

**DSHS Community Mental Health and Substance Abuse Services
Resiliency and Disease Management
Fidelity Manual – November 2007
II.D Adult Mental Health Programs – Psychosocial Rehabilitation (PSR)**

Overview of the DSHS PSR Model

The DSHS PSR model offers an integrated therapeutic team whose training and low caseload allows extensive linking, advocating and delivery of broad-based rehabilitative services. PSR staff are trained to provide PSR training and supports including coordination services, essential supported housing and Co-Occurring Psychiatric and Substance use Disorders (COPSD) supports as needed by individuals. The intensity of the supports available will vary among individuals. Within the team framework individuals are provided medications and individual and family education according to the Texas Implementation of Medication Algorithms (TIMA). As resources allow, a subset of individuals will receive supported employment services by a supported employment specialist on the team. After the period of intensive supported employment services and supports by the supported employment specialist, they will receive supported employment follow-along from their therapeutic team. PSR services enable the members of the therapeutic team to turn traditional case management activities into rehabilitation opportunities thereby teaching the individual how to be their own case manager.

Necessary principal diagnosis for receiving PSR:

- Schizophrenia and Related Disorders, or
- Bipolar Disorder, or
- Major Depressive Disorder with psychotic features, and
- Global Assessment of Functioning (GAF) rating of less than 50 at intake.

Overview of the PSR Fidelity Scale

This fidelity scale is intended to measure the extent of and faithfulness of implementation of the evidence-based elements of PSR which include TIMA, integrated co-occurring psychiatric and substance use disorders (COPSD) treatment, rehabilitation, peer support, supported housing, and supported employment. It is expected that the fidelity scale and its supporting documentation will be used as a training tool that expands upon didactic presentations and furthers practical understanding of an integrated PSR model and its appropriate implementation. The scale thus serves as an implementation guide and ideally is also used internally as part of the quality monitoring system. It also provides a common tool for validation of fidelity by external reviewers.

Elements of the Fidelity Scale

The Primary Provider Services and Staff Training sections are organizational or team measures. The remaining sections are based either on the individual or if across all individuals receiving the service model the primary information source will be encounter data.

- A. Teams and Services
- B. Staff Training
- C. Community Integration and Highly Individualized Services
- D. Assertive Approach
- E. Emphasis on Supported Employment/Housing Services
- F. Criminal Justice
- G. Co-Occurring Psychiatric and Substance Abuse Disorders (COPSD) Services
- H. Family Support and Education

The sections include the essential elements of PSR agreed upon by a workgroup consisting of DSHS staff and representatives from community mental health centers. The group further divided some of the essential elements into sub-elements for the purpose of mapping levels of adherence to PSR and making the fidelity rating system practical and useful.

How Items are Rated

The PSR fidelity review instrument consists of 34 items which are to be rated individually on a yes/no scale with "1" denoting no or minimal implementation of the services, and "5" reflecting a faithful implementation.

Rapid Review Process

A subgroup of the fidelity review elements will be reviewed as a part of the Rapid Review process. Some of the elements, designated by gray fill and (RR) on the Fidelity Instrument, are items to be reviewed as a part of the Rapid Review process. The Rapid Review process has been developed to serve as both a readiness measure and to ensure that critical structural elements remain in compliance on an ongoing basis. The Rapid Review Instrument is a self-assessment checklist designed to be administered by LMHA/MMCO quality management staff with assistance from provider staff. All internal and external providers of each service model should be assessed. Provider staff most familiar with the service should complete a checklist for each service model. The LMHA/MMCO staff will collect the provider checklist to compile the aggregate results. The Rapid Review rating scales will consist of "Yes" for current practice or "No" for not evident; the five point likert-type scale will not be used. The results will be used both internally and externally to monitor structural adherence to the service model. The Rapid Review process may involve different elements over time, allowing for a more complete picture of service. The rapid review elements will be evaluated until readiness is achieved. Both state and local authorities will use fidelity data to improve internal processes and compliance.

Sources of Information

Information used in rating elements is obtained from clinical record reviews, observations made through site visits, Human Resource records, policies and procedures, organizational charts, supervision notes, program descriptions, on-call logs, encounter data, and interviews with individuals, staff and/or other providers. Many elements are scored using multiple sources of data and information.

