

- At risk of severe withdrawal from sedative hypnotic agents;
- Patients whose underlying co-morbid medical or psychiatric condition will be significantly exacerbated by moderate to severe withdrawal symptoms.

c) **Opioids**

- Patients whose underlying medical or psychiatric co-morbid condition will be significantly exacerbated by severe withdrawal.
- Psychopharmacologic treatment can only be done under medical management (e.g., pharmacological induction).

5. Admission of pregnant women for detoxification:
   - Pregnant women requiring inpatient detox treatment must meet criteria for inpatient detox, as well as having had an evaluation by their treating OB/GYN giving medical clearance prior to admission.

C. Exclusion Criteria

Any of the following criteria is sufficient for exclusion from this level of care:

a) Individual can be safely maintained and effectively treated at a less intensive level of care.

b) Threat of assault toward others is not accompanied by a DSM-IV diagnosis.

c) Individuals with the following conditions are excluded from admission in the absence of a superseding episode of an acute psychiatric condition that is clearly documented and causes criteria for inpatient admission:
   - Autism
   - Mental Retardation
   - Organic Mental Disorder delirium, dementia, amnestic and cognitive mental disorders due to a medical condition
   - Primary Substance Abuse Problems

d) Individuals with respiratory conditions requiring airborne isolation or negative pressure rooms.

e) For detox admissions, the individual has abstained from regular, ongoing use of drugs or alcohol for at least 7 days and is not demonstrating signs or symptoms of significant

withdrawal

f) High risk pregnancy as documented by patient's medical record.

g) Additional medical guidelines for admission should be reviewed and followed:

1. These medical conditions are appropriate for admission:

STOMAS (colostomy, ileostomy)
ENTERAL FEEDING TUBES (inserted prior to admission)
OXYGEN TREATMENT
PREGNANCY (uncomplicated)
INTRAVENOUS TREATMENT (Heplocks)
SEIZURE DISORDER
DIABETES
COUMADIN TREATMENT
FOLEY CATHETERS
CROHN'S DISEASE
ULCERATIVE COLITIS
METHICILLIN RESISTANT STAPHLOCCUS AURES MULTIPLE DRUG RESISTANC E

2. These medical conditions need further evaluation for admission and a consultation generated automatically for the patient to be evaluated by a provider:

PERITONEAL DIALYSIS— (dependent upon frequency/duration/time of dialysis, as this may prevent participation in treatment. If condition is stable, then this should not be a barrier to admission):

DECUBITUS ULCERS--(Dependent on stage of decubiti)
INTRAVENOUS LINES- (PICC, Central Access lines)
CHEMOTHERAPY
POST-OPERATIVE PROCEDURE
DYSPHAGIA
ABSCESSES REQUIRING I&D
PLATELET COUNT LESS THAN 25,000
HEMOGLOBIN—LESS THAN 8 (unless chronic or stable)
HEMATOCRIT LESS THAN 25 (unless chronic or stable)
POTASSIUM GREATER THAN 6 OR LESS THAN 3
PULSE<40 IN EATING DISORDERS
SYSTOLIC BLOOD PRESSURE GREATER THAN 220 OR LESS THAN 80 (sustained)
DIASTOLIC BLOOD PRESSURE GREATER THAN 120
SHINGLES
RECENT GI BLEED
EATING DISORDER WITH ABNORMAL EKG
RECENT LATE TERM ABORTION

RECENT HEAD INJURY
RECENT POST-OPERATIVE SURGERY WITH COMPLICATIONS
HIGH RISK PREGNANCY

3. These medical conditions are currently inappropriate for admission, or if a current patient's medical condition deteriorates to this level, transfer to BMH is warranted.

RESPIRATOR/VENTILATOR TREATMENT
HEMODIALYSIS
UNRESPONSIVE/UNCONSCIOUS
UNSTABLE CHEST PAIN
SEVERE COPD (PULSE OXIMETER READING LESS THAN 80%)
UNSTABLE SPINAL FRACTURE
SYMPTOMATIC AORTIC ANEURYSM
CHEST TUBE
ACUTE DEEP VEIN THROMBOSIS
HEPARIN TREATMENT (excluding Heplocks)
PULSE LESS THAN 40 OR GREATER THAN 140 (sustained)
DIABETIC KETOACIDOSIS
MEASLES
TUBERCULOSIS—active, with positive sputum
CHICKEN POX
MUMPS
RUBELLA
HYPERALIMENTATION TREATMENT

D. Continuing Stay Criteria

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

a) Individual's condition continues to meet admission criteria for inpatient care, acute treatment interventions (including psychopharmacological) have not been exhausted, and no other less intensive level of care would be adequate.
b) Treatment planning is individualized, appropriate to the individual's changing condition with realistic and specific goals and objectives stated.
c) All service and treatment are carefully structured to achieve optimum results in the timeliest way possible.
d) Progress in relation to specific symptoms or impairments is clearly evident and reportable in describable and observable terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident.
e) Care is rendered in a clinically appropriate manner and focused on individual's outcomes as described in the discharge plan.

f) The patient and family (when appropriate) are participating to the extent he/she or they are medically and psychologically capable, with a program that is considered adequate to alleviate the signs and symptoms justifying admission.
g) When medically necessary, appropriate psychopharmacological intervention has been prescribed.

