Integrated Dual Disorders Treatment (IDDT) Fidelity Index

*Inpatient Adaptation**

ORGANIZATIONAL ITEMS:	1	2	3	4	5
Item 1. Identification of DD Patients. All new and existing patients are screened for substance use (both drug(s) and alcohol) using a standardized protocol/instrument (e.g., CAGE, UNCOPE). New patients are screened within 24-72 hours of admission; existing patients are screened at the time of integrated DD services implementation. The screening, including both the process and the measure, is included in the patient's record. ***Standardization is defined as use of the same process or instrumentation with all patients to collect data on the items specified above.*** **Sources of Information:** Patient record review, clinician interview.					
1.**Identification of DD Patients**	No standardized method to screen all patients for DD is used	Fewer than 75% of all patients are screened for DD using a standardized screening protocol	All newly admitted patients are screened for DD using a standardized screening protocol, but not within 72 hours	Every newly admitted patient is screened for DD within 24 -72 hours using a standardized protocol	Every newly admitted patient is screened for DD within 24 -72 hours **AND** ≥ 75% of existing patients have been screened for DD using a standardized screening protocol.
Item 2. Assessment Patient needs are assessed comprehensively and updated upon re-admission and/or whenever clinical course dictates. Assessment should include impact of psychiatric illness and substance use in multiple life areas, as well as interaction between psychiatric symptoms and substance use. Numerous data sources are important; there is an expectation that family members will be contacted. Substance use should be assessed using a standardized protocol. ***Standardization is defined as use of the same process or instrumentation with all patients to collect data on all of the items specified above.*** **Sources of Information:** Patient record review, clinician interview, patient/family member interviews.					
2. **Assessment**	<30% of patients receive standardized assessment that is updated as clinically and administratively indicated	30-49% of patients receive standardized assessment that is updated as clinically and administratively indicated	50-69% of patients receive standardized assessment that is updated as clinically and administratively indicated	70-89% of patients receive standardized assessment that is updated as clinically and administratively indicated	≥90% of patients receive standardized assessment that is updated as clinically and administratively indicated

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Item 3. Patient Staging. Patients are in various stages of readiness to address one or both of their disorders which should inform the type of treatment approaches utilized. The expectation is that newly admitted patients are staged for both disorders, using a standardized instrument/protocol (e.g., BHO SATS adaptation, see attached) by the treatment team prior to development of the first comprehensive Treatment Plan, **within 5 days of admission,** and that existing patients are staged, using the same protocol, within 5 days of identification. All patients should be re-staged as needed and appropriate. ***The results of the staging process should determine the selection of treatment goals and interventions (see item #14).***
Sources of Information: Clinician interview, team meeting/supervision observation and patient record review (reference staging tool).

3. **Patient Staging**	<30% of newly admitted patients are staged within 5 days of DD identification **AND** <30% of existing patients are staged within 5 days of DD	30 - 49% of newly admitted patients are staged within 5 days of DD identification **AND** ≥ 30 - 49% of existing DD patients are staged within 5 days of DD identification	50 - 69% of newly admitted patients are staged within 5 days of DD identification **AND** ≥ 50 - 69% of existing patients are staged within 5 days of DD identification	70 - 89% of newly admitted patients are staged within 5 days of DD identification **AND** ≥ 70 - 89% of existing patients are staged within 5 days of identification	≥ 90% of newly admitted patients are staged within 5 days of DD identification **AND** ≥ 90% of existing patients are staged within 5 days of DD identification

Item 4. Integration and Currency of the Treatment Plan. Patient treatment plans address both mental health and substance use treatment needs, with both specificity and integration of treatment recommendations. Specificity refers to treatment recommendations that identify both the target of the intervention (e.g., specific symptoms, social problems, substance use behaviors) and an intervention designed to address that problem and how it will bring about changes. Integration refers to treatment recommendations that address the interactions between substance use and mental illness. One example of such integration is helping patients to cope with psychiatric symptoms that appear to contribute to their substance use. Another example is providing psycho-education to patients to help them understand how substance use worsens their psychiatric illness. The treatment plan must reflect the patient's stages of treatment for both disorders. The community (outpatient) provider should be part of the treatment team, with direct (in-person, if feasible) contact and participation with the hospital treatment team and activity during the patient's hospital stay (see item # 5).
Sources of Information: Patient record review, team meeting observation.

