COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CLINICAL RECORDS BULLETIN

Edition 2009-01

Program Support Bureau
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Announcements

The **Benefits Assessment Tool** is a quick glance at where the client is in the benefits establishment process and is designed to assist in increasing the number of clients enrolled in benefits. The form is completed on-line; however, it should be printed out and placed in both the client's clinical record (sequentially in the Administrative Section) and in the client's financial folder. The clinical snapshot section of the form should be completed once a clinician is familiar with the client; it is a non-billable function. Any questions on the **Benefits Assessment Tool** should be directed to the Revenue Management Division at RevenueManagement@dmh.lacounty.gov.

REVISIONS TO ADULT INITIAL ASSESSMENT AND ALL ADULT CO-OCCURRING DISORDERS FORMS

Revised Forms Available on Internet

(http://dmh.lacounty.gov/Forms.asp—see Co-Occurring Disorders)

DMH Official Form Usage

Directly Operated Clinics: *must* use these forms, when applicable, in their original format.
Contractors: *must* use these forms, when applicable, without alteration in their original format.

In conjunction with the Office of the Medical Director and the DMH COD Coordinators, the forms associated with the 9 Point Module for Co-Occurring Disorders have been revised to assist clinicians in identifying the link between a client's mental health diagnosis and his/her substance use/abuse. Additionally, the forms have been revised to assist clinicians in being able to provide brief COD interventions based on this documented link. When used appropriately, the forms assist in lowering the risk of Medi-Cal disallowance.

Below outlines the flow, purpose, use, and key revisions of the adult co-occurring disorders forms and their associated documents.

Step One: MH 659 Co-Occurring Joint Action Council (COJAC) Screening Instrument (New Form)

Purpose: The primary document to screen for substance use/abuse and determine if a full COD Assessment should be completed.

Use: Used in conjunction with the Adult Initial Assessment (during an initial face-to-face assessment contact). The questions on the form can be integrated into the Adult Initial Assessment. Prompts added to the Adult Initial Assessment reference this form and direct the clinician to whether or not the full COD Assessment should be completed.

Used by: This form must be completed by a clinician eligible to complete the Adult Initial Assessment.

DO YOU KNOW THE ANSWERS TO THESE QUESTIONS?

1. Which of the following is NOT a required form for Contract Providers?
   A. MH 636 Client Care Coordination Plan (CCCP)
   B. MH 515 Progress Note
   C. MH 500 Consent for Services
   D. MH 224 Client Face Sheet

Answers on the last page

Step Two: MH 532 Adult Initial Assessment (Revised Form)

Purpose: This required Assessment form is used to document assessment information and establish Medical Necessity and Clinical Interventions.

Use: Used upon intake of a new adult client

Used By: Licensed or registered and waivered PhD/PsyD, licensed or registered/waivered LCSW & MFT, Licensed RN, Certified NP or CNS, MD/DO, or students of these disciplines with co-signature (this listing of disciplines is also referred to as LPHA)

Revisions:

- Removed detailed substance use/abuse questions and replaced with references to COJAC screening instrument to prevent clinicians from having to complete detailed substance use/abuse information if it is not relevant.
- Added a question regarding the impact of substance use on mental health which is vital to supporting Medi-Cal reimbursement; the answer to this question can be pulled from the COD Assessment sections regarding benefits and costs.
- Added prompts on Page 1, Section III Part A and Page 5, Section IX Part I regarding impairments in daily functioning to ensure information vital to supporting Medi-Cal reimbursement is documented.

Step Three: MH 633 Supplemental COD Assessment (Revised Form)

Purpose: To assess substance use/abuse, family history of use, previous treatment, benefits of use, costs of use, and readiness for change. By completing this form, clinicians will be able to determine the impact of substance use/abuse on the mental health of a client and to evaluate what treatment goals are most appropriate (based on mental health behaviors and items identified in the benefits/costs section of the form).

