CSP Structure/Guide/Fidelity Items

Community Support Program (CSP) consists of mental health and substance abuse rehabilitation services and supports necessary to assist the individual in achieving and maintaining the highest degree of independent functioning. The service utilizes a team approach to provide intensive, rehabilitative community support, crisis intervention, group and individual psycho-education, and skill building for activities of daily living.

CSP includes a comprehensive array of rehabilitation services most of which are provided in non-office settings (50% in the community) by a mobile team. Services are focused on skill building with a goal of maximizing independence. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to his/her living environment. The team services and interventions are highly individualized and tailored to the needs and preferences of the individual.

CSP services focus on building and maintaining a therapeutic relationship with the individual while delivering rehabilitative, skill building interventions and activities, facilitating connections to the individual's community recovery supports, providing access to a Certified Peer Support Specialist (AU certified) who is specially trained and can provide effective self-help strategies and expertise through their lived experience, targeted case management (TCM) and emphasizing the individual's choices, goals and recovery path.

Fidelity Scale Item #	Notes
Domain 1 -Staffing	
#1 Certified Recovery Support Specialist	Need to be AU certified; if not certified by AU, score = 1
#2 CSP Team Availability	These hours should be listed on your agency's CSP Member Handbook and Brochure; CSP team operates at least 10 hrs./day, 5 days/week; available for scheduled evening/weekend appointments as needed. Teams should ensure that CSP individuals are aware of these hours. Agencies do not need to staff their clinics for additional hours with secretaries, clinicians and other staff to meet this requirement. CSP staff working the extended hours can be in the community meeting with individuals, looking for individuals that are missing or not yet engaged, and/or doing paperwork at another location (not home).
# 3 of FTE's	Capacity/20 =expected # of FTE's.
# 4 CSP Team Meetings	These meetings could be ½ hour in length and are often called "morning meetings". It may be that not all staff can be at all of these meetings, given the extended hours' schedule. These meetings can take place by conference call. These meetings are different than group supervision meetings. The agenda for these routine weekly meetings can include daily update on current individual issues, week in review, weekend or emergency individual's concerns, daily schedules, and case presentations. The agenda is generally around supporting each other and working in concert. The CSP team must meet together at least 2 times weekly in order to meet fidelity for this item.
# 5 Supervision	In order to meet CSP requirement each CSP staff member should receive over 2.5 hours of supervision monthly (could be a mix of individual /group) Supervision: **Basic Principles**: 1. Supervision focuses on the counselor* and not on the individual, 2. It occurs within the relationship between the counselor and the supervisor,

	3. It asks the questions, "what does the counselor want/need and how can I, as the supervisor, help", 4. It addresses obstacles and roadblocks that may be hampering the relationship between the counselor and the individual, 5. It addresses models, techniques, and implementation of the evidence-based practices endorsed by the agency, 6. It defines and supports ethical practices, 7 .It clarifies and supports training initiatives, and 8. It builds on the strength of the counselor. * Counselor is broadly defined as a staff member who works directly with individuals in a helping or support role. He/she can be a licensed mental health professional, a recovery specialist, case manager, residential counselor, etc. Reviewers will ask for a supervision log or other documentation (e.g., agendas) during the fidelity review that shows evidence of the frequency and content of the individual and group sessions.
Domain 2 – Service Intensity & Location	Program Supervisors should have access and review the EDW Reports (Service Utilization and Location, Service Intensity (Client Contacts) Reports are available quarterly. Expectation is 55% staff productivity. FTE ~ 20.6 hrs. /week F2F client contact.
#6 CSP In-vivo services	At least 50% of total face-to-face service hours occur in the community.(Source: EDW report-Service Utilization and Location-Community)
# 7 Clients with 0 F2F contacts	Expected # of clients enrolled for entire quarter receiving 0 services meet the benchmark (less than 7%). (Source: EDW report-Service Intensity report (Client Contacts)- (Clients with 0 F2F contacts). Program staff with access to EDW can click on the hyperlink where the number is designated to access a list of the clients that did not have any contacts.
# 8 CSP Capacity	Program served at least the number of CSP clients that their contracted/agreed upon capacity indicates. (Source: EDW report- Service Utilization and Location -Capacity/Undup. clients). This report captures individuals that were admitted and discharged throughout the quarter.
# 9 CSP Overall Hours/Staff Productivity	Program delivered at least the expected number of face-to-face CSP service hours overall that their contracted/agreed upon capacity indicates. (FTE~37.5 hours x 55% productivity=20.63 hours per FTE X # of FTES's x 12 weeks(quarter) =expected hours per quarter) (Source: EDW report: Service Utilization and Location report)- Total Face-to Face(rehab/TCM) Svc Hrs hours
Domain 3 – Documentation, Treatment Planning	
#10 &11 Functional Assessment	**Admission** -full FA (DMHAS approved) . The frequency should be upon admission (within 90 days) or more often based on changing needs and/or establishment of a new rehab goal). If using the DLA-20, please include the Self Advocacy/Rights domain. The full FA's Functional skills assessments need to be fully completed and accurate which include: 1) LOAs completed; 2) Summary page and integrated summary included on full FA's. In terms of the functional assessment (FA) update, there is flexibility in how

