Division of Substance Abuse and Mental Health

DSAMH Bureau of Policy Compliance and Workforce Development

Documentation of treatment team interventions regarding Substance Use Disorders

May 4, 2021

DSAMH Audit Compliance and Risk Management teams have identified a theme during audits, critical incident reports, and death reviews regarding lack of appropriate documentation of treatment team interventions regarding Substance Use Disorders (SUDS).

The assessments and staff knowledge of the presence of current or historical presence of SUDS history are generally present in agency documentation. After the assessment process, however, the inclusion of the SUDS history on the "Person Directed Recovery Plan" (PDRP), provision of specific staff interventions, and accurate ongoing documentation and adaptability to the client's situation is inconsistent and often found deficient against required standards.

Delaware ranks second highest in the country for age-adjusted overdose death rates (CDC, 2019) for Overdose Use Disorder deaths. We also rank third per capita in Ethanol consumption.

In contrast to the seriousness of this issue, here are some general trends of chart deficiencies related to ACT programs:

- SUDs identified but not included in PDRP (without details of motivational interviewing or any connection to client stages of change, etc.)
- SUDS identified on PDRP, but staff interventions are generic, lacking in definition, and missing essential elements (SMART: Specific, Measurable, Attainable, Real, Timely)
- Pscyho-education mentions risk/benefit discussions, but progress notes and documentation do not support intervention details or information provided to client or client response
- Family education efforts are rarely documented (provision of education material or referral to NAMI or other community resources
- The role of the Chemical Dependency Specialist gets lost in the overall team shared responsibilities practiced on ACT teams leaving the SUDS interventions and updates vulnerable to missed opportunities to engage clients
- High awareness of Medication Assistance Use Disorder value and importance of close monitoring and participation of these services if with another agency (Collaboration)

DSAMH's auditors and risk managers will be looking for written documentation that reflects the clients PDRP acknowledge SUDS when it is present, includes appropriate interventions by the staff, includes progress notes that have details of staff follow-up, and has PDRP modifications that reflect client

changes in status with relation to SUDS. We request program managers refresh teams on the following requirements:

- Include SUDS needs on PDRP
- Ensure PDRP has SMART elements (or similar content based on your agencies model)
- Ensure key staff person is responsible for SUDS interventions and follow up
- Ensure details of interventions are in progress notes
- Ensure the information provided (educational material, risk/benefits, self-help groups, and other resources) are documented in the client's file

(SAMSHA has numerous evidence-based publications and client-friendly education material available to you and the public. Many of these publications are directed at Co-Occurring populations.

ACT was originally developed for patients with severe mental illness and provides personalized community care by multidisciplinary teams [37]. The days of programs treating only mental health conditions are long gone. It is commonly recognized that the critical elements of the ACT model are assertive engagement, delivery of services in the community, high intensity of services, holistic and integrated services by multidisciplinary teams, and continuity of care [38].

Several program features appear to be associated with co-occurring disorders, including assertive outreach, case management, and a longitudinal, stage-wise, motivational approach to substance abuse treatment. ACT teams are well-suited to meet this goal.

The staff at the program level can describe their interventions and discussions with clients on many of these interventions and processes. However, the records are not detailing the information, which jeopardizes the teamwork approach of the ACT model and leaves the agency at risk for failing a compliance audit.

The appendix attached covers the primary elements required as detailed in the 2019 ACT standards for your reference. How the ACT teams meet these elements is an agency decision.

This notice is provided to raise awareness to the program managers, quality assurance staff, and direct service staff regarding contractual and Medicaid certifications requirements for ACT teams regarding SUDS.

DSAMH, including the Bureau of Community Mental Health, the Bureau of Policy, Compliance and Workforce Development, and the Medical Director's Office, are available for consultation as needed.

Appendix: Excerpts from 2019 ACT Standards

3.1.3 Criterion C 3.1.3.1: The individual must meet at least one (1) of the following: 3.1.2.1.2 Psychiatric or Substance Abuse Hospitalizations/Juvenile Placement within the past twelve (12) months: 3.1.2.1.2.1 Two or more psychiatric hospitalizations or substance abuse-related hospitalizations 3.1.2.1.2.2 One psychiatric or substance abuse-related hospitalization in excess of 10 days 3.1.2.1.2.3 Two or more juvenile placements in a secure facility

4.3.3.1.2 Chemical Dependency Specialist: Face-to-face evaluation minimally every fourteen (14) days for the first sixty (60) days after admission, and then as prescribed in the Individualized Treatment Plan that details ongoing SUD evaluation schedule that is appropriate to the substance abuse.

