

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
<i>Client-centered services</i> 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 $\leq 20\%$ 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 $\geq 80\%$ 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 $\leq 20\%$ 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 $\geq 80\%$ 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 $\leq 20\%$ 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 $\geq 80\%$ 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	