	this can be accomplished. There is an optional DMHAS FA Update template on the DMHAS website. Two of the Champions developed alternative FA Update templates that you can use. The FA update could be an expanded progress note that documents in some detail the updated FA assessment information and how that links to the updated treatment/recovery plan. In addition, you could document on the recovery plan review that the FA was reviewed/updated to inform the recovery plan update. The charts reviewed during a fidelity review must show evidence of this.
# 12-15 Individualized Recovery Plan (IRP)	Goals in IRP are recovery life goals and in the client's own words • Each client has an IRP with the following structure: 1) target dates for objectives 2) identified persons/positions assigned to action steps; 3) frequency, intensity and duration of interventions 4) inclusion of person in recovery and natural supports, as appropriate • Each client has an IRP with the following content-related pieces: 1) Identification of strengths & barriers (including from FA); 2) Objectives are measurable; 3) Skill-building language is used in some interventions 4) TCM is included, if needed • Each recovery plan is reviewed & updated every 90 days **** If any of the subcomponents of these items are missing in all charts reviewed, the rating will be a one "1" for the relevant fidelity scale items.**
# 16 Encounter Notes	Encounter noted should follow the GIRP format (**G**oal/Objective, **I**ntervention, **R**esponse, **P**lan (what the next steps will be). Notes should show evidence that the "G/O" for goal/objective should reference back to the IRP and not for the "goal for the day". Encounter notes should include: 1) interventions relate to goals & objectives in IRP; 2) Interventions written in behavioral terms specifying teaching, coaching, cueing, etc.; 4) date, start/end time 5) location of service; 6) staff sign, date & credentials. If staff are documenting a lot of notes for a specific goal/objective and it is not on the IRP they should be updating the IRP earlier than the 90 day requirement.
Domain 4 –Interventions	
# 17 Stages of Change	Stage of change is assessed and interventions are appropriately matched. Charts should show evidence of stagewise services and staff should be able to articulate appropriate matching strategies. See chart below on next page:

Stages of Change	Stage of Tx	Interventions
Precontemplation Does not see substance use or mental health issue as a problem, is unwilling to change, or feels unable to change.	Engagement	* Develop a working-together relationship * Remain positive and optimistic * Remember that engagement does not equate to enabling* Use *Motivational Interviewing* to **Express Empathy** and **Establish Personal Goals *** Provide practical assistance * Reduce harmful consequences * Provide outreach if necessary *Listen for ambivalence about problem behavior * Reflect individual's statements of the downside of problem behavior * Learn how individual's experiences life now and how this is different from hopes and aspirations *Increase awareness of the problem* Express benefits of change* Don't push treatment *
Contemplation Has become aware that substance use/mental health issue is a problem and is ambivalent about change	Persuasion	*Individual's will think a lot and say a lot, but may not do a lot * Be aware that individuals are weighing the pros and cons of problem behavior* Avoid the **Righting Reflex** by not offering advice or correcting misperceptions * Use *Motivational Interviewing* for **Developing Discrepancy** between problem behavior and individual's goals/values * Provide information about substance use/mental health and benefits of treatment * Use individual MI, Persuasion Groups, and Family interventions * Use *Motivational Interviewing* to **Support Self-efficacy,** to **Avoid Arguments,** and **Roll with the Resistance *** Assure individual that ambivalence is normal * Use Decisional Balance worksheet *
Preparation Made the decision to change soon and is developing a growing commitment to change.	Persuasion	* Use *Motivational Interviewing* to **Support Self-efficacy** * Teach about alcohol, drugs, mental health, activities that promote health and wellness * Improve social support * Refer to therapy, self-help groups * Offer skills training/CBT * Reach out and support families * Encourage commitment to change * Generate a plan and set-up action goals * Support small steps toward change to "test the waters" * Reinforce small successes and problem-solve ways to handle difficulties that arise *
Action Attempts change by implementing a plan. Problem behavior is decreased or stopped for 1 to 180 days.	Active Treatment	* Verbally reinforce efforts and celebrate action steps * Use *Motivational Interviewing* to **Support Self-Efficacy** * Link new behaviors with positive outcomes you see * Teach new skills such as drug-refusal skills, identifying and managing triggers and cravings, mental health symptom management skills, social skills, stress management, wellness * Expand support to self-help/mutual support groups, peer supports and substance-free social and wellness activities * Encourage lifestyle changes to support recovery and gain meaningful activity * Attend Active Treatment Group.
Maintenance Committed to change, uses strategies and has not had problem behavior for 6 months	Relapse Prevention	*Develop a Relapse Prevention plan to deal with people, places, and things that trigger cravings * Develop *Illness Management and Recovery(IMR)* plan and/or *Wellness Recovery Action Plan (WRAP)* to relieve difficult feelings and maintain wellness and/or encourage use of other recovery tools including workbooks such as *Pathways to Recovery* and *A Mindfulness-Based Stress Reduction Workbook* * Attend Relapse Prevention and/or symptom management and/or wellness groups * Participate in self-help/mutual support groups * Expand meaningful activity * Develop new goals to enhance quality of life * Help maintain awareness that substance use/mental health relapse can occur * Discourage over-confidence * Empathize with feelings about slips/lapses and reframe as opportunity to learn, be stronger, cope better * Teach CBT/Coping Skills

