

# Integrated Dual Diagnosis Treatment Supervisor's



## Field Reference Guide

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# Integrated Dual Diagnosis Treatment Supervisors' Guide

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## Introduction

To a large degree the success of an evidence-based practice is determined by the attitude and actions of the supervisor. Integrated Dual Diagnosis Treatment is a complex model comprised of several, varied clinical skills. Without the knowledge and ongoing focus of the supervisor implementation and maintenance of these skills is very likely to be compromised.

This toolkit is offered as an aid to help IDDT supervisors stay focused and effective in helping the clinicians they supervise to learn and effectively use the skills of the model. Successful implementation and faithfulness to this model does not come easily and will not occur without a high level of intentional supervisory action. The goal of this toolkit is to help the supervisor to target goals and action steps that will lead to greater clinical effectiveness.

The chapters are divided into different target areas listed below, each with their own tools and resources. Each one of these will help the supervisor to think about what is needed and what to do to move toward high fidelity. And we always need to remember that fidelity is not the ultimate goal, but a means to the end of client recovery. All we do is in support of helping clients have a bigger, better life. The IDDT skills are, in the end, about nothing more or less than client recovery. Recovery is supported by clinical effectiveness. Clinical effectiveness is supported by good supervision. Supervision is one of the key elements in client recovery.

1. Supervision
  - a. Group
  - b. Individual
2. Building and Enhancing Treatment Skills
  - a. Field Mentoring
  - b. Group Skill Practice
3. Enhancing the Quality of Service Components
  - a. Quality Review of Documentation
  - b. Core Competencies
  - c. Job Descriptions
4. Managing Outcomes
  - a. Fidelity Scales
  - b. Substance Abuse Treatment Scale

The goal of clinical work is to elicit and support recovery behaviors. The goal of supervision is to elicit and support effective clinical behaviors. It is our hope that these tools and resources will help you to focus your attention and effort toward greater clinical effectiveness and improved client outcomes.

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Office of Mental Health Research and Training

## What Makes For Good Supervision

### Meets

- Meets regularly with team in regularly scheduled times
- Team meetings start and end on time
- Manages meeting according to EPB guideline
- Available to team members on a PRN basis
- Celebrates successes publically
- Criticism not done in public setting

### Models

- Attitudes, knowledge and skills of EBP model are displayed in all discussions and interactions
- Person centered (not disease-modeled) language used
- Documents staffings and conferences
- Oversees training of new staff in model
  - Documentation of training components completed
  - Regularly observes CM skills, provides feedback
  - Seeks and uses feedback from clients re CM abilities, attitude

### Manages

- Provides feedback to staff in specific and behavioral manner
- Assures all clients have access to case manager or
- Ensures or provides coverage for vacations, illnesses
- Uses productivity data and CM report sure that clients are seen and reviewed regularly
- Uses data to observe client outcomes, shares with CM's
- Monitors treatment non-responders, staffs as needed for new ideas
- Provides critical information to upper management, shares needs, celebration

## Overview of supervision

The main purpose of supervision from the perspective of any evidence-based model is facilitating improvement in the lives of our clients. The means to this end is skillful, compassionate engagement on the part of treating clinicians. The supervisor's main task in this regard is making sure that case managers and other treatment providers understand the use of IDDT skills and perspectives and that they can and are effectively using them. This is accomplished in three main ways: training, group supervision, and assessment and coaching/feedback in individual supervision

### Training

IDDT is a complicated skill set that for many case managers will be difficult to learn. Ongoing skill training is probably a necessity for the learning and honing of these skills. The supervisor and IDDT specialist need to make and implement a long-term training plan that will help case managers and other clinicians on the team to not only understand but also practice these skills in team trainings. The initial 5 day training is really only an orientation to the skills. The real learning takes place in follow up trainings and in actual practice with clients.

### Group supervision

For many evidence-based case management practices group supervision is the bedrock of the supervision process. In group supervision case managers meet together primarily for structured case presentations which provide opportunities to identify helpful ways to think about clients and to target specific, stage-appropriate interventions with clients. The structure is vital; without it the case presentation is in danger of turning into a "complaint fest" which may actually make the case manager more stuck. The idea here is to use group questions and brainstorming to help the case manager think outside the box and approach the client in new, more effective ways. A case presentation model is provided in this section of the toolkit.

### Individual supervision

Individual supervision gives the chance to really find out in depth what is going on with clients and what the case manager is doing with them. A nonjudgmental, encouraging attitude on the part of the supervisor is the foundation for good supervision. Looking for what the case manager is already doing right and reinforcing that provides a helpful context for assessing the case manager's interventions with his/her clients. Field mentoring can be a very useful chance to see the case manager in action and to provide positive reinforcement and coaching.

## Supervisory Practices Group Supervision

Demonstrates understanding of EBP principles as evidenced by demonstration of skills, consultation given in case presentations and theory of the model.