Information sources may include:

- Record review - a sample of records is selected randomly and each record is individually reviewed and an aggregate score obtained by simple average.
- Interview - a sample of appropriate persons to interview is selected, responses are individually rated and an aggregate score obtained by simple average.
- Combination of records and interviews - scores may be reported separately or averaged to get a final score.
- Policies and procedures - requirements related to new employee orientation, requisite staff training, credentialing, recruitment, hiring
- Encounter data
- Organizational charts - scope of authority and lines of supervision
- Other documentation - human resource records, job descriptions, staff training records

When scoring records or interviewing individuals, family members, or staff; information is gathered that covers a specific time period as measured backwards in time from the review date. The sample should consist of individuals receiving PSR services and the staff who provided those services within the last 3 months. Reviews not involving interviews or individual records are scored as to their status at the time of the review. This allows for progress in implementation and corrections of systemic problems to be reflected in subsequent review in a reasonable time frame.

PSR Fidelity Review Protocol

A. Teams and Services

The items in this section are the essential structure and process elements of PSR that ensure that appropriate resources and processes are implemented. The elements reflect the importance of the interdisciplinary team, leadership, communication, training, recovery, range of services, and individual participation.

Element #1 – Caseload

Definition: Caseload size should not exceed a individual to staff ratio of 30:1

Rationale: The small caseload size helps the team provide most services with minimal referrals to other mental health programs or providers.

Sources of Information: Human resource records, staff training records, job description, interviews

Scoring Item: [Yes (5) or No (1)]

- 1.) The individual/clinician ratio exceeds 30:1.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) The individual/clinician ratio is 30:1 or less

Element #2 – Therapeutic Teams (Rapid Review)

Definition: Interdisciplinary teams include at a minimum PSR staff, a registered nurse, psychiatrist, employment specialist, and supported housing specialist. Therapeutic Teams are assigned a group of individuals but all team members may not necessarily work with each individual.

Rationale: To measure the interdisciplinary team's composition and ensure delivery of program services by full range of professional expertise. The Therapeutic Treatment Team shares responsibility for each individual, each clinician contributes expertise as appropriate. The team approach ensures continuity of care and allows for services to be individually tailored to each individual.

Sources of Information: Program description, team roster, human resource records, and interviews.

Scoring Item: [Yes (5) or No (1)]

- 1.) Team does not consist of all necessary members
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) Team consists of all necessary members.

Element #3 – Therapeutic Team Meeting (Rapid Review)

Definition: Communication among team members is for the purpose of creative planning, problem solving, sharing knowledge of resources and information, cross training, systematic consultation and support of the team members. Possible topics for discussion include, but are not limited to clinical highlights, challenging issues for individuals, crisis planning, and treatment changes. Communication may be accomplished via teleconference, televideo, or a communication log in which important events or occurrences related to individuals are documented for the purpose of sharing the information with other team members.

Rationale: To measure the frequency and modality of the teams' communication, problem solving, training and consultation among its members.

Sources of Information: Team meeting notes, interviews, observation

Item Scoring: [Yes (5) or No (1)]

- 1.) There is not regularly documented team meetings or other documented opportunities for intra-team consultation
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) There is at least one documented team meeting a week.

Element #4 - Team Leader Qualifications (RAPID REVIEW)

Definition: Team Leaders are at least a Qualified Mental Health Professionals-Community Services (QMHP-CS) with at least three years of experience working with people with severe and persistent mental illness (SPMI).

Rationale: The Team Leader must have a clear understanding of the problems and symptoms associated with severe and persistent mental illnesses.

Sources of Information: Human resource records and interviews, job description

Scoring: [Yes (5) or No (1)]

- 1.) Team Leaders are not QMHP-CSs and/or do not have at least three years experience with people with SPMI.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) 100% of Team Leaders are QMHP-CSs with at least three years of experience working with people with SPMI.

Element #5 - Team Leaders Duties

Definition: Team Leaders duties include monitoring individual services, assigning case loads, and ensuring that services are delivered according to treatment plans and service package guidelines for persons being served on their team. The Team Leader ensures cross-functional knowledge by all treatment team members of persons being served. The Team Leader encourages the development of staff in clinical and resource expertise by ensuring the occurrence of periodic treatment team meetings, by ensuring the occurrence of periodic clinical supervision meetings and by ensuring the participation of the designated team psychiatrist in treatment team meetings and clinical consultations. Team Leader duties also include facilitation of the process of identifying areas of improvement which would result in improved individual outcomes and implementing processes to ensure the attainment of those goals.

Rationale: To ensure that the Team Leader job descriptions and job evaluation outline important areas of responsibility and accountability for PSR. Team Leader is vital in maintaining effective team communication, reliance on internal and external expertise and ensure that team members receive adequate support and guidance

Sources of Information: Human resource records such as job descriptions, job evaluations, and team member interviews, team meeting minutes, supervisory logs

Scoring: [Yes (5) or No (1)]

- 1.) Team Leaders do not demonstrate adequate performance of leadership duties.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) Team Leaders demonstrate adequate performance of leadership duties.

Element #6 – Staff Coverage (Rapid Review)

Definition: The PSR team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services 24 hours a day, seven days a week as needed.

Rationale: Flexibility, accessibility, and timeliness of service delivery are reflected in the team's ability to provide needed support and rehabilitation to individuals and their natural support system on evenings and weekends as needed, based on the consumers' needs and on an individual-by-individual basis. The individual consumer may have immediate needs not considered "a crisis"; such services are those deemed necessary to prevent a crisis situation or to prevent hospitalization.

Information Sources: Encounter data, on call records, staffing schedules

Item Scoring: [Yes (5) or No (1)]

- 1.) There is not documented evidence that staff is available to provide service on evenings and weekends as needed.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) There is documented evidence that staff is available to provide service on evenings and weekends as needed.

Element #7 – Registered Nurse on the Team (Rapid Review)

Definition: Registered Nurse as team member. Prior to delivering services, the registered nurse must receive training on episodes of acute symptomology and the nature of severe psychiatric illness. This team member may provide services to individuals in other service packages.

Rationale: Registered Nurse to provide medication management, health assessment, guidance, and quality assurance to respond to the medical needs that accompany individuals who are vulnerable to the cyclical episodes of acute symptomatology and low cognitive functioning.

Information Sources: Human Resources records, staff training records, encounter data, job description

Item Scoring: [Yes (5) or No (1)]

- 1.) There is not a Registered Nurse on the team with required training.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) There is a Registered Nurse on the team with required training.

Element #8 – Supported Employment Specialist on the Team (Rapid Review)

Definition: The PSR team includes at least one FTE who has received training and competency in vocational rehabilitation and employment support. Supported employment services result in community employment in regular jobs, with non-disabled coworkers. A staff member may provide other services in addition to assisting individual with employment needs. (Supported employment specialists who work at agencies authorized to offer PSR services may provide services to individuals in other services packages.)

Rationale: Supported employment services require specialized knowledge of vocational rehabilitation and employment strategies.

Information Sources: Human Resources records, staff training records

Item Scoring: [Yes (5) or No (1)]

- 1.) There is no staff with supported employment training and competency.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) There is at least one FTE team member with supported employment training and competency.

Element #9 – Supported Housing Specialist on the Team (Rapid Review)

Definition: Team includes at least one FTE with expertise in housing issues, linkage with landlords, public housing, and Section 8 resources. It is the team's responsibility to provide individuals supported housing services without outside referrals. A staff member may provide other services in addition to assisting individual with housing needs. (Supported housing specialists who work at agencies authorized to offer PSR services may provide services to individuals in other services packages.)

Rationale: Supported housing services require specialized knowledge of housing issues and services.

Information Sources: Human Resources records, staff training records

Item Scoring: [Yes (5) or No (1)]

- 1.) There is not any team member with housing competency.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) There is at least one FTE team member with housing competency.

Element #10 – Peer Provider Participation (Rapid Review)

Definition: Peer providers are fully integrated PSR employees who provide individualized services and supports. Peer providers are a catalyst to improving individual engagement and retention.

Rationale: The organization recognizes the value of having experiential knowledge tied to the services provided and to the individual receiving those services. To measure the extent to which peer provider positions are implemented in PSR programs.

Information Sources: Clinical record, team roster, program description, job description, meeting logs, and interviews

Item Scoring: [Yes (5) or No (1)]

- 1.) The PSR team does not have a paid peer provider(s) involved in treatment planning and service delivery.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) The PSR team has a paid peer provider(s) involved in treatment planning and service delivery.

B. Staff Training

PSR teams require adequate numbers of staff members with sufficient individual competence to carry out the array of services and to establish quality supportive relationships with individuals.

Element #11 – Critical Staff Training (Rapid Review)

Definition: Staff providing PSR services are trained prior to delivering services and receive subsequent refresher training. Training must include competency measures in PSR, rehabilitation, Co-Occurring Psychiatric and Substance Abuse Disorders, the Patient and Family Education Program, assessment and treatment planning, uniform assessment, cultural competency, recovery model, stages of change, Utilization Management Guidelines, and Resiliency and Disease Management.

Rationale: To measure the training of PSR team members. PSR teams require competence to carry out the array of services.

Information Sources: Human resources data, staff training records

Item Scoring: [Yes (5) or No (1)]

- 1.) PSR team members did not receive initial training and a refresher (as applicable).
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) All of the PSR team members received initial training and a refresher (as applicable).

