COMPASS-EZ™

A Self-assessment Tool for Behavioral Health Programs

Creating Welcoming, Recovery-oriented, Co-occurring-capable Services for Adults, Children, Youth, and Families with Complex Needs

Version 1.0

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COMPASS-EZ™ Users Guide

Welcome! We are delighted that your program has an opportunity to use **COMPASS-EZ™** to help improve services for individuals and families with complex lives. **COMPASS-EZ™** is designed to help your program develop welcoming services that inspire hope and provide help to people and families with co-occurring issues. Individuals and families that have multiple co-occurring issues are the expectation in behavioral health settings, and with hope and help, all can make progress toward having healthier, happier, and more meaningful lives. **COMPASS-EZ™** helps programs begin the process of developing recovery and resiliency-oriented co-occurring capability. **COMPASS-EZ™** brings together critical knowledge of what we all have learned over the years about what helps individuals and families--knowledge about integrated treatment and services, trauma informed services, person-centered planning, cultural competency, population-specific services, and most fundamentally, empathic relationships that inspire hope and help. As you will see in the instructions below, **the most important purpose of COMPASS-EZ™ is to create a foundation for an improvement process through an empowered conversation** that involves as many people working together to build the program and its services as possible.

We hope that you find your group conversation an enlightening, creative and enjoyable experience.

Definitions

Co-occurring Issues (Also termed Co-occurring Conditions, Co-occurring Disorders and Dual Diagnosis): An individual has co-occurring behavioral health issues if he or she has any combination of any mental health or any substance use problem, even if the issues have not yet been diagnosed. Many systems and programs are including trauma issues, problem gambling and nicotine dependence in the list of co-occurring behavioral health issues. Co-occurring behavioral health issues also apply to **families ("families with co-occurring issues" or "co-occurring families")** where one member has one kind of problem, such as a child with an emotional disturbance, and another member has another kind of problem, such as a family member or caregiver with a substance use issue.

Co-occurring Capability: For any type of program, within the mission and resources of that program, recovery-oriented co-occurring capability involves designing every aspect of that program at every level on the assumption that the next person "coming to the door" of the program is likely to have co-occurring issues and needs, and they need to be welcomed for care, engaged with empathy and the hope of recovery, and provided what they need in a person-specific and integrated fashion in order to make progress toward having a happy productive life. Recovery oriented co-occurring capability necessitates that all care is welcoming and person-centered. This dynamic approach to service and care is attuned to people and families with diverse goals, strengths, histories and cultures. Co-occurring capability involves looking at all aspects of program design and functioning in order to embed integrated policies, procedures and practices in the operations of the program to make it easier and more routine for each clinician to deliver integrated care successfully.

CCISC--CCISC (Comprehensive Continuous Integrated System of Care) (Minkoff and Cline, 2004[1], 2005[2]) is both a framework and a process for designing a whole system of care to be about the complex needs of the individuals and families being served. In CCISC, **all programs in the system engage in partnership with other programs, along with the leadership of the system, and consumer and family stakeholders, to become welcoming, recovery oriented, and co-occurring capable.** In addition, every person delivering and

supporting care is engaged in a process to become welcoming, recovery-oriented, and co-occurring competent as well.

Implementation of CCISC in real world systems with limited resources is based on significant advances in clinical knowledge in the last two decades. We now have enough knowledge to know how to successfully embed practices in any program in order to be helpful to individuals and families with complex needs. Such practices are organized by **Eight Core CCISC Principles** (See Minkoff and Cline, 2004[1], 2005[2]), and placed in an integrated recovery framework to create a common language throughout the whole system. Such practices involve welcoming access, integrated screening and assessment, empathic hopeful integrated relationships, stage matched interventions, strength-based skill-based learning, and using positive contingencies to reward progress a day at a time. CCISC implementation helps all programs in the system, through the use of **COMPASS-EZ™**, to learn how to apply the CCISC principles to build recovery-oriented co-occurring capability into all areas of practice and programming.

