

Community Support (Adult Mental Health)

Definition

Community Support is a rehabilitative and support service for individuals with primary Axis I diagnosis consistent with a serious and persistent mental illness. Community Support Workers provide direct rehabilitation and support services to the individual in the community with the intention of supporting the individual to maintain stable community living, and prevent exacerbation of mental illness and admission to higher levels of care. Service is not provided during the same service delivery hour of other rehabilitation services; with the exception of availability for individuals 30 days prior to discharging from a 24 hour treatment setting.

Policy

Community Support mental health services are available to Medicaid Managed Care eligible adult members, age 21 and over.

Program Requirements

Refer to the “Facility Program Standards” for additional requirements and a brief description of Medicaid Rehabilitation Option (MRO) services.

Licensing/Accreditation

NA

The agency must have written policies and procedures related to:

Refer to the “Standards Common to all Levels of Care” for a potential list of policies generally related to the provision of mental health and substance abuse treatment. Agencies must develop policies to guide the provision of any service in which they engage clients, and to guide their overall administrative function.

Features/Hours

Access to service during weekend/evening hours, or in time of crisis with the support of a mental health professional is required. Services should be available to the person served 24 hours a day, 7 days per week.

Service Expectations

- A diagnostic interview conducted by a licensed, qualified clinician prior to admission
- A bio-psychosocial and strengths-based assessment prior to admission by licensed and credentialed mental health professionals practicing within their scope, with ongoing assessment as needed, or completed by another provider within 12 months prior to the date of admission, approved and updated by the current licensed professional.
- A strengths-based needs assessment completed within 30 days of admission
- A treatment/rehabilitation/recovery plan developed with the individual, integrating individual strengths & needs, considering community, family and other supports, stating measurable goals and specific interventions, that include a documented discharge and relapse prevention plan, completed within 30 days of admission, reviewed, approved and signed by the Clinical Supervisor, or other licensed person.

- Review the treatment/rehabilitation/recovery and discharge plan with treatment team, including the individual, every 90 days, making necessary changes then, or as medically indicated. Each review should be signed by members of the treatment team, at a minimum the Clinical Supervisor, or other licensed person, care staff and client/family..
- Provision of active rehabilitation and support interventions with focus on activities of daily living, education, budgeting, medication compliance 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 their community
- Provide service coordination and case management activities, including coordination or assistance in accessing medical, psychiatric, psychopharmacological, psychological, social, education, housing, transportation or other appropriate treatment/support services as well as linkage to other community services identified in the treatment/rehabilitation/recovery plan
- Develop and implement strategies to encourage the individual to become engaged and remain engaged 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/abuse, application of education and skills, and the recovery environment (areas identified in the plan).
- Provide therapeutic support and intervention to the individual in time of crisis and work with the individual to develop a 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.

Staffing

Clinical Supervision by a licensed person (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 each case plan monthly at a minimum (face-to-face preferable but phone review will be accepted) with the Community Support worker. The Clinical Supervisor will in addition, continually incorporate new rehabilitation information and best practices into the program to assure program effectiveness and viability, and assure quality of rehabilitation clinical records.

For Community Support workers a BS degree or higher in psychology, sociology, or a related human service field is preferred, but two years of course work in a human services field, and two years experience/training with demonstrated skills and competencies in treatment with individuals with a mental health diagnoses is acceptable. All Community Support workers should be educated/trained in rehabilitation and recovery principles.

*Other individuals could provide non-clinical administrative functions.

Staff Ratios

- Clinical Supervisor to Community Support Worker ratio as needed to meet all responsibilities
- 1:20 Community Support worker to individual served

Training

Refer to “Standards Common to all Treatment Services” for a list of potential training topics related to the provision of mental health and substance abuse treatment. Agencies should provide adequate pre-service and ongoing training to enhance the capability of all staff to treat the individuals they serve and provide the maximum levels of safety for themselves and others. All staff must be educated/trained in rehabilitation and recovery principles.

Clinical Documentation

The program shall follow the agency’s written policy and procedures regarding clinical records. The agency’s policies must include specifics about timely record entry by all professionals and paraprofessionals providing services in the program.

The clinical record must provide information that fully discloses the extent and outcome of treatment/rehabilitation services provided to the client. The clinical record must contain sufficient documentation to justify Medicaid Managed Care participation.

The record must be organized with complete legible documents. When reviewing a clinical record, a clinician not familiar with the client or the program must be able to review, understand and evaluate the mental health and substance abuse treatment for the client. The clinical record must record the date, time, and complete name and title of the facilitator of any treatment service provided to the client. All progress notes should contain the name and title of the author of the note.

In order to maintain one complete, organized clinical record for each client served, the agency must have continuous oversight of the condition of the clinical record. The provider shall make the clinical record available upon Medicaid and/or the ASO’s request to review or receive a copy of the complete record. All clinical records must be maintained for seven years following the provision of services.

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 make progress on individual treatment/recovery goals.

Special Procedures

None allowed.

Clinical Guidelines: Community Support – Adult Mental Health

Admission Guidelines:

All of the following must be present:

1. DSM (current version) Axis I diagnosis consistent with a serious and persistent mental illness; i.e. a primary diagnosis of

- schizophrenia, major affective disorder 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:
 - Grooming, hygiene, washing clothes, meeting nutritional needs;
 - Care of personal business affairs;
 - Transportation and care of residence;
 - Procurement of medical, legal, and housing services; or
 - Recognition and avoidance of common dangers or hazards to self and possessions.
 - 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.

Exclusionary Guidelines:

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

1. The individual does not meet DSM (current version) Axis I diagnosis consistent with severe and persistent mental illness.
2. The primary reason for Community Support would be to address non-mental health related needs.
3. The persistent mental illness has not been present for the last 12 months or is not expected to last 12 months or longer.
4. The persistent mental illness does not seriously interfere with the client's ability to function independently in two of three functional areas.
5. The individual is in an inpatient or psychiatric residential rehabilitation setting and is not within 30 days post-admission and 30

- days pre-discharge from these levels of care.
6. The individual is authorized for ACT services.
 7. The individual is a resident of a nursing facility.

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.

Discharge Guidelines:

All of the following are required for discharge from this level of care:

1. Maximum benefit has been achieved and consumer can function independently without extensive support (Deficits in daily living have improved. Deficits in functional areas have improved and now manageable without extensive supports).
2. Rehabilitation goals have been substantially achieved and the consumer can function independent of active supports.
3. Services are primarily monitoring in nature.
4. Sustainability plan for supports is in place.
5. Formal and informal supports have been established.
6. A crisis relapse plan is in place
OR: The individual requests discharge from the service.
OR: The individual is not making progress toward rehabilitation goals despite alterations to the treatment plan and/or increased contacts.
OR: The individual no longer agrees to participate at the necessary level of intensity for rehabilitation