Element #12 – Staff Development and Supervision

Definition: The following staff development strategies and supervision are used to ensure that all staff achieve and maintain the competency needed to provide services. Implementation of this requirement is demonstrated by experienced supervisors holding regular supervision conferences with the PSR team, staff with limited experience are paired with mentors, and the organization establishes a functioning system to increase levels of staff knowledge and competence. Each PSR team shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. Other creative strategies are also implemented to increase staff competency.

Rationale: To measure the training of PSR staff (rehabilitative case managers), the expertise of supervisory staff, the mentoring of less experienced staff and the effectiveness of the provider's ongoing training initiatives.

Scoring minimum: Strategies are used to increase staff competency.

Information Sources: resources data, staff training records, team meeting minutes, supervisory notes

Item Scoring: [Yes (5) or No (1)]

- 1.) There is not evidence of supervision, mentoring, and other staff development strategies.
- 2.) N/A

- 3.) N/A
- 4.) N/A
- 5.) There is evidence of supervision, mentoring, and other staff development strategies.

C. Community Integration and Highly Individualized Services

Treatment plans, developed with the individual, are based on individual strengths and needs, hopes and desires. The plans are modified as needed through an ongoing assessment and goal setting process. Services are provided within the community settings, such as: a person's home and neighborhood, local restaurants, parks and nearby stores. Coordination services assist individuals in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Services are delivered in-vivo with a limited amount of provider office-based services. The PSR team uses rehabilitation opportunities and/or supportive interventions to teach the individual how to be their own case manager and will help further their independent functioning in the community. Rehabilitation occurs in-vivo and promotes community integration, increases community tenure, and maintains the individual's quality of life. Service includes but is not limited to: activities and training to address the illness or symptom-related problems and behaviors that preclude an individual's function in living, learning, and working environments. Initially, PSR team members deliver as much of the "help" as possible with minimal referrals and then gradually replace the "help" they offer with natural supports and community resources. The length of services is indeterminate and expected to be ongoing although the intensity, at any point in time, may vary.

Element #13 – Initial Provider Assessment and Treatment Plan

Definition: An initial provider assessment and treatment plan must be completed a team member who is at least a QMHP, preferably the Team Leader or psychiatrist. Provider assessment and treatment planning should include participation by designated team members.

Rationale: To assess mental status, psychiatric history and to provide an accurate diagnosis from those listed in the American Psychiatric Association's DSM IV and then to effectively plan with the individual and the individual's family the best treatment approach to eliminate or reduce symptomatology.

Information Sources: Encounter data, clinical records

Item Scoring: [Yes (5) or No (1)]

- 1.) The individual's initial provider assessment and treatment plan are not completed by the Team Leader or psychiatrist, or a team member who is at least a QMHP.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) The individual's initial provider assessment and treatment plan are completed by the Team Leader or psychiatrist, or a team member who is at least a QMHP.

Element #14 –Treatment Services Provided to PSR Individuals (Needs-based)

Definition: The treatment plan addresses the individual's mental health service needs as determined by the Adult-TRAG, and specific needs identified by the individual. Individuals identified as needing PSR services will be prioritized for medications, individual and family education and psychosocial rehabilitative services which may include COPSD treatment, coordination services, rehabilitation, peer support, and supported housing. Supported Employment will be available for a limited number of persons in need of and desiring to work. The provision of services is directly related to the goals and objectives provided in the treatment plan.

Rationale: To measure the extent to which the team members assess and address the full range of individual needs as identified in the treatment plan.

Recovery oriented services are provided based on needs identified in the TRAG and goals determined in collaboration with the individual.

Information Sources: Clinical records, support and treatment plans

Item Scoring: [Yes (5) or No (1)]

- 1.) The individual's full range of needs was not addressed in the treatment plan.
- 2.) N/A
- 3.) N/A

- 4.) N/A
- 5.) The individual's full range of needs was addressed in the treatment plan.

Element #15 – In-vivo Service Delivery

Definition: Psychosocial rehabilitative services are provided in the individual's natural-environment. These services are provided within the community settings, such as a person's home and neighborhood, local restaurants, parks and nearby stores. The PSR team uses rehabilitation methods and/or supportive interventions to teach the individual how to be their own case manager. Exceptions to in-vivo service delivery include medication services and groups. Service time will be used to determine percentage of in-vivo service delivery.

Rationale: Individuals experience greater attainment and generalization of rehabilitation provided in their natural environment. A more accurate assessment of individuals and service delivery is more easily accomplished in a natural setting.

Information Sources: Progress notes and encounter data

Item Scoring: [Yes (5) or No (1)]

- 1.) The individual received less than 70% of services in-vivo.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) The individual received at least 70% of services in-vivo.

