Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence
Case Western Reserve University
www.ohiosamiccoe.case.edu
11.26.03

IDDT FIDELITY SCALE

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Integrated Dual Disorders Treatment (IDDT) Fidelity Scale
*Individual Rating Sheet**

_____	_____
Name of Chair	**Program Reviewed**
_____	_____
Name of Reviewer	**Date of Site Visit**

*Adapted by S. Leibbrandt and B. Wieder from the IDDT Fidelity Scale (Version 8/9/02-**R**) developed by the National Evidence-Based Practice Implementation Project.

PART I: ORGANIZATIONAL FACTORS

Item O1. Program Philosophy. The program is committed to a clearly articulated philosophy (assertive outreach, integrated mental health and substance abuse treatment, stage-wise interventions, comprehensive services, and a long-term perspective) consistent with IDDT, based on the following 5 data sources: Program leader, senior staff, clinicians, clients and/or families and written brochures.

O1. Program Philosophy	Rating	Rationale for Rating
1 of the 5 sources shows evidence of a clear understanding of the program philosophy	1	
2 of the 5 sources shows evidence of a clear understanding of the program philosophy	2	
3 of the 5 sources shows evidence of a clear understanding of the program philosophy	3	
4 of the 5 sources shows evidence of a clear understanding of the program philosophy	4	
5 of the 5 sources shows evidence of a clear understanding of the program philosophy	5	

Item O2. Eligibility/Client Identification. All clients with severe mental illness in the community support program, crisis clients and institutionalized clients are screened to determine whether they qualify for IDDT, using standardized tools or admissions criteria. Also, the agency tracks the number of eligible clients in a systematic fashion.
Data Sources: Interviews with the program leader, senior staff and clinicians; chart review

O2. Eligibility/Client Identification	Rating	Rationale for Rating
≤ 20% of clients receive standardized screening and/or agency DOES NOT systematically track eligibility	1	
21% - 40% of clients receive standardized screening and agency systematically tracks eligibility	2	
41% - 60% of clients receive standardized screening and agency systematically tracks eligibility	3	
61% - 80% of clients receive standardized screening and agency systematically tracks eligibility	4	
> 80% of clients receive standardized screening and agency systematically tracks eligibility	5	

Item O3. Penetration. Penetration is the maximum number of eligible clients receiving IDDT, as defined by a ratio. ***The SAMI CCOE will calculate this ratio using your responses below. Please disregard the information in the shaded box.***
Data Sources: Interviews with the program leader and senior staff; review of strategic plan

1. How many adults with severe mental illness (SMI) disorders (e.g., Schizophrenia, Bipolar, severe Depression with or without psychosis, Psychosis NOS) are currently served by your agency _____?

2. How many clients at your agency are eligible for IDDT (i.e., have a co-occurring substance abuse disorder)? _____?

3. How many clients at your agency receive IDDT _____?

O3. Penetration	Rating	Rationale for Rating
Ratio < .20	1	
Ratio between .21 and .40	2	
Ratio between .41 and .60	3	
Ratio between .61 and .80	4	
Ratio > .80	5	

Item O4. Assessment. Full standardized assessment of all clients who receive IDDT services. Assessment includes history and treatment of medical/psychiatric/substance use disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors.
Data Sources: Interviews with the program leader, senior staff and clinicians; chart review

O4. Assessment	Rating	Rationale for Rating
Assessment is completely absent or completely non-standardized	1	
The agency is seriously deficient in both criteria	2	
The agency is somewhat deficient in both criteria **OR** seriously deficient on one of the criteria	3	
61% - 80% of clients receive standardized assessment **OR** information is less than comprehensive across all assessment domains	4	
> 80% of clients receive standardized assessment **AND** the information is comprehensive across all assessment domains	5	

Item O5. Treatment Plan. For all clients receiving IDDT, there is a specified treatment plan *related to IDDT* for individualized treatment. This plan is consistent with the assessment and is updated every 3 months.
Data Sources: Interviews with the program leader, clinicians and clients; chart review; observation of team meeting/supervision

O5. Treatment Plan	**Rating**	**Rationale for Rating**
≤ 20% of clients receiving IDDT have a specified treatment plan, updated every 3 months	1	
21%- 40% of clients receiving IDDT have a specified treatment plan, updated every 3 months	2	
41% - 60% of clients receiving IDDT have a specified treatment plan, updated every 3 months	3	
61% - 80% of clients receiving IDDT have a specified treatment plan, updated every 3 months	4	
> 80% of clients receiving IDDT have a specified treatment plan, updated every 3 months	5	

Item O6. Treatment. Clients receive IDDT services consistent with their individualized treatment plan that is clearly *related to IDDT*.
Data Sources: Interviews with the program leader, clinicians and clients; chart review

O6. Treatment	**Rating**	**Rationale for Rating**
≤ 20% of clients served by IDDT receive services consistent with their treatment plan	1	
21% - 40% of clients served by IDDT receive services consistent with their treatment plan	2	
41% - 60% of clients served by IDDT receive services consistent with their treatment plan	3	
61% - 80% of clients served by IDDT receive services consistent with their treatment plan	4	
> 80% of clients served by IDDT receive services consistent with their treatment plan	5	

Item O7. Training. All new clinicians receive standardized training in IDDT (at least a 2-day workshop or its equivalent). Existing clinicians receive annual refresher training (at least 1-day workshop or its equivalent).
Data Sources: Interviews with the program leader, senior staff and clinicians; review of training curriculum, schedule and participation via human resources records

O7. Training	**Rating**	**Rationale for Rating**
≤ 20% of clinicians receive standardized training annually	1	
21% - 40% of clinicians receive standardized training annually	2	
41% to 60% of clinicians receive standardized training annually	3	
61% - 80% of clinicians receive standardized training annually	4	
> 80% of clinicians receive standardized training annually	5	

Item O8. Supervision. Clinicians receive weekly supervision (individual or group) *from a clinician experienced in IDDT*. Sessions explicitly address the IDDT model and its application.
Data Sources: Interviews with the program leader, senior staff and clinicians; observation of team meeting/supervision

O8. Supervision	**Rating**	**Rationale for Rating**
≤ 20% of clinicians receive weekly supervision	1	
21% - 40% of clinicians receive weekly supervision	2	
41% - 60% of clinicians receive weekly supervision	3	
61% - 80% of clinicians receive weekly supervision	4	
> 80% of clinicians receive weekly supervision	5	

Item O9. Process Monitoring. Supervisors and program leaders monitor the process of implementing IDDT every 6 months and use the data to improve the program. Monitoring involves a systematic approach, e.g., fidelity scale, training and supervision activity, service/attendance data.
Data Sources: Interviews with the program leader, senior staff and clinicians; review of internal reports/documentation

O9. Process Monitoring	Rating	Rationale for Rating
No attempt at monitoring the process is made	1	
A non-systematic approach to monitoring is used at least annually	2	
A non-systematic approach to process monitoring is used at least semi-annually (twice a year)	3	
Systematic process monitoring occurs less frequently than semi-annually (twice a year)	4	
Systematic process monitoring occurs semi-annually (twice a year)	5	

Item O10. Outcome Monitoring. Supervisors/program leaders monitor standardized outcomes for IDDT clients every 6 months and share the data with IDDT clinicians. Monitoring involves a standardized approach to assessing key outcomes related to IDDT, e.g., psychiatric admissions, substance abuse treatment scale, or employment rate.
Data Sources: Interviews with the program leader, senior staff and clinicians; review of internal reports/documentation, chart review (see ODMH Adult Form A, SATS, Cluster Form, progress notes, treatment plan)

O10. Outcome Monitoring	Rating	Rationale for Rating
No attempt at monitoring is made	1	
A non-standardized approach to monitoring is used at least annually	2	
A non-standardized approach to outcome monitoring is used at least semi-annually	3	
Standardized outcome monitoring occurs less frequently than semi-annually **AND** results are shared with IDDT clinicians	4	
Standardized outcome monitoring occurs semi-annually **AND** results are shared with IDDT clinicians	5	

Item O11. Quality Improvement (QI). The agency has a QI committee or representative with an explicit plan to review IDDT, or components of the program, every 6 months.
Data Sources: Interviews with the program leader and QI committee member

O11. Quality Improvement (QI)	Rating	Rationale for Rating
No review or no committee/representative	1	
Infrequent, disorganized QI review	2	
Occasional review, but not a regular, organized activity	3	
Explicit QI review occurs annually	4	
Explicit review every 6 months by a QI committee or representative	5	

Item O12. Client Choice. All clients receiving IDDT services are offered choices; the IDDT clinicians consider and abide by client preferences when offering and providing services.
Data Sources: Interviews with the program leader, clinicians and clients; observation of team meeting/supervision; chart review

O12. Client Choice	Rating	Rationale for Rating
Client-centered services are absent (or all IDDT decisions are made by staff)	1	
Few sources agree that type and frequency of IDDT services reflect client choice	2	
Half the sources agree that type and frequency of IDDT services reflect client choice	3	
Most sources agree that type and frequency of IDDT services reflect client choice	4	
All sources agree that type and frequency of IDDT services always reflect client choice	5	

PART II: TREATMENT CHARACTERISTICS

Item T1a. Multidisciplinary Team: A multidisciplinary team consists of a DD clinician and two or more of the following: a physician, nurse, case manager and providers of ancillary services who *work collaboratively* on the mental health team. Collaboration suggests that team members regularly communicate about the client's progress and are not merely component parts.
Data Sources: Interviews with the ancillary service providers, clinicians and clients; chart review

T1a. Multidisciplinary Team	Rating	Rationale for Rating
≤ 20% of clients receive care from a multidisciplinary team	1	
21% - 40% of clients receive care from a multidisciplinary team	2	
41% - 60% of clients receive care from a multidisciplinary team	3	
61% - 79% of clients receive care from a multidisciplinary team	4	
≥ 80% of clients receive care from a fully multidisciplinary team with a strong emphasis on accessing a broad range of services and excellent communication between all disciplines	5	

Item T1b. Integrated Substance Abuse Specialist. Substance abuse specialist, having at least two years experience, works collaboratively with the treatment team.
Data Sources: Interviews with clinical supervisor, clinicians, QI staff and clients; chart review

T1b. Integrated Substance Abuse Specialist	Rating	Rationale for Rating
No substance abuse specialist connected with agency	1	
Dual disorder clients are referred to a separate substance abuse department within the agency (e.g., referred to drug and alcohol staff)	2	
Substance abuse specialist serves as a consultant to treatment team; does not attend meetings; is not involved in treatment planning	3	
SA specialist is assigned to the team, but is not fully integrated; attends some meetings; may be involved in treatment planning but not systematically	4	
SA specialist is a fully integrated member of the treatment team; attends all team meetings; involved in treatment planning for DD clients	5	

Item T2. Stage-Wise Interventions. Treatment is consistent with the client's stage of recovery (engagement, persuasion, action, relapse prevention).
Data Sources: Interviews with clinical supervisor, clinicians, clients and QI staff; chart review

T2. Stage-Wise Interventions	Rating	Rationale for Rating
Clinicians do not know or apply this framework **OR** ≤ 20% of interventions are consistent with client's stage of recovery	1	
Less than half of clinicians have a vague awareness of stages **AND** 21% - 40% of interventions are consistent with client's stage of recovery	2	
Less than half of clinicians have a good awareness of stages **AND** 41% - 60% of interventions are consistent with client's stage of recovery	3	
Most clinicians are knowledgeable but only 61% - 79% of interventions are consistent with client's stage of recovery	4	
All clinicians understand stage-wise framework, know which stage each client is in, **AND** ≥ 80% of interventions are consistent with client's stage of recovery	5	

Item T3. Access to Comprehensive DD Services. To address a range of needs of clients with DD, the agency offers residential service, supported employment, family psychoeducation, illness management and ACT or ICM.
Data Sources: Interviews with the program director/coordinator, clinicians and ancillary service providers; chart review

T3. Access to Comprehensive DD Services	Rating	Rationale for Rating
Less than 2 services are provided by the service provider	1	
2 services are provided by the service provider **AND** IDDT clients have genuine access to these services	2	
3 services are provided by the service provider **AND** IDDT clients have genuine access to these services	3	
4 services are provided by the service provider **AND** IDDT clients have genuine access to these services	4	
All 5 services are provided by the service provider **AND** IDDT clients have access within two months of referral to these services	5	

Item T4. Long-Term Services. Clients with DD are treated on a time unlimited basis with intensity modified according to need and degree of recovery. Examples of these services include: substance abuse counseling, residential services, supported employment, family psychoeducation, illness management and ACT or ICM
Data Sources: Interviews with the program director/coordinator, clinicians and ancillary service providers

T4. Long-Term Services	Rating	Rationale for Rating
≤ 20% of services are provided on a time unlimited basis (e.g., clients are closed out of most services after a defined period of time)	1	
21% - 40% of services are provided on a time unlimited basis	2	
41% - 60% of services are provided on a time unlimited basis	3	
61% - 79% of services are provided on a time unlimited basis	4	
≥ 80% of services are provided on a time unlimited basis with intensity modified according to each client's needs	5	

Item T5. Outreach. Clinicians provide DD clients in the Engagement stage (see **Item T2**) with assertive outreach, characterized by some combination of meetings and practical assistance.
Data Sources: Interviews with the ancillary service providers, clinicians and clients

T5. Outreach	Rating	Rationale for Rating
Program is passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms	1	
Program makes initial attempts to do outreach but generally focuses efforts on most motivated clients	2	
Program attempts outreach and uses legal mechanisms only as convenient	3	
Program usually has plan for outreach and uses most of the mechanisms that are available	4	
Program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate	5	

Item T6. Motivational Interventions. All interactions with DD clients are based on motivational interviewing techniques.
Data Sources: Interviews with clinicians, clients; observations of team meeting/supervision

T6. Motivational Interventions	Rating	Rationale for Rating
Clinicians do not understand motivational interventions **AND** ≤ 20% of interactions with clients are based on motivational approaches	1	
Some clinicians understand motivational interventions **AND** 21% - 40% of interactions with clients are based on motivational approaches	2	
Most clinicians understand motivational interventions **AND** 41% - 60% of interactions with clients are based on motivational approaches	3	
All clinicians understand motivational interventions **AND** 61%- 79% of interactions with clients are based on motivational approaches	4	
All clinicians understand motivational interventions **AND** ≥ 80% of interactions with clients are based on motivational approaches	5	

Item T7. Substance Abuse Counseling. Clinicians demonstrate understanding of the basic substance abuse principles.
Data Sources: Interviews with the program director/coordinator, clinicians, clients; chart review

T7. Substance Abuse Counseling	Rating	Rationale for Rating
Clinicians do not understand basic substance abuse counseling principles **AND** ≤ 20% of clients in active treatment stage or relapse prevention stage receive SA counseling	1	
Some clinicians understand basic SA counseling principles **AND** 21% - 40% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	2	
Most clinicians understand basic SA counseling principles **AND** 41% - 60% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	3	
All clinicians understand basic SA counseling principles **AND** 61% to 79% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	4	
All clinicians understand basic SA counseling principles **AND** ≥ 80% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	5	

Item T8. Group Dual Disorder Treatment. All clients with DD are offered a group treatment specifically designed to address both mental health and substance abuse problems, and approximately two-thirds are engaged regularly (i.e., at least weekly) in some type of peer-oriented group. Groups could be family, persuasion, psychoeducation or social skills.
Data Sources: Interviews with the program director/coordinator, clinicians, clients; chart review

T8. Group DD Treatment	Rating	Rationale for Rating
< 20% of clients regularly (i.e., at least weekly) attend a DD group	1	
20% – 34% of clients regularly (i.e., at least weekly) attend a DD group	2	
35% - 49% of clients regularly (i.e., at least weekly) attend a DD group	3	
50% - 65% of clients regularly (i.e., at least weekly) attend a DD group	4	
Two-thirds or more of clients regularly (i.e., at least weekly) attend a DD group	5	

Item T9. Family Dual Disorder Treatment. Where available and if the client is willing, clinicians always attempt to involve family members (or long-term social network/significant others). The purpose is to give psychoeducation about DD and coping skills to reduce stress in the family, and to promote collaboration with the treatment team. Percentage is based on the number of family/social supports in contact with the provider.
Data Sources: Interviews with the program director/coordinator, clinicians and clients; chart review

T9. Family DD Treatment	Rating	Rationale for Rating
< 20% of families (or friends/significant others) receive psychoeducation on dual disorder	1	
20% – 34% of families (or friends/significant others) receive psychoeducation on dual disorder	2	
35% - 49% of families (or friends/significant others) receive psychoeducation on dual disorder	3	
50% - 65% of families (or friends/significant others) receive psychoeducation on dual disorder	4	
Two-thirds or more of families (or friends/ significant others) receive psychoeducation on dual disorder	5	

Item T10. Self-Help Liaison. Clinicians connect clients in the active stage or relapse prevention stage with substance abuse self-help programs in the community, such as Alcoholics Anonymous, Narcotics Anonymous, Rational Recovery Anonymous, Double Trouble or Dual Recovery Anon.
Data Sources: Interviews with the program director/coordinator and clinicians; chart review

T10. Self-Help Liaison	Rating	Rationale for Rating
< 20% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	1	
20% - 34% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	2	
35% - 49% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	3	
50% - 65% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	4	
Two-thirds or more of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	5	

Item T11. Pharmacological Treatment. Physicians or nurses prescribing medications are trained in dual disorder treatment and work with the client and the IDDT team to increase medication adherence, to decrease the use of potentially addictive medications and to offer medications such as clozapine, disulfiram or naltrexone to help reduce addictive behavior. (**SU** = substance use)
Data Sources: Interviews with the medication prescriber (if available) and clinicians; chart review

T11. Pharmacological Treatment	Rating	Rationale for Rating
Prescribers are not trained in DD treatment, prescribe without input regarding substance use (doctor outside treatment team) **OR** require abstinence prior to prescribing psychiatric meds.	1	
A minority of prescribers are trained in DD and there is minimal contact with treatment team; no efforts to ↑ adherence or to ↓ SU, using meds.	2	
About half of prescribers are trained in DD but few prescribers work with team/client to increase adherence and reduce substance use	3	
All prescribers have DD training but have minimal input from IDDT team to maximize adherence; there is evidence of efforts to ↓ addictive meds.	4	
All prescribers are trained in DD and work with clients/IDDT team to ↑ adherence; use of anti-psychotics if necessary; offer meds known to be effective in decreasing substance use	5	

T12. Interventions to Reduce Negative Consequences. *Negative consequences* of substance abuse include the physical effects, social effects, effects on self-care and independent functioning and the use of substances in unsafe situations. *Interventions* consist of needle exchange programs, teaching safe sex practice, supporting clients who switch to less harmful substances, providing support to families, helping clients avoid high-risk situations for victimization, "safe driver" programs and securing housing that recognizes clients' ongoing substance abuse problems.
Data Sources: Interviews with the program director/coordinator, clinicians and clients

T12. Interventions to ↓ Neg. Consequences	**Rating**	**Rationale for Rating**
Staff offer no form of education on reducing negative consequences	1	
There is no structured program; staff may know some ways of reducing negative consequences but rarely use these interventions	2	
Less than half of all DD clients receive a structured educational program on reducing neg. consequences; individual staff do not use interventions systematically	3	
50% - 79% of clients receive a structured educational program on reducing negative consequences; all staff are well-versed in techniques of reducing negative consequences	4	
≥ 80% of clients receive a structured basic education on how to reduce negative consequences; all staff are well-versed in techniques to reduce negative consequences	5	

T13. Secondary Interventions for Treatment Non-Responders. The program has a specific plan to identify non-responders, to evaluate them for secondary, more intensive interventions, and to link them with appropriate secondary interventions. Secondary interventions might include arranging supervised housing, intensive family interventions, and residential treatment.
Data Sources: Interviews with the program director/coordinator, clinicians, clients; chart review

T13. Secondary Interventions	**Rating**	**Rationale for Rating**
≤ 20% of non-responders are evaluated **AND** referred for secondary interventions	1	
21% - 40% of non-responders are evaluated **AND** referred for secondary interventions	2	
41% - 60% of non-responders are evaluated **AND** referred for secondary interventions	3	
61% - 79% of non-responders are evaluated **AND** referred for secondary interventions	4	
≥ 80% of non-responders are evaluated **AND** referred for secondary intervention	5	

IDDT FIDELITY SCALE – ITEM DEFINITIONS, RATIONALE AND DATA SOURCES

PART I: Organizational Characteristics

O1. Program Philosophy

Definition: The program is committed to a clearly articulated philosophy (assertive outreach, integrated mental health and substance abuse treatment, stage-wise interventions, comprehensive services, and a long-term perspective) consistent with IDDT.

Rationale: In mental health rehabilitation programs that truly embrace the best practices, staff members at all levels embrace the program philosophy and practice it in their daily work.

Data Sources: Interviews with the program leader, senior staff (e.g., executive director, psychiatrists), clinicians, clients and/or family members; review of written materials (brochures)

O2. Eligibility/Client Identification

Definition: All clients in the community support program, crisis clients, and institutionalized clients are screened using standardized tools or admission criteria.

- The *target population* refers to all adults with severe mental illness disorders served by the provider agency (i.e., Schizophrenia, Bipolar, severe Depression with or without psychosis, and Psychosis NOS). If the agency serves clients at multiple sites, then assessment is limited to the site or sites that are targeted for IDDT. If the target population is served in discrete programs (e.g., case management, day treatment, residential, etc.), then ordinarily all adults with severe mental illness are included in this definition.
- *The intent is to identify any and all who could benefit from the IDDT.* For integrated dual disorder treatment, the admission criteria are specified and specific assessment tools are recommended. In every case, the program should have an explicit, systematic method for identifying the eligibility of every client.
- *Screening* typically occurs at program admission, but for a program that is newly adopting IDDT, there should be a plan for systematically reviewing clients already active in the program.

Rationale: Accurate identification of clients who would benefit most from IDDT requires routine review for eligibility.

Data Sources: Interviews with the program leader, senior staff and clinicians; chart review

O3. Penetration

Definition: Penetration is the maximum number of eligible clients receiving IDDT, as defined by a ratio (calculated by the SAMI CCOE):

# of clients receiving an IDDT
divided by
# of clients eligible for the IDDT

All clients who could benefit from IDDT have access to IDDT.

Rationale: Surveys have repeatedly shown that access is very limited to IDDT and most other EBP's. The goal of dissemination of IDDT is not simply to create small exclusive programs but to make these practices easily accessible within the public mental health system.

Data Sources: Interviews with the program leader, senior staff; review of strategic plan for agency

O4. Assessment

Definition: All severely mentally ill clients receive a full, standardized assessment that is updated at least yearly. Assessment includes history and treatment of medical, psychiatric, and substance use disorders, current stages of all existing disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors.

Rationale: Comprehensive assessment/re-assessment is indispensable in identifying target domains of functioning that may need intervention, in addition to the client's progress toward recovery.

Data Sources: Interviews with the program leader, senior staff and clinicians; chart review

O5. Treatment Plan

Definition: For all severely mentally ill clients, there is a specified treatment plan for individualized treatment consistent with the assessment that is updated every 3 months. Specificity refers to treatment recommendations that identify both the target of the intervention (e.g., specific symptoms, social problems, substance abuse behaviors) and an intervention designed to address that problem and how it will bring about changes.

Rationale: Core values of IDDT include individualization of services and supporting clients' pursuit of their goals and progress in their recovery at their own pace. Therefore, the treatment plan needs ongoing evaluation and modification with consumer input.

Data Sources: Interviews with the program leader, clinicians and clients; chart review; observation of team meeting/supervision

O6. Treatment

Definition: All IDDT clients receive treatment consistent with their individualized treatment plan clearly *related to IDDT*.

Rationale: The key to the success of IDDT is an individualized treatment plan that is implemented in a timely fashion.

Data Sources: Interviews with the program leader, clinicians and clients; chart review

O7. Training

Definition: All new clinicians receive standardized training in IDDT (at least a 2-day workshop or its equivalent). Existing clinicians receive annual refresher training (at least 1-day workshop or its equivalent). All clinicians who might provide some aspect of IDDT are to be considered as eligible for training.

Rationale: Clinician training and retraining are warranted to ensure that IDDT services are provided in a standardized manner.

Data Sources: Interviews with the program leader, senior staff and clinicians; review of training curriculum, schedule and participation via human resources records

O8. Supervision

Definition: Clinicians receive weekly supervision (individual or group) from a clinician experienced in IDDT. Sessions explicitly address the IDDT model and its application.

Rationale: Regular supervision is critical not only for individualizing treatment, but also for ensuring the standardized provision of IDDT services.

Data Sources: Interviews with the program leader, senior staff and clinicians; observation of team meeting/supervision

O9. Process Monitoring

Definition: Supervisors/program leaders monitor the process of implementing IDDT every 6 months and use the data to improve the program. Process monitoring involves a systematic approach, e.g., use of a fidelity scale, training, supervision, or examination of data on service use, group attendance or minutes from implementation committee meetings.

Rationale: Systematic and regular collection of process data is imperative to evaluating program fidelity.

Data Sources: Interviews with the program leader, senior staff and clinicians; review of internal reports/documentation

O10. Outcome Monitoring

Definition: Supervisors/program leaders monitor the outcomes of IDDT clients every 6 months and share the data with IDDT practitioners in an effort to improve services. Outcome monitoring involves a systematic approach to assessing clients, e.g., psychiatric admissions, a substance abuse treatment scale, number of job placements, MACSIS, or ODMH tools.

Rationale: Systematic and regular collection of outcome data is imperative to evaluating program effectiveness. Effective programs also analyze such data to ascertain what is working and what is not working, and use the results to improve the quality of services they provide.

Data Sources: Interviews with the program leader, senior staff and clinicians; review of internal reports/documentation, chart review (see ODMH Adult Form A, SATS, Cluster Form, progress notes, treatment plan)

O11. Quality Improvement (QI)

Definition: The agency's QI committee or representative has an explicit plan to review IDDT progress or components of the program every 6 months.

Rationale: Research has shown that programs that most successfully implement IDDT have better outcomes. Again, systematic and regular collection of process and outcome data is imperative to evaluating program effectiveness.

Data Sources: Interviews with the program leader and QI committee members/representative

O12. Client Choice

Definition: All clients receiving IDDT services are offered choices; IDDT clinicians consider and abide by client preferences when offering and providing services.

Rationale: A major premise of IDDT is that clients are capable of playing a vital role in the management of their illnesses and in making progress towards achieving their goals. Providers accept the responsibility of getting information to clients so that they can become more effective participants in the treatment process.

Data Sources: Interviews with the program leader, clinicians and clients; observation of team meeting/supervision; chart review

PART II: Treatment Characteristics

T1.a) Multidisciplinary Team

Definition: All clients with DD receive care from a multidisciplinary team that includes DD expertise. A multidisciplinary team consists of a DD clinician and two or more of the following: a physician, nurse, case manager and providers of ancillary services who *work collaboratively* on the mental health team. Collaboration suggests that team members regularly communicate about the client's progress and are not merely component parts.

Rationale: Although a major focus of treatment is the elimination or reduction of substance abuse, this goal is more effectively met when other domains of functioning in which clients are typically impaired are also addressed. Competent IDDT programs coordinate all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative manner.

Data Sources: Interviews with the ancillary service providers, clinicians and clients; chart review

T1.b) Integrated Substance Abuse Specialist

Definition: A substance abuse specialist who has at least 2 years of experience works collaboratively with the treatment team. The experience can be in a variety of settings, preferably working with clients with a dual disorder, but any substance abuse treatment experience will qualify for rating this item.

Rationale: Having an experienced substance abuse specialist integrated into the treatment team is essential for ensuring a sustained focus on substance use.

Data Sources: Interviews with program leader, clinician, substance abuse specialist; chart review

T2. Stage-Wise Interventions

Definition: All interventions (including ancillary services) are consistent with and determined by the client's stage of treatment or recovery. The concept of stages of treatment include:

1) ***Engagement***: Regular contact is maintained with agency staff
2) ***Persuasion***: Helping the engaged client develop the motivation to participate in recovery-oriented interventions.
3) ***Action***: Helping the motivated client acquire skills and supports for managing illnesses and pursuing goals.
4) ***Relapse Prevention***: Helping clients in stable remission develop and use strategies for maintaining recovery.

Rationale: Research suggests that modifications in maladaptive behavior occur most effectively when stages of treatment are taken into account.

Data Sources: Interviews with clinical supervisor, clinicians, clients and QI staff; chart review

T3. Access to Comprehensive DD Services

Definition: To address a range of needs of clients with DD, the agency offers the following five ancillary services. (For a service to be considered "available," it must both exist and be accessible by clients with DD, with needs met within 2 months of referral):

1) ***Residential service***: Supervised residential services that accept clients with DD, including supported housing (i.e., outreach for housing purposes to clients living independently) and residential programs with on-site residential staff. Exclude short-term residential services (i.e., a month or less).
2) ***Supported Employment***: Vocational program that stresses competitive employment in integrated community settings and provides ongoing support.
3) ***Family Psychoeducation***: A collaborative relationship between the treatment team and family (or significant others) that includes basic psychoeducation about SMI and its management, social support and empathy, interventions targeted to reducing tension and stress in the family as well as improving functioning in all family members.
4) ***Illness management***: Systematic provision of necessary knowledge and skills through psychoeducation, behavioral tailoring, coping skills training and a cognitive-behavioral approach, to help clients learn to manage their illness, find their own goals for recovery, and make informed decisions about their treatment.
5) ***Assertive Community Treatment (ACT)*** or ***Intensive Case Management (ICM)***: A multidisciplinary team (client-to-clinician ratios of 15:1 or lower) providing 24-hour care, at least 50% of the time in the community.

Ancillary services are consistent with IDDT philosophy and stages of treatment/recovery. For example, a housing program encompasses approaches for clients who are in engagement and motivation stages of recovery.

Rationale: Individuals with DD have a wide range of needs, such as developing a capacity for independent living, obtaining employment or some other meaningful activity, improving the quality of their family and social relationships, and managing anxiety and other negative moods. Competent IDDT programs must be comprehensive because the recovery process occurs longitudinally in the context of making many life changes.

Data Sources: Interviews with the program director/coordinator, clinicians, and ancillary service providers; chart review

T4. Long-Term Services

Definition: Clients with DD are treated on a time unlimited basis with intensity modified according to need and degree of recovery.

Rationale: The evidence suggests that both disorders tend to be chronic and severe. A time unlimited service that meets individual client's needs is believed to be the most effective strategy for this population.

Data Sources: Interviews with the program director/coordinator, clinicians and ancillary service providers

T5. Outreach

Definition: Clinicians provide clients with DD in the *Engagement* stage (see **Item T2**) with assertive outreach, characterized by some combination of meetings and practical assistance (e.g., housing, medical care, crisis management, legal aid, etc.) in their natural living environments as a means of developing trust and a working alliance. Other clients continue to receive outreach as needed.

Rationale: Many clients with DD tend to drop out of treatment due to the chaos in their lives, low motivation, cognitive impairment, and hopelessness. Effective IDDT programs use assertive outreach to keep the clients engaged.

Data Sources: Interviews with the ancillary service providers, clinicians and clients

T6. Motivational Interventions

Definition: All interactions with dual disorder clients are based on motivational interviewing that include:

1) ***Expressing empathy***.
2) ***Developing discrepancy between goals and continued use***.
3) ***Avoiding argumentation***.
4) ***Rolling with resistance***.
5) ***Instilling self-efficacy and hope***.

Rationale: Motivational interviewing involves helping the client identify his/her own goals and to recognize, through a systematic examination of the individual's ambivalence, that not managing one's illnesses interferes with attaining those goals. Research has demonstrated that clients with DD who are unmotivated can be readily identified and effectively helped with motivational interventions.

Data Sources: Interviews with clinicians and clients; observations of team meeting/supervision

T7. Substance Abuse Counseling

Definition: Clinicians demonstrate understanding of basic substance abuse principles. Clients who are in the *action* stage or *relapse prevention* stage receive substance abuse counseling aimed at:

1) Teaching how to manage cravings;
2) Teaching relapse prevention strategies;
3) Problem-solving skills training to avoid high-risk situations;
4) Challenging clients' beliefs about substance use; and
5) Coping skills training to deal with symptoms or negative mood states related to substance abuse (e.g., relaxation training, teaching sleep hygiene, cognitive-behavioral therapy for depression or anxiety, coping strategies for hallucinations)

The counseling may take different forms and formats, such as individual, group (including 12-Step based treatment programs), or family therapy or a combination thereof.

Rationale: Once clients are motivated to manage their own illnesses, they need to develop skills and supports to control symptoms and to pursue an abstinent lifestyle. Effective IDDT programs provide some form of counseling that promotes cognitive-behavioral skills at this stage.

Data Sources: Interviews with the program director/coordinator, clinicians and clients; chart review

T8. Group DD Treatment

Definition: All clients with DD are offered a group *treatment* specifically designed to address both mental health and substance abuse problems, and approximately two-thirds are engaged regularly (e.g., at least weekly) in some type of peer-oriented group. Groups could be family, process-oriented persuasion or active treatment, psychoeducation, relapse prevention or social skills.

Rationale: Research indicates that better outcomes are achieved when group treatment is integrated to address both disorders. Additionally, the group format is an ideal setting for clients to share experiences, support, and coping strategies.

Data Sources: Interviews with the program director/coordinator, clinicians, clients; chart review

T9. Family DD Treatment

Definition: Where available and if the client is willing, clinicians *always attempt* to involve family members (or long-term social network/significant others) to give psychoeducation about DD and coping skills to reduce stress in the family, and to promote collaboration with the treatment team. Percentage is based on the number of family/social supports in contact with the provider.

Rationale: Research has shown that social support plays a critical role in reducing relapse and hospitalization in persons with SMI, and that family psychoeducation can be an especially powerful approach for improving substance abuse outcomes in clients with SMI. However, the decision to involve significant others is the client's choice. Clinicians should discuss the benefits of family treatment with the client, and respect his/her decision about whether and in what ways to involve them.

Data Sources: Interviews with the program director/coordinator, clinicians and clients; chart review

T10. Self-Help Liaison:

Definition: Clinicians connect clients in the *active* stage or *relapse prevention* stage with substance abuse self-help programs in the community, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Rational Recovery Anonymous (RRA), Double Trouble, Cocaine Anonymous (CA) or Dual Recovery Anonymous.

Rationale: Although pressuring reluctant clients to participate in self-help groups is contraindicated, social contacts with other members of self-help groups play an important role in the recovery of clients with DD, who are motivated to achieve or maintain abstinence.

Data Sources: Interviews with the program director/coordinator and clinicians; chart review

T11. Pharmacological Treatment:

Definition: Physicians or nurses prescribing medications are trained in DD treatment and work with the client and the IDDT team to increase medication adherence, to decrease the use of potentially addictive medications such as benzodiazepines, and to offer medications such as clozapine, disulfiram, or naltrexone that may help to reduce addictive behavior.

Rationale: Research indicates that psychotropic medications are effective in the treatment of SMI, including clients who have active substance abuse problems. Access to such medications including antipsychotics, mood stabilizers, and antidepressants is critical to effective treatment of SMI clients.

Data Sources: Interviews with the medication prescriber (if available) and clinicians; chart review

T12. Interventions to Reduce Negative Consequences:

Definition: Efforts are made to directly reduce the negative consequences of substance abuse using methods other than substance use reduction itself. Typical negative consequences of substance abuse that are the focus of intervention include physical effects (e.g., disease,

triggering mental illness relapses, prostitution involving unsafe sex), social effects (e.g., loss of family support, victimization), self-care and independent functioning (e.g., housing instability, incarceration, malnutrition), and use of substances in unsafe situations (e.g., driving while intoxicated). Examples of strategies designed to reduce negative consequences include: needle exchange programs, teaching safe sex practice, supporting clients who switch to less harmful substances, providing support to families, helping clients avoid high-risk situations for victimization, securing housing that recognizes clients' ongoing substance abuse problems, and "safe driver" programs.

Rationale: Clients with DD are at higher risk than general population for detrimental effects of substance abuse described above.

Data Sources: Interviews with the program director/coordinator, clinicians and clients

T13. Secondary Interventions for Treatment Non-Responders:

Definition: The program has a specific plan to identify non-responders, to evaluate them for secondary more intensive interventions, and to link them with appropriate secondary interventions. Potential secondary interventions might include arranging supervised housing, intensive family interventions, protective payeeship, changing medications, residential treatment, and conditional discharge.

Rationale: Consumers that do not effectively engage in or respond to the treatment plan may need more a more intensive treatment experience that will provide any number of elements necessary for their recovery. In order to provide an adequate intensity of service, a protocol to identify, evaluate, and follow up with the client is necessary.

Data Sources: Interviews with the program director/coordinator, clinicians, clients; chart review