



## Mid-Valley Behavioral Care Network

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### *Memorandum*

**To: Quality Managers and Integration Group**

**From: Kathy Savicki**

**Date: April 6, 2010**

**Subject: COD Chart Review**

Spring is the time for the COD chart review again this year. Given everybody's workload, I want you to have lots of time, so am asking that this be completed and **SCORES returned to BCN by MAY 31.** There are no changes from last time, so I hope the materials below provide everything you need. Please let me know if you have questions, or if you haven't done this before, or if you can't get it done by the end of May.

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### **CHART REVIEW PROTOCOL**

***A. Select 10 charts opened since July 1, 2009, from each separate program in your agency, in which Co-Occurring Disorders were identified at assessment. Select charts from as many staff as possible. If after initial screening the cases do not involve Co-Occurring Disorders, increase the sample so that you have 10 COD files to review.***

***B. Use this protocol for rating the items:***

#### **CO-OCCURRING DISORDERS FIDELITY SCALE PROTOCOL (BCN adaptation of Dartmouth Dual Diagnosis Fidelity Scale)**

How items are rated. Each item on the COD Fidelity Scale is rated on a 5-point rating scale ranging from 1 ("Not Implemented") to 5 ("Fully Implemented"). The standards used for establishing the anchors for the "fully-implemented" ratings were determined through a variety of expert sources, as well as empirically-based research (Drake et al., 2001; Mueser & Fox, 2001).

What is rated. The COD Fidelity Scale is rated on current behavior and activities, not planned or intended behavior. For example, if there is a vacancy for a substance abuse counselor, it is not enough that the clinic is currently hiring in order to get full credit for that item.

**BCN will use the information to map region wide needs for training and technical assistance. We are not treating this as an 'audit' or a 'report card', but as a quality improvement tool for Integration Group use and to assist with agency assessment of clinical training needs.**

## **FIDELITY SCALE PROTOCOL: ITEM DEFINITIONS AND SCORING**

### **1. Integrated Assessment of COD Clients**

**Definition:** *Integration* refers to the evaluation of how one disorder influences the other disorder, suggesting possible avenues of treatment (e.g., a client with poor social skills uses substances in social situations to meet interpersonal needs; someone with schizophrenia smokes cannabis to relax, but it worsens his paranoia and risk of relapse; client has repeatedly left CD treatment as depression worsens with sobriety). This is likely to show up in the clinical formulation, or in the ASAM assessment summary.

### **2. Integrated Treatment Plan**

**Definition:** Treatment plans for COD clients address both mental health and substance abuse treatment needs, with both specificity and integration of treatment recommendations. Specificity refers to treatment recommendations that identify both the target of the intervention (e.g., specific symptoms, social problems, substance abuse behaviors) and an intervention designed to address that problem and how it will bring about changes. Integration refers to treatment recommendations that address the interactions between substance abuse and mental illness. One example of such integration is helping clients to cope with psychiatric symptoms that appear to contribute to their substance use. Another example is providing psychoeducation to clients to help them understand how substance abuse worsens their psychiatric illness. A third example: providing symptom management for depression for client in CD treatment.

### **3. Motivation-Based Treatment**

**Definition:** Use of specific interventions based on an evaluation of the client's motivation to address and work on substance abuse or mental health problems. Stages of change are reflected in the understanding that a therapeutic alliance must be established before attempting to address substance abuse or mental health issues. Following establishing such a relationship attention is paid to helping clients understand the effects of substance use/mental health problems on their lives, and motivating them to address these issues. Then, attention turns to recovery planning and, and finally to relapse prevention.

### **4. Reducing Negative Consequences**

**Definition:** Because chronic co-occurring disorders have such detrimental effects for people, and treatment is often a lengthy process, it can be helpful to use strategies to reduce negative consequences. These are particularly important early in the course of COD treatment. Efforts are made to directly reduce the negative consequences of substance abuse using methods other than substance use reduction itself. Typical negative consequences of substance abuse that are the focus of intervention include physical effects (e.g., medical disease, triggering mental illness relapses, prostitution involving unsafe sex), social effects (e.g., loss of family support, victimization), self-care and independent functioning (e.g., housing instability, incarceration, malnutrition), and use of substances in unsafe situations (e.g., driving while intoxicated). Examples of strategies designed to reduce negative consequences include: needle exchange programs, teaching safe sex practice, supporting clients who switch to less harmful substances, providing support to families, helping clients avoid high-risk situations for victimization, securing housing that recognizes clients' ongoing substance abuse problems, and maintaining psychotropic medications even when the person is using. The key to this strategy is supporting incremental change at a pace that keeps the consumer engaged.

**C. Score each chart using this scale. Show results for each chart on Table D.**

<b>Question</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
1. Integrated Assessment of COD Clients	One disorder assessed with some specificity and the other disorder not assessed	Both disorders assessed, with good specificity of one disorder	Both disorders assessed with good specificity but no integration	Both disorders assessed with good specificity and integration is mentioned	Both disorders assessed with specificity and integration points to initial treatment strategies
2. Integrated Treatment Plan	One disorder addressed in treatment plan	Both disorders addressed in treatment plan	Both disorders addressed in plan, but plan lacks specificity and integration	Both disorders are addressed in plan, plus good specificity	Both disorders addressed in plan, plus good specificity and integration
3. Motivation-Based Treatment for COD Clients	Interventions contrary to client's motivational stage	Some (< 40%) interventions are consistent with clients' motivational stage	Many (40-59%) interventions consistent with motivational stage	Most (60-79%) interventions consistent with motivational stage	Most (80% or more) interventions consistent with motivational stage and <i>explicitly</i> reflect stages of treatment
4. Reducing Negative Consequences	Clients who continue to use substances are refused services	No awareness of this principle reflected in chart notes, though continued substance use is 'tolerated'	Chart shows little awareness of principle, although some interventions are consistent with it	Chart shows some implementation of strategies consistent with this philosophy	Chart shows routine implementation of strategies consistent with this philosophy

**D. Score individual charts**

<b>CHART #</b>		<b>Integrated Assessment</b>	<b>Integrated Tx Plan</b>	<b>Motivation-Based Treatment</b>	<b>Reducing Negative Consequences</b>
<b>Scoring</b>	Staff Initial*	Score 1-5	Score 1-5	Score 1-5	Score 1-5
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
<b>Average Score</b>					

\*Staff initials are for supervisory use. Please note for your own later use any system, policy, program structure or clinical practice issues unrelated to clinical competencies that contribute to low scores.

E-mail Gwen (gfrancy@mvbcn.org) or fax (503-585-4989) your average score for each of the four items **BY May 31**.

Questions: address to Kathy at 585-4985, or [kathys@mvbcn.org](mailto:kathys@mvbcn.org)