Element #16- Recovery Orientation in Service Delivery

Definition: Recovery can be defined as the overarching message that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily of 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. Recovery is a process by which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that persons with the most severe mental illnesses can lead productive and satisfying lives and that having hope plays an integral role in an individual's recovery.

Rationale: To measure the degree to which treatment is focused on increasing an individual's ability to live, work, learn and participate fully in their community, on facilitating and maintaining recovery, and on building resilience, not just on managing symptoms.

Information Sources: Clinical record review for evidence of recovery with emphasis on the individual's achievement of positive outcomes such as finding a job or a safe affordable house.

Item Scoring: [Yes (5) or No (1)]

- 1.) No evidence of recovery in treatment planning and service delivery for each individual.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) There is evidence of recovery in treatment planning and service delivery for each individual.

Element #17 – Training Methods

Definition: Effective training methods are the specific techniques staff will employ with individuals during training sessions. Rehabilitation is taught through a combination of techniques such as: modeling and demonstration, role playing, practicing in a simulated situation, positive and corrective feedback, homework assignments, and repetition. Effective strategies include: defining the skill to be taught, breaking the skill down into components, emphasis of training on behavioral rehearsal, level of training (e.g., rate of presentation, size of components, rate of repetition) geared to the individual, minimize demands on cognitive capacity as needed (e.g., handouts, have individuals describe what they will do before role play/rehearsal), shaping the new behavior by reinforcing successive approximations, and prompting and reinforcing the desired behavior in natural environment. Discussion and didactic teaching in isolation of other techniques are not effective strategies.

Rationale: Learning is enhanced with the purposeful and individualized application of proven training techniques and strategies.

- Instructions – Directions for how an action, behavior, method, or task is to be accomplished
- Modeling – A physical demonstration of a desired outcome
- Role-play or rehearsal – The attempt by an individual to place themselves in the position of another, or as themselves, and deal with unfamiliar circumstances, and through such an experience increase their understanding of, either the role they have adopted or the circumstances they face, or both.
- Positive feedback and shaping – Information given by staff to the individual that provides either an honest assessment of a job well-done, or a helpful assessment of how the job could have been done better.
- Repetition of role-plays or rehearsal – Repetition of an action

Information Sources: clinical records

Item Scoring: [Yes (5) or No (1)]

- 1.) Less than 3 different rehabilitation methods are described in at least 75% of an individual's progress notes.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) At least 3 different rehabilitation methods are described in at least 75% of an individual's progress notes.

Element #18 – Rehabilitation Curriculum (Rapid Review)

Definition: Staff uses a rehabilitation-based training curriculum that provides a structured approach to systematically teach individuals specific behaviors and skills. Rehabilitation is taught through the use of methods described in #17 above.

Rationale: The use of established curriculum increases the probability that staff will utilize proven training techniques and strategies.

Information Sources: Training curriculum present at service delivery sites and staff offices, training curriculum used for staff training.

Item Scoring: [Yes (5) or No (1)]

- 1.) Training curriculum is not in use.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) Training curriculum utilizing proven techniques and strategies is in use.

Element #19 – Service Intensity

Definition: Service intensity refers to the frequency of various service contacts with the individual. Service intensity reflects active engagement strategies to reach out to individuals, the provision of supports and life management training at a frequency sufficient for the individual's functional impairments, and the provision of medical services at a frequency that ensures adequate assessment of treatment response or side effects and encourages adherence to effective medication regimens. High intensity service is provided as needed with **an average of 8.6 hours per month** across all individuals on the PSR team. There is active engagement to reach out to individuals, to provide supports and rehabilitation on a frequent and intense level to assist individual in symptom reduction and increased functioning.

Rationale: Services should be provided at a high level of intensity to ensure individuals receive services sufficient to support progress towards recovery.

Information Sources: Encounter data, billing data, and progress notes.

Item Scoring: [Yes (5) or No (1)]

- 1.) The team does not provide **an average of 8.6 hours** a month across all individuals on the PSR team.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) The team provides **an average of 8.6 hours** a month across all individuals on the PSR team.

E. Assertive Approach

PSR staff members are pro-active with individuals, assisting them to participate in and continue treatment, live independently, and focus on recovery.

Element #20 –Crisis Availability (Rapid Review)

Definition: Team members are available by phone for after-hours/crisis services predominantly in consulting role. Individuals have 24-hour, 7 days per week access to therapeutic team members who have familiarity and a relationship with the individual. This requires a system by the LMHA/MMCO through which the PSR team is notified of all crisis calls from a PSR individual.

