

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):

$$\frac{\text{\# of clients receiving an IDDT}}{\text{\# of clients eligible for the IDDT}}$$

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