E. Discharge Criteria

Any of the following criteria are sufficient for discharge from this level of care:

a) Individual's documented treatment plan goals and objectives have been substantially met.
b) Individual no longer meets admission criteria and acute treatment interventions (including psychopharmacological) have been exhausted, or meets criteria for less intensive level of care.
c) The individual is non-compliant with treatment or in following program rules and regulations. On weekdays, the attending provider should consult with the nurse manager and the treatment team prior to making a final decision, and on weekends, evenings and holidays the doctor on call should attempt to consult with the assigned attending provider, and also the Administrator on Call. The term "Administrative Discharge" is not used. However, a patient **may** be considered for discharge when certain of the following behavior(s) are exhibited (the list is not exhaustive):
    - Possession, sales, or ingestion of contraband (esp. illicit substances)
    - Violence or threat of violence toward other patients or staff
    - Verbal abuse of patients or staff, and unwillingness to stop the behavior
    - Intentional destruction of property
    - Theft from another patient, staff, or hospital property
    - Smoking on the unit or on grounds
    - Inappropriate physical contact or sexual activity with another patient
d) Consent for treatment is withdrawn, and either it has been determined involuntary inpatient treatment is inappropriate or the court has denied involuntary inpatient treatment.
e) Support systems which allow the patient to be maintained in a less restrictive treatment environment have been secured.
f) Patient is not making progress toward treatment goals and there is no reasonable election of progress at this level of care.
g) In the case of detox admissions, the individual's withdrawal symptoms have been eliminated or reduced to a stable and safe level.
h) If chemical dependence diagnosis is present, any concomitant medical condition that was influenced or exacerbated by alcohol/drug abuse has been evaluated, monitored, and found to be stable.

F. Transfer Criteria

Patients who continue to meet continuing care criteria may be transferred as clinical needs or personal preferences necessitate in consultation and with, and agreement of, the treatment team.

a) CHILD AND ADOLESCENT RESIDENTIAL TREATMENT SERVICES

Description of Services:

Brattleboro Retreat Residential Treatment Services are provided to children and adolescents who require 24-hour treatment and supervision in a safe therapeutic environment. Services are a 24 hour a day/7 day a week facility-based level of care. Services provide individuals with severe and persistent psychiatric disorders and chemical dependency issues therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. Services address 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 cannot be provided in a community setting. The services are provided in the context of a comprehensive, multidisciplinary and individualized treatment plan that is frequently reviewed and updated based on the individual's clinical status and response to treatment. This treatment primarily provides psychiatric, social, psychosocial, educational and rehabilitative training, and focuses on family or caregiver reintegration. Active family/caregiver involvement through family therapy is a key element of treatment and is strongly recommended where possible. Discharge planning begins at admission, including plans for reintegration into the home, school and community. If discharge to a home/family is not an option, alternative placement will be identified. Services provide for coordination of educational activities that are age appropriate.

A. Admission Criteria (Intensity of Service)

The following criteria are utilized to determine admission:

1. The child/adolescent demonstrates symptomatology consistent with a DSM-IV-TR (Axes I-V) diagnosis which requires, and can reasonably be expected to respond to, therapeutic intervention.

2. The child/adolescent 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.

3. The child/adolescent demonstrates a capacity to respond favorably to rehabilitative counseling and training in areas such as problem solving, life skills development, and medication compliance training.

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

5. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs.
6. The family situation and functioning levels are such that the child/adolescent cannot safely remain in the home environment and receive community-based treatment.

7. The child or adolescent is between the ages of six (6) and seventeen (17). If the individual is eighteen (18) years of age a variance, from the State of Vermont Residential Licensing Unit, can be obtained for admission.

B. Exclusion Criteria

The following criteria may exclude admission to the residential level of care:

1. The child or adolescent exhibits severe suicidal, homicidal or acute mood symptoms/thought disorder, which requires a more intensive level of care.

2. Parent, guardian, or child over the age of fourteen (14) does not *voluntarily* consent to admission or treatment.

3. The child/adolescent can be safely maintained and effectively treated at a less intensive level of care.

4. The child/adolescent has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications.

5. The child/adolescent has exhibited recent (within past 6-12 months) sexually reactive or assaultive behavior. The child or adolescent will be considered if they have successfully completed a sex offense program and have demonstrated decreased risk of offending behavior.

6. The child has exhibited recent (within past 6-12 months) fire setting behavior that requires specific treatment and intervention. The child or adolescent will be considered if they have successfully completed a fire setting/prevention program and have demonstrated decreased risk of fire setting behavior.

C. Continued Stay Criteria:

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

1. The child/adolescent's condition continues to meet admission criteria at this level of care.

2. The child or adolescent's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.

3. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. Treatment planning must include active family or other support systems involvement, along with social, occupational and interpersonal assessment unless contraindicated. The expected benefits from all relevant treatment modalities are documented. The treatment plan has been implemented and updated, with consideration of all applicable and appropriate treatment modalities.

4. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.

5. If treatment progress is not evident, then there is documentation of treatment plan adjustments to address such lack of progress and there is fair likelihood that the child/adolescent will demonstrate progress with these changes

6. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's behavioral and functional outcomes.

7. An individualized discharge plan has been 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.

8. Child/adolescent is actively participating in treatment to the extent possible consistent with his/her condition, or there are active efforts being made that can reasonably be expected to lead to the child/adolescent's engagement in treatment.

9. 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.

10. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.

11. There is a documented active attempt at coordination of care with relevant outpatient providers and community support systems when appropriate.

D. Discharge Criteria

1. The child/adolescent'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.

2. The child/adolescent no longer meets admission criteria, or meets criteria for a less or more intensive level of care.

3. The child/adolescent, family, guardian and/or custodian are competent but non-participatory in treatment or in following the program rules and regulations. There 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.

4. Consent for treatment is withdrawn, and it is determined that the child/adolescent or parent/guardian has the capacity to make an informed decision and does not meet criteria for an inpatient level of care.

5. The child/adolescent is not making progress toward treatment goals despite persistent efforts to engage him/her, and there is no reasonable expectation of progress at this level of care nor is it required to maintain the current level of function.

6. The child/adolescent can be safely treated at an alternative level of care.

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

BIRCHES TREATMENT CENTER

The Birches Treatment Center offers both Partial Hospitalization (PHP) and Intensive Outpatient (IOP) programs. Both are comprehensive treatment programs for adults that provide mental health and addiction treatment.

A. Scope of services

The levels of care provided in the Birches include:

1. Partial Hospitalization (PHP) for Substance Abuse or Mental Health Primary Diagnoses
2. Intensive Outpatient (IOP) for Substance Abuse or Mental Health Primary Diagnoses

B. Referral procedure

When patients are referred directly from a Retreat inpatient program, and when the patient is able to begin treatment in the program within 2 business days of discharge from that program,

the procedure is as follows:

1. Referral information will be reviewed by a clinician to insure patient meets level of care criteria, and is conditionally accepted, pending provider's certification/approval at the time of their admission to the program
2. Within one business day of admission, the program provider will certify the patient's need for admission for PHP into the level of care indicated, and document this in the patient's chart; for IOP admissions, the MD will approve the admission and indicate this in their initial clinical note

For other referrals, such as from the patient directly, from other (not Retreat) inpatient settings, from community providers, from other Retreat outpatient programs (such as AMBCC or Starting Now), the following procedure will be followed:

1. Admissions department conducts initial phone screening, and schedules the patient for an evaluation for the program
2. Patient is evaluated by clinical staff, and admission made based on level of care determination of that staff
3. Program provider will certify/approve the need for treatment at the indicated level of care, and will document this in the patient's medical record

All patients complete a screening questionnaire for possible co-morbid physical health conditions. In cases where patient, clinician, or provider assesses that further medical treatment (including pain management) is necessary, the patient is referred for medical services through their primary care provider, or to an emergency room in a time-frame that is commensurate with the problem in question. The program will make efforts to obtain a copy of the most recent physical examination, or to encourage patient to obtain a physical exam during the course of active treatment, if indicated. Information collected in the initial medical screening includes:

1. Active medical problems, regardless of whether the patient is receiving treatment
2. A list of all medications, including dosages, that the patient is currently taking
3. Self-reported history for specific past and present illnesses, including HIV, AIDS, and Hepatitis; a complete list is kept and reviewed periodically with supervising medical staff
4. Nutritional status questionnaire
5. Functional status screening
6. Pain screening

C. Admission Criteria

1. Partial Hospitalization (PHP)

In order to be eligible for treatment and services in this program beyond an

assessment/evaluation, patient must meet the following criteria:

a) Documented DSM-IV diagnosis of a mental health or substance use disorder
b) Symptoms of this disorder are severely interfering with multiple areas of the patient's daily life, including emotional, social, vocational/educational and/or task functioning
c) The disorder has either an acute onset or is an acute exacerbation of a persisting condition, or an acute exacerbation of the severe disorder would be expected in the absence of partial hospitalization services. Ex. Inpatient psychiatric or addictions treatment admission/re-admission is likely without this level of treatment services
d) Symptoms are of a significant enough severity that less-restrictive levels of care would not be adequate to address the symptoms or there has been a failure of less-intensive levels of treatment
e) The patient must be able to engage and participate in treatment
f) There is a reasonable a likelihood the patient will benefit from the services provided
g) For substance use disorders, the patient meets admission criteria for ASAM PPC-2R at level II.5

2. **Intensive Outpatient Services (IOP)/Hospital Outpatient Services (HOP)**
   a) Patient does not meet, or no longer meets, criteria for Partial Hospitalization level of care
   b) The patient has a documented mental health or addictive disorder
   c) This disorder continues to cause significant impairment in multiple areas of the patient's life
   d) Symptoms continue to be present at a level of intensity that could not be managed in routine outpatient psychiatric/mental health or addictions care.
   e) The patient must be able to engage and participate in treatment
   f) There is a reasonable a likelihood the patient will benefit from the services provided
   g) For substance-use disorders, the patient meets criteria for ASAM PPC-2R level II.1