5.1.1.8 Substance abuse counseling and co-occurring counseling;

7.3 Chemical Dependency Specialist* – At least one FTE team member must be a dedicated Chemical Dependency Specialist (i.e. the identified staff person cannot also function in another role as well, such as the team leader). 7.3.1 Chemical Dependency Specialists may be with one of the Master's Level or Bachelor's level clinicians on the team. 7.3.1.1 Certification by the State of Delaware as a Certified Alcohol and Drug Counselor (CADC) or Certified Co-occurring Disorder Professional (CCDP); or 7.3.1.2 At least three (3) years of supervised work experience in the substance abuse treatment field and; 7.3.1.2.1 Forty (40) hours of training specific to substance abuse assessment and treatment.

13.1.6 During the daily organizational staff meeting, the ACT team shall also work with the individual to revise person directed recovery plans as needed, anticipate emergency and crisis situations, and adjust service contacts on the daily staff assignment schedule per the revised recovery plans.

17 Person-Directed Recovery Planning (PDRP)

17.3.4 establish the specific approaches and interventions necessary for the individual to meet his/her goals, 17.3.5 improve his/her capacity to function as independently as possible in the community, and 17.3.6 seek to achieve the maximum level of recovery possible as defined by the individual (i.e., a meaningful, satisfying, and productive life) and Delaware State Standards for Assertive Community 2019 Treatment (ACT) Services 46 17.3.7 Identify interventions that have been helpful or that pose particular risks to the individual.

17.8.2.2 Skills training around his/her role in developing his/her own person directed recovery plan.

17.8.5.3 Identify who will carry out the approaches and interventions

17.8.8 Measurable goals with current status.

18 Core ACT Services

18.2.1.6 To act as principle contact and educator

18.4.1 Psycho-education regarding: 18.4.1.1 Substance use and co-occurring disorders, when appropriate;

18.5.5.4 Developing a personal definition of relapse; 18.5.5.5 Identifying triggers for relapse and 18.5.5.5.1 rating strategies for reducing relapse frequency and severity; Delaware State Standards for Assertive Community 2019 Treatment (ACT) Services 52 18.5.5.6 Identifying personal stressors and coping positively with those stressors. 18.5.5.7 Identifying and coping with symptoms.

20 Co-Occurring Disorders Services:

20.1 ACT individuals with a positive screen for co-occurring substance use disorder shall receive an integrated mental health/substance use assessment during the first thirty (30) days of treatment.

The assessment will include:

20.1.1 Substance use history;

20.1.2 Trauma history; 20.1.3 Parental and familial substance use summary;

20.1.4 Effects/impact of substance use;

20.1.5 Functional assessment: role played by substances in the individual's life;

20.1.6 Factors that have contributed to past successes and relapses;

20.1.7 Individual strengths;

20.1.8 Social support network (including both individuals who use substances and people who support recovery);

20.1.9 Individual's self-identified goals and aspirations; 20.1.10 ACT individuals will receive integrated treatment that is:

20.1.10.1 Non-confrontational,

20.1.10.2 Considers interactions of mental illness and substance abuse; and

20.1.10.3 Results in a person directed recovery plan that incorporates goals determined by the individual.

20.2 Treatment will follow a harm reduction model. This may include: 20.2.1 individual and/or group interventions in:

20.2.1.1 Developing motivation for decreasing use;

20.2.1.2 Developing skills to minimize use;

20.2.1.3 Recognition of negative consequences of use; and

20.2.1.4 Adoption of an abstinence goal for treatment.

20.2.2 Engagement (e.g., empathy, reflective listening).

20.2.3 Ongoing assessment (e.g., stage of readiness to change, individualdetermined problem identification).

20.2.4 Motivational enhancement (e.g., developing discrepancies, psychoeducation). 20.2.5 Active treatment (e.g., cognitive skills training, community reinforcement).

20.2.6 Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans.