Community Treatment Team – Clinically Supported Living

Program Description

The Community Treatment Team – Clinically Supported Living (CTT – CSL) provides services for individuals aged 18 and older who have chronic and pervasive mental illness. Programs offer structured specialized services for individuals also experiencing hearing loss, traumatic brain injuries, history of self-harm/aggression, persistent suicidal behaviors and/or co-occurring substance use disorders.

CTT – CSL maintains individuals in the least restrictive setting by offering therapeutic interventions to emotional, behavioral and symptom management, independence, and peer and community engagement, while working closely with those providing support in the most-appropriate living environment. The model promotes the engagement of families and other natural supports, with additional referrals and services suggested as indicated.

The treatment team includes a psychiatrist, clinicians, case managers, behavioral specialists, mental health workers, recovery specialists, certified peer specialists and/or registered nurses. Following the provision of CTT – CSL treatment modalities, it is expected that the individual will be better prepared to navigate these important relationships in the community, manage mental health symptoms, and live in a more independent manner.

Goals for the program include:

- Targeting symptom and behavioral stabilization to engage/re-engage involvement with recovery supports through medication management and clinical interventions.
- Empowering service participants to maximize independence while managing behavioral health symptoms and developing skills to attain increased independence and community engagement.
- Facilitating wellness to reduce the use of inpatient behavioral health and medical care.
- Identifying, engaging, and developing recovery capital to support stability.
- Engaging in opportunities and utilizing supports to get back on track when setbacks occur.
- Developing and maintaining a network of natural supports and community connections to provide a social safety net for managing life's challenges.

Scope of Services

Intensity of supports will vary to permit the individual to utilize the level of service required to maintain a consistent degree of functioning in the community setting. All programs offer structured,

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supervised care with an array of clinical, behavioral, and skill building services. Support staff and crisis team are available 24 hours a day, 7 days a week to provide supervision and monitoring, activate crisis intervention and emotional supports, and promote ongoing family contact and community engagement.

CTT – CSL services are tailored to the needs of the individual; as such, length of treatment episode varies considerably from person to person, based on the individual's history, symptom presentation, and desire to commit to services. Reflecting this, the course of treatment is highly customized to the individual's needs and there is no prescribed or targeted length of treatment episode. Supports are available to provide immediate access to and provision of behavioral health services. This model promotes the engagement of families and other natural supports, with additional referrals and services suggested as indicated.

CTT – CSL provides targeted interventions to address a variety of behaviors and symptoms, specifically long-term, persistent symptoms. Therapeutic contacts are scheduled routinely but are flexible to also be arranged on an as-needed basis.

Admissions Criteria

A. A primary DSM-5 diagnosis that results in significant functional and psychosocial impairment; the individual's presentation can be expected to stabilize through the provision of intensive clinical interventions through multiple dimensions that are adjunct to and integrated with the CTT – CSL service.

and

B. Less intensive services have been found or deemed to be insufficient (resulting in increased symptoms or behavioral challenges). Stabilization and transition to a lower level of care cannot be supported with less intensive services based on clinical evidence.

and

C. The individual requires active support to ensure the skills necessary to live safely, participate in self-care and treatment, and manage the symptoms of his/her diagnosis. As a result of the individual's clinical condition, there is a significant risk of one of the following:

1. Hospitalization or other inpatient care as evidenced by the current course of illness or by the past history of illness.

2. Harm to self or others as a result of the behavioral health diagnosis, evidenced by current behavior or past history.

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3. Deterioration in functioning in the absence of supported community-based services that would lead to hospitalization.

4. Loss of housing/disruption of current living environment due to active behavioral health symptomology.

and

D. The individual's own resources and social support systems are inadequate to provide the level of support currently needed, as evidenced by:

1. The individual lacks natural family, social, or institutional support to keep them safe in the community.

2. The individual either has limited support or is unable to use their current relationships to ensure safety; there is heightened risk of disconnection and personal harm or harm to others.

Continued Stay Criteria

A. There is a persistence of symptoms which meet admission criteria.

B. There is a reasonable expectation that withdrawal of this level of care will result in rapid decompensation or the re-occurrence of behaviors which cannot be managed in a less intensive treatment setting.

C. There is evidence that current available alternative resources and social supports do not effectively meet the needs of the person relative to safety, active participation in treatment, supervision, stabilization, recovery, and rehabilitation.

Discharge Criteria

A. The symptoms, functional impairments, and coexisting conditions that necessitated admission or continued stay have diminished in severity, and the person can continue to recover in a less intensive level of care.

B. A viable discharge plan, including a crisis plan, that is based on recovery principles has been developed and shared with the person and their appropriate supports and community resources.

C. The person exhibits behaviors or symptoms that cannot be safely managed in this level of care warranting a referral to a more intensive level of care.