F. Exclusion criteria

Exclusion criteria common to all levels of care within the Birches programs include:

1. The patient does not meet admission criteria for levels of care outlined above
2. The patient does not have adequate supports to maintain safety during treatment
3. The patient is not able to manage his/her own health status and independently take all prescribed medications
4. There is a possibility of acute intoxication or withdrawal or other signs that patient's substance abuse treatment needs cannot be met at this level of care
5. Patient exhibits verbal or physical behavior that is threatening or would put others'

safety at risk

6. The presence of medical or psychiatric conditions that would prevent them from being able to safely engage in, or benefit from, treatment at this level of care. Examples include: active eating disorder with medical complications; acute or chronic medical problems requiring frequent follow-up or monitoring; active disorganization.
7. The patient is unable to maintain attention and engagement in the treatment process, despite offered supports, treatment, and redirection
8. The patient is on a medication or combination of medications judged by the program psychiatrist to be interfering with their ability to receive treatment for the underlying condition

G. Continuing stay criteria

All of the following criteria are necessary for continuing treatment at any given level of care offered within the Birches program:

1. The patient continues to meet criteria for the specified level of care, and less intensive treatment would increase likelihood of relapse of the patient's presenting condition.
2. Progress in relation to specific symptoms or impairments is clearly evident and reportable in describable and observable terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident.
3. Treatment planning is individualized, appropriate to the individual's changing condition with realistic and specific goals and objectives stated.
4. The patient is participating to the extent he/she is medically and psychologically capable, with a program that is considered adequate to alleviate the signs and symptoms justifying admission.
5. All services and treatment are carefully structured to achieve optimum results and are in line with best practices in the mental health and/or addictions treatment fields. Care is rendered in a clinically appropriate manner and focused on individual's outcomes as described in the discharge plan.

H. Discharge criteria

Any of the following criteria are sufficient for discharge from this level of care:

1. Individual's documented treatment plan goals and objectives have been substantially met.
2. Individual meets criteria for less intensive level of care.
3. The individual, family, guardian and/or custodian is non-compliant with treatment or in following program rules and regulations.
4. Consent for treatment is withdrawn.
5. Patient is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care

6. Patient's safety cannot be managed in this level of care
7. Administrative discharge is initiated. Reasons for such discharge may include:
    a. Violent or threatening behavior
    b. Endangering staff or co-patient health or well-being in any way
    c. Repeated substance use while in treatment
    d. Refusal or inability to adhere to attend scheduled treatment services
    e. Refusal to provide a urine drug screen or breathalyzer when asked
    f. Non-payment of services
    g. Other reasons as determined by the treatment team

Transfer criteria

Patients who continue to meet continuing care criteria may be transferred to another facility or to another level of care as clinical needs or patient preferences necessitate in consultation and with, and agreement of, the treatment team.

The Brattleboro Retreat Uniformed Services Program

The Uniformed Services Program offers both Partial Hospitalization (PHP) and Intensive Outpatient (IOP/HOP) programs for current or retired Uniformed Service Personnel. Both are comprehensive treatment programs for adults that provide mental health and addiction treatment.

A. Scope of services

The levels of care provided in the Uniformed Services Program include:

1. Partial Hospitalization (PHP) for Substance Abuse or Mental Health Primary Diagnoses
2. Intensive Outpatient (IOP)/Hospital Outpatient (HOP) for Substance Abuse or Mental Health Primary Diagnoses

B. Referral procedure

When patients are referred directly from a Retreat inpatient, residential, or other Partial Hospitalization program, and when the patient is able to begin treatment in the program within 2 business days of discharge from that program, the following procedure will be followed:

1. Referral information will be reviewed to insure patient meets level of care criteria, and is conditionally accepted, pending MD certification/approval at the time of their admission to the program
2. Within one business day of admission, the program provider will certify the patient's need for admission for PHP into the level of care indicated, and document this in the patient's chart; for IOP admissions, the MD will approve the admission and indicate

this in their initial clinical note

For other referrals, such as from the patient directly or from community providers, from Retreat outpatient programs offering a lower level of care (such as outpatient), the following procedure will be followed:

1. Admissions department conducts initial phone screening, and schedules the patient for an evaluation for the program
2. Patient is evaluated by clinical staff, and admission made based on level of care determination of that staff
3. Program provider will certify/approve the need for treatment at the indicated level of care, and will document this in the patient's medical record

All patients complete a screening interview for possible co-morbid physical health conditions. In cases where patient, clinician, or provider assesses that further medical treatment (including pain management) is necessary, the patient is referred for medical services through their primary care provider, or to an Emergency room in a time-frame that is commensurate with the problem in question. The program will make efforts to obtain a copy of the most recent physical examination, or to encourage patient to obtain a physical exam during the course of active treatment, if indicated. Information collected in the initial medical screening includes:

1. Active medical problems, regardless of whether the patient is receiving treatment
2. A list of all medications, including dosages, that the patient is currently taking
3. Self-reported history for specific past and present illnesses, including HIV, AIDS, and Hepatitis; a complete list is kept and reviewed periodically with supervising medical staff
4. Nutritional status questionnaire
5. Functional status screening
6. Pain screening

C. Admission Criteria

3. Partial Hospitalization (PHP)

In order to be eligible for treatment and services in this program beyond an assessment/evaluation, patient must meet the following criteria:

a) Documented DSM-IV diagnosis of a mental health or substance use disorder
b) Symptoms of this disorder are severely interfering with multiple areas of the patient's daily life, including emotional, social, vocational/educational and/or task functioning

c) The disorder has either an acute onset or is an acute exacerbation of a persisting condition or an acute exacerbation of the severe disorder would be expected in the absence of partial hospitalization services. Ex. Inpatient psychiatric or addictions treatment admission/re-admission is likely without this level of treatment services
d) Symptoms are of a significant enough severity that less-restrictive levels of care would not be adequate to address the symptoms or there has been a failure of less-intensive levels of treatment
e) The patient must be able to engage and participate in treatment
f) There is a reasonable a likelihood the patient will benefit from the services provided
g) For substance use disorders, the patient meets admission criteria for ASAM PPC-2R at level II.5

4. Intensive Outpatient Services (IOP)/Hospital Outpatient Services (HOP)

a) Patient does not meet, or no longer meets, criteria for Partial Hospitalization level of care
b) The patient has a documented mental health or addictive disorder
c) This disorder continues to cause significant impairment in multiple areas of the patient's life
d) Symptoms continue to be present at a level of intensity that could not be managed in routine outpatient psychiatric/mental health or addictions care.
e) The patient must be able to engage and participate in treatment
f) There is a reasonable a likelihood the patient will benefit from the services provided
g) For substance-use disorders, the patient meets criteria for ASAM PPC-2R level II.1

F. Exclusion criteria

Exclusion criteria common to all levels of care within the Uniformed Service Program:

1. The patient does not meet admission criteria for levels of care outlined above
2. The patient does not have adequate supports to maintain safety during treatment
3. The patient is not able to manage his/her own health status and independently take all prescribed medications
4. There is a possibility of acute intoxication or withdrawal or other signs that patient's substance abuse treatment needs cannot be met at this level of care
5. Patient exhibits threatening verbal or physical behavior that is threatening or would put others' safety at risk
6. The presence of medical or psychiatric conditions that would prevent them from being

able to safely engage in, or benefit from, treatment at this level of care. Examples include: Active eating disorder with medical complications; acute or chronic medical problems requiring frequent follow-up or monitoring; active disorganization.

7. The patient is unable to maintain attention and engagement in the treatment process, despite offered supports, treatment, and redirection
8. The patient is on a medication or combination of medications judged by the program psychiatrist to be interfering with their ability to receive treatment for the underlying condition

G. Continuing stay criteria

All of the following criteria are necessary for continuing treatment at any given level of care offered within the Uniformed Services Program:

1. The patient continues to meet criteria for the specified level of care, and less intensive treatment would increase likelihood of relapse of the patient's presenting condition.
2. Progress in relation to specific symptoms or impairments is clearly evident and reportable in describable and observable terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident.
3. Treatment planning is individualized, appropriate to the individual's changing condition with realistic and specific goals and objectives stated.
4. The patient is participating to the extent he/she is medically and psychologically capable, with a program that is considered adequate to alleviate the signs and symptoms justifying admission.
5. All services and treatment are carefully structured to achieve optimum results and are in line with best practices in the mental health and/or addictions treatment fields. Care is rendered in a clinically appropriate manner and focused on individual's outcomes as described in the discharge plan.

H. Discharge criteria

Any of the following criteria are sufficient for discharge from this level of care:

1. Individual's documented treatment plan goals and objectives have been substantially met.
2. Individual meets criteria for less intensive level of care.
3. The individual, family, guardian and/or custodian is non-compliant with treatment or in following program rules and regulations.
4. Consent for treatment is withdrawn.
5. Patient is not making progress toward treatment goals and there is no reasonable election of progress at this level of care
6. Patient's safety cannot be safely managed in this level of care
7. Administrative discharge is initiated. Reasons for administrative discharge may include:

a. Violent or threatening behavior
b. Endangering staff or co-patient health or well-being in any way
c. Repeated substance use while in treatment
d. Refusal or inability to adhere to attend scheduled treatment services
e. Refusal provide a urine drug screen or breathalyzer when asked
f. Non-payment of services
g. Other reasons as determined by the treatment team

I. Transfer criteria

Patients who continue to meet continuing care criteria may be transferred to another facility or to another level of care as clinical needs or patient preferences necessitate in consultation and with, and agreement of, the treatment team.

Anna Marsh Behavioral Care Clinic (AMBCC)

The Anna Marsh Behavioral Care Clinic, in accordance with the Retreat's mission and policies, provides outpatient behavioral health services to individuals who meet criteria for admission and continuing care.