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4. **Integration and Currency of the Treatment Plan**	One disorder is addressed **OR** both disorders are addressed with no specificity and/or integration and stages of treatment are updated less frequently than clinically indicated	Both disorders are addressed in 30-49% of the treatment plans with poor specificity and integration OR stages of treatment are updated less frequently than clinically indicated	Both disorders are addressed in 50-69% of plans with some specificity and integration AND stages of treatment are updated as clinically indicated	Both disorders addressed in 70-89% of plans with good integration and specificity AND stages of treatment are updated as clinically indicated	Both disorders are addressed in ≥90% of plans with good specificity and integration AND stages of treatment are updated as clinically indicated.

Item 5. Involvement of Outpatient Providers in Treatment and Discharge Planning. For patients who are connected to community (outpatient) care prior to admission, the outpatient case manager should be part of the treatment team, with direct (in-person, if feasible) contact and participation with hospital treatment team and activity over the course of the patient's hospital stay (see item # 4). It is essential that outpatient providers be involved in discharge planning. When it is anticipated that a patient's stay will brief, it is especially important to begin to collaboratively plan the discharge at the time of intake (see item # 6).
Sources of Information: Patient record review, team meeting observation.

5. **Involvement of Outpatient Providers in Treatment and Discharge Planning**	> 30% of patients have their outpatient provider involved in both treatment and discharge planning	≥ 30 - 49% of patients have their outpatient provider involved in both treatment and discharge planning	≥ 50 - 69% of patients have their outpatient provider involved in both treatment and discharge planning	≥ 70 - 89% of patients have their outpatient provider involved in both treatment and discharge planning	≥ 90% of patients have their outpatient provider involved in both treatment and discharge planning

Item 6. Integrated Discharge Plan. Written discharge plans should address continuity of care for both mental and substance use disorders following discharge from the hospital to outpatient care; this includes assuring that plans address stage-appropriate recommendations for specific issues as well as basic needs such as securing housing prior to discharge. Uninterrupted care requires involvement of the community treatment provider and possibly ancillary professionals (e.g., Probation Officers, etc.) with the inpatient treatment team throughout the patient's stay (see item # 5). When it is anticipated that a patient's stay will brief, it is especially important to begin to collaboratively plan the discharge at the time of intake.
Sources of Information: Patient record review, team meeting observation, hospital policy and procedure manual.

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6. **Integrated Discharge Plan**	< 30% of patient discharge plans target both substance use and mental illness	30 – 49% of patient discharge plans target both substance use and mental illness	50 – 69% of patient discharge plans target both substance use and mental illness	70 – 89% of patient discharge plans target both substance use and mental illness	≥ 90% of patient discharge plans target both substance use and mental illness

Item 7. Clinical Staff Training in the IDDT Model. Clinical staff members should receive standardized training in the Integrated Dual Disorder Treatment model appropriate to their roles and functions, at least annually. Comprehensive training for all practitioners and supervisors in core principles as well as basic and advanced skills is essential to providing IDDT services. All direct care staff members should receive training relevant to their clinical functions and level of patient involvement (see levels chart). This should involve an initial intensive overview as well as ongoing skill enhancement/development tracked annually.
Sources of Information: Program Leader/clinician interviews, training records.