Use: Whenever "yes" is checked for either question 1 or 2a on Section VI Substance Use/Abuse of the Adult Initial Assessment

Used by: Any staff

Revisions:

- Moved detailed substance use/abuse information from Adult Initial Assessment to this form
- This form should be filed separately in the COD section of the client's chart
- Added benefit/costs questions to allow for ease in making the link between Mental Health and Substance Use and treatment planning/goal setting
- Added Readiness for Change to assist in identifying appropriate brief interventions

Step Four: Complete COD interventions on the CCCP (Use MH 636)

Purpose: Goals and interventions are required on the CCCP in order to get reimbursed by Medi-Cal for any service provided. There must be substance use/abuse interventions listed on the CCCP in order to support any of these types of interventions.

OVERALL PURPOSE OF THE COD FORMS PROCESS

While substance use/abuse is not an included mental health diagnosis and cannot be the principle mental health diagnosis of a DMH Medi-Cal client, many DMH clients are severely impacted by their substance use/abuse which increases or compounds mental health symptoms/behaviors. Because of this, it is important to recognize the impact of substance use/abuse on a client's included mental health diagnosis when treating him/her. The Adult COD forms are designed to assist clinicians in gathering important information regarding a client's substance use/abuse in such a way as to allow the clinician to determine how substance use/abuse is impacting the client's mental health symptoms. The information gathered should assist the clinician to develop appropriate interventions or referrals based on this impact and the client's readiness for change.

(Continued from Previous Page)

Step Four: Complete COD interventions on the CCCP (Use MH 636)

Use: Can pull information from Supplemental COD Assessment regarding benefits/costs and readiness for change regarding appropriate interventions to assist the client in meeting their mental health goals. This can be done as long as a link has been made on the Initial Assessment between mental health and substance use.

Used by: Goals/Objectives and Interventions may be written by any staff but must be signed by an LPHA.

Step Five: MH 660 COD Session Guide (New Form):

Purpose: To help drive/direct clinical COD interventions as well as to remind clinicians to be checking in about a client's substance use. Clinicians should, on a regular basis, check in with clients regarding their substance use/abuse and assess for any impact it may be having on their mental health.

Use: To be used during any client contact, along with a Progress Note, in which COD is addressed. Prompts are provided to help direct the session.

Used by: Any staff

The following forms are no longer in use:

- **MH 555 COD Self-Evaluation:** This form did not appear to be fulfilling its purpose.
- **MH 631 COD Re-Assessment Checklist:** While it is important to re-assess clients' substance use/abuse on a regular basis, it was determined that this could more adequately and efficiently be done with the above COD Session Guide.
- **MH 632 COD Treatment Plan:** When the Initial Assessment and CCCP were modified to include the information on this form, the form became obsolete.

Implementation of the New/Revised Forms

The revised Adult Initial Assessment and new/revised COD forms are to be effective as of the date of this Bulletin. However, forms are not expected to be implemented until training has been received. Training will be provided to Directly-Operated Adult Providers on the use of the new/revised forms during the COD Part 2 trainings at each clinic (see attached letter regarding setting up a COD training). Training will be provided to Contract agencies at the Service Area QIC meetings.

For additional information regarding the 9 Point Module and COD, please refer to the Office of the Medical Director's website at http://www.rshaner.medem.com under "Integrated Treatment Setting."

Any questions regarding the use of these forms should be addressed at the COD training. After the training, further questions may be directed to Jennifer Eberle at jeberle@dmh.lacounty.gov.

c: Executive leadership Team	Program Heads	ACHSA	QIC Chairs
District Chiefs	Provider Record Keepers	RMD	OMD COD Staff

I KNOW THE ANSWERS TO THOSE QUESTIONS!

1. Both B and C are not REQUIRED forms for Contract Providers. While Contract Providers are required to have a progress note for each service provided, they are not required to use the official DMH progress note. Contract Providers may use the DMH Progress Note or may make one of their own. The MH 500 may not be used by Contract Providers. Contract Providers must take ownership of the consent and have one of their own making. Both the CCCP and the Client Face Sheet are required forms for Contract Providers and they must be used in their original format without alteration.

MH 659
12/29/08

CO-OCCURRING JOINT ACTION COUNCIL SCREENING INSTRUMENT

Section 1: Mental Health		
Yes	No	
☐	☐	Have you ever been worried about how you are thinking, feeling, or acting?
☐	☐	Has anyone ever expressed concerns about how you were thinking, feeling, or acting?
☐	☐	Have you ever harmed yourself or thought about harming yourself?

Section 2: Alcohol & Drug Use		
Yes	No	
☐	☐	Have you ever had any problem related to your use of alcohol or other drugs?
☐	☐	Has a relative, friend, doctor, or other health worker been concerned about your drinking or other drug use or suggested cutting down?
☐	☐	Have you ever said to another person, "No, I don't have an alcohol or drug problem," when around the same time you questioned yourself and felt, *maybe I do have a problem?*

Section 3: Trauma/Domestic Violence		
Yes	No	
☐	☐	Have you ever been in a relationship where your partner has pushed or slapped you?
☐	☐	Before you were 13, was there any time when you were punched, kicked, choked, or received a more serious physical punishment from a parent or other adult?
☐	☐	Before you were 13, did anyone ever touch you in a sexual way or make you touch them when you did not want to?

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

ADULT
INITIAL ASSESSMENT

Admit Date: _____

I. Demographic Data:

Age: _____ Gender: _____ Ethnicity: _____ Marital Status: _____ Preferred Language: _____

Referral Source:

II. Reason for Referral/Chief Complaint

Describe precipitating event(s), current symptoms and impairments in life functioning, including intensity and duration, from the perspective of the client as well as significant others:

III. Psychiatric History:

A. Hospitalizations [date(s) & location(s)]. **Outpatient treatment** [date(s) & location(s)]. History and onset of current symptoms/manifestations/precipitating events (i.e., aggressive behaviors, suicidal, homicidal). Treated & non-treated history.

B. Describe the **impact of treatment and non-treatment history** on the client's level of functioning, e.g., ability to maintain residence, daily living and social activities, health care, and/or employment.

C. Family history of mental illness

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Los Angeles County – Department of Mental Health

ADULT INITIAL ASSESSMENT

IV. Medical History

MD Name: _____ **MD Phone:** _____ **Date of Last Physical Exam:** _____

Major medical problem (treated or untreated) (Indicate problems with check: Y or N for client, Fam for family history.)

Fam	Y	N		Fam	Y	N		Fam	Y	N		Fam	Y	N	
☐	☐	☐	Seizure/neuro disorder	☐	☐	☐	Cardiovascular disease/symp	☐	☐	☐	Liver disease		☐	☐	Weight/appetite chg
	☐	☐	Head trauma	☐	☐	☐	Thyroid disease/symp	☐	☐	☐	Renal disease/symp		☐	☐	Diarrhea
	☐	☐	Sleep disorder	☐	☐	☐	Asthma/lung disease	☐	☐	☐	Hypertension	☐	☐	☐	Cancer
☐	☐	☐	Vision/glaucoma	☐	☐	☐	Blood disorder	☐	☐	☐	Diabetes		☐	☐	Sexual dysfunction
☐	☐	☐	Allergies (If Yes, specify):										☐	☐	Sexually trans disease
	☐	☐	Pap smear If yes, date: _____		☐	☐	Mammogram If yes, date: _____		☐	☐	HIV Test If yes, date: _____		☐	☐	Pregnant If yes, date: _____

Comments on above medical problems, other medical problems, and any hospitalizations, including dates and reasons.

V. Medications

List "all" past and present medications used, prescribed/non-prescribed, psychotropic, by name, dosage, frequency. Indicate from client's perspective what seems to be working and not working.

Medication	Dosage/Frequency	Period Taken	Effectiveness/Response/Side Effects/Reactions

VI. Substance Use/Abuse

"MH659 -Co-Occurring Joint Action Council Screening Instrument"

1. Were any of the questions checked "Yes" in Section 2 "Alcohol & Drug Use"? ☐ Yes* ☐ No **If yes, complete MH633**
2. Were any of the questions checked "Yes" in Section 3 "Trauma/Domestic Violence"? ☐ Yes ☐ No **If yes, answer 2a**

2a. Was the Trauma or Domestic Violence related to substance use? ☐ Yes* ☐ No **If yes, complete MH633**

Be sure to document re: Trauma or Domestic Violence in Part A of "Psychosocial History" on page 3 of the Initial Assessment.

How is Mental Health impacted by substance use (Clinician's Perspective)?

* MH 633 "Supplemental Co-Occurring Disorders Assessment" completed on: _____

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Los Angeles County – Department of Mental Health

VII. Psychosocial History

A. Family & Relationships: Family constellation, family of origin and current family, family dynamics, cultural factors, nature of relationships, domestic violence, physical or sexual abuse, home safety issues (i.e., the presence of firearms.)

B. Dependent Care Issues: #_____ of Adults, #_____dependent children, age(s) of child(ren), school attendance/behavior problems learning problems, special need(s), including physical impairments, discipline issues, juvenile court history, dependent care needs; any unattended needs of children, child support, child custody, and guardianship issues, foster care/group home placement.

C. Current Living Arrangement & Social Support Systems: Type of setting and associated problems, support from community, religious, government agencies, and other sources (i.e., Section 8 Housing, SRO, Board and Care, Semi-independent, family and transitional living, etc.)

D. Education: Highest grade level completed, educational goals. Skill level: literacy level, vocabulary, general knowledge, math skills, school problems, motivation.

E. Employment History/Employment Readiness/Means of Financial Support: Longest period of employment, employment history, military service, work related problems, money management, source of income. Areas of strength.

F. Legal History and Current Legal Status: Parole, probation, arrests, convictions, divorce, child custody, conservatorship

Name: **IS#:**

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VIII. Mental Status Evaluation

Length of current treatment: _____ **Is this part of a 5150?** ☐ Yes ☐ No **Medication:** ☐ Yes ☐ No **Client is:** ☐ Stable ☐ Unstable

Instructions: Check all descriptions that apply

General Description

Grooming & Hygiene: ☐ Well Groomed
☐ Average ☐ Dirty ☐ Odorous ☐ Disheveled
☐ Bizarre
Comments:

Eye Contact: ☐ Normal for culture
☐ Little ☐ Avoids ☐ Erratic
Comments:

Motor Activity: ☐ Calm ☐ Restless
☐ Agitated ☐ Tremors/Tics ☐ Posturing ☐ Rigid
☐ Retarded ☐ Akathesis ☐ E.P.S.
Comments:

Speech: ☐ Unimpaired ☐ Soft
☐ Slowed ☐ Mute ☐ Pressured ☐ Loud
☐ Excessive ☐ Slurred ☐ Incoherent
☐ Poverty of Content
Comments:

Interactional Style: ☐ Culturally congruent
☐ Cooperative ☐ Sensitive
☐ Guarded/Suspicious ☐ Overly Dramatic
☐ Negative ☐ Silly
Comments:

Orientation: ☐ Oriented
☐ Disoriented to:
☐ Time ☐ Place ☐ Person ☐ Situation
Comments:

Intellectual Functioning: ☐ Unimpaired
☐ Impaired
Comments:

Memory: ☐ Unimpaired
☐ Impaired re: ☐ Immediate ☐ Remote ☐ Recent
☐ Amnesia
Comments:

Fund of Knowledge: ☐ Average
☐ Below Average ☐ Above Average
Comments:

Mood and Affect

Mood: ☐ Euthymic ☐ Dysphoric ☐ Tearful
☐ Irritable ☐ Lack of Pleasure
☐ Hopeless/Worthless ☐ Anxious
☐ Known Stressor ☐ Unknown Stressor
Comments:

Affect: ☐ Appropriate ☐ Labile ☐ Expansive
☐ Constricted ☐ Blunted ☐ Flat ☐ Sad
☐ Worried
Comments:

Perceptual Disturbance

☐ None Apparent

Hallucinations: ☐ Visual ☐ Olafactory
☐ Tactile ☐ Auditory: ☐ Command
☐ Persecutory ☐ Other
Comments:

Self-Perceptions: ☐ Depersonalizations
☐ Ideas of Reference
Comments:

Thought Process Disturbances

☐ None Apparent

Associations: ☐ Unimpaired ☐ Loose
☐ Tangential ☐ Circumstantial ☐ Confabulous
☐ Flight of Ideas ☐ Word Salad
Comments:

Concentration: ☐ Intact ☐ Impaired by:
☐ Rumination ☐ Thought Blocking
☐ Clouding of Consciousness ☐ Fragmented
Comments:

Abstractions: ☐ Intact ☐ Concrete
Comments:

Judgments: ☐ Intact
☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
Comments:

Insight: ☐ Adequate
☐ Impaired re: ☐ Minimum ☐ Moderate ☐ Severe
Comments:

Serial 7's: ☐ Intact ☐ Poor
Comments:

Thought Content Disturbance

☐ None Apparent

Delusions: ☐ Persecutory ☐ Paranoid ☐ Grandiose
☐ Somatic ☐ Religious ☐ Nihilistic
☐ Being Controlled
Comments:

Ideations: ☐ Bizarre ☐ Phobic ☐ Suspicious
☐ Obsessive ☐ Blames Others ☐ Persecutory
☐ Assaultive Ideas ☐ Magical Thinking
☐ Irrational/Excessive Worry
☐ Sexual Preoccupation
☐ Excessive/Inappropriate Religiosity
☐ Excessive/Inappropriate Guilt
Comments:

Behavioral Disturbances: ☐ None ☐ Aggressive
☐ Uncooperative ☐ Demanding ☐ Demeaning
☐ Belligerent ☐ Violent ☐ Destructive
☐ Self-Destructive ☐ Poor Impulse Control
☐ Excessive/Inappropriate Display of Anger
☐ Manipulative ☐ Antisocial
Comments:

Suicidal/Homicidal: ☐ Denies Ideation Only
☐ Threatening ☐ Plan ☐ Past Attempts
Comments:

Passive: ☐ Amotivational ☐ Apathetic
☐ Isolated ☐ Withdrawn ☐ Evasive ☐ Dependent
Comments:

Other: ☐ Disorganized ☐ Bizarre
☐ Obsessive/compulsive ☐ Ritualistic
☐ Excessive/Inappropriate Crying
Comments:

Name: **IS#:**

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Los Angeles County – Department of Mental Health

ADULT
INITIAL ASSESSMENT

IX. Summary and Diagnosis

I. Diagnostic Summary: (Be sure to include significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e., Work, School, Home, Community, Living Arrangements, etc, and justification for diagnosis)

II. Admission Diagnosis (check one Principle and one Secondary)

Axis I ☐ Prin ☐ Sec Code _____ Nomenclature _____
(Medications cannot be prescribed with a deferred diagnosis)
☐ Sec Code _____ Nomenclature _____
Code _____ Nomenclature _____
Code _____ Nomenclature _____
Code _____ Nomenclature _____

Axis II ☐ Prin ☐ Sec Code _____ Nomenclature _____
☐ Sec Code _____ Nomenclature _____
Code _____ Nomenclature _____

Axis III _____ Code _____
_____ Code _____
_____ Code _____

Axis IV Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis

Primary Problem #: ___
Check as many that apply:

1. ☐ Primary support group
2. ☐ Social environment
3. ☐ Educational
4. ☐ Occupational
5. ☐ Housing
6. ☐ Economics
7. ☐ Access to health care
8. ☐ Interaction with legal system
9. ☐ Other psychosocial/environmental
10. ☐ Inadequate information

Axis V Current GAF: _____ DMH Dual Diagnosis Code: _____
Above diagnosis from: _____ Dated: _____

III. Disposition/Recommendations/Plan:

IV. Signatures

_____	_____	_____	_____
Assessor's Signature & Discipline	Date	Co-Signature & Discipline	Date

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

SUPPLEMENTAL CO-OCCURRING DISORDERS ASSESSMENT

I. Current Substance Use

A. Alcohol Screening Questions — 1 Drink = 12 Ounces of Beer

1. How often do you have a drink containing alcohol? If "Never", proceed to Drug Screening Questions.	☐ Never	☐ Monthly or less	☐ 2-4 times a month	☐ 3 times a week	☐ 4+ times a week
1a. How many drinks containing alcohol do you have on a typical day when you are drinking?	☐ 1 or 2	☐ 3 or 4	☐ 5 or 6	☐ 7 to 9	☐ 10+
1b. How often do you have six or more drinks on one occasion?	☐ Never	☐ Less than monthly	☐ Monthly	☐ Weekly	☐ Daily or almost daily

B. Drug Screening Questions

1. Have you used any drug in the past 30 days that was NOT prescribed by a doctor? ☐ Yes ☐ No

2. Drug Type(s) Used (Indicate with an "*" which substances are most preferred.)	Ever Used? Yes	Ever Used? No	Recently Used? (Past 6 Months) Yes	Recently Used? (Past 6 Months) No	Route of Administration or other comments (IV use, smoking, snorting, etc.)
Amphetamines (Meth, crank, ice, etc.)	☐	☐	☐	☐	
Cocaine or crack	☐	☐	☐	☐	
Hallucinogens	☐	☐	☐	☐	
Inhalants	☐	☐	☐	☐	
Marijuana	☐	☐	☐	☐	
Nicotine (Cigarettes, cigars, smokeless tobacco)	☐	☐	☐	☐	
Opiates (Heroin, codeine, etc.)	☐	☐	☐	☐	
Over the Counter Meds (Cough syrup, diet aids, etc.)	☐	☐	☐	☐	
Sedatives (Pain meds, etc.)	☐	☐	☐	☐	
Other (specify): _____	☐	☐	☐	☐	

C. Additional Comments:

II. Family History of Alcohol and/or Drug Use

Please describe any history of family alcohol and/or drug use (i.e. mother, father, etc.)

III. Past and Current Substance Use Treatment/Self-Help

1. Have you received help in the past for substance use issues (e.g. Self-Help or Professional)? ☐ Yes ☐ No
   If yes, please list the dates you were enrolled: From _____ To _____ From _____ To _____
   Was it beneficial? If so, how?

2. Are you currently enrolled in a substance use program? ☐ Yes ☐ No
   If yes, what was your date of enrollment? _____
   Please specify the type of program it is:

   Were you referred to mental health services by this program? ☐ Yes ☐ No
   Referred by: _____ Contact Number: _____
   ☐ Records were requested on (date): _____

3. Additional comments:

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

SUPPLEMENTAL CO-OCCURRING DISORDERS ASSESSMENT

IV. Benefits of Substance Use

How true is the following about substance use for you:	Very True	Somewhat True	Not True	Comments
It is important in socializing with friends	☐	☐	☐	
It helps me meet and get to know people	☐	☐	☐	
It lowers my anxiety when I'm with people	☐	☐	☐	
It makes me feel less depressed or empty	☐	☐	☐	
It makes me feel less anxious	☐	☐	☐	
It helps me forget my problems	☐	☐	☐	
It helps me sleep better	☐	☐	☐	
It gives me something to look forward to	☐	☐	☐	
It is an important source of pleasure to me	☐	☐	☐	
It helps reduce my boredom	☐	☐	☐	
It is one of the only things that makes me feel okay	☐	☐	☐	
It is chiefly a habit or helps to avoid withdrawal	☐	☐	☐	
It enhances sexual experiences	☐	☐	☐	
It helps me lose weight	☐	☐	☐	

V. Costs of Substance Use

Is it possible that your substance use has played a role in or contributed to any of the following:	Yes	No
Problems keeping or getting housing (i.e. eviction, homeless)?	☐	☐
Problems at school or work?	☐	☐
Legal problems (i.e. DUI, possession, public intoxication, dealing)?	☐	☐
Money problems (i.e. lack of money)?	☐	☐
Developing or not attending to health problems (i.e. physical exams, dental exams, treatment)?	☐	☐
Feeling sick before or after using?	☐	☐
Ignoring my mental health treatment?	☐	☐
Increasing my mental health symptoms?	☐	☐
Not taking my medications as prescribed?	☐	☐
Being rejected or judged by others?	☐	☐
Conflicts with or losing friends and/or family?	☐	☐
Getting into dangerous situations (i.e. that involve weapons, unprotected sex, trading sex for drugs, sharing needles)?	☐	☐
Feeling a sense of anger/guilt/shame or feeling like a failure?	☐	☐

VI. Readiness for Change/Treatment Plan Identification

1. In looking over the benefits and costs of your alcohol/drug use, how do the costs compare to the benefits?

2. Which benefits seem most important to you?

3. If we could identify or develop healthier ways for you to achieve those benefits (identified in #2), do you think it might be easier for you to cut down on your alcohol/drug use? ☐ Yes ☐ No
4. Which of the costs do you think cause the most overall problems for you?

5. Are you willing or wanting to address any of these costs? If so, how?

6. Which of these costs do you think affects your Mental Health symptoms the most and might be important to try to reduce?

7. On a scale of 0-5, how ready are you to start working on finding new ways of achieving the benefits? _____
   On a scale of 0-5, how ready are you to start working on reducing the costs? _____

Assessor's Signature & Discipline	Date	Co-Signature & Discipline (if required)	Date

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

MH 660
12/29/08

SUPPLEMENTAL COD SESSION GUIDE

TRIGGER → THOUGHT → CRAVING → USE

Today's Date: _____

1. What were your treatment goals as related to the impact of substance use on your mental health?

2. How did working towards these goals or not working towards them contribute to how you are doing today?

3. Was there any substance use since your last session?

4. How did this impact your working or not working on your treatment goals?

Check the client's current level of readiness to work toward change.
Please use suggested activities/treatment goals to guide today's session and document in a Progress Note.

☐ **1. Pre-Contemplation**

- Offer factual information
- Explore the meaning of events that brought the person to treatment
- Explore results of previous efforts
- Explore pros and cons of targeted behaviors

☐ **2. Contemplation**

- Explore the person's sense of self-efficacy
- Explore expectations regarding what the change will entail
- Summarize self-motivational statements
- Continue exploration of pros and cons

☐ **3. Determination**

- Offer a menu of options for change
- Help identify pros and cons of various change options
- Identify and lower barriers to change
- Help person enlist social support
- Encourage person to publicly announce plans to change

☐ **4. Action**

- Support a realistic view of change through small steps
- Help identify high-risk situations and develop coping strategies
- Assist in finding new reinforcers of positive change
- Help access family and social support

☐ **5. Maintenance**

- Help identify and try alternative behaviors (drug-free sources of pleasure)
- Maintain supportive contact
- Help develop escape plan
- Work to set new short and long term goals

☐ **6. Recurrence**

- Frame recurrence as a learning opportunity
- Explore possible behavioral, psychological, & social antecedents
- Help to develop alternative coping strategies
- Explain Stages of Change and encourage person to stay in the process
- Maintain supportive contact

_____ Staff Signature and Title

_____ Date

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

SUPPLEMENTAL COD SESSION GUIDE

SEMEL INSTITUTE UCLA

Integrated Substance Abuse Programs (ISAP)
Jane & Terry Semel Institute for Neuroscience & Human Behavior

Department of Psychiatry and Biobehavioral Sciences
David Geffen School of Medicine at UCLA
1640 Sepulveda Blvd., Suite 200
Los Angeles, CA 90025 - 7535

Tel (310) 267-5444
Fax (310) 312-0538

January 9, 2009

Dear TAY, Adult and Older Adult Provider,

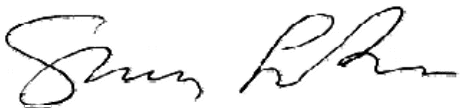
Thank you for participating in the DMH-UCLA sponsored trainings on "Integrated Screening, Assessment, and Brief Intervention for Co-occurring Disorders" held across the county this past October and November (www.uclaisap.org/cod). As you may recall, the training you/your staff attended was the first of a set of two trainings conducted for DMH Directly-Operated staff to better understand screening, assessment and treatment strategies for consumers with co-occurring mental health and substance use disorders (COD).

The Office of the Medical Director, in collaboration with DMH COD Coordinators, Clinic staff, and members of the Quality Assurance unit have revised the forms associated with COD to assist clinicians in identifying the link between a consumer's mental health diagnosis and his/her substance use/abuse. Between January and March, 2009 staff from UCLA Integrated Substance Abuse Programs (UCLA-ISAP) and DMH will be conducting trainings at each DMH Directly-Operated Clinic to introduce staff to the Revised Adult Co-Occurring Disorders Forms, and provide technical assistance on their use. The trainings will be 2 hours in length and will consist of forms review, practice exercises and Q&A.

Please find enclosed a calendar with open training dates/times for us to come to your site to conduct the 2-hour Technical Assistance training. Please review with your team and identify appropriate staff who should attend the training. Please identify a first and second choice of training dates and contact Richell Jose (rjose@ucla.edu; 310.267.5408) to confirm your training.

Thank you again, and we look forward to your participation in the upcoming trainings.

Sincerely,



Sherry Larkins, Ph.D.

Director, COD Training Programs
UCLA Integrated Substance Abuse Programs
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310.267.5376
323.828.8850

Follow-Up On-Site Trainings for Revised Adult COD Forms

The county-wide trainings on Co-Occurring Mental Health and Substance Use Disorders held in October and November, 2008 were the first of a two-part training series conducted by DMH and UCLA-ISAP.

We are excited to begin part two of this training series. Over the next 3 months, we will be conducting 2 hour on-site training at each of the 25 directly operated clinics in Los Angeles County to introduce DMH staff to the Revised Adult Co-Occurring Disorders Forms and provide technical assistance on their use.

Below you will find available dates and times. Areas in gray are NOT available. The two time slots available are either **10:00-12:00 noon** or **2:00-4:00pm**

Please email Richell Jose rjose@ucla.edu or call 310-267-5408 with the dates and times of your top 3 choices (please label which is your first, second and third choice).

*** First come first serve
Submit your date and time ASAP ***

January 2009

Sunday	Monday	Tuesday	Wed.	Thursday	Friday	Saturday
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	10:00-12:00pm 2:00-4:00pm 27	2:00-4:00pm 28	10:00-12:00pm 2:00-4:00pm 29	30	31

February 2009

Sunday	Monday	Tuesday	Wed.	Thursday	Friday	Saturday
1	2	10:00-12:00pm 2:00-4:00pm 3	10:00-12:00pm 2:00-4:00pm 4	10:00-12:00pm 2:00-4:00pm 5	6	7
8	9	10:00-12:00pm 2:00-4:00pm 10	2:00-4:00pm 11	10:00-12:00pm 2:00-4:00pm 12	13	14
15	16	10:00-12:00pm 2:00-4:00pm 17	10:00-12:00pm 2:00-4:00pm 18	10:00-12:00pm 2:00-4:00pm 19	20	21
22	23	10:00-12:00pm 2:00-4:00pm 24	2:00-4:00pm 25	10:00-12:00pm 2:00-4:00pm 26	27	28

*Scroll to next page to see the month of March.

March 2009						
Sunday	**Monday**	**Tuesday**	**Wed.**	**Thursday**	**Friday**	**Saturday**
1	**2**	10:00-12:00pm 2:00-4:00pm **3**	10:00-12:00pm 2:00-4:00pm **4**	10:00-12:00pm 2:00-4:00pm **5**	**6**	**7**
8	**9**	10:00-12:00pm 2:00-4:00pm **10**	2:00-4:00pm **11**	10:00-12:00pm 2:00-4:00pm **12**	**13**	**14**
15	**16**	10:00-12:00pm 2:00-4:00pm **17**	10:00-12:00pm 2:00-4:00pm **18**	10:00-12:00pm 2:00-4:00pm **19**	**20**	**21**
22	**23**	10:00-12:00pm 2:00-4:00pm **24**	2:00-4:00pm **25**	10:00-12:00pm 2:00-4:00pm **26**	**27**	**28**
29	**30**	**31**				