A. Scope of Services

The levels of care provided in this program include:
1. Psychological evaluation services
2. Outpatient psychotherapy for children, adolescents and adults (individual, group, family)
3. Outpatient psychiatry, psychopharmacology, and medication evaluation for children, adolescents and adults
4. Psychological testing services

B. Referral procedure

Patients can self-refer or be referred by other providers or social service organizations, medical providers, or Retreat inpatient or ambulatory services.

Following a phone call/referral, central registration conducts an initial phone screening and schedules the patient for an evaluation with a clinician. The patient is subsequently evaluated over a period of one to three sessions to determine appropriateness of treatment and assessment of the patient's ability to adhere to and benefit from treatment offered. A treatment plan is developed at this time if the patient is to remain in treatment beyond the evaluation phase.

All patients complete a screening questionnaire for possible co-morbid physical health

conditions. In cases where patient, clinician, or provider assesses that further medical treatment is necessary, the patient is referred for medical services through their primary care provider, or to an Emergency room in a time-frame that is commensurate with the problem in question. Information collected in the initial medical screening includes:

1. Active medical problems, regardless of whether the patient is receiving treatment
2. A list of all medications, including dosages, that the patient is currently taking
3. Self-reported history for specific past and present illnesses; a complete list is kept and reviewed periodically with supervising medical staff
4. Nutritional status questionnaire
5. Functional status screening
6. Pain screening

Patients being referred for psychiatry and/or medication management are typically seen initially for assessment by a therapist and then referred to a psychiatrist or other prescriber for further medication management evaluation. The medication management service of the practice is generally limited to patients seen for psychotherapy within the clinic or associated outpatient clinics at the Retreat (Starting Now, for example).

C. Admission Criteria

In order to be eligible for treatment and services in this program beyond an assessment/evaluation, patient must meet the following criteria:

1. Documented diagnosis of a mental health disorder that is within the scope of the practice's ability to treat
2. Symptoms of this disorder are interfering with multiple areas of the patient's life in ways possibly including but not limited to emotional, social, vocational/educational and/or task functioning
3. The patient must be able to engage in and participate in treatment
4. There is a reasonable likelihood the patient will benefit from the services provided
5. The patient is not better served in a higher or lower level of care, or that more intensive care is not accessible to the patient at the time of the evaluation

D. Exclusion Criteria

Exclusion criteria for AMBCC are as follows:

1. The patient does not meet admission criteria outlined above
2. The patient does not have adequate supports to maintain safety during treatment
3. The patient is not able to manage his/her own health status and independently take all prescribed medications

4. There is a possibility of acute intoxication or withdrawal or other signs that patient's substance use treatment needs cannot be met at this level of care
5. Patient exhibits verbal or physical behavior that is threatening or would put others' safety at risk
6. The patient is unable to maintain attention and engagement in the treatment process, despite offered supports, treatment, and redirection

E. Continuing Stay Criteria

All of the following criteria are necessary for continuing treatment within AMBCC:

1. Individual's condition continues to meet admission criteria for the specified level of care, and no other less intensive level of care would be adequate to manage the patient's needs safely
2. Treatment planning is individualized, appropriate to the individual's changing condition with realistic and specific goals and objectives stated.
3. Services and treatment are structured to achieve optimum results in a timely way.
4. Progress in relation to specific symptoms or impairments is evident and reportable in describable and observable terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident; alternatively, services are needed to maintain functioning or prevent exacerbation of symptoms.
5. Care is rendered in a clinically appropriate manner and focused on individual's outcomes as described in the ongoing plan of care.
6. The patient is participating to the extent he/she or they are medically and psychologically capable, with a program that is considered adequate to address the signs and symptoms justifying admission.

F. Discharge Criteria

Any of the following criteria are sufficient for discharge from this level of care:

1. Individual's documented treatment plan goals and objectives have been substantially met.
2. Individual meets criteria for less intensive level of care.
3. The individual, family, guardian and/or custodian are non-compliant with treatment or in following program rules and regulations.
4. Consent for treatment is withdrawn.
5. Continued treatment is no longer benefitting the patient
6. Patient's safety cannot be reasonably managed in this level of care
7. Discharge is initiated against the wishes of the patient. Reasons for such discharge may include:
   a. Violent or threatening behavior
   b. Endangering staff or co-patient health or well-being in any way
   c. Refusal or inability to adhere to scheduled treatment services

d. Refusal to provide a urine drug screen or breathalyzer when asked
e. Non-payment of services
f. Other reasons as determined by the treatment team

G. Transfer criteria

Patients who continue to meet continuing care criteria may be transferred to another facility or to another level of care as clinical needs or patient preferences necessitate in consultation with, and agreement of, the treatment team.

MIND-BODY PAIN MANAGEMENT PROGRAM

The Mind-Body Pain Management Program, in accordance with the Retreat's mission and policies, provides outpatient pain management services to individuals who meet criteria for admission and continuing care.

A. Scope of Services

The levels of care provided in this program include:

1. Chronic Pain Intake/Assessment Services for adults
2. Chronic Pain Individual Consultation Services for adults
3. Chronic Pain Individual Outpatient Services for adults
4. Chronic Pain Group Outpatient Services for adults
5. Individual and couples / family meetings for development of daily activity plans
6. Other medical conditions which may contribute to chronic pain and are deemed within the scope of practice of program personnel (e.g., tobacco use disorder)

B. Referral procedure

For all assessment and treatment services, with the exception of consultation services, patients can be referred by Retreat inpatient or outpatient services, themselves, community sources, or other treatment providers for assessment and/or treatment services. Prior to admission referral information from a medical provider may be requested, such as documented assessments, medications, and treatment notes.

The following admission procedure will be followed:

1. Patient contacts Central Intake or Pain Clinic staff, or treatment provider makes a direct referral
2. Intake staff verify patient's financial eligibility
3. Patient is evaluated by clinical staff and admission made based on appropriateness of treatment and assessment of the patient's ability to comply with treatment
4. Program provider will certify/approve the appropriateness of treatment based on a review of the patient's medical records, and a physical examination of the patient if

deemed necessary

All patients are assessed by the program provider for possible co-morbid physical health conditions. In cases where patient, clinician, or provider assesses that further medical treatment is necessary, the patient is referred for medical services through their primary care provider, or to an Emergency room in a time-frame that is commensurate with the problem in question. Information collected in the initial medical and/or clinical screening includes:

1. Active medical problems, regardless of whether the patient is receiving treatment
2. A list of medications, including dosages, that the patient is currently taking
3. Self-reported history for specific past and present illnesses, including HIV, AIDS, and Hepatitis
4. Functional status screening (i.e., Activities of Daily Living, Activities of Valued Living)
5. Pain screening

For consultation services patients must be referred by a Provider. The following admission procedure will be followed:

1. Upon receipt of referral clinical staff request Intake staff to verify patient's financial eligibility
2. Clinician contacts a primary treatment provider (e.g., Provider, Therapist, Case Worker) to determine nature of consult requested
3. Clinician contacts patient or treatment provider to schedule an appointment

C. Admission Criteria

In order to be eligible for a consultation or treatment and services in this program beyond an assessment/evaluation, patient must meet the following criteria:

a) Documented diagnosis of a chronic pain condition (e.g., chronic pain, diabetic neuropathy, multiple sclerosis, spinal cord damage, arthritis, spinal degeneration, fibromyalgia) from a licensed medical provider, and/or related medical condition which may contribute to chronic pain
b) The symptoms are severely interfering with multiple areas of the patient's daily life, including emotional, social, vocational/educational and/or task functioning
c) The patient must be able to engage in and participate in consultation or treatment
d) There is a reasonable likelihood the patient will benefit from the services provided

D. Exclusion Criteria

Exclusion criteria within the Mind-Body Pain Management Program are as follows:

1. The patient does not meet admission criteria outlined above
2. The patient does not have adequate supports to maintain safety during treatment

3. The patient is not able to manage his/her own health status and independently take all prescribed medications
4. The patient is abusing alcohol or other substances
5. There is a possibility of acute intoxication or withdrawal or other signs that patient's substance abuse treatment needs are not being adequately addressed (by other programs or providers)
6. Patient exhibits verbal or physical behavior that is threatening or would put others' safety at risk
7. The presence of medical or psychiatric conditions that would prevent the patient from being able to safely engage in, or benefit from, treatment at this level of care. Examples include: Active eating disorder with medical complications; acute or chronic medical problems requiring frequent follow-up or monitoring; active disorganization.
8. The patient is unable to maintain attention and engagement in the treatment process, despite offered supports, treatment, and redirection
9. The patient is on a medication or combination of medications judged by Retreat medical personnel to be interfering with their ability to receive treatment for the underlying condition

E. Continuing Stay Criteria

Once a patient is admitted for treatment, the following criteria are necessary for continuing treatment within the Mind-Body Pain Management Program:

1. Individual's condition continues to meet admission criteria for the Mind-Body Pain Management Program
2. Treatment planning is individualized and appropriate to the individual's needs with realistic and specific goals and objectives stated.
3. All services and treatments are structured to achieve mutually agreed upon results and are delivered at a pace manageable by the patient
4. As chronic pain is an ongoing condition there is not an expectation that treatment will eliminate physical pain. The goal of treatment is to assist the patient in re-engaging in activities that give their life a sense of meaning and purpose, reducing the impact that pain has on their ability to live a meaningful life. Progress is assessed in terms of patient's willingness and ability to engage in specific behaviors related to their values. These values and behaviors are collaboratively identified by the patient and clinician and can change over the course of treatment. A byproduct of treatment may be a decrease in pain related distress (e.g., sleep, mood, relationships) and perception of physical pain.
5. The patient is participating to the extent he/she or they are medically and psychologically capable, with a program that is considered adequate to address the signs and symptoms justifying admission.

Once a patient is accepted for a consultation the following criteria are necessary for additional

consultations within the Mind-Body Pain Management Program

1. Consultations are expected to be one session
2. An additional consultation can take place when the patient and clinician agree that more time is needed for the patient to obtain specific information or learn a specific skill related to ongoing management of their pain
3. There is a reasonable expectation the patient will benefit
4. The patient does not pose a risk to themselves or others

F. Discharge Criteria

Any of the following criteria are sufficient for discharge from treatment:

1. Individual's documented treatment plan goals and objectives have been substantially met.
2. The individual, family, guardian and/or custodian are non-compliant with treatment or in following program rules and regulations.
3. Consent for treatment is withdrawn.
4. Patient is not making progress toward treatment goals and there is no reasonable expectation of progress
5. Patient's safety cannot be reasonably managed
6. Administrative discharge is initiated. Reasons for administrative discharge may include:
    a. Violent or threatening behavior
    b. Endangering staff or co-patient health or wellbeing in any way
    c. Repeated substance use while in treatment
    d. Refusal or inability to adhere to scheduled treatment services
    e. Non-payment of services
    f. Repeated non-attendance of treatment
    g. Other reasons as determined by the treatment team

G. Transfer criteria

Patients in treatment who continue to meet continuing care criteria may be transferred to another program as clinical needs or patient preferences necessitate in consultation with, and agreement of, the treatment team.

Linda Rossi
President and Chief Executive Officer

Karl Jeffries, MD
Chief Medical Officer

Amelia Shillingford, MSN, PMHNP
Interim Chief Nursing Officer

Attachment 2

DBT is a therapeutic method developed by Dr. Marsha Linehan that merges cognitive behavioral approaches and mindfulness to help people develop the skills to control and regulate their emotions. DBT aims to replace problem behaviors with skillful behaviors, to help people experience a range of emotions without necessarily acting on those emotions, to navigate relationships in their environment, and to help people create a life worth living. Dr. Jill Rathus and Dr. Alec Miller adapted Dr. Linehan's method to develop adolescent skills training modules for mindfulness, distress tolerance, emotional regulation, interpersonal effectiveness, and walking the middle path in their text, DBT Skills Manual for Adolescents (2015) New York, NY: Guildford Press. Included in the adaptation are "Eight DBT Assumptions" which provide the framework for helping to build lagging skills. These include:

The things we agree are true for everyone:

- People are doing the best they can.
- People want to improve.
- People need to do better, try harder, and be more motivated to change.
- People may not have caused all of their own problems and they have to solve them anyway.
- The lives of emotionally distressed teenagers and their families are painful as they are currently being lived.
- Teens and families must learn and practice new behaviors in all the different situations in their lives (e.g., home, school, work, neighborhood).
- There is no absolute truth.
- Teens and their families cannot fail in DBT

Admission Criteria:

This intensive PRTF will admit fifteen Vermont youth who:

- Demonstrate symptomatology consistent with a DSM-V diagnosis which requires, and can reasonably be expected to respond to, therapeutic intervention.
- Are experiencing emotional or behavioral problems in the home, community or treatment setting and who are not sufficiently stable either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment.
- Demonstrate a capacity to respond to the milieu programming which includes life skills development, ADLs, emotional and behavioral regulation, and education or school programming.
- Have a history of multiple hospitalizations or other treatment episodes at other levels of care and/or recent inpatient stay with a history of poor treatment adherence or outcome.
- Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs.

- The family situation and functioning levels are such that the youth cannot safely remain in the home environment and receive community-based treatment.
- Are between the ages of twelve (12) and seventeen (17). If the individual is eighteen (18) years of age a variance from the State of Vermont Residential Licensing Unit can be obtained for admission or continued treatment.

Youth who meet following criteria might be denied or deferred admission at this time if:

- The youth exhibits severe suicidal, homicidal or acute mood symptoms/thought disorder, which requires a more intensive level of care.
- Parent, guardian, or youth over the age of fourteen (14) does not *voluntarily* consent to admission or treatment.
- The youth can be safely maintained and effectively treated at a less intensive level of care.
- The youth has medical conditions or impairments that would prevent beneficial utilization of services, or is not stabilized on medications.
- The youth has exhibited recent (within past 6-12 months) sexually reactive or assaultive behavior. The youth will be considered if they have successfully completed a program to address the sexually reactive behavior and have demonstrated decreased risk of offending behavior.
- The youth has exhibited recent (within past 6-12 months) fire-setting behavior that requires specific treatment and intervention. The youth will be considered if they have successfully completed a fire-setting/prevention program and have demonstrated decreased risk of fire-setting behavior.
- The youth had been diagnosed with an eating disorder with medical complications (within the last 6-12 months) that requires a specialized program. The youth will be considered if they have successfully completed a program.

Referrals Process:

Referrals to the program will be submitted through to the Brattleboro Retreat's Admissions Department which is available 7-days a week. Clinical staff will review referrals once we have received the CRC packet and completed Child and Adolescent Residential Services Referral Packet with supporting documentation. The residential clinical team will review complete referrals, determine if there is a need for additional information, complete the interview, and notify the referring agency if the youth has either been accepted or declined within 5 business days. Once the youth is accepted, we will coordinate with the referral agency, youth, parent or guardian to schedule the admission. Part of this admission process includes consent for treatment, consent for medication, and consent to collaborate with the resident's family, guardians, and outpatient team.