Ensures review of client situations remains a focused, task-oriented process that produces specific plan or menu of options appropriate for EBP model. Supervisor prepares staff for presenting good case presentations

Supervisor documents discussions and provides follow-up on ideas and suggestions from previous meetings and ensures implementation occurred where feasible.

Requires completion and distribution of EBP relevant material (Strengths Assessment, contextual analysis, vocational profile, etc) prior to staffing.

Ensures that all team members display behavior and language and the focus of the interventions and brainstorming is consistent with EBP philosophy elements (respect for client choice, attention to strengths, hopeful, recovery-oriented).

Supervisor minimizes extraneous information and distractions (i.e. phone calls) and creates an environment where all participants are encouraged to both give and receive feedback from peers in a positive manner as evidenced by group participation and attention.

Supervision is held weekly and follows an organized structure that includes case reviews, celebrations and brainstorming.

The supervisor assists team in generalizing specific client situations reviewed in team meeting, ideas generated and lessons learned from those specific situations to staff's caseload

The supervisor knows and enforces rules for good brainstorming to create a climate within team meeting where good brainstorming can occur.



## The Supervisor's Role in Group Supervision

1. Provide expectations to the team in terms of:
  - process
  - involvement of all team members
  - rules of brainstorming
  - focus on clients strengths
  - Strengths assessment is distributed at every review
2. During the group supervision, ensures that the structure and process of the group supervision is followed with no deviation.
3. Assist staff in skills needed for presenting clients in group supervision – including pre-planning of the presentation:
  - Identifying what is needed from the group
  - Ability to describe concisely an overview of relevant information about the client
  - Ability to concisely describe what has been tried that did not work.
4. Assist the team in keeping the focus on the needs identified by the presenting staff as well as the strengths assessment.
5. Ability to stop the group if they get off track (e.g. brainstorming) and assist them in staying focused.

## Group Supervision Guiding Principles

The following are areas that supervisors need to pay attention to during group supervision. The supervisor should address any areas where there is deviation from the areas of evidenced-based practice.

1. **Client Preferences:** Is the case manager focused on getting help with a goal that the client wants or is the discussion focused on what the case manager thinks the client needs?
2. **Stage of Treatment:** Is the Stage of Treatment stated at the beginning of the presentation and is it accurate? Is the case manager pacing her efforts at the stage that the client is in or is she moving too fast or too slow?
3. **Integration:** Are all members of the team participating in the client presentation process or is it dominated by one or two team members? Am I as the Team Leader the only person making suggestions during brainstorming?
4. **Teaching:** Once brainstorming is complete are suggestions reviewed to make sure they are stage appropriate? (This can be an effective way to reinforce/review understanding of the IDDT Model).
5. **Updated Plan:** Does the case manager walk away with clear direction of next steps to be taken?
6. **Follow-up:** Do I have a plan to following up on the outcome of the action taken by the case manager as a result of the case presentation.

## Group Supervision: Process Description

Group supervision is the fuel that keeps strengths model practice alive and strong on a team level. The structure is designed to keep the team focused on generating creative strategies, rather than digressing into venting or rehashing of problems. For each client discussed, the process consists of seven steps; each is distinct and critical to the success of the process.

**Step 1: Hand out Strengths and Longitudinal Assessments, as well as any other IDDT evaluations** - The presenting staff person makes copies of a strengths assessment for every team member and hands them out. The process will NOT work unless each team member has his or her own copy of the strengths assessment for the person being presented. CM must state what Stage of Treatment the person is in.

**Step 2: What is the client goal(s) and what help do I specifically need from the group?** - For example, "Joe has a goal to go back to work. I would like some ideas on jobs that might match his interests," "Mary wants more friends in her life. I would like some ideas on where she might go to meet more people." The client's goal(s) takes center stage in this process. If the client does not have a specific goal, then the question to the group should revolve around how to engage with the person to find a goal that is passionate and meaningful to him or her. Being specific at this point in the process keeps the team focused on what is to be accomplished. things that have already been tried.

**Step 3: What is the current situation and what has been already tried?** - The presenting staff person gives a quick one to two minute description of the current situation and a few things have already been tried.

**Step 4: What does the team need clarified from the assessments?** - At this point it might be good for the team to take a few minutes to look over the assessments. Then, for five to ten minutes the team asks questions of the presenting staff person to further clarify anything that is written down or areas that have not been fully explored. For example, "It says here that the grandmother is supportive. Tell us more about her role in the person's life." No advice can be given in this section. The intent here is to understand as much about the person as possible so that creative and specific suggestions can be offered in the next step to help the person achieve their goal.