Rationale: To measure the degree to which therapeutic team members are available to provide 24-hour emergency services for individuals.

Information Sources: On-call logs, crisis documentation in individual records, encounter data, and interviews.

Item Scoring: [Yes (5) or No (1)]

- 1.) For each individual in crisis, a PSR team member did not respond at least by telephone in a consulting role.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) For each individual in crisis, a PSR team member responded at least by telephone in a consulting role.

Element #21 – Responsibility for hospital admission

Definition: PSR team members coordinate or are involved in all hospital admissions decisions. This involvement should occur for both local and state hospitalizations. The LMHA should also keep community collaboration with EMS, the local police department, collaterals (i.e., family, community), and hospital/ER personnel regarding notifications of an individual's hospitalization. Follow-up with the individual while hospitalized is a combined effort of the local authority staff and team members. Communication regarding hospital admission may include face-to-face, telephone, or e-mail.

Rationale: To measure the degree of team involvement when individuals are in referral situations or being admitted and/or discharged from a hospital.

Information Sources: Clinical records

Item Scoring: [Yes (5) or No (1)]

- 1.) The PSR team did not coordinate or have involvement in the individual's hospital admission(s).
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) The PSR team did coordinate or have involvement in the individual's hospital admission(s).

Element #22 – Responsibility for hospital discharge planning

Definition: Activities designed to ensure uninterrupted services are provided to PSR individuals by team members, especially during a transition between service types (e.g., referral situations, hospital admission and discharge). Follow-up with the individual while hospitalized is a combined effort of the local authority staff and team members.

Rationale: To measure the degree of team involvement when individuals are in referral situations or being admitted and/or discharged from a hospital.

Information Sources: Clinical records, treatment plans

Item Scoring: [Yes (5) or No (1)]

- 1.) The PSR team did not participate in an individual's discharge planning.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) The PSR team participated in an individual's hospital discharge planning.

F. Emphasis on Supported Employment/Housing Expectations

As symptoms lessen and concentration improves; and as the individual begins to express some interest or need for employment, supported employment services are provided. The PSR team directly provides employment services by actively assisting the person served to find, obtain, and maintain employment opportunities in community-based sites that are consistent with their recovery goals, values and preferences. The team will also offer long-term supports that will assist individuals in keeping employment and/or finding another job as necessary. Services are for individuals that have significant functional impairments or increased symptoms but who have stabilized to the point where they are able to fully participate and benefit from intensive specialized vocational services. The team encourages all individuals to participate in community employment and provides many vocational rehabilitation services directly.

Integrated Supported Housing is defined as normal, ordinary living arrangements typical of what is available to the general population. Integration is achieved when individuals with serious mental illness choose ordinary, typical housing units that are located among units for individuals who do not have mental illness. Housing without supports or services is not Supported Housing.

Supported Employment and Supported Housing are provided by team member(s) who has competency in housing/employment services.

Element #23 – Benefits Planning

Definition: Supported employment services include providing information about how employment might impact SSA benefits.

Rationale: Lack of understanding about the impact of employment on Social Security is a major factor affecting people's choices about work.

Information Source: Clinical records

Item Scoring: [Yes (5) or No (1)]

- 1.) There is no documentation reflecting discussion or understanding of SSA benefits and employment for the individual with an assessed need.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) There is documentation reflecting discussion or understanding of SSA benefits and employment for the individual with an assessed need.

Element #24 – Zero Exclusion Criteria (Rapid Review)

Definition: There are no eligibility exclusions for individuals with a history of substance abuse, violent behavior, or impaired intellectual functioning. As symptoms lessen and concentration improves, as the individual begins to express some interest or need in employment, the vocation plan becomes the primary means of structuring time and activities, encouraging and engaging the individual in obtaining employment. This service is provided to the extent resources are available.

Rationale: This service is intended for people with very significant disabilities. No one should be ineligible for the service because of their disability or the challenges they may present to service providers.

Information Sources: Interviews, program description, and clinical record

Item Scoring: [Yes (5) or No (1)]

- 1.) There are treatment exclusion criteria in effect for an individual with an assessed need.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) There are not any treatment exclusion criteria in effect for an individual with an assessed need.

Element #25 – Rapid Job Search for Competitive Job is Used

Definition: Individuals are assisted in finding jobs by making contacts with employers. A individual's first contact with an employer about a competitive job is within 3 months of authorization of employment services.

Rationale: Jobs are not secured by training to look for jobs, but are secured instead by actually looking for jobs. Supported employment should not involve long term training or preparation prior to job search.

Information Source: Clinical records

Item Scoring: [Yes (5) or No (1)]

- 1.) The individual's first contact with an employer about a competitive job is not within 3 months of the authorization of employment services.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) The individual's first contact with an employer about a competitive job is within 3 months of the authorization of employment services.

Element #26– Individualized Job Search

Definition: Employer contacts by the employment specialist are based on individual's job preferences, needs and abilities, rather than the available job market.

Rationale: To ensure employer contacts based on individual preference, skills, needs, and abilities.

Information Source: Clinical records, encounter data

Item Scoring: [Yes (5) or No (1)]

- 1.) Job contacts are not based on the individual's preferences, needs and abilities.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) Job contacts are based on the individual's preferences, needs and abilities.

Element #27 – Vocational Interventions

Definition: Vocational interventions include a range of activities that assist individuals in choosing, getting and keeping employment. The interventions include career goal development, job and social life management training, support on and off the job site, job development and employer relations, coping skills, and work-related crisis interventions.

Rationale: To measure the extent to which the full array of vocational activities have been provided for individuals in supported employment or clinical documentation must indicate why individual did not receive services.

Information Source: Clinical records, encounter data

Item Scoring: [Yes (5) or No (1)]

- 1.) A full array of vocational activities was not provided to the individual with an assessed need.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) A full array of vocational activities was provided to the individual with an assessed need.

Element #28 – Self- Sufficiency Plans

Definition: The PSR team has mechanisms in place to insure that temporary rental assistance recipients make applications for Section 8, public housing or has a plan to increase personal income making housing affordable without assistance.

Rationale: This element measures the adequacy of the Plan for Self-Sufficiency for those people with temporary rental assistance or other financial subsidies. The reviewer must see clear documentation of provider activities to develop a Plan for Self-Sufficiency. When the Public Housing Authority is not accepting applications, a self-sufficient plan is still needed.

Item Scoring:

- 1.) A Plan for Self-Sufficiency addressing housing is not evident for the individual with an assessed need.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) A Plan for Self-Sufficiency addressing housing is evident for the individual with an assessed need.

F. Criminal Justice

The PSR team addresses the needs of individuals with criminal justice involvement, ensures the provision of services that support mental health recovery and address problems that could lead to negative legal involvement, including re-arrest. It is important to understand the circumstances that led up to an arrest and incorporate this understanding into the individualized treatment plan. Because of the stigma attached to criminal history and mental illness, there will be special challenges in obtaining and maintaining housing, employment and benefits. Successful community integration is driven by the successful implementation of an integrated treatment plan combining a variety of interventions to address the individual's clinical and legal circumstances. The PSR team must contain at least one member who has the competency to address the special needs of persons who have a criminal history, or who have been incarcerated, or who are at risk of entering the criminal justice system. The team will coordinate services with law enforcement entities such as probation, parole, and the courts as necessary.

Element # 29 – Linkage with Law Enforcement

Definition: The team addresses the needs of individuals with criminal justice involvement, ensures the provision of services that support mental health recovery and address problems that could lead to negative legal involvement, including re-arrest. For each individual who is assessed with criminal justice needs, the team helps the individual to overcome the stigma attached to arrest and/or incarceration, addresses their special clinical and legal needs, and promotes appropriate coordination with criminal justice agencies. The team will ensure linkage with law enforcement entities such as probation, parole, and the courts as necessary.

Rationale: This element supports the coordination of mental health and legal interventions and enhances the development of the individual's personal accountability in addressing their mental health needs and legal responsibilities.

Information Source: Clinical records, encounter data

Item Scoring: [Yes (5) or No (1)]

- 1.) There is no documented evidence of coordinated interventions and collaboration among the individual, the team and applicable law enforcement entities.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) There is documented evidence of coordinated interventions and collaboration among the individual, the team and applicable law enforcement entities.

G. Co-Occurring Psychiatric and Substance Abuse Disorders (COPSD) Services

The PSR Team addresses both psychiatric and substance abuse disorder needs and ensure the effective and coordinated provision of services to individuals with COPSD.

Element #30 – Integrated Treatment Plan

Definition: For each individual assessed and diagnosed with COPSD, there is an individualized integrated treatment plan. (Both mental illness and substance use disorders are addressed).

Rationale: This item requires that both disorders be addressed simultaneously in treatment.

Information Sources: Interviews with the program staff and clinicians; clinical records.

Item Scoring: [Yes (5) or No (1)]

- 1.) There is not an integrated treatment plan for the individual assessed and diagnosed with COPSD.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) There is an integrated treatment plan for the individual assessed and diagnosed with COPSD.

Element #31 – Stage-Wise Interventions

Definition: COPSD treatment is consistent with the individual's stage of change (Prochaska, J. & DiClemente, C., 1992: precontemplation, contemplation, preparation, action, maintenance, relapse). The Stages of Change model shows that, for most persons, a change in behavior occurs gradually, with the individual moving from being uninterested, unaware or unwilling to make a change (pre-contemplation), to considering a change (contemplation), to deciding and preparing to make a change. Genuine, determined action is then taken and, over time, attempts to maintain the new behavior occur. Relapses are almost inevitable and become part of the process of working toward life-long change. The stages of change are:

- Pre-contemplation (Not yet acknowledging that there is a problem behavior that needs to be changed). Education and treatment models: Locus of Control, Health Belief Model, and Motivational Interviewing.
- Contemplation (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change). Education/ treatment models: Health Belief Model, and Motivational Interviewing.
- Preparation/Determination (Getting ready to change) Education/treatment model: Problem solving, cause and effect relationships, the recovery process.
- Action/Willpower (Changing behavior) Education/treatment model: Psychosocial Rehabilitative services, 12-Step Program
- Maintenance (Maintaining the behavior change) Education/treatment model: 12-Step Program
- Relapse (Returning to older behaviors and abandoning the new changes) Education/treatment model: 12-Step Program, Motivational Interviewing.

Rationale: This item required person-centered treatment whereby services match the individual's level of readiness to participate and benefit from services.

Information Sources: Interviews with clinical supervisor, clinicians, individuals; clinical records

Item Scoring: [Yes (5) or No (1)]

- 1.) Treatment does not reflect the individual's stage of change.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) Treatment reflects the individual's stage of change.

Element #32 – Self-help Liaison

Definition: Clinicians show attempts to engage individuals with COPSD in community-based substance appropriate self-help programs, such as Alcoholics Anonymous, Narcotics Anonymous, Double Trouble or Dual Recovery.

Rationale: This item supports the development of the individual's community support network.

Information Sources: Interviews with the program director/coordinator, clinicians and individuals; clinical records

Item Scoring: [Yes (5) or No (1)]

- 1.) Evidence indicates attempts were not made to engage the individual in self-help programs.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) Evidence indicates attempts were made to engage the individual in self-help programs.

Element #33 – Secondary Intervention for Treatment Non-Responders

Definition: Individuals who are not responding to COPSD treatment are identified, evaluated and offered appropriate secondary interventions. Secondary interventions might include arranging supervised housing, intensive family interventions, and residential treatment.

Rationale: This item requires an ongoing monitoring of treatment and a change to more beneficial treatment options.

Information Sources: Interviews with the team leader, clinicians and individuals; clinical records

Item Scoring: [Yes (5) or No (1)]

- 1.) The treatment non-responder was not identified, evaluated, and offered alternative interventions.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) The treatment non-responder was identified, evaluated, and linked to alternative interventions.

H. Family Support and Education

With active involvement of the individual, PSR staff work to include the individual's community support systems (e.g., family, significant others, landlords, employers) as a part of PSR services. Individuals and their support network are taught about mental illness and the skills needed to better manage their illnesses and their lives. It is often necessary to help improve family relationships in order to reduce conflicts and increase individual autonomy. These services may include:

- individualized education about the individual's illness and the support system's role in the therapeutic process,
- intervention skills to assist the individual,
- on-going communication and collaboration between PSR staff and the support network,
- referrals to support programs and advocacy organizations, and
- assistance to individuals with children (e.g., parenting training, counseling, and assistance in restoring relationship with children not in the individual's custody).

Element #34 – Work with Support System

Definition: The PSR team provides frequent support and education for the support network (e.g., family, significant others, church, AA, local clubs, support groups, school groups, landlords, employers) of each individual.

Rationale: To determine if the individual's support network received education and support in accordance with the individual's desires and needs identified in the treatment plan.

Information Sources: Clinical records, individual/family interviews, treatment plans, encounter data

Item Scoring: [Yes (5) or No (1)]

- 1.) Documentation does not indicate the support network was engaged in treatment or documentation does not indicate an individual's preference for support network involvement.
- 2.) N/A
- 3.) N/A
- 4.) N/A
- 5.) There is documentation that the PSR team has made attempts to engage the individual's support network or that the individual refused.

Reference:

**Program for Assertive Community Treatment - http://www.nami.org/Template.cfm?Section=ACT-TA_Center
Criminal Justice/Mental Health Consensus Project, coordinated by the Council of State Governments –
<http://consensusproject.org/mhcp/Navigating-MHC-Maze.pdf>
<http://gainscenter.samhsa.gov/html/resources/publications.asp>**