# 18 Skill-Building Interventions	Staff should routinely use skills lists, skill-builder toolkits and curricula to guide skill-building interventions. Documentation should show evidence of skill building language i.e. **Teaching, Coaching , Assisting, Prompting/prompted ,Cuing, Role-played, Modeled**, etc.
# 19 Mutual Support Groups	Examples of assertive linkage to mutual support groups include: staff attend with individual for 1st time, find sponsor/group, 12-step facilitation curriculum used, role play first meeting, debrief experiences. Mutual support is a purposeful gathering of individuals with a shared lived experience or condition intended to offer caring support and share practical coping strategies (e.g., AA, NA, Double Trouble in Recovery (DTR), Dual Recovery Anonymous (DRA)). Charts should show evidence of this.
# 20 Wellness/ Recovery Groups	These are usually more structured interactive experiences intended to promote health and well-being: Stress management, meditation, yoga, smoking cessation, exercise. WRAP, Recovery Pathways & Intentional Peer Support are recovery groups that offer a structured program led by individuals who have first undergone training. Charts should show evidence of this.
#21 and # 22 Family/Natural Support Involvement	•Family" is broadly defined to include all natural support persons (e.g., significant other, friend, sponsor, religious affiliation etc.) •Family Group requirement: 12 times per year requirement (or at least 3 times per quarter; could be weekly). • Concerning family involvement: Team has regular contact with family members(natural supports) of at least 50% of individuals. (This is based on the whole CSP caseload.) CSP individuals that have some type of family involvement in CSP services/recovery process and briefly what that involvement looks like (e.g., attending a tx plan meeting; be added to the recovery plan to assist with a certain goal/objective…to do a certain intervention; regular contact with the CSP staff member etc.) This list is also an opportunity to meet the Family Group requirement by documenting which families attend the family group.

Updated: 3/23/17

CSP Fidelity Review Process

There will be five main parts to the fidelity scale review process:

1. Entry meeting with CSP program/agency leadership (30mins.)
2. Interview with CSP team or a sample of the team. (45mins.)
3. Focus group with individuals enrolled in the program. Ideally, this would include about 6-10 CSP individuals. (45 mins.)

4. Chart reviews (**5**-active) across different staff on the team. It is expected that at least some of the charts will have documentation of family involvement, inclusion of mutual support groups, and recovery/wellness groups. (2 hours)

5. Exit interview with leadership. This will be an opportunity for the reviewers to ask any remaining questions and give preliminary feedback. (30 mins.)

The reviews will take at least 4 hours. Your reviewers may ask for some materials before the visit to facilitate the process. For example, they **may** request the chart review material (e.g., 2 fully completed yearly FAs, 2 FA updates, Recovery plan, Recovery plan updates, Encounter Notes for 5 individuals etc.).

Items your program should have prepared for the visit:

- Team meeting schedule
- Supervision schedule and log
- Skill-builder toolkit (i.e curricula, lists, resources etc.)
- 5 Charts as described above
- Schedules of brochure, skill-building groups, recovery/wellness groups, and mutual support groups
- Family/Natural Support group agendas/attendance log
- Documentation showing percentage of clients with families/natural support person(s) that are engaged with the team(e.g., attending a tx plan meeting; be added to the recovery plan to assist with a certain goal/objective…to do a certain intervention; regular contact with the CSP staff member etc.)

Please note: To achieve full fidelity each domain must score a "4" or above.