7. **Clinical Staff Training in the IDDT model**	<30% of clinicians/direct care staff members receive training as per competencies criteria	30-49% of clinicians/direct care staff members receive raining as per competencies criteria	50-69% of clinicians/direct care staff members receive training as per competencies criteria	70-89% of clinicians/direct care staff members receive training as per competencies criteria	≥90% of clinicians/direct care staff members receive training as per competencies criteria

Item 8. Clinical Guidance & Monitoring. Clinical staff members should receive guidance and monitoring of clinical practice on a regular basis appropriate to their role and functions from a practitioner experienced in the Integrated Dual Disorder Treatment model. The guidance can be provided either in groups or individually and might happen in the context of treatment team meetings and other naturally occurring activities. Monitoring and guidance should not be primarily peers-only but should involve a designated and experienced IDDT clinician. The guidance should be patient-focused and explicitly address IDDT principles and their application to *specific patient situations.*
Sources of Information: Program Leader/Clinician Interviews, Treatment team meeting observation, Treatment group observation, Practitioner competency logs

8. **Clinical Guidance & Monitoring**	≤ 1 type of clinical guidance is monitoring are provided	2 types of clinical guidance and monitoring are provided	3 types of clinical guidance and monitoring are provided	4 types of clinical guidance and monitoring are provided	5 types of clinical guidance and monitoring are provided

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Item 9. Process Monitoring. Supervisors/program leaders monitor the process of implementing the IDDT *Inpatient Adaptation* every 3 months and use process data to improve the program. Effective process monitoring involves a standardized approach, e.g., use of a fidelity scale, training records, supervision logs, and examination of data on service use or group/session attendance. The expectation is that a specific Action Plan based on data/report recommendations would be developed that would include documentation of action steps, time frames, responsible parties, and results.
Sources of information: Program Leader/clinician interviews, review of internal reports/documentation.

9.**Process Monitoring**	No attempt to monitor implementation process is made	A non-standardized approach to monitoring is used at least annually	A non-standardized approach to process monitoring is used at least semi-annually	Standardized process monitoring occurs at least semi-annually	Standardized process monitoring occurs at least quarterly

Item 10. Patient Outcomes Monitoring. Program Leaders/Supervisors monitor patient outcomes at least quarterly and discuss the data with practitioners in an effort to improve individual and program-level services. Outcomes monitoring involves a systematic approach to assessing patients on a range of indicators, e.g., movement through stages of treatment, patient and family satisfaction survey information, and monitoring other effects, e.g., rapid or frequent re-admission rates following discharge.
Sources of Information: Program leader/Clinician interviews, review of internal reports/documentation, review of patient records.

10.**Patient Outcomes Monitoring**	No standardized outcomes monitoring occurs	Standardized outcomes monitoring occurs at least annually but results are not discussed with practitioners	Standardized outcomes monitoring occurs at least semi-annually, but results are not discussed with practitioners	Standardized outcomes monitoring occurs at least semi-annually and results are discussed with practitioners	Standardized outcomes monitoring occurs at least quarterly and results are discussed with practitioners

Item 11. Quality Improvement. The hospital's QI Committee has an explicit plan to review the IDDT *Inpatient Adaptation* implementation or components of the program every 6 months.
Sources of Information: Program leader/QA-QI Committee Members interviews.

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11.**Quality Improvement**	QI review that includes specific IDDT elements does not occur	QI review that includes specific IDDT elements occurs sporadically	QI review that includes specific IDDT elements occurs occasionally	Routine QI review that includes specific IDDT elements occurs annually	Routine QI review that includes specific IDDT elements occurs every 6 months

Item 12. Patient Choice. All patients receiving IDDT services during the hospital stay are offered choices. All direct care staff members consider and abide by patient preferences when offering and providing services.

Sources of Information: Program leader/Clinician interviews, Team meeting/supervision observation, Patient/family member interviews, Patient record reviews.

12.**Patient Choice**	Patients are not informed of the range of services; services are determined by staff	Few patients are fully informed of the range of services and are offered choices based on their preferences	Some patients are fully informed of the range of services and are offered choices based on their preferences	Most patients are fully informed of the range of services and are offered choices based on their preferences	All patients are fully informed of the range of services and are offered choices based on their preferences