Complexity Capability: In the past decade, CCISC has evolved to address more than just mental health and substance use issues. **COMPASS-EZ™** has similarly evolved. In real world behavioral health and health systems, individuals and families with multiple co-occurring needs are an expectation, not an exception. Individuals and families not only have substance use and mental health issues, they frequently have medical issues, legal issues, trauma issues, housing issues, parenting issues, educational issues, vocational issues and cognitive/learning issues. In addition, these individuals and families are culturally and linguistically diverse. In short, these are people and families who are characterized by "**complexity**", and they tend to have poorer outcomes and higher costs of care. However, instead of systems being designed to clearly welcome and prioritize these complex individuals and families with high risk and poor outcomes, individuals and families with complexity have historically been experienced as "misfits" at every level. This realization has become a major driver for comprehensive system change. In order for systems with scarce resources to successfully address the needs of the individuals and families with complex co-occurring issues who are the "expectation", it is not adequate to fund a few "special programs" to work around a fundamentally mis-designed system. We need to engage in a process of organizing everything we do at every level with every scarce resource we have to be about all the complex needs of the people and families seeking help. By doing a self-assessment of its own capability to routinely address complexity in an integrated manner, each program can begin an organized process to become a welcoming recovery-oriented "Complexity Capable" program. Some systems implementing CCISC have begun to use this terminology to reflect this broader perspective. Although **COMPASS-EZ™** primarily uses the terminology Co-occurring Capability, we anticipate that over time this term may well be replaced with Complexity Capability.

What is COMPASS-EZ™?

COMPASS-EZ™ is a key tool in the successful implementation of the **Comprehensive Continuous Integrated System of Care.** **COMPASS-EZ™** is designed to help individual programs organize a baseline self-assessment of recovery-oriented co-occurring capability as the first step in a continuous quality improvement process in which the program designs an action plan to make progress. **COMPASS-EZ™** is designed to help programs have a consistent method for measuring progress, and continuing the learning and change process, by repeating the self-assessment at regular intervals. Most broadly, **COMPASS-EZ™** is designed to be used globally by systems in transformation. All programs in the system can work in partnership, with each program using a shared process to make progress toward the collective vision of recovery-oriented co-occurring capability across the whole system.

COMPASS-EZ™ is organized by sections that address aspects of a co-occurring capable program's design. These are:

1. **Program Philosophy**
2. **Program Policies**
3. **Quality Improvement and Data**
4. **Access**
5. **Screening and Identification**
6. **Recovery-Oriented Integrated Assessment**
7. **Integrated Person-Centered Planning**
8. **Integrated Treatment/Recovery Programming**
9. **Integrated Treatment/Recovery Relationships**
10. **Integrated Treatment/Recovery Program Policies**
11. **Psychopharmacology**
12. **Integrated Discharge/Transition Planning**
13. **Program Collaboration and Partnership**
14. **General Staff Competencies and Training**
15. **Specific Staff Competencies**

COMPASS-EZ™ is designed to be helpful to a vast array of programs:

- **Mental health settings, including inpatient, outpatient, and other levels of care**
- **Addiction settings, including residential, outpatient, and other levels of care**
- **Adult and Older Adult services**
- **Child and Adolescent services**,
- **Supportive services settings, such as homeless shelters, correctional settings, child welfare settings, and**
- **COMPASS-EZ™ is informative for other service settings, such as primary care programs.**

COMPASS-EZ™ is designed to produce a number of important organizational outcomes. **COMPASS-EZ™** helps programs, agencies and systems:

- **Communicate a common language and understanding of recovery-oriented co-occurring capable services for individuals and families with complex needs,**
- **Understand the program baseline of recovery-oriented co-occurring capability so that there is an organized and rational foundation for a change process toward this vision,**
- **Provide a common tool and shared process that can be used in any system for an array of diverse programs working collectively on co-occurring capability development, and**
- **Create a continuous quality improvement framework regarding co-occurring capability development for ALL types of programs in any system of care that serves individuals and families with complex lives.**

COMPASS-EZ™ also has companion tools that have been tailored to meet the needs of specialized services. Examples are:

- **COMPASS-Prevention™ - For prevention and early intervention programs (Issue-2008),**
- **COMPASS-DD™ - For programs working with individuals and families in DD/MR services (Issue 2008), and**
- **COMPASS-Primary Care™ - For Primary Health Care Settings (Issue-2009)**

What is the Difference between COMPASS-EZ™ and COMPASS™

COMPASS™ (2001) was the first tool that could help a variety of programs (mental health, substance abuse, adult, child or adolescent) perform an assessment of what was then termed Dual Diagnosis Capability (DDC), and is now more commonly termed Co-occurring Capability (Minkoff & Cline, 2006[3]**).**

COMPASS-EZ™ is a significant simplification and update of the original **COMPASS™. COMPASS-EZ™** is used the same way as the original **COMPASS™**. For systems or programs that wish to continue using the original tool, the **COMPASS-EZ™** may be used as an occasional "lite" substitute for the original tool.

Why did we create this update?

- To simplify and shorten the original **COMPASS™** to make it easier to understand and quicker to use,
- To strengthen the language about consumer and family involvement, hope, recovery, and resiliency,
- To improve the relevance of the tool for children, youth and family programs, and
- To reflect current "state-of-the-art" indicators of co-occurring capability.

Thank you to the hundreds of programs over the years that have used the original COMPASS™. Your experiences and recommendations have helped make the COMPASS-EZ™ come to life!

What is the Best Way to Use the COMPASS-EZ™?

1. **Self-Survey:** **COMPASS-EZ™** is used primarily as a program self-survey. The goal is for the participants in the process to discuss the items on the tool and be empowered to examine diverse perceptions about the program policies, procedures, and practices in order to identify the program baseline and opportunities for improvement. **COMPASS-EZ™** is designed to help programs develop and take ownership of the continuous quality improvement process. Note: *For systems that wish to develop indicators of co-occurring capability that can be used in program oversight, ZiaPartners, Inc. has designed a tool/process called* ***COCAP™*** *to help systems partner to select indicators that developmentally fit the programs in the system. This approach to "auditing" supports transformational partnering and sustains change.* ***COCAP™*** *should be used only after the programs in the system have used the* ***COMPASS-EZ*** *over a period of time, usually at least one year.*

2. **Small Group Discussion:** The **COMPASS-EZ™** is designed to be used in a small group discussion format that includes representation from all of the different perspectives in the program: **managers, supervisors, front line clinicians, support staff, peer recovery specialists, and, when possible, representative consumers and/or families who are or have been in service**. A typical group may

have 10 to 15 participants, depending on the size of the program. Your group size may be larger or smaller. One of the most important outcomes of using the tool is the discussion people have who hold different perspectives. It is quite striking how often people in the same program have very different opinions about what the "policies" really are regarding individuals with co-occurring issues. This opportunity for a deep and rich discussion engages the **COMPASS-EZ™** participants in learning about co-occurring capability, often gets people excited about the opportunity to make real change, and jump starts the process of improvement. The most common mistake that programs make is to have the tool completed by a single manager, or to have people complete the tool separately without a discussion, and then "average" the scores. Proceeding this way is a missed opportunity to get the most value out of using **COMPASS-EZ™**.

3. **Preparing the Group:** It is extremely helpful for the group to have some background about the process of co-occurring capability development before using the **COMPASS-EZ™**. If this is part of a larger system effort, this should be explained. If the agency or program is committing to make some changes, this should be explained and discussed as well. It may be helpful for group members to review some material about CCISC ahead of time, and to read through the **COMPASS-EZ™** briefly (without answering the questions) in order to get ready to talk to each other.

4. **Structuring the Discussion:** It is not necessary to have a facilitator for the **COMPASS-EZ™.** Most programs organize themselves to have the conversation quite well. One person, usually NOT the program manager, can be identified as a "timekeeper" to remind the group to come to closure on the items and to stay on track. The same person, or a different person, may take notes to capture important parts of the conversation and write down scores. It is important to keep the discussion "democratic", in that everyone's opinion and perspective counts equally in the conversation, and contributes to the consensus score. This will be discussed further below, in the scoring section.

5. **Planning the Time:** Completing the **COMPASS-EZ™** takes approximately two hours. It is ideal if the whole tool is done in a single session, but this is not always possible. Many programs will take a small amount of time (like 30 minutes) in a regular weekly meeting with a consistent group and go through a few sections at each sitting. This way the process has continuity, but is less disruptive of normal work activities. As noted above, because the discussions on some items can get pretty far ranging, while other items go very quickly, it is helpful to have a timekeeper to bring everyone to closure in order to stay on schedule. Going too fast through the process or too slowly may be an indication that the group needs to have a little more framework built for the discussion to work well.

6. **Specifying the Program:** The **COMPASS-EZ™** is designed as a survey of a "program". In very small agencies, it is often easy to determine what the program is --it's the whole agency and everybody gets involved in the **COMPASS-EZ™**! In larger agencies, this may sometimes be harder to figure out. Here are some guidelines:
    a. **A large agency should plan to have each distinct program use the COMPASS-EZ to perform its own self-survey.**
    b. **A distinct program means that the program has a unique set of services, and/or that it is a distinct administrative unit that would be responsible for its own improvement activities.** For example, in a large mental health center, the Assertive Community Treatment team would use the COMPASS-EZ™ as it is a separate program, distinct from the Outpatient Counseling Center, Targeted Case Management Team, or the School Based Team. Similarly, in a large substance abuse treatment agency, the Women's Residential Unit would complete the COMPASS-EZ™ separately from the Men's Program, the Partial Hospital Program, or the Outpatient Counseling Program.
    c. **It is possible, and sometimes helpful, to bring representative teams (not just individuals) from different programs in an agency together to share a common conversation and experience. In this instance, the distinct programs might score themselves differently from one another on various items, maintaining a unique scoring for each program.**
    d. **Learning from the Experience: The most important outcome of using the tool is the collective learning experience for the program and translating that learning into an**

improvement approach. The scoring, which is described in the next section, is not the main point. It is simply a method for focusing the conversation in order to facilitate a constructive conversation. Therefore, it is important for the program to take notes during the process to keep track of what is learned, and what the program members feel might be inspiring ideas for next steps to make the program better. These notes can be jotted down in the boxes labeled "Action Plan Notes" at the bottom of each section.

How do We Score the COMPASS-EZ™?

1. **Read Each Item Aloud:** The best way for the **COMPASS-EZ™** to be scored is for each member in the group discussion to have his or her own copy of the tool, and to have reviewed it briefly ahead of time, without answering the questions. Then, the timekeeper identifies one member of the group to read the first question aloud, and then opens up the discussion about what the group thinks the score should be for the program, based on a Likert scale of 1 to 5. This process is repeated, taking turns reading each successive question aloud.

2. **Reach Consensus as a Group:** Members of the group will have differing opinions about the various items. It is important that the group discuss each item to achieve consensus, and to literally poll each member to come to a conclusion on the score. In fact, one of the most important reasons for specifying a score is to reinforce the importance of continuing the discussion until consensus is reached. Often, the most quiet members of the group will have important contributions to the discussion if their opinion is solicited. Their contribution may even change the consensus score on the item. As with most consensus processes, absolute agreement is necessary. If after adequate discussion, some group members remain in disagreement, simply note the rationale and be aware that often this indicates an important issue that might become an improvement opportunity. It is helpful to remind each other that you do not need to solve the issue during the **COMPASS-EZ™,** just recognize there is one.

3. "**Evidence-Based" Scoring:** Just like an accreditation survey, the purpose of the **COMPASS-EZ™** is to score based on "the evidence". **COMPASS-EZ™** does not ask questions like: "How welcoming do we feel?" It asks about the content of welcoming in specific policies, procedures, practices, and documentation. The group should therefore score based on objective content. This does not mean that the group should sit and read the policy manual or do chart reviews, although there are times when programs will actually look things up in the course of the discussion. It is enough to simply discuss what the group members believe the policies and procedures to be. It is important to realize, however, that because many programs are not well organized in their approaches to co-occurring individuals, there will be much uncertainty and inconsistency in these perceptions within the group. There will also be inconsistency between the types of practices the group members feel are provided and what is actually written down. This is an important part of the learning experience. Try not to be too troubled by this...progress, not perfection.

4. **Using the Likert Scale:** Each item is rated on a Likert scale from 1 "Not at All" to 5 "Completely". The ratings are easy to interpret. There is no "0". Each program can give itself a 1 just for answering the question. When scoring by consensus, individual group members may be advocating for different numbers on the scale. It is the task of the group to achieve closure by "picking a number". We recommend that the group chooses a whole number whenever possible. If the group gets stuck and cannot choose a whole number, it is acceptable to split the difference and pick 1.5, or 2.5 and so on. Do not try to pick other decimals. It is beyond the purpose of the tool to have the score be that precise. Just do your best to pick a number reflecting your approximation of consensus, and move on to the next item.

5. **Scoring Honestly:** One of the challenges of using the **COMPASS-EZ™** is the temptation to try to make your score "look and feel good". This is defeating the purpose of the tool. The goal of the conversation is for the group to have an open and honest discussion of the program's current status of recovery-oriented co-occurring capability. In this type of process, the best score is the most accurate score. An honest "1" deserves a round of applause for recognizing an improvement opportunity. A "4" or "5" that is essentially over rating is much less helpful. This is an important part of shifting the system culture to valuing efforts to improve. Give yourselves a big round of applause every time you discover opportunities for improvement for your program. *Note: If your program is having extraordinary difficulty with having an open conversation, it is reasonable to talk this through with each other, rather than missing out on the value of the* ***COMPASS-EZ™*** *by continuing on in the process. Sometimes creating a safe environment for conversation is part of the framework that needs to be built prior to doing the* ***COMPASS-EZ™****. On the other hand,* ***COMPASS-EZ™*** *often provides enough structure to the conversation so that people discover how to talk more openly with each other.*

6. **Scoring Children's Programs:** When scoring children's programs it is important to apply each item to not only co-occurring individuals but to co-occurring families as well. This language should be included when each question is read aloud.

7. **Consider Diverse Issues:** As the group talks, it is likely that highly prevalent issues like trauma, will naturally be incorporated into the conversation and identified as a co-occurring issue. But, just in case, it is a good idea to spell this out in the beginning and reinforce it during the conversation. Trauma issues are common and they are a routine consideration in co-occurring capable care. The same applies for addictive behaviors like problem gambling and addiction to substances that are very unhealthy, but not frequently identified or addressed in routine services, such as nicotine. When present, these issues are serious and need attention in the framework of integrated treatment. Remember, nicotine dependence will result in more illness and death than all other drug use combined when we are focusing on people in public behavioral health settings.