**Step 5: Brainstorming** - For ten to fifteen minutes the team brainstorms ideas. It is important that these ideas are related to the person's goal(s). The presenting staff person MUST write down every idea without speaking (i.e., no evaluation of the ideas or "yes, buts"). The intent here is to allow the team to get creative and solution-focused. Often some of the best ideas come toward the end of brainstorming as the ideas begin to build. A good brainstorming will generate between 20 to 40 ideas.

**Step 6: What will be my plan based upon the suggestions made?** - The presenting staff person reviews the ideas and then states clearly what next steps they will take. For example, "I meet with Jean this Thursday. I will take this list with me and see if she wants to pursue any of these suggestions to help her get more involved in the community," "I like the idea of taking Jim out to the zoo since he loves animals. While we are there I will use some of the motivational interviewing techniques to gauge where he is at in his goal of sobriety. I will also build on the strengths assessment to see what supports have been helpful to him in the past when he has been sober.

**Step 7: Supervisor Follow Up** - At the next meeting the supervisor or team leader needs to follow up on implementation of ideas and get feedback on the progress. If it's working, wonderful; if not, schedule another staffing or use field mentoring.

## Quality Review of Group Supervision Process

Client's Name \_\_\_\_\_ Date Reviewed \_\_\_\_\_

Presenting Staff Person's Name \_\_\_\_\_

Reviewer's Name \_\_\_\_\_

- |     |          |    |  |
|-----|----------|----|--|
| Yes |          | No | Were Strengths Assessments and other EBP related materials given to all team members?  |
| Yes | Somewhat | No | Did the presenting staff person clearly state the client's goal(s)? (If the presenting staff is not aware of the client's goal, then this should be stated.)   |
| Yes | Somewhat | No | Did the presenting staff person clearly state what specific help they need from the team?  |
| Yes | Somewhat | No | Did the team ask questions to clarify anything written on the Strengths Assessment and other EBP related material? (While the team is free to ask any questions relevant to providing the presenting staff person help, the majority of these questions should come directly from the Strengths Assessment or other EBP related material.) |
| Yes | Somewhat | No | Did the team provide specific and constructive suggestions for the presenting staff person based on the Strengths Assessment and other EBP related materials? (While a good brainstorming session should generate between 20-40 ideas, a minimum of 10 should be expected)   |
| Yes | Somewhat | No | Did the presenting staff person clearly state what next steps they will take in working with the client based on the suggestions made?   |

Comments

## Group Supervision Checklist

0-Not at all 1-Somewhat 2-Moderately 3-Too a large extent 4-A great deal

\_ 1. Did case managers and other clinicians present give and receive help/ideas around the identified situation being presented?

\_ 2. Was the atmosphere optimistic and positive (i.e., focused on what could be done)?

\_ 3. Was the language being used about the client respectful and focused on possibilities rather than on negative client characteristics and obstacles?

\_ 4. Did the presentation end with clear and specific ideas for interventions?

\_ 5. Was the client's stage of treatment identified accurately?

\_ 6. Was there brainstorming around possible interventions?

\_ 7. Was the presentation and the suggested interventions consistent with the client's stage of treatment and their own motivations?

\_ 8. Were appropriate tools (Strengths Assessment, Longitudinal Analysis, Contextual Assessment, etc.) handed out for the presentation?

\_ 9. Did the supervisor keep the group on track?

\_ 10. Were proposed interventions from prior case presentations followed up on?

## GROUP SUPERVISION: WORKSHEET

\* Strengths Assessment Provided For Review: Yes or No

\* Client's Goal(s):

\* What I Want Help with from the Team:

\* Overview of the Current Situation:

\* Team Brainstorming:

\* Next Steps:

\* Follow-up Report (1 wk):

## Case Presentation Follow-up Form

Client you presented on \_\_\_\_\_

Situation/Problem discussed \_\_\_\_\_

Intervention(s) decided on \_\_\_\_\_

\_\_\_\_\_

Were you able to use the intervention(s)? \_\_\_\_\_

If not, what got in the way? \_\_\_\_\_

\_\_\_\_\_

If you did use them how did it go? \_\_\_\_\_

\_\_\_\_\_

Any other feedback needed? \_\_\_\_\_

\_\_\_\_\_

What is your next step? \_\_\_\_\_

\_\_\_\_\_

## Group Supervision Log

Client Presented	Date Presented	Plan of Action	Follow-Up Information



## Providing Feedback

Providing feedback is central for helping staff to build and enhance their skills in engagement, assessment, employment planning, job development and follow-along support.

Providing verbal and written feedback about skills in an ongoing and consistent way will insure quality IDDT. In order to be successful with delivering feedback, the following are six minimum conditions that need to exist:

### Minimum Conditions for Successful Feedback:

1. Make standards for the work clear.
2. Create a learning environment.
3. Believe your staff can learn, grow and change.
4. Know and recognize the strengths of your staff.
5. Recognize and view feedback as a helpful tool rather than a punitive action.
6. Be specific when giving feedback.

## Process of Giving Feedback

Using the same staff you identified earlier, write out a “script” of how you might give feedback to him/her using the following five steps.

1. Identify the person’s strengths

(e.g., rather than starting off by identifying the problem (step 2), you might say... “I wanted to meet with you to give you some feedback. First of all, you are doing a great job of discovering new resources like the food bank and new job leads for the team... etc.)

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2. State the situation in behavioral terms

(e.g., Rather than, “You are not getting your paper work done”, you might say “I was reviewing charts the other day and I found that three of your clients did not have assessments completed.”)

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3. Set the tone for the discovery process

(e.g., Rather than, “I would like you to get these completed by next week”, you might say... “I am wondering if you could help me better understand what is happening that the assessments are not being completed”.)

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4. Brainstorm alternative strategies

(e.g., Rather than, “I am going to...”, you might say... “I would like you to give me some suggestions as to what I could do to help you get your assessments done in a timely manner.”)

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5. Set a time frame and next steps

(e.g., Rather than, “OK, we’ll see how it goes”, you might say... “I would like to schedule a time to meet with you in a week to see how it is going. How about the 15<sup>th</sup>?”)

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## Giving Feedback Assessing the Situation

Identify a specific staff member whom you have had a challenge supervising in the past. Fill out the following information related to a SPECIFIC ISSUE that has presented a problem.

1) What is happening that presents a problem?

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2) What do you want? What are your expectations?

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3) What are the person's strengths? What is he or she doing well?  
Be specific.

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4) What are some things that you might be able to do to help?

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# Professional Development Plan

Clinician \_\_\_\_\_ Supervisor \_\_\_\_\_  
Date \_\_\_\_\_

Goal \_\_\_\_\_  
\_\_\_\_\_

Action Step \_\_\_\_\_

Target Date \_\_\_\_\_ Date Accomplished \_\_\_\_\_

Action Step \_\_\_\_\_

Target Date \_\_\_\_\_ Date Accomplished \_\_\_\_\_

Action Step \_\_\_\_\_

Target Date \_\_\_\_\_ Date Accomplished \_\_\_\_\_

Action Step \_\_\_\_\_

Target Date \_\_\_\_\_ Date Accomplished \_\_\_\_\_

Goal \_\_\_\_\_  
\_\_\_\_\_

Action Step \_\_\_\_\_

Target Date \_\_\_\_\_ Date Accomplished \_\_\_\_\_

Action Step \_\_\_\_\_

Target Date \_\_\_\_\_ Date Accomplished \_\_\_\_\_

Action Step \_\_\_\_\_

Target Date \_\_\_\_\_ Date Accomplished \_\_\_\_\_

Action Step \_\_\_\_\_

Target Date \_\_\_\_\_ Date Accomplished \_\_\_\_\_

## IDDT Skill Enhancement

### **In-House Training/Practice**

IDDT is a complicated skill set that for many case managers will be difficult to learn. Ongoing skill training is probably a necessity for the learning and honing of these skills. The supervisor and IDDT specialist need to make and implement a long-term training plan that will help case managers and other clinicians on the team to not only understand but also practice these skills in team trainings. The initial training series is really only an orientation to the skills. The real learning takes place in follow up trainings and in actual practice with clients. While it is important to ensure that staff understand and use specific stage appropriate skills at each stage; the exercises outlined in this section focus on those skills that are generally new or need additional practice to reach and sustain a level of competency.

### **Field Mentoring**

Field Mentoring is another way form of individual supervision in the field with the staff member in an actual client situation. This section describes in detail the purpose and format of field mentoring as well as providing worksheets to document and track field mentoring progress.

## Supervisory Practices for Staff Skill Building and Enhancement

The Supervisor specifically provides feedback to staff on EBP skills and their ability to operationalize the philosophy and principles of the EBP.

1. The supervisor provides staff with quality feedback that meets the following criteria :
  - Identifies strengths of the practitioner
  - Engages staff member, “we’re in this together”
  - Is able to clearly identify the behavior or practice needing attention
  - Is specific and clear
  - Is able to clearly articulate what behavior or actions they want to see
  - Is able to identify with the practitioners a plan of corrective action
  - Is able to identify how the supervisor can help with the corrective plan of action.
  - Follows up on corrective action plan.
2. The supervisor has staff role play skills in an array of settings (individual supervision, group supervision) as a tool to provide feedback on those skills.
3. The supervisor spends at least 10% of their supervisory time each month doing field mentoring. Field mentoring consists of the supervisor:
  - Spending time out in the field with staff
  - Observing the skills of the EBP
  - Modeling the skills of the EBP
  - Giving feedback on skills of the EBP
  - Creating a learning plan with staff
4. The supervisor provides feedback on the skills of the EBP:
  - during group supervision
  - during individual supervision
5. The supervisor provides rewards and recognition for incremental steps staff take toward improvement in skills/implementation of the EBP.
6. The supervisor has a structured way of providing new staff training on the evidence-based practice.
7. The supervisor interacts with clients on a regular basis to learn about individual client situations so they can give feedback to staff and help staff to impact change. The supervisor has had personal contact with 80% of the team’s clients.

## IDDT Assessments/Plans

### Longitudinal, Contextual Analysis, Payoff Matrix, Functional Analysis & Relapse Prevention Plan

1. Pass a blank copy of the assessment to be practiced.
2. Recreate the form on a Dry Erase board or Flipchart.
3. Complete the assessment as group.
4. Choose a client that everyone is familiar with if possible so that all members can contribute to the discussion.
5. The Supervisor takes the role as case manager and asks the questions of the (case manager) team writing it on the board. The team provides the information to begin the assessment.
6. It is fine if the assessment has some missing information since this can be used to give the case manager direction on filling in the unknown information with the client.
7. End the exercise by having each case manager pick someone on their case load that is in the appropriate stage and gives permission to practice the assessment with. Set a date for completion and review in either group or individual supervision.

Longitudinal Analysis for \_\_\_\_\_ Age: \_\_\_\_\_

Stage of Change: \_\_\_\_\_

Date: \_\_\_\_\_

Age Range	What was going on in my life?	Mental Illness, symptoms, treatment	Substance abuse symptoms treatment	Interaction of symptoms and substance abuse
Birth - 10 years				
11 - 20 years				
21-30				
31-45				



46-55				
56+				

Client Name \_\_\_\_\_ Client ID# \_\_\_\_\_

### Longitudinal Assessment Form p. 2

- Remember to consider how much questioning/planning is appropriate for the client's stage.
- Locate the times that are most significant to the client. What was going on...

When the problem was especially bad (these are circumstances to watch out for)

Mental Health –

Substance Abuse –

When things were especially good (get details...what did the client do to make things go well?)

Mental Health –

Substance Abuse –

## Payoff Matrix

	PRO	CON
STAY THE SAME		
MAKE A CHANGE		

## Functional Analysis Summary

Client name:

Date:

- A. Complete a Payoff Matrix (see Form C.6) that identifies the advantages and disadvantages of using substances, and the advantages and disadvantages of not using substances. For a client who is currently using substances, the perceived advantages of using substances (and disadvantages of not using substances) should *outweigh* the perceived advantages of not using substances (and the disadvantages of using substances). The short-term advantages of using substances (and disadvantages of not using) often maintain substance use behavior, despite the long-term disadvantages of using substances and (advantages of not using).
- B. Based on the perceived advantages of using substances, and the disadvantages of not using substances, what factors seem to be most critical in maintaining the client's use of substances (or, if the client is not abusing substances, what factors pose the greatest risk for relapse)?
- C. What strategies might be used to *reduce* some of the negative consequences (or the "costs") of the client's not using substances? Consider rehabilitation-based interventions, such as teaching the client skills to cope with symptoms; providing social skills training to improve social competence and ability to make friends; assisting the client in developing new social outlets and new recreational activities; and helping the client find something meaningful to do (such as employment, supported education for school, or increased parenting responsibilities).
- D. What strategies might be used to *increase* the advantages of not using substances? Consider motivation-based interventions, such as motivational interviewing and contingency contracting.

## Contextual Analysis

Eternal Triggers (People, Places, Things, etc...)	Internal Triggers (Thoughts)	Internal Triggers (Feelings)	Action Taken (Use Substance/Not Use Substance)	Short Term Consequences (Immediate)	Longer Term Consequences (Generally Next Day)

## Mental Illness Relapse Prevention Worksheet

A. Early warning signs that I may be about to experience a relapse of my mental illness (e.g., trouble sleeping, being isolated from others, confused thinking):

- 1.
- 2.
- 3.

B. Feelings I experience when I want to start using substances again (e.g. angry, sad, bored, nervous, anxious, guilty, excited, self-confident)

- 1.
- 2.
- 3.

C. Plan to be implemented when early warning signs or feelings appear (e.g., call my doctor, call my case manager, call a support person, go to a Twelve-Step meeting):

- 1.
- 2.
- 3.

Doctor's name:

Phone number:

Therapist's name:

Phone number:

Case Manager's name:

Phone number:

Support person's name:

Phone number:

Support person's name:

Phone number:

## Substance Abuse Relapse Prevention Worksheet

A. Early warning signs that I may be about to experience a relapse of my substance abuse (e.g., going to places where I used to drink or use drugs, hanging out with people I used to drink or use drugs with, cravings, decreased need for sleep, becoming more isolated):

- 1.
- 2.
- 3.

B. Feelings I experience when I want to start using substances again (e.g., angry, sad, bored, nervous, anxious, guilty, excited, self-confident):

- 1.
- 2.
- 3.

C. Plan to be implemented when early warning signs or feelings appear (e.g., call my doctor, call my case manager, call a support person, go to a Twelve-Step meeting):

- 1.
- 2.
- 3.

Doctor's name:

Phone number:

Therapist's name:

Phone number:

Case Manager's name:

Phone number:

Support person's name:

Phone number:

Support person's name:

Phone number:

# Motivational Interviewing exercises

Review the 5 skills used in Motivational Interviewing:

1. Open-ended questions
2. Affirm
3. Reflective listening
4. Summarize
5. Elicit change talk

Reflective listening tends to be the skill most needing practice so you can begin with the following exercise:

## Exercise 1: Forming Reflections

1. Have team members break-up into pairs or groups of threes depending on team size.
2. Preparation: everyone complete this sentence:  
“One think I’d like to change about myself is ...” (Make this statement is fairly abstract so that the conversation can go back and forth several times before switching to the next person).
3. Speaker can answer normally in this exercise (answer more than yes or no so another reflection can be made).
4. Listener(s) take turns making reflective statements only
  - a. “You mean that you \_\_\_\_\_”
  - b. “You’re wondering if \_\_\_\_\_”
  - c. “It sounds like you \_\_\_\_\_” or
  - d. “So you feel \_\_\_\_\_”
5. Remember, in statements tone of voice goes DOWN at end of sentence, questions go UP.
6. If there are 3 people in the group alternate between the 2 listeners making reflective statements.
7. Each person needs to have the opportunity to be both speaker and listener.



## Exercise 2: Forming Reflections

1. Have team members break-up into pairs only for this exercise.
2. Preparation: each person completes the following sentence:  
“Something I’m thinking of changing...”
3. Speaker: speak and answer normally
4. Listener: Elicit Change Talk by Using OARS  
Open Ended Questions  
Affirmations  
Reflective Statements  
Summaries
5. Switch roles after 7-10 minutes
6. Visit each pair during the exercise to evaluate skill practice

## Exercise 2: Group Role Play

1. Ask one team member to role play a client or present a situation he feels ambivalent about.
2. Ask one team member to role play the counselor/case manager
3. Give a brief summary of the situation
4. Have 3 team members sit behind the “counselor” each responding to statements made by the “client”
5. The “counselor” chooses the answer she feels is the most MI appropriate and the client responds.
6. Continue the conversation for 10-15 minutes and then review as a group

From *Motivational Interviewing, Preparing People for Change, Second Addition* by William Miller, Stephen Rollnick. Copyright 2002 by the Guilford Press.

# Field Mentoring

Field mentoring is when the supervisor goes out into the field with their staff for the purpose of observing, providing feedback, modeling, and prompting skills in order to assist staff in improving their skills or helping staff with situations in which they feel “stuck”. Field mentoring is the most effective way to build and enhance skills.