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<table>
<tr><th>TREATMENT ITEMS:</th><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th></tr>
<tr><td colspan="6">Item 13. Multi-Disciplinary Approach to Integrated Services. Services to patients with co-occurring disorders are provided by clinicians/direct care staff representing the range of professional disciplines, including psychiatrists/APNs, psychologists, nurses, social workers, recreational and occupational therapists and other ancillary specialists, who have excellent communication and work collaboratively.
Sources of Information: Program Leader/Clinician interviews, shift change reports.</td></tr>
<tr><td>13. Multi-Disciplinary Approach to Integrated Services</td><td>No evidence of communication or collaboration across disciplines and shifts</td><td>Evidence shows poor communication and collaboration across disciplines and shifts</td><td>Evidence shows fair communication and collaboration across disciplines and shifts</td><td>Evidence shows good communication and collaboration across disciplines and shifts</td><td>Evidence shows excellent communication and collaboration across disciplines and shifts</td></tr>
<tr><td colspan="6">Item 14. Stage-wise Treatment. Use of specific interventions based on an evaluation of the patient’s motivation to address and work on substance use and mental illness. Stages of treatment reflect the understanding that a clinical relationship must be established before attempting to address either disorder. Following the establishment of such a relationship, attention is paid to helping patients understand the effects of substance use and mental illness on their lives and helping them to make informed choices to address their behaviors. Then, attention may turn to resolving ambivalence about recovery and making a commitment to abstinence from substance use and finally to planning for relapse prevention.
Sources of Information: Program Leader/Clinician/Patient interviews; patient record and other documents review; Team meeting/supervision observation.</td></tr>
<tr><td>14.Stage-wise Treatment</td><td><30% of interventions are consistent with patients’ treatment stages</td><td>30-49% of interventions are consistent with patients’ treatment stage</td><td>50-69% of interventions are consistent with patients’ treatment stage</td><td>70-89% of interventions are consistent with patients’ treatment stage</td><td>≥90% of interventions are consistent with patients’ treatment stage</td></tr>
<tr><td colspan="6">Item 15. Comprehensiveness of Services. To address a range of patient needs, multiple ancillary rehabilitation services are available. For a service to be considered “available” it must both exist and be accessible by patients and their Social Support Network members within a reasonable period of time following screening (see item #15) and should be available throughout the hospitalization. Services are to include: Psychoeducation, Wellness Self-Management, Vocational Support, Inpatient Self-Help, Spiritual Support, Leisure Activities.
Sources of Information: Program Leader/Clinician interviews, patient record review.</td></tr>
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15. **Comprehensiveness of Services**	Patients have access to two or fewer service categories	Patients have access to three of the service categories	Patients have access to four of the service categories	Patients have access to five of the service categories	Patients have access to all service categories

Item 16. Timeliness and Duration of Services. Services, (including those (listed in item # 14) should begin in a timely fashion after admission to the hospital and continue until the patient is discharged, with no time limits set on treatment. Timeliness is defined as 2-3 days post-screening. Access to appropriate services should **not** be delayed until all assessments are completed.
Sources of Information: Patient record review, patient and clinician interviews.

16. **Timeliness and Duration of Services**	For <30% of patients, services begin within 2-3 days of screening and continue through discharge	For 30-49% of patients, services begin within 2-3 days of screening and continue through discharge	For 50-69% of patients, services begin within 2-3 days of screening and continue through discharge	For 70-89% of patients, services begin within 2-3 days of screening and continue through discharge	For ≥90% of patients, services begin within 2-3 days of screening and continue through discharge

Item 17. Outreach Capability. The provision of services *where the patient lives* as opposed to the expectation that the patient will gravitate to a central location. Outreach includes both engagement of new patients and (re)engagement of patients previously engaged who are not participating in hospital services. For example, if a patient will not leave his/her room to attend a group meeting, the staff member or clinician would go to the patient's room, attempt to encourage group attendance, or alternatively, spend time with the patient individually. Outreach to patients is done for emergency purposes (e.g., behavioral crises, medication/symptom monitoring, to attend to basic needs (e.g., nutrition, self-care), to engage the patients and encourage attendance at programmed activities, and to maintain the therapeutic alliance.
Sources of Information: Program Leader/Clinician/Patient interviews, patient record reviews.

17. **Outreach Capability**	Outreach is done for emergency purposes only	Outreach is done for emergency purposes and medication and symptom monitoring	Outreach is done for emergency purposes, medication/symptom monitoring, and to attend to basic needs (e.g., nutrition, self-care, etc.)	Outreach is done for emergency purposes, medication/symptom monitoring, to attend to basic needs (e.g., nutrition, self-care, etc.), and to encourage patient attendance at programmed activities, but there is no outreach to maintain the therapeutic alliance	Outreach is done for emergency purposes, medication/symptom monitoring, to attend to basic needs (e.g., nutrition, self-care, etc.), to encourage patient attendance at programmed activities, and to maintain the therapeutic alliance

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<tr><td colspan="6">Item 18. Motivational Interviewing. Motivational Interviewing is a conversational technique shown to be effective for enhancing patient movement through the stages of change that are necessary to adequately address the many issues related to recovery. It is a style that can and should be utilized by all hospital staff. Elements of motivational interviewing include: expressing empathy, identifying personal goals, developing discrepancy, rolling with resistance, and supporting self-efficacy. Although the ideal would involve all BHO staff achieving fluency with MI, the expectation is that staff members who have demonstrated proficiency with MI skills are dispersed throughout the units in a way that ensures that all patients can benefit from this approach. To achieve high fidelity, the hospital must have a written plan that outlines the manner in which staff members proficient in MI are made accessible to all patients.
[Proficiency in MI can be assessed using a variety of observational rating instruments and processes]</td></tr>
<tr><td>18. Motivational Interviewing</td><td><30% of patients have access to staff members proficient in MI techniques</td><td>30-49% of patients have access to staff members proficient in MI techniques</td><td>50-69% of patients have access to staff members proficient in MI techniques</td><td>70-89% of patients have access to staff members proficient in MI techniques</td><td>≥ 90% of patients have access to staff members proficient in MI techniques</td></tr>
<tr><td colspan="6">Item 19. Cognitive Behavioral Therapy (CBT). Cognitive Behavioral Therapy (CBT) is one of the most effective forms of psychotherapy. It is a general approach to helping people overcome problems and make progress toward personal goals. CBT is an active, structured, time-limited, directive form of therapy that is based on the belief that the way a person perceives and structures the world determines his/her feelings and behaviors. Depression treatment, for example, is aimed at discovering negative views that patients have about themselves or a given situation and helping them gather evidence against distorted aspects of this self-perception or situation. The goal of this therapy is to identify and correct the patient's distorted negative cognitions, to clarify and challenge underlying beliefs, and to increase the patient's adaptive problem solving capacity. Counseling may take several forms, including developing relapse prevention plans, teaching strategies for dealing with cravings, training in problem-solving to address "high risk situations," or teaching specific strategies for coping with symptoms or mood states that lead to substance use.
Sources of Information: Program Leader/Clinician/Patient interviews; evidence of curriculum used, group observations, written plan for ensuring patient access to CBT practitioners.</td></tr>
<tr><td>19. Cognitive Behavioral Therapy (CBT)</td><td><30% of stage-appropriate patients have access to a practitioner skilled in CBT</td><td>30-49% of stage-appropriate patients have access to a practitioner skilled in CBT</td><td>50-69% of stage-appropriate patients have access to a practitioner skilled in CBT</td><td>70-89% of stage-appropriate patients have access to a practitioner skilled in CBT</td><td>≥ 90% of stage-appropriate patients have access to a practitioner skilled in CBT</td></tr>
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Item 20. Integrated Group Treatment for DD Patients. All patients are offered group interventions specifically designed to address both mental health and substance use problems at the same time.
Sources of Information: Program Leader/Clinician/Patient interviews; patient record review; group observation; copy of current group treatment schedule.

