

SERVICE CATEGORY: REHABILITATION SERVICES

SERVICE DEFINITION

Service Name	COMMUNITY SUPPORT – MENTAL HEALTH
Funding Source	Behavioral Health
Setting	Community Based – Most frequently provided in the home; not facility or office based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Community Support is a rehabilitative and support service for individuals in the community with a primary mental health diagnosis consistent with a serious and persistent mental illness and who have complex and extensive treatment needs. Community Support Workers provide service coordination and restorative interventions for development of interpersonal, community, coping and independent living skills to maintain wellbeing, community living, and stabilize mental health symptoms.
Service Expectations	<ul style="list-style-type: none"> • A mental health assessment conducted at admission by a licensed, qualified clinician or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information then a mental health assessment addendum would be necessary. The assessment will serve as the treatment plan until the treatment plan can be developed. The addendum should be completed within 30 days of admission. • Clinically appropriate programmatic assessments, as determined necessary, which may include skills inventories, interviews and/or use of other tools for the purpose of identifying treatment and rehabilitation goals and plans with the individual, should be completed within 30 days of admission. • A treatment/rehabilitation/recovery plan developed with the individual, which includes individual strengths and needs, community, family and other supports, measurable goals and specific interventions, and includes a documented discharge and relapse prevention plan. This is completed within 30 days of admission, reviewed, approved and signed by the Clinical Supervisor. • Review the treatment/rehabilitation/recovery and discharge plan with the individual and treatment team, every 90 days, or more often as clinically indicated. Each review should be signed by the individual and members of the treatment team, and at a minimum the Clinical Supervisor or other licensed professional, and community support worker.

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	<ul style="list-style-type: none"> • Provision of active rehabilitation and support interventions with focus on activities of daily living, education/employment, budgeting, medication adherence and self-administration (as appropriate and part of the overall treatment/recovery plan), relapse prevention, social skills, and other independent living skills that enable the individual to reside in the community. • Provide service coordination and case management activities, such as accessing medical, psychiatric, psychopharmacological, psychological, social, education/employment, housing, transportation or other appropriate treatment/support services as well as linkage to other community resources identified in the treatment/rehabilitation/recovery plan. • Develop and implement strategies to encourage the individual’s engagement in necessary mental health treatment services as recommended and included in the treatment/rehabilitation/recovery plan. • Participate with and report to treatment/rehabilitation team on the individual’s progress and response to community support intervention in the areas of relapse prevention, substance use, application of education and skills, and the recovery environment as identified in the plan. • Provide therapeutic support and intervention to the individual in time of crisis and work with the individual to implement the crisis relapse prevention plan. • If hospitalization or residential care is necessary, facilitate, in cooperation with the treatment provider, the individual’s transition back into the community upon discharge. • Face to-face contact a minimum of 3 times per month or 3 total hours of contact • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the client’s ability to demonstrate progress on individual treatment/recovery goals. The amount, duration, and frequency of the service will be documented in the treatment plan.

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Staffing	<ul style="list-style-type: none"> • Clinical Supervision by a licensed professional (APRN, RN, LMHP, PLMHP, LIMHP, Licensed Psychologist, Provisionally Licensed Psychologist) working with the program to provide clinical supervision, consultation and support to community support staff and the individuals they serve. The Clinical Supervisor will review client clinical needs with the worker every 30 days. The review should be completed preferably face to face but phone review is acceptable. The Clinical Supervisor may complete the review in a group setting with more than one worker as long as each client on the worker’s case load is reviewed. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years’ direct care experience in a human service field; two years of training in a human service field; or a bachelor’s degree or higher in psychology, sociology, or related human service field, which is preferred.
Staffing Ratio	Clinical Supervisor to Community Support Worker ratio as needed to meet all clinical supervision responsibilities outlined above. 1:25 Community Support worker to individuals served
Hours of Operation	24/7 Access to service during weekend/evening hours; in times of crisis, access to a mental health professional
Individual Desired Outcome	<ul style="list-style-type: none"> • The individual has substantially met the treatment plan goals and objectives • The precipitating condition and relapse potential is stabilized such that individual’s condition can be managed without this level of professional interventions and external supports • Individual has natural support systems secured to help the individual progress in active recovery and stability in the community • The individual has progressed through stages of change and is willing to engage in treatment at a higher level of care if clinically indicated

UTILIZATION GUIDELINES

COMMUNITY SUPPORT – MENTAL HEALTH

I. Admission Guidelines:

All of the following must be present:

1. DSM (current version) diagnosis consistent with a serious and persistent mental illness; i.e. a primary diagnosis of schizophrenia, major affective disorders, PTSD, OCD or other major mental illness under the current edition of DSM.
2. Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate manner in two of three functional areas.
3. Presence of functional deficits in two of three functional areas: Vocational/education, Social Skills, and Activities of Daily Living.
 - a. Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
 - b. Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
 - c. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in three of five of the following:
 - a) Grooming, hygiene, washing clothes, meeting nutritional needs;
 - b) Care of personal business affairs;
 - c) Transportation and care of residence;
 - d) Procurement of medical, legal, and housing services; or
 - e) Recognition and avoidance of common dangers or hazards to self and possessions.
 - f) Client is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed rehabilitation services are not provided.
4. Symptoms and functional deficits are related to the primary diagnosis.

5. There is an expectation that the client will benefit from rehabilitation treatment.

II. Continued Stay Guidelines:

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

1. The individual continues to meet admission guidelines.
2. The individual does not require a more intensive level of services and no less intensive level of care is appropriate.
3. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
4. The individual is making progress towards rehabilitation goals.