8. **Scoring Programs that do not Provide Treatment:** When scoring service programs that do not provide treatment such as homeless shelters or child welfare services, the **COMPASS-EZ™** may be adapted, based on the services provided by that program. Each such program should review the tool ahead of time and determine which domains relate to activities that the program does and which ones are not relevant to the service provided. For example, in some types of programs, the sections that relate to clinical functions like assessment and treatment planning may not apply and would not be scored. However, some types of programs do perform assessment and treatment planning. Consequently, the adaptation of the tool needs to be individualized by each program.

9. **Not Applicable Does Not Apply.:** For treatment programs, with very few exceptions, every item applies to every program. If, for example, your program does not have anyone on staff who writes prescriptions, it is still applicable to have policies and procedures related to helping clients take medication properly and to communicate with their prescribers. Only a few of items might not apply to your program. These items specify that you may skip them if you meet the criteria spelled out at the end of the question. These criteria are in italics and are clear.

10. **Taking Notes:** During the discussion, the group will generate ideas about next steps for action or questions to be followed up. It is best to take notes in the box at the end of each section as referenced above. In addition, group members often like to take more detailed notes for their own purposes. This is encouraged, as long as it does not distract from the conversation.

11. **Section Scoring:** After completing the **COMPASS-EZ™**, it is helpful to summarize scoring in each of the sections. There is a score sheet in the back of the tool for this purpose. Each section will have a Total Section Score and an Average Item Score for the Section. There is also a place to record the Total **COMPASS-EZ™** Score. Scoring prompts are written at the bottom of each section to help with filling out the **COMPASS-EZ™** Score Sheet.

12. **Learning from the experience:** Don't forget. The most important part of the process is the collective learning experience as a team, not the score itself.

What Do We Do after We Complete the COMPASS-EZ™?

1. **Developing an Action Plan:** The most important next step for the program, based on the learning experience with the **COMPASS-EZ™**, is to find some starting places for making progress. These starting places do not have to be numerous or complicated. They should, however, be connected to the vision and the values of the program, they should be achievable, and they should make sense. Many programs start by trying to make progress in the area of welcoming individuals and families with co-occurring issues. Another common starting place is working on improving screening and identification of co-occurring individuals and families, both clinically and in the data system. Other programs choose to work on integrated assessment or stages of change. The goal is to begin an organized quality improvement process by creating a written "action plan" that helps the program to continually improve over time in the direction of recovery-oriented co-occurring capability.

2. **Using the "Serenity Prayer of System Change":** Many programs focus on issues over which they have no control. This leads to frustration. The goal of this process is to identify the areas of improvement that the program does have some control over in order to feel capable of making progress. Note that none of the items on the tool requires the program to hire additional staff, acquire additional funding resources, or change its program designation or licensure. All of the items relate to improvement activities that not only can be accomplished within existing resources, they can often result in more efficient use of those resources.

3. **Sharing the Scores:** If the program is part of a larger organization or a larger system, that larger system may want the program to share its scores. If the scores are collected, it may be helpful for programs to know where they have scored in relation to other similar programs, and therefore it may be useful for the system to post average scores in each Section for each type of program. However, it is important not to place too much value in the numbers themselves.
    - First, the most important message is to facilitate an honest conversation, not to have anyone think they should perform around the score. Every program should find opportunities to improve. That is the point.
    - Second, systems should resist the temptation to over analyze the scores. The tools are designed to stimulate quality improvement partnerships. Using statistical analyses may be more confusing than helpful in the process.
    - Third, this is a learning process, and many programs will find that the first time they use the tool they are still learning what "co-occurring capability" means. Programs will often work hard, and make progress, and then repeat the **COMPASS-EZ™** a year later, only to find that the scores went down slightly on certain items. This represents a situation in which increasing knowledge about the item leads to more accurate scoring over time. This is GOOD.
    - Lastly, in some systems, programs may feel that having to share their scores would inhibit their ability to have an open conversation. In those systems, it may be better for programs just to report when they have completed the tool, and what they learned, without sharing specific scores.

4. **Repeating the Process:** In most instances, programs will use the **COMPASS-EZ™** approximately once a year for several years in order to support regular self-assessment in the quality improvement process. After repeated use, the programs are more likely to demonstrate real progress on many of the items. Then the **COMPASS-EZ™** and **COCAP™** may be used to

inform the development of "co-occurring capability" standards for the system that can then be anchored in place through routine program monitoring and technical assistance activities.

5. **Progress, Not Perfection:** The goal for any program should not be to achieve a perfect score on all items on the **COMPASS-EZ™**. Over time, many programs will make significant change within existing resources and will continue finding opportunities to improve. In this type of honest process, **COMPASS-EZ™** scores will in fact slowly improve. Hopefully, the changes programs have made will be incorporated into evolving system policies and standards so that they are held in place. New concepts, knowledge and capabilities emerge in light of the progress, and the cycle of change continues.

WE HOPE YOU ALL HAVE A GREAT CONVERSATION, LEARN MUCH FROM SHARING YOUR IDEAS WITH EACH OTHER , AND FEEL MUCH BETTER PREPARED TO IMPROVE SERVICES AS A RESULT OF THIS PROCESS.

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[1] Minkoff K & Cline CA, Changing the world: the design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. Psychiat Clin N Am (2004), 27: 727-743.

[2] Minkoff K & Cline CA, Developing welcoming systems for individuals with co-occurring disorders: the role of the Comprehensive Continuous Integrated System of Care model. Journal of Dual Diagnosis (2005), 1:63-89.

[3] Minkoff K &. Cline CA, Dual diagnosis capability: moving from concept to implementation. Journal of Dual Diagnosis (2006), 2(2):121-134.

Section 1: Program Philosophy

1. The program operates under a written vision, mission or goal statement that officially communicates to all staff and stakeholders the agency-wide goal of all of its programs becoming welcoming, recovery oriented, and co-occurring capable.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. Written program descriptions specifically say that individuals and families with co-occurring issues are welcomed for care.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

3. Written program descriptions specifically say that individuals and families with co-occurring issues will be helped to use their strengths to address all their issues in order to achieve their goals.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

4. The program environment (i.e. waiting room, treatment spaces, wall posters, flyers, etc...) creates a welcoming atmosphere that supports engagement and recovery for individuals and families with both mental health conditions and substance use conditions.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

5. Program brochures for clients welcome individuals and families with co-occurring issues into service, and offer hope for recovery.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Total Section Score: _____
(Sum of All Items Answered)
Average Item Score for the Section : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 2: Program Policies

1. Program billing instructions support delivery of integrated approaches within <u>each</u> billing event.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

2. The program confidentiality or release of information policy is written to promote appropriate routine sharing of necessary information between mental health providers, substance abuse providers, <u>and</u> medical providers to promote quality of care.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

3. Clinical record keeping policies support documentation of integrated attention to mental health, health, and substance use issues in a <u>single</u> progress note and in a <u>single</u> client chart or record.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

<u>Total Section Score</u>: _____
(Sum of All Items Answered)
<u>Average Item Score for the Section</u> : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 3: Quality Improvement and Data

1. The program has a culture of empowered partnership in which leadership, supervisors, representative front line staff (clinical and support) and consumers and families work together to design and implement a vision of recovery-oriented co-occurring capable services.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

2. The program has a continuous quality improvement team, with representation from leadership, supervisors, front line staff, and consumers and families that meets regularly and uses a written plan to guide, track, and celebrate progress toward being recovery-oriented and co-occurring capable.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

3. The program has identified and empowered change agents or champions to assist with the continuous quality improvement process.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

4. Program management information systems are designed to collect accurate data on how many individuals in the program have co-occurring issues.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

5. Program management information systems in infant/child/youth services are designed to collect data on how many families served have co-occurring issues. *(You may omit this question if the program does not specifically serve infants, children and youth.)*

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

Total Section Score: _____
(Sum of All Items Answered)
Average Item Score for the Section : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 4: Access

1. The program has "no wrong door" access policies and procedures that emphasize welcoming and engaging <u>all</u> individuals and families with co-occurring issues from the moment of initial contact.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. Individuals and families receive welcoming access to appropriate service regardless of active substance use issues (e.g., blood alcohol level, urine toxicology screen, length of sobriety, or commitment to maintain sobriety.)

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

3. Individuals and families receive welcoming access to appropriate service regardless of active mental health issues (e.g., active symptoms, type of psychiatric diagnosis, or type of prescribed psychiatric medications, such as anti-psychotics, stimulants, benzodiazepines, opiate maintenance, etc...)

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

<u>Total Section Score</u>: _____
(Sum of All Items Answered)
<u>Average Item Score for the Section</u> : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 5: Screening and Identification

1. The program's screening policy states that all individuals are to be screened in a welcoming and respectful manner for co-occurring mental health issues (including trauma), substance use issues, medical issues, and basic social needs, and for immediate risk concerns in each of these areas.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. The program uses screening processes, checklists, and/or tools for each co-occurring issue that are appropriately matched to the population being screened.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

3. Staff follow a procedure for clearly documenting positive screenings for co-occurring issues in the program data system.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

4. The program has a screening process for identifying and documenting co-occurring nicotine use/ dependence.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

5. The program has a clear protocol on how to facilitate access to primary health care for every client.

Not at All = 1	Slightly = 2	Somewhat= 3	Mostly= 4	Completely = 5	

6. The program has a formal screening procedure for identifying high risk infectious diseases, including Hepatitis C, HIV, and TB.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Total Section Score: _____
(Sum of All Items Answered)
Average Item Score for the Section : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 6: Recovery-Oriented Integrated Assessment

1. Assessments document individual and/or family goals for a hopeful, meaningful and happy life using the person/family's own words.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. The assessment identifies and elaborates on a specific time period of recent strength or stability, and skills and supports the individual or family used in order to do relatively well during that time.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

3. The assessment documents data to support the presence of a substance use/gambling issue or diagnosis, including distinguishing between use, abuse and dependence for each substance or behavior.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

4. The assessment documents current and past information to support the identification of a mental health issue or diagnosis when present, including if possible, describing mental health symptoms during previous periods of non-harmful substance use or sobriety.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

5. Assessments routinely document <u>each</u> co-occurring condition, active or stable, when previously diagnosed or when identified/diagnosed during the current assessment process.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

6. The assessment documents the stage of change (i.e. precontemplation, contemplation, preparation, early action, etc...) the individual is in regarding <u>each</u> disorder, condition or issue.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

<u>Total Section Score</u>: _____
(Sum of All Items Answered)
<u>Average Item Score for the Section</u> : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 7: Integrated Person Centered Planning

1. The person's/family's hopeful goals, recent successes and strengths are the foundation of the service plans.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. Service plans list all the relevant co-occurring issues in the plan.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

3. For each of the co-occurring issues listed in the plan, there is an identified stage of change, stage matched interventions, and achievable steps to help the person feel and be successful.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

4. Person centered plans focus on building skills and supports using positive rewards for small steps of progress in learning and using skills and supports.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Total Section Score: _____
(Sum of All Items Answered)
Average Item Score for the Section : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 8: Integrated Treatment/Recovery Programming

1. Educational materials about co-occurring disorders and recovery are routinely provided to clients and families.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. <u>All</u> clients are engaged in group or individual work that provides basic education and assistance with choices and decisions regarding co-occurring issues.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

3. Clients have access to group programming that is matched to their stage of change for each issue. *(You may omit this question if the program does not have groups.)*

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

4. There are specific group or individual interventions for <u>all</u> clients providing education about psychiatric medications, including how to take medication as prescribed, and how to take medications more safely if continuing to use substances.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

5. There are specific co-occurring <u>skills manuals</u> that are used regularly in the program for individual or group skill building regarding co-occurring disorders, such as manuals on managing trauma symptoms while in addiction treatment or sobriety skill building while in mental health treatment.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

6. Clients with co-occurring issues are helped to get involved with individual and group peer support for both mental health and substance use issues, including dual recovery support programs.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

<u>Total Section Score</u>: _____
(Sum of All Items Answered)
<u>Average Item Score for the Section</u> : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 9: Integrated Treatment/Recovery Relationships

1. Each client has a primary relationship with an individual clinician or team of clinicians that integrates attention to co-occurring issues inside the relationship.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. The primary clinician or team continues working with the client on each issue even when the person may still using substances, may not be taking medication prescribed, or may be having trouble following other aspects of the treatment plan.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

3. Each clinical staff person on the team directly provides and documents the delivery of integrated services.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Total Section Score: _____
(Sum of All Items Answered)
Average Item Score for the Section : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 10: Integrated Treatment/Recovery Program Policies

1. Program policies state clearly that individuals are <u>not</u> routinely discharged or "punished" for substance use, displaying mental health symptoms, or having trouble following a treatment plan.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. Program policies and procedures are designed to <u>reward</u> individuals for asking for help when they are having difficulty or beginning to relapse with any issue.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

3. Integrated service plans and behavioral policies provide for positive reward for small steps of progress in addressing any problem, rather than focusing on negative consequences for "treatment failure", "relapse", "inappropriate behavior" or "non-compliance".

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

4. For co-occurring clients who are also involved with the court or with child welfare, integrated service plans are designed to reward small steps of progress to help clients be successful with their multiple issues, not just to monitor compliance with external mandates.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

<u>Total Section Score</u>: _____
(Sum of All Items Answered)
<u>Average Item Score for the Section</u> : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 11: Psychopharmacology

1. Whether prescribing is done on or off site, there are procedures, forms, and materials to help clients learn about medications, communicate openly with prescribers and take medication as prescribed.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. The program provides and documents for all clients routine communication between clinical staff and medical and mental health prescribers.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

3. Policies or practice guidelines specify access to medication assessment and prescription without requiring a mandatory period of sobriety.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

4. Policies or practice guidelines ensure that necessary medications for treatment of serious mental illness are appropriately maintained even though clients may continue to use substances.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

5. Medications with addictive potential (e.g., benzodiazepines) are neither routinely initiated nor routinely refused in the ongoing treatment of individuals with substance dependence. Prescription of such medications is individualized based on evaluation and consultation or peer review.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

6. Medications used specifically for treatment of substance use disorders are prescribed routinely for clients who might benefit from such medications as part of their treatment.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Total Section Score: _____
(Sum of All Items Answered)
Average Item Score for the Section : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 12: Integrated Discharge/Transition Planning

1. Discharge plan policies, procedures, practices and forms address specific stage matched continuing care requirements for each co-occurring issue.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. Each discharge plan for individuals and/or families with co-occurring issues provides for continuing integrated care with a clinician or team, ideally in a single setting.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Total Section Score: _____
(Sum of All Items Answered)
Average Item Score for the Section : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 13: Program Collaboration and Partnership

1. The program has developed a network of partner programs offering differing services to function as a learning collaborative to develop its own recovery-oriented co-occurring capability and to help other programs do the same.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. The program has policies and procedures for documentation of care coordination and collaborative service planning for co-occurring clients who attend services in another program.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

3. There is a routine process where program staff provides co-occurring consultation (ideally on site) to a collaborative program providing services in the "other" domain.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

4. There is a routine process where program staff receives co-occurring disorder consultation (ideally on site) from a collaborative program providing services in the "other" domain.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

5. Designated program clinicians participate in a regularly scheduled mental health and substance abuse provider interagency care coordination meeting that address the needs of individuals and/or families with complex issues.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Total Section Score: _____
(Sum of All Items Answered)
Average Item Score for the Section : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 14: General Staff Competencies and Training

1. There are specific recovery-oriented co-occurring competencies for all staff included in human resource policies and job descriptions.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. The program has a written scope of practice for co-occurring competency for all clinicians trained or licensed in only one area of service (e.g. licensed or formally trained in mental health OR substance abuse, but not both).

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

3. The program has written procedures for routinely documenting co-occurring issues and interventions provided by any clinician with any level of licensure or training.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

4. The program has a written plan for recovery-oriented co-occurring competency development (e.g., supervision, training activities, etc...) related to all staff (e.g., clinical, support, management, etc...).

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

5. Supervisors have the appropriate knowledge and skills to help staff become more welcoming, recovery-oriented and co-occurring competent.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

6. Recovery/resiliency and co-occurring competencies are evaluated as part of annual staff performance reviews.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Total Section Score: _____
(Sum of All Items Answered)
Average Item Score for the Section : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

Section 15: Specific Staff Competencies

1. The program staff demonstrate competency to welcome and address the needs of clients with co-occurring issues who are from different cultures and linguistic backgrounds.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

2. The program staff demonstrate specific competency in working on co-occurring issues with clients who have cognitive impairments (i.e., clients with learning disabilities, intellectual impairments, thought processing difficulties, etc....).

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

3. The program staff demonstrate specific competency in providing family support, family psycho-education, family-to-family peer support, and in addressing co-occurring issues with families in the context of these individual or group interventions.

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

4. The program staff demonstrate specific competency in providing developmentally matched services to seniors and older adults with co-occurring issues. *(You may omit this item if the program does not provide senior or older adult services.)*

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

5. The program staff demonstrate specific competency in providing developmentally matched services to children and youth with co-occurring issues. *(You may omit this item if the program does not provide services to children and youth.)*

Not at All = 1	Slightly = 2	Somewhat = 3	Mostly = 4	Completely = 5	

Total Section Score: _____
(Sum of All Items Answered)
Average Item Score for the Section : _____
(Total Section Score Divided by the Number of Items Answered in the Section)

Action Plan Notes:

COMPASS-EZ™ SCORE SHEET Sections:	Total Section Score	Average Item Score for the Section
1. Program Philosophy		
2. Program Policies		
3. Quality Improvement and Data		
4. Access		
5. Screening and Identification		
6. Recovery-Oriented Integrated Assessment		
7. Integrated Person-Centered Planning		
8. Integrated Treatment/Recovery Programming		
9. Integrated Treatment/Recovery Relationships		
10. Integrated Treatment/Recovery Program Policies		
11. Psychopharmacology		
12. Integrated Discharge/Transition Planning		
13. Program Collaboration and Partnership		
14. General Staff Competencies and Training		
15. Specific Staff Competencies		
Total COMPASS-EZ™ Score:		