20. **Integrated Group Treatment for DD Patients**	No groups are offered	Groups are offered for mental health only	Separate groups for mental health and substance use are offered but there is no integration of the disorders in the groups	Separate groups for mental health and substance use are offered, but some discussion of the other disorder does take place	Integrated groups are offered where both mental health and substance use disorders are the focus of the treatment

Item 21. Types of Group Treatment. The provision of different stage-appropriate group interventions led by professionals specifically targeting co-occurring disorders. Five different types of groups are identified: education, persuasion, active treatment, skills training, and relapse prevention.
Sources of Information: Program Leader/Clinician/Patient interviews; group attendance logs; Program's protocols for types of groups

21. **Types of Group Tx**	1 or no group is offered	2 group types are offered	3 group types are offered	4 group types are offered	5 or more group types are offered

Item 22. Patient to Clinician Ratio in Group Treatment. The number of patients relative to the number of clinicians in a group intervention. Research and professional literatures suggest that process-oriented groups are less effective if group size exceeds 12 patients with co-facilitators. Psychosocial groups may be larger in size.
Sources of Information: Clinician/Patient interviews; group attendance logs, group observations.

22. **Patient to Clinician Ratio in Group Tx**	> 20 patients with one facilitator	13-20 patients with one facilitator	13-20 patients with co-facilitators	12 or fewer patients with one facilitator	12 or fewer patients with co-facilitators

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Item 23. Interventions for Patients and Members of their Social Support Networks. A Social Support Network (SSN) may include parents, siblings, lovers, extended family, friends, and/or others who comprise a patient's significant social support system. SSN intervention by professionals is intended to educate SSN members about co-occurring disorders, reduce stress, and to promote collaboration with the treatment team.
Sources of Information: Program Leader/Clinician/Patient/SSN member interviews, patient record review; team meeting observation.

23. **Interventions for Patients and Members of their Social Support Networks**	No routine mechanism to identify SSN member(s) and/or engage patients in signing releases for staff contact	Mechanism to identify SSN member(s)/obtain release but no mechanism to provide/refer for services	Mechanisms in place and ≥ 3 services available, including ≥ 2 on-site	Mechanisms in place and ≥ 4 services available, including ≥ 3 on-site	Mechanisms in place and ≥ 5 services available, including ≥ 4 on-site

Item 24. Pharmacological Treatment Approach. Treatment approaches are tailored to the needs of patients with co-occurring disorders and incorporate the following practices: 1) Patients receive medication for detoxification, when needed; 2) Psychotropic medications are not withheld from patients based on current or past use of substances; 3) Psychotropic medications prescribed reflect consideration of abuse liability and potential for interaction with drugs of abuse; 4) Drug screens are utilized; 5) Pharmacological approaches to decrease relapse risk are considered.
Sources of Information: Clinician (including Psychiatrist)/Patient interviews; review of patient records; Hospital records, e.g., PHS.

24. **Pharmacological Tx Approach**	≤ 1 of the 5 issues above is evident	2-3 of the 5 practices listed above are evident	3 of the 5 practices listed above are evident	4 of the 5 practices listed above are evident	All 5of the practices listed above are evident

Item 25. Community Self-Help Linkages. Connecting patients with community consumer-run self-help groups for addiction problems, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), Dual Recovery Anonymous (DRA) or Double Trouble, is shown to result in increased rates of abstinence when living in the community. The expectation is that all stage-appropriate patients are offered on-site self-help groups to introduce them to these fellowships, their principles and steps during hospitalization (see item #15). For patients with off-site privileges, the expectation is that the hospital facilitates attendance at community meetings to ease patients' transition to the community at discharge. "Active linkage" (score of 5) is defined as hospital staff or outpatient provider accompanying patients to the first community meeting(s) followed by patients' attendance on their own. This provides an opportunity to process the experience in individual counseling sessions prior to discharge.
Sources of Information: Program Leader/Clinician/Patient interviews; review of patient records; Self-help group protocols.

25. **Community Self-Help Linkages**	No client opportunity to participate in 12-step groups while hospitalized (on-site or off-site)	Staff-led self-help meetings offered and accessible on-site but no community liaison attending	Staff-led self-help groups offered and accessible on-site with hospital staff member liaison to community 12-step groups	Peer- or staff-led self-help groups offered and accessible on-site with outside [peer] liaison to community 12-step groups	Peer-led self-help groups offered and accessible on-site with active linkage to community 12-step groups.

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