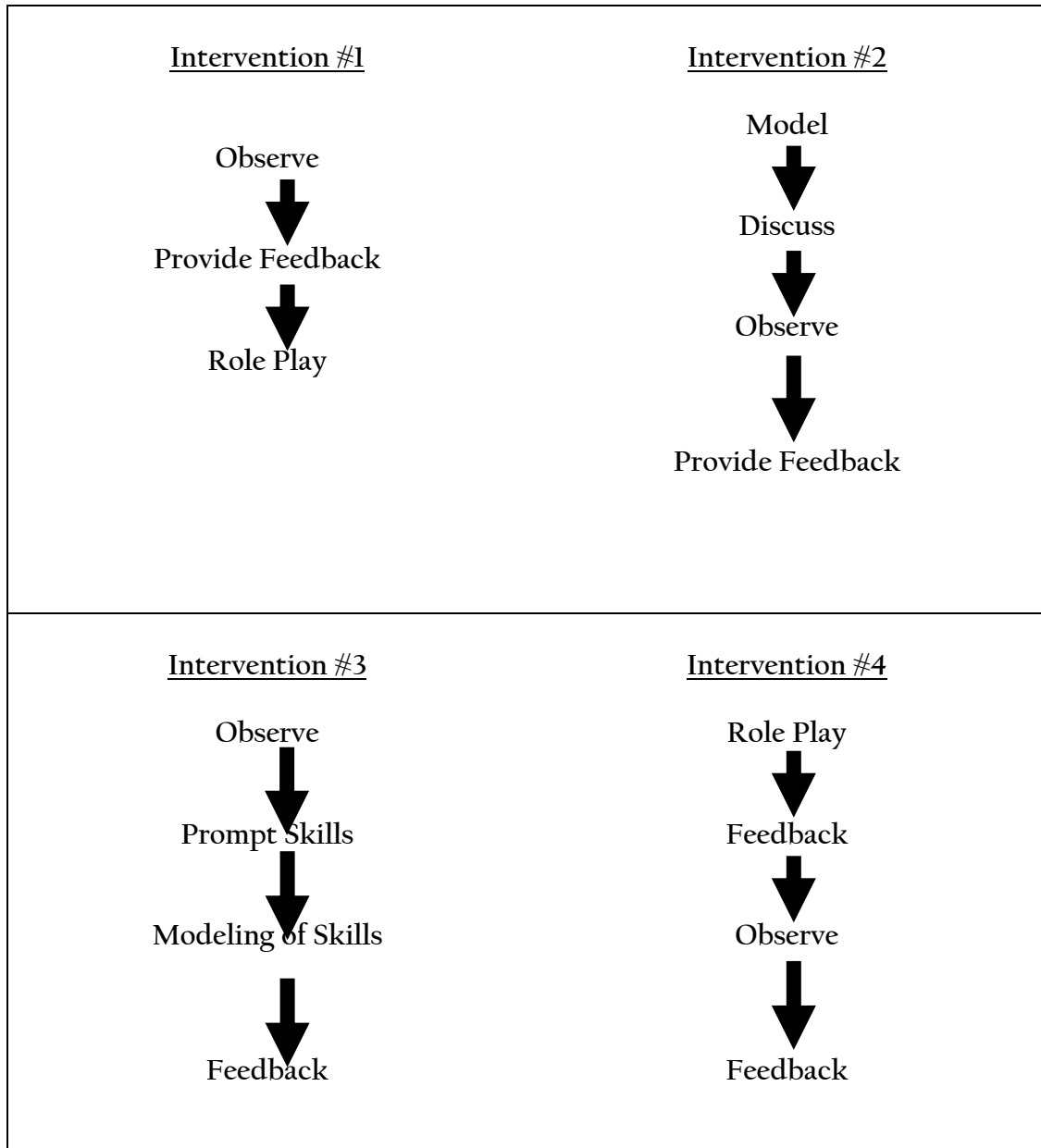
The benefits of field mentoring are that supervisors can reinforce the strengths of staff, enhance transfer of training, build skills and confidence, and to better assist staff in areas in which they identify struggles.

## **Format of Field Mentoring:**

1. State the purpose of the particular field mentoring session  
  
(e.g. “we will be going out with you today because you have identified difficulty in engaging employers effectively. I will take the lead the first visit and model the skill, then, on the next visit, I will observe you engaging an employer. If you get stuck, I will prompt or model the skill again. We will then discuss the interactions.
2. Point out specifics strengths of the employment specialist observed during the field mentoring session.
3. Point out specific words, behaviors or actions that might have been obstacles to the employment specialist reaching his or her desired outcomes.
4. Make a plan for follow-up.

## Field Mentoring Interventions

There are six activities of field mentoring: Observing, modeling, providing feedback, discussing the interaction, prompting skills, and role play. When field mentoring, there are various ways to sequence these activities depending on the situation and learning style of the person. Below are various sequencing interventions for field mentoring.



## Field Mentoring Checklist

1. Goal: \_\_\_\_\_

2. Identify skill/area of focus: \_\_\_\_\_

3. Reason for Field Mentoring (could include combination):

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Observe      | <input type="checkbox"/> Provide Feedback on Skills |
| <input type="checkbox"/> Model Skills | <input type="checkbox"/> Prompting of Skills        |

4. Feedback:

What Were the Strengths Observed During Field Mentoring?

What Were the Effective Interventions/Approaches Used?

What Were the Obstacles Encountered?

What Alternative Interventions/Approaches Could Have Been Used?

Role Play Alternatives

5. Plan for Follow-up

- 
- 
- 
-

### IDDT Case Manager Skill Evaluation Form

On a scale from 0-5 rate skill level on the following IDDT interventions

Skill/intervention	0	1	2	3	4	5
Open ended questions						
Affirmations						
Simple reflections						
Amplified reflections						
Double-sided reflections						
Shifting focus						
Agreement with a twist						
Summarizing						
Eliciting change talk						
Express empathy						
Develop discrepancy						
Avoid argumentation						
Roll with resistance						
Support self-efficacy						
Recognize ambivalence						
Importance/confidence ruler						
Recognize change talk						
Permission to give advice						
Make action plan						
Thought record						
Increase positive thoughts						
Increase positive activities						
Relaxation skills						
Identify social problems						
Increase social skills						
Automatic thought record						
Mental Illness Relapse Prevention Worksheet						
Mini-WRAP plan						
Worked on immediate needs						
Longitudinal assessment						
Payoff matrix						
Contextual analysis						
Engage with family						

## Quality Review of Documentation

It is important for supervisors to look anew upon documentation. It is the final step of integration theory and skills of an EBP. When staff can document why they are doing (purpose & theory) what they are doing (skill) with a client in a specific way they not only demonstrate understanding, but reinforce what they have learned.

The following forms are intended to serve as supervisory tools in aiding the supervisor in review of documentation to ensure quality and reinforce learning.

## Quality Review of Treatment Plan (Update)

Client's Name \_\_\_\_\_ Date Reviewed \_\_\_\_\_

Case Manager's Name \_\_\_\_\_

Reviewer's Name \_\_\_\_\_

Yes		No	Evidence of Substance Abuse Treatment Scale (SATS) being updated in the last 90 days and documented on the Treatment Plan.
Yes	Somewhat	No	Evidence that the long term goals are taken from the person's Strengths Assessment (desires and aspirations column).
Yes	Somewhat	No	The long term goals are listed, prioritized and written in person's own language (vs. professional jargon).
Yes	Sometimes	No	Goal is broken down into smaller, specific, measurable action steps (date recorded when the action step is written)
Yes	Sometimes	No	Action steps have specific target dates (Things that can be achieved in the next meeting or two - no "ongoing" action steps)
Yes	Somewhat	No	Goals and objectives (action steps) are consistent with the person's Stage of Treatment.
Yes	Somewhat	No	Services (interventions) are also consistent with Stage of Treatment.
Yes	Somewhat	No	Clear indication of the person's involvement in the treatment plan - (e.g. signature, personal comments, information written by person, written in person's own words, quotes, etc.)

Comments

**Treatment Plan**

Date: February 2<sup>nd</sup>, 2010

Client: Joe Smith

Stage: 3 (Early Persuasion)

Long Term Goal #1: “Have enough energy to do the things I enjoy, instead of feeling depressed.”

Objective 1: “Keep my physical health up”

Activities:

1. CM and Joe will find a Primary Care Physician and schedule checkup in the next 4 weeks. **Target date: March 3, 2010**
2. Talk with psychiatrist about medication side effects at next appt. **Target Date: February 21, 2010**
3. Meet with CM weekly to explore how to have a healthy body (i.e, what to eat, what not to eat, healthy activities) and develop a list of healthy activities in the next 6 weeks. **Target Date: March 17, 2010**

Objective 2: “Feel happy or at least not depressed.”

Activities: 1. Over the next 4 weeks, CM and Joe will explore activities that improve Joe’s mood and make a list of the ones he wants to try. **Target Date: March 3, 2010**

2. In the next 2 weeks, CM will assist Joe in writing a list of the important points that Joe wants to talk with his psychiatrist about at next appt. **Target Date: February 16<sup>th</sup>, 2010**
3. In the next 3 weeks, CM and Joe will complete a Payoff Matrix re: use of alcohol and how it affects Joe’s mood. **Target Date: February 23, 2010**
4. In the next 8 weeks, CM and Joe will review his Longitudinal Assessment to explore trends between drinking and mood. **Target Date: April 3, 2010**



**Treatment Plan**  
**Date: February 2<sup>nd</sup>, 2010**

Client: Joe Smith

Stage: 3 (Early Persuasion)

**Long Term Goal #2:** “Get along better with my family: my Mom and sister.”

Objective 1: Identify what “get along better” means

- Activities:
1. Joe wants to focus primarily on his health goal for now, but he and Case Manager (CM) will list some times in the past when his interactions with his mom and sister were more positive. **Target Date: March 10, 2010**
  2. After generating the above list, Joe and CM will look for trends regarding what is going on when he is (or is not) getting along with mother and sister. **Target Date: March 24, 2010**
  3. Identify and list specifically what Joe will be doing and what he will notice his family doing to indicate that they are “getting along better.” **Target Date: March 24, 2010**

Objective 2: Improve family members’ understanding of each others’ points of view.

- Activities:
1. With Joe’s permission (see signed releases), CM will contact Joe’s mother and sister to assess their needs/desires regarding their relationship with Joe and their understanding of dual dx. **Target Date: April 2, 2010**
  2. If needed/desired, CM will provide education to family regarding mental illness, substance abuse, and how the two interact. **Target Date: April 9, 2010**
  3. If mother and sister agree, CM will meet with them and Joe to discuss what the family does well and what improvements they would like to see. **Target Date: April 30, 2010**

## Quality Review of Progress Toward Client's Goals (Progress Notes)

Client's Name \_\_\_\_\_ Date Reviewed \_\_\_\_\_

Case Manager's Name \_\_\_\_\_

Reviewer's Name \_\_\_\_\_

### Progress Notes

- |     |           |    |   |
|-----|-----------|----|---|
| Yes | Sometimes | No | Every progress note reflects the goal/objective being worked on.  |
| Yes | Sometimes | No | Every progress notes states a clear, specific and purposeful intervention being used to help the client achieve his or her goal.  |
| Yes | Sometimes | No | Progress notes related to IