Coordinated Specialty Care Manual

Blue Ridge Behavioral Health

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Contents

Coordinated Specialty Care (CSC)

CSC Manual Online Download as Word .docx Download as PDF

I. Introduction

Coordinated Specialty Care (CSC) is an evidence-based, individual-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have experienced a first episode of psychosis (FEP).

Important Characteristics of Coordinated Specialty Care Treatment Programs:

Emerging Psychosis

CSC programs serve individuals with **emerging psychosis** through a collaborative approach. Individuals appropriate for this service have been diagnosed with a primary psychotic disorder within two years of enrollment. Symptoms such as auditory and visual hallucinations, delusions and thought disorder can create significant disruptions in terms of educational and occupational functioning and relationships with families and the social support network.

Because of the limitations of traditional mental health services, these individuals may not receive services that meet their needs through traditional clinical treatment and are at greater risk of dropping out of services but continuing to need mental healthcare in the future.

Multidisciplinary Approach

CSC services are delivered by a **multidisciplinary group** of mental health staff who work as a team to address the breadth of an individual's needs. One of the fundamental charges of CSC programs is to be

the first-line, if not sole provider, of all the services that the individual needs. Many, if not all, staff share responsibility for addressing the needs of all individuals requiring frequent contact.

Mobility

The CSC team is **mobile** and can deliver services in non-traditional or community locations to promote engagement and flexibility. At least twenty-five percent or more of the services are provided outside of the program offices in locations that are comfortable and convenient for individuals engaged in services.

Time-Limited

CSC services are delivered in a **time-limited** framework of at least two-years and up to five years post-psychosis onset in order to consolidate gains achieved through treatment, aid the process of recovery and ensure continuity of care.

Collaborative

CSC is a **collaborative** approach involving individuals, treatment team members, and when appropriate, relatives, as active participants. CSC emphasizes shared decision-making as a means for addressing the unique needs, preferences, and recovery goals of individuals with . Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with the individual and their family members over time.

CSC teams utilize a shared decision-making collaborative process in which treatment decisions should be made collaboratively between the individuals and their care team and should be based on scientific evidence and individual's values and preferences.

Flexible

CSC teams assist individuals in advancing towards personal goals with a focus on enhancing social functioning and regaining valued roles (e.g. employee, spouse, parent, friend). CSC teams are expected to thoughtfully carry out planned assertive engagement techniques to identify and focus on the individual's life goals and what he or she is motivated to change. CSC teams demonstrate this level of **flexibility** at various levels of engagement throughout the individual's time in the program.

Recovery-Based Philosophy

CSC teams deliver all services according to a **recovery-based** philosophy of care, where the team promotes self-determination, respects the individual as expert in his or her own right, and engages peers in the process of promoting hope that the individual can recover from mental illness and regain meaningful roles and relationships in the community.

II. Definitions

A. Coordinated Specialty Care (CSC) Definition

Coordinated Specialty Care (CSC): A self-contained interdisciplinary team of at least four full-time equivalent staff, and a full-or part-time psychiatric care provider. The CSC team takes a multi-element approach to treating individuals who have experienced a first episode of psychosis. Component interventions include assertive case management, individual or group psychotherapy and resiliency skills training, supported employment and education services, family education and support, peer support, medication management, and primary care coordination.

CSC teams utilize a proactive community education and engagement approach to offering rapid initiation of care and treatments demonstrated effective in promoting recovery in people with . CSC services are individually tailored to respect individual needs and treatment preferences. This is accomplished with each individual through relationship building, individualized assessment and planning, and active involvement with individuals to enable each to find and maintain work in community job, complete educational programs, improve social functioning, better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The CSC team is mobile and delivers services in community locations as applicable rather than expecting the individual to come to the program.

B. CSC Care Coordination Definition

CSC Care Coordination: A process of organization and coordination within the multidisciplinary team to carry out the range of treatment, rehabilitation, and support services each individual expects to receive per his or her written individualized treatment plan and is respectful of the individual's wishes. Care coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

C. Primary Clinician Definition

CSC Primary Clinician: The team member with primary responsibility for establishing and maintaining a therapeutic relationship with the individual in services on a continuing basis, whether the individual is in the hospital, in the community, or involved with other agencies. In addition, the Primary Clinician leads and coordinates the activities of the individual treatment team (ITT). He or she is the responsible team member to be knowledgeable about the individual's life, circumstances, and goals and desires.

Responsibilities

D. CSC Team Leader Definition

CSC Team Leader: The team member with the primary role of managing the program, including monitoring and improving the quality of services and serving as the liaison between the team and the host agency. This individual may take on multiple roles to include outreach and recruitment, assessing and providing needs for family psychoeducation and support, serving as a CSC Primary Clinician, and providing supervision for clinicians, peer support, and supported employment and education staff.

Responsibilities

E. Individual Definition

Individual: The person who has agreed to receive services and is receiving person-centered treatment, rehabilitation, and support services from the CSC team. The individual is a team member role with unique strengths and goals. The individual has responsibilities to the team, including communicating their needs to the treatment team.

F. Individualized Service Plan Definition

Individualized Service Plan (ISP): The culmination of a continuing process involving each individual, his or her family, and the CSC team, which individualizes service activity and intensity to meet individual-specific treatment, rehabilitation, and support needs. The written treatment plan documents the individual's self-determined goals and the services necessary to help the individual achieve them. The plan also delineates the roles and responsibilities of the team members who will carry out the services. The plan is reviewed and updated on a quarterly basis or as needed.

Requirements

G. Clinical Supervision Definition

Clinical Supervision: A systematic process to review each individual's clinical status and to ensure that the individualized services and interventions that team members (including the peer specialist) provide are evidence-based and in line with the CSC model, effective and planned with, purposeful for, and satisfactory to the individual. The team leader and the psychiatric care provider have the responsibility to provide clinical oversight that occurs during organizational staff meetings, treatment planning meetings, and in individual meetings with team members. Clinical supervision also includes review of written documentation (e.g., assessments, treatment plans, progress notes, correspondence).

Requirements

H. Comprehensive Assessment Definition

Comprehensive Assessment: The organized process of gathering and analyzing current and past information with each individual and the family, support system, and/or other significant people to evaluate: 1. Mental and functional status 2. Effectiveness of past treatment 3. current treatment, rehabilitation and support needs to achieve individual goals and support recovery. The results of the information gathering and analysis are used with each individual to establish immediate and longer-term service needs, to set goals, and to develop the first individualized treatment plan.

Requirements

I. Duration of Untreated Psychosis (DUP) Definition

Duration of Untreated Psychosis (DUP): The period from the onset of fully psychotic symptoms to the commencement of appropriate treatment. Research from the National Institute of Mental Health reveals that engaging and providing treatment to young people aged 16 to 25 will reduce the duration of untreated psychosis. This results in improved functioning and medication efficacy, both in the short term and the long term for people diagnosed with non-affective psychotic disorders.

J. Individual Treatment Team (ITT) Definition

Individual Treatment Team (ITT): A group or combination of at least five CSC staff members who fulfill core elements of CSC service. The ITT members are assigned to work with the individual by the team leader by the time of the first treatment planning meeting or thirty days after admission. The core members are the primary clinician, the psychiatric care provider, one supported employment and educational services staff person and the peer support specialist. The supported employment and educational services staff person can provide care coordination and back up services to the primary clinician, if needed.

The individual treatment team has continuous responsibility to:

1. Be knowledgeable about the individual's life, circumstances, goals and desires
2. Collaborate with the individual to develop and write the treatment plan
3. Offer options and choices in the treatment plan

4. Ensure that immediate changes are made as the individual's needs change
5. Advocate for the individual's wishes, rights, and preferences. The ITT is responsible to provide much of the individual's treatment, rehabilitation, and support services. Individual treatment team members are assigned to take separate service roles and individuals can choose which team members to work with depending on their preference and goals.

Roles and Responsibilities

K. Initial Assessment and Person-Centered Individualized Service Plan Definition

Initial Assessment and Person-Centered ISP: The initial evaluation of: 1. The individual's mental and functional status 2. The effectiveness of past treatment 3. The current treatment, rehabilitation, and support service needs. The results of the information gathering and assessment are used to establish the initial service plan to support recovery and help the individual achieve their goals. Completed upon admission, the individual's initial assessment and treatment plan guide team services until the comprehensive assessment and treatment plan are completed.

Requirements

L. Coordinated Specialty Care (CSC) Team Definition

Coordinated Specialty Care Team: A self-contained interdisciplinary team of at least four full-time equivalent clinical staff, and a psychiatric care provider that: 1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses; 2. Minimally refers individuals to outside service providers; 3. Provides services on a long-term care basis with continuity of caregivers over time; 4. Serves no more than 50 individuals per 4.0 FTE staff ratio 5. Delivers 25% or more of the services outside program offices; and 6. Emphasizes flexible engagement and outreach, relationship building, and individualization of services.

M. Medication Management Definition

Medication Management: A collaborative effort between the individual and the Psychiatric Care Provider with the participation of the Individual Treatment Team (ITT) to:

1. Carefully evaluate the individual's previous experience with psychotropic medications and side-effects as well as current feelings about taking medication.
2. Identify and discuss the benefits and risks of psychotropic and other medication utilizing a shared decision-making approach;
3. Choose a medication treatment
4. Establish a method to prescribe and evaluate medication according to evidence-based practice standards.

The goal of medication management is to respect the individual's preferences and work collaboratively to explore which medications work best for individuals to help them achieve their goals.

N. Peer Support Definition

Peer Support: A supportive team member with experience as a recipient of mental health services. Peer specialists draw on common experiences as well as use and share their own practical experiences and knowledge gained as a recipient of mental health services. Peer support is recovery-focused and validates individuals' experiences. It provides guidance and encouragement to individuals to take responsibility and actively participate in their own recovery.

Responsibilities

O. Psychotropic Medication Definition

Psychotropic Medication: any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing or antianxiety agents.

P. Recovery Definition

Recovery: Does not have a single agreed-upon definition. SAMHSA defines recovery as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential (SAMHSA, 2018).

"The overarching message is that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society." (NIH, 1999, p. 97)

Q. Treatment Plan Review Definition

Treatment Plan Review: A thorough, written summary describing the individual's and the treatment team's evaluation of the individual's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services.

R. Treatment Planning Meeting Definition

Treatment Planning Meeting: A regularly scheduled meeting conducted under the supervision of the team leader. The purpose of these meetings is for the staff, as a team, to thoroughly prepare for their work with each individual. The team meets together to present and integrate the information collected through assessment in order to learn as much as possible about the individual's life, their experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each individual and their goals and aspirations; to participate in the ongoing assessment and reformulation of issues/problems; to problem-solve treatment strategies and rehabilitation options; and to fully understand the treatment plan rationale in order to carry out the plan for each individual.

S. Weekly Organizational Staff Meeting Definition

Weekly Organizational Staff Meeting: A staff meeting held at a minimum of once per week, at regularly scheduled times under the direction of the team leader (or designee) to: 1) briefly review the service contacts which occurred and the status of all program individuals; 2) review the service contacts which are scheduled to be completed during the current day and revise as needed; 3) assign staff to carry out needed service activities; and 4) revise treatment plans and plan for emergency and crisis situations as needed.

III. Admission and Discharge Criteria

A. Admission Criteria

1. Diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, other specified schizophrenia spectrum or other psychotic disorder.

    - Affective disorder with psychosis can also be used for admission.
    - Individuals with a sole diagnosis of substance use disorder or intellectual disability will not be eligible for services.
    - Individuals with a co-occurring diagnosis of substance use disorder can be admitted if the substance use is not a determining factor of their psychosis.

    - Individuals with a co-occurring diagnosis of intellectual disability will need to be able to demonstrate understanding of the concepts utilized in the treatment modalities.

2. Individuals must be between the ages of 16-30 with allowable variances between 14-35, although exceptions can be made for individuals who have a diagnosed psychosis before the age of 15.

3. The Duration of Untreated Psychosis (DUP) should be within 24 months

B. Discharge Criteria

Individuals must be discharged when they meet this criteria:

1. The individual has successfully completed the Coordinated Specialty Care (CSC) program.
    - This is usually between two and three years
2. Change in the individual's residence to a location out of the service area
3. The individual chooses to be discharged from the program;
4. Death of the individual
5. The individual is not compliant with services for a period of six months.

IV. Service Intensity and Capacity

A. Staff-to-Individual Ratio

CSC teams shall include a minimum number of employees (counting contractors but not counting the psychiatric care provider and program assistant) to maintain an employee to individual ratio of at least 1:10

B. Staffing Capacity

- A CSC team shall have at least five full-time equivalent clinical employees or contractors (including SEES and peer specialists).
- CSC teams may serve no more than 50 individuals.
- A transition plan shall be required of CSC teams that will allow for "start-up" when newly forming teams are not in full compliance with the CSC model relative to staffing patterns and individuals receiving service capacity.

C. Frequency of Individual Contact

- The CSC team shall have the capacity to provide multiple contacts per week to individuals experiencing severe symptoms or significant problems in daily living, for an aggregate average of three contacts per individual per week.
- Each individual receiving CSC services shall be seen face-to-face by an employee or contractor; or the employee or contractor should attempt to make contact as specified in the ISP.

D. Gradual Admission of Individuals

Each new CSC team shall stagger individual admissions (e.g., 1-3 per month) to gradually buildup capacity.

V. Treatment Team and Staffing Plan

Services are delivered by interdisciplinary teams, and shall include the following positions:

Role	Hours
Team leader	1.0 FTE
Clinical Staff	2.0 FTE
SEES	1.0 FTE
Peer	1.0 FTE
Psychiatric Care Provider	0.2 FTE

Allowable Variances: Nurse, Occupational Therapist, Co-Occurring Substance Use Disorder Specialist

A. Roles and responsibilities

Required Roles

Team Leader Qualifications

One full time licensed mental health professional with at least three years of experience in the provision of mental health services.

Responsibilities

- Overseeing the administrative operations of the team, including monitoring the census.
- Providing clinical oversight of services in conjunction with the psychiatric care provider.
- Serves as the primary contact called on when the individual is in crisis
- Supervising team members to assure the delivery of best and ethical practices
- Modeling behaviors through service provision for the purpose of clinical supervision.
- Serve as a lead clinician who can provide services such as therapy, case managementand crisis intervention to individuals in the community
- Assuming an active role in community outreach, screening referrals, assessing individuals at intake
- Participating in person-centered planning meetings
- Working with individual's natural supports.
- Promote recovery-oriented care among team members

Clinical Staff Qualifications

- Two full time Human Services clinicians who meet qualifications for QMHP-A and QMHP-C at a minimum with at least one year experience in the provision of mental health services to adolescents and/or young adults with serious mental illness.
- Positions may have dual titles and roles. Positions may be titled Primary Therapist, Case Manager, Recovery Coach, or Family Education Specialist.
  Therapeutic Responsibilities
- Providing psychotherapy such as individual, family and group therapy, as identified, to meet treatment needs.

  - Therapeutic interventions will be aimed at restoring the individual's sense of personal wellness, reinforcing coping and resilience and lessening the likelihood of subsequent psychotic episodes and preventing or treating co-occurring disorders.

  - Interventions used such as cognitive behavioral therapy, motivational interviewing or seeking safety will emphasize resilience training, illness and wellness management and coping effectively.
  - provide individual and group evidence-based therapeutic interventions, such as Individual Resiliency Training (IRT) and Cognitive Behavioral Therapy for Psychosis (CBTp).

- Helping individuals clarify goals, cope with stressful situations, interact more effectively with other people, and in general, overcome barriers to their recovery.
- Providing services within a framework that is empowering and cultivates peer support through the use of structured behavioral interventions aimed at learning new skill and supporting behavior change, including social skills training, treatment of substance use disorders, behavioral activation, coping skills training and psychoeducation.
- Providing crisis intervention and management services as well as monitoring and treatment planning for suicide prevention.
- Reduce internalized stigma .
- Support communication between individuals and other team members on topics such as medication concerns.
- Use specific techniques (such as simple, concrete communication and repetition) to help address feelings of ambivalence, problematic substance use, and cognitive challenges.
- May have dual roles providing additional services to include case management, outreach and engagement and family psycho-education.
  Case management Responsibilities
- Serve as the main point of contact for individuals on their caseloads
- Identify risk factors and need for crisis services
- Work with the individual and team to develop the treatment plan
- Provide family support and education for individuals who agree to have families involved in their treatment.
- Support immediate and concrete needs around housing, income, and transportation.

- Support immediate and concrete needs around criminal justice involvement.
- Provide education about and link to available community resources for both children and adults.

- Support individuals outside the office (in the community).
- Coordinate with all treatments and team members.
- Reinforce the messages of other team members and maintain a hopeful recovery-oriented stance.
- Advocate for the individual's wishes, rights, and preferences

Supported Employment Education Specialist (SEES) Qualifications

- One full-time vocational/educational specialist with a minimum of Bachelor's level education and QMHP-A and QMHP-C.
  Responsibilities
- Assisting participants to continue, resume, or adapt their academic or vocational activities successfully.
- Provide direct services to individuals in their area of specialty and provide collaboration and guidance with other team members who can also assist individuals with their self-identified employment goals.
- Employment services would be provided by an IPS supported framework.
- Engages the individual on the topic of school or work, particularly competitive employment, educating them about their opportunities and the benefits of working and school;
- Completes a pre-vocational assessment that is focused on individual's strengths and preferences, and on-the-job assessments, where appropriate;

- Conducts job development, where the vocational specialist builds relationships with local businesses and educates them about the services that the vocational specialist provides, collects information about positions, and ideally determines potential for job carving options
- Facilitates individualized job placement according to individual's preferences, with a focus on competitive employment
- Provides job coaching and ongoing supports, assisting the individual in learning the job skills, navigating the work place, managing work relationships with other employees and supervisor
- Provides benefits counseling directly, as well as connects individuals to experts for more extensive benefits counseling as needed; such as Social Security Administration and development of SSI/SSDI Work Incentives
- Facilitates the Person Centered Planning process for individuals assigned to him or her
- Serves as a consultant and educator to fellow team members on the topic of evidence-based supported employment
- Supports individual with educational goals in terms of high school, college or trade school.
- Works with individuals by attending IEP meetings to provide input and advocate for appropriate accommodations. Work with employers in the community to develop and tailor jobs for individuals
- Help people apply for and initiate jobs
- Provide ongoing advice, coaching and support to individuals in their vocational and educational pursuits

- Help people decide on career paths
- Serve as a liaison between individuals and outside educators or employers to support their functioning in work or school
- Engage people in CSC services

- Support individuals in navigating how much to disclose about their mental health conditions to employers and educators
- Observe individuals in the community and bring that knowledge to the rest of the treatment team

Peer Support Specialists Qualifications

- One full-time equivalent C-PRS or C-PRS eligible, who is willing to become a C-PRS within one year of employment. * Is or has been a recipient of mental health services for severe and persistent mental illness and/or received services for substance related issues.
  Responsibilities
- A fully integrated team member who provides peer support directly to individuals and provides collaboration and guidance to other team members in understanding and supporting individuals' recovery goals.
- Draws on common experiences as well as using and sharing their own practical experiences and knowledge gained as a recipient.
- Validates individuals' experiences and provides guidance and encouragement for individuals to take responsibility and actively participate in their own recovery.
- Provides coaching, mentoring, and consultation to the individual to promote recovery, self-advocacy, and self-direction
- Promotes wellness management strategies, which includes delivering manualized interventions (e.g., Wellness Recovery Action Planning or Illness Management and Recovery)
- Assists individuals in developing psychiatric advance directives if trained and certified
- Models recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience
- Provides consultation to team members to assist in understanding of recovery and the role of the Peer Support Specialists, promoting a culture in which individuals' points of view and preferences are recognized, understood, respected, and integrated into treatment
- Supports and empowers the individual to exercise his or her legal rights within the community

Psychiatric Care Provider Qualifications

- Physician or psychiatric nurse practitioner who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia.
  Responsibilities
- Diagnose, assess, and treat psychiatric conditions, suicidality, medication side effects, and routine health management
- Visit with patients at least monthly and ideally every two weeks for the first 6 months
- Coordinate with the clinic nurse to provide medication and routine health assessments to the participant
- Attend clinical team meetings and participate in a shared-decision-making framework with each participant
- Collaborates with the team leader in sharing overall clinical responsibility for monitoring an individual's psychiatric treatment
- Educates non-medical team members on psychiatric & non-psychiatric medications, their side effects, & health-related conditions
- Provides brief therapy (formal or informal)
- Provides urgent psychiatric consult to team members when available and able prior to team consulting with agency's after-hours and weekends on-call psychiatric care provider. (Note: may be on a rotating basis if other psychiatric care providers who share on-call have access to individual's current status and medical records/current medications)
- Follow evidence-based pharmacologic approaches guide medication selection and dosing for persons with which begins with a low and slow dose approach of a single antipsychotic medication and involves monitoring for psychopathology, side effects, and attitudes towards medication at every visit. Special emphasis should be given to cardiometabolic risk factors such as smoking, weight gain, hypertension, dyslipidemia, and pre-diabetes
- Maintain close contact with primary care providers to assure optimal medical treatment
- Provide comprehensive and continuous evaluation of psychosis and co-occurring behavioral health conditions
- Engage in shared decision making around medication, including providing education and eliciting individuals' and families' needs and goals

Allowable Variances Nursing Staff

Responsibilities

- Manages the medication system in conjunction with the psychiatric care provider, administers and documents medication treatment
- Screens and monitors individuals for medical problems and side effects; Engage in health promotion, prevention, and education activities
- Collaborate with the individual to maximize taking medications as prescribed;
- Communicate and coordinate services with other medical providers
- Educate the team in monitoring psychiatric symptoms and medication side-effects.

Occupational Therapist

Responsibilities

- Provide assessment of participants ADLs and IADLs
- Complete Treatment Plan
- Assist participants with being as independent as possible by helping them make a meal, do things around the house, understand their finances and how to budget.
- Help participants gain confidence with doing things or going places they used to and think about how to spend their time.

B. Staff Training and Supervision Requirements

CSC services shall be provided by a team of individuals who have strong clinical skills, professional qualifications, experience, and competency to provide the range of practices. All team members are expected to receive initial and ongoing training in core and evidence-based practices that support the implementation of ethical, person-centered, high-fidelity CSC practice, as defined in the Addington Fidelity Scale or its successor as approved by DBHDS and SAMSHA.

Additional Training

Each CSC team staff member shall successfully complete the CSC programs jurisdiction's initial trainings as well as CSC specific evidence-based training for specific role on the team as well as understand roles of others on team (ie on Navigate or On TrackNY manuals or in person training).

Broader topics of additional training may include:

- Benefits counseling
- Cognitive behavioral therapy for psychosis
- Critical Time Intervention
- Culturally and Linguistically Appropriate Services (CLAS)
- DHHS Approved Individual Placement and Support- Supported Employment
- Family Psychoeducation
- Functional assessments and psychiatric rehabilitation
- Integrated Dual Disorders Treatment
- Limited English Proficiency (LEP), blind or visually impaired, and deaf and hard of hearing accommodations
- Medication algorithms
- NAMI Psychoeducational trainings
- Psychiatric advanced directives
- Recovery Oriented Systems of Care: policy and practice
- SOAR (SSI/SSDI Outreach, Access and Recovery) Stepping Stones to Recovery
- Permanent Supportive Housing, such as the SAMHSA evidenced based practices toolkit, Housing First: The Pathway's Model to End Homelessness for People with Mental Illness and Addiction, and other evidenced based models
- Trauma-informed care
- Wellness and integrated healthcare
- Wellness management and recovery interventions (includes WRAP, IMR/WMR)
- Supervising VA Certified Peer Recovery Specialists.
- Tenancy Supports

The team leader shall maintain documentation of both supervision and training activities, including cross-training activities.

Clinical Supervision

All team members shall receive ongoing **clinical supervision** from CSC team clinical leadership, with the CSC team leader as the primary clinical supervisor. The majority of team members shall receive scheduled clinical supervision bi-weekly, either in individual or group format. No staff shall go without a supervision session in a given month in accordance with Administrative Publication System Manual 30-01 (APSM).

Clinical Supervision is the provision of guidance, feedback, and training to team members to assure that quality services are provided to individuals (e.g., following evidence-based practices, negotiating ethical quandaries, managing transference and counter transference) and maintaining and facilitating the supervisee's

competence and capability to best serve individuals in an effective manner. Clinical supervision is a critical factor in determining the appropriate acquisition of evidence-based practices by supervised staff.

The following clinical supervision may be delivered within CSC:

1. Meeting as a group (separately from the daily team meeting) or individually to discuss specific clinical cases
2. Field mentoring (e.g., helping staff by going out in the field with them to teach, role model skills, and providing feedback on skills)
3. Reviewing and giving feedback on the specific tools (e.g., the quality of assessments, treatment plans, progress notes) to better capture and document clinical content
4. Didactic teaching and individual and group cross-training
5. Formal in-office individual supervision (includes both impromptu and scheduled supervision).

VI. Program Organization and Communication

A. Hours of Operation and Staff Coverage

Requirements

- CSC teams shall operate a minimum of 8 hours per day, 5 days per week and shall provide services on a case-by-case basis in the evenings and on weekends.
- CSC teams shall provide 24 hour crisis support through team or through Emergency Services Department 365 days a year.
- The CSC team may make crisis services directly available 24 hours a day or may arrange coverage through another crisis services provider if the team coordinates with the crisis services provider daily.

B. Staff Communication and Planning

Requirements

CSC teams shall conduct a weekly organizational meeting at a regularly scheduled time to review the status of all individuals and the outcome of the most recent employee or contractor contact, assign daily and weekly tasks to employees and contractors, revise treatment plans as needed, plan for emergency and crisis situations, and to add service contacts that are identified as needed.

C. Staff Supervision {supervision}

Requirements

Each CSC team should develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. The team leader and psychiatric care provider should assume responsibility for supervising and directing all staff activities.

This supervision and direction should consist of:

1. Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with individuals in regularly scheduled or crisis meetings to assess staff performance, give feedback, and model alternative treatment approaches;
2. Participation with team members in weekly organizational staff meetings and regularly scheduled treatment planning meetings to review and assess staff performance and provide staff direction regarding individual cases;
3. Regular meetings with individual staff to review their work with individuals, assess clinical performance, and give feedback;
4. Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, treatment plans, treatment plan reviews); and
5. Written documentation of all clinical supervision provided to CSC team staff.

D. Crisis Planning

Requirements

- The CSC Team Leader is responsible for developing a crisis plan that details the responsibilities of each team member when an individual reports that they are in crisis.
- The Team Leader is to serve as the main point of contact and primary person to identify when an individual is experiencing a crisis. The individual or other team members may also report risk factors and crisis identification to the Team Leader.

- When a crisis occurs outside of regular working hours, a crisis may be reported to the Emergency Crisis Line or an on-call provider.

VII. Individual-Centered Assessment and Individualized Service

A. Individual-Centered Assessment

Assessment Process

The provider shall solicit the individual's own assessment of their needs, strengths, goals, preferences, and abilities to identify the need for recovery-oriented treatment, rehabilitation, and support services and the status of their environmental supports within the individual's cultural context. Any decision-making regarding treatment involves the individual and their support system whenever possible.

** The provider will collaborate with the individual and assess the following:**

1. Primary and secondary symptoms, course and duration.
2. Psychiatric history, mental status and diagnosis
3. Associated physical conditions
4. Current and past substance use
5. Family and individual history
6. Family and social network, including the current scope and strength of an individual's network of family, peers, friends, and co-workers, and their understanding and expectations of the team's services;
7. Strengths of the individual and his/her support system
8. Education and Employment
9. Social development and functioning including childhood and family history, religious beliefs, leisure interests, and social skills
10. Legal and criminal justice involvement, including guardianship, commitment, representative payee status, and experience as either a victim or an accused person.

B. Individualized Service Planning

Treatment Plan Process

- The treatment plan should be developed in collaboration with the individual served and the support system when feasible and appropriate. Treatment planning is a dynamic process where the individual's needs, strengths and preferences are assessed.
  - The treatment plan should:
    1. Identify individually driven goals and objectives
    2. Set specific measurable long- and short-term goals
    3. Establish the specific approaches and interventions necessary for the individual to meet his or her goals
    4. Identify individual responsible for assisting individual with goals
    5. Clearly outline time frames for completion of goals
    6. Include transition goals and plans
- Staff, the individual and their support network should meet at regularly scheduled times for treatment planning meetings. At each treatment planning meeting all staff should attend, if feasible, including: the team leader, the primary clinician, the supported employment and education specialist and the peer specialist.
- Treatment planning is culturally aware by including interpreters and translation services for the preferred language of individuals and their families and following the individual's values and preferences.

VIII. Required Services

Care Coordination

Each individual will be assigned a case manager who coordinates and monitors the activities of the individual's treatment team and the greater CSC team. Oftentimes this role is fulfilled by clinical staff in the primary clinician role.

Definition

Crisis Assessment and Intervention

The CSC team shall provide mobile crisis assessment, interventions to prevent or resolve potential crisis, and admissions to and discharge from psychiatric hospitals. Team members who are skilled in crisis-intervention procedures shall be available to respond to individuals by telephone. During working hours staff serve as the first point of contact to assist individuals who present in crisis. CSC staff will triage, assess, and review with the individual their safety plan. The CSC team will coordinate any face-to-face contacts needed by individuals with Emergency Services. After hours face to face contacts will be coordinated with the Emergency Services Unit.

Symptom Assessment and Management

This shall include but is not limited to the following:

1. Ongoing comprehensive assessment of the individual's mental illness symptoms, accurate diagnosis, and the individual's response to treatment
2. Psychoeducation regarding mental illness and the effects and side effects of prescribed medications
3. Symptom-management efforts directed to help each individual identify/target the symptoms and occurrence patterns of their mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects
4. Individual supportive therapy
5. Psychotherapy
6. Ongoing support services to individuals, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover

Psychiatric Care

The individual will receive psychiatric medical case management, psychiatric assessment, and treatment.

Roles and Responsibilities

Clinical Treatment

The individual will receive individual and group treatment as defined by clinical staff responsibilities.

This shall include but is not limited to:

1. Engagement (e.g., empathy, reflective listening, rapport- building strategies)
2. Comprehensive Assessment
3. Evaluation of each individual's needs, strengths, preferences to develop an individual centered individualized treatment plan
4. Motivational enhancement (e.g., developing discrepancies, psychoeducation)
5. Active treatment (e.g., cognitive skills training, community reinforcement)

Employment and Education Services

Services to help individuals value, find, and maintain meaningful employment or education in the community.

Including but is not necessarily limited to:

1. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs, in collaboration with a SEES clinician
2. Assessment of the effect of the individual's mental illness on employment with identification of specific behaviors that interfere with the individual's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations
3. Development of an ongoing employment rehabilitation plan to help each individual establish the skills necessary to find and maintain a job
4. Individual supportive therapy to assist individuals to identify and cope with mental illness symptoms that may interfere with their work performance
5. On-the-job or work-related crisis intervention
6. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.
7. Finding, enrolling, and supporting participation in school/training programs

Psychiatric Rehabilitation

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist individuals to gain or use the skills required to:

1. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating; and procuring necessities(such as telephones, furnishings, linens)
2. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry
3. Carry out personal hygiene and grooming tasks, as needed
4. Develop or improve money-management skills
5. Use available transportation
6. Have and effectively use a personal physician and dentist

Social/Interpersonal Relationship and Leisure-Time Skill Training

Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure individuals' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:

1. Improve communication skills, develop assertiveness, and increase self-esteem
2. Develop social skills, increase social experiences, and develop meaningful personal relationships
3. Plan appropriate and productive use of leisure time
4. Relate to landlords, neighbors, and others effectively
5. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

Peer Support Services

Services to validate individuals' experiences and to guide and encourage individuals to take responsibility for and actively participate in their own recovery. In addition, services to help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce individuals' self-imposed stigma:

1. Peer support (e.g. Wellness and Recovery Action Plan-WRAP)

2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery
3. Develop authentic, meaningful relationships with individuals and families through empathy, sharing experiences, listening and collaboration

Psycho-education, Support, and Consultation to Individuals' Families and Other Major Supports

Services provided regularly under this category to individuals' families and other major supports, with individual's agreement or consent, include:

1. Individualized psychoeducation about the individual's illness and the role of the family and other significant people in the therapeutic process
2. Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people
3. Ongoing communication and collaboration, face-to-face and by telephone, between the CSC team and the family (e.g., individualized treatment teams, family meetings)
4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery
5. On-going involvement of the psychiatric care provider with the family
6. Enhancing community integration to promote community adjustment

Program Evaluation and Fidelity Monitoring

CSC teams should be evaluated according to a standardized fidelity measure to evaluate the extent to which defining elements of the program model are being implemented annually. The Addington D - First-Episode Psychosis Services Fidelity Scale (CSCS-FS) (Addington et al, 2016) or The Early Assessment and Support Alliance (EASA) as approved by DBHDS, will be used to evaluate teams. The aim of these evaluations is not only to ensure that the model is being implemented as intended, but also to provide a mechanism for quality improvement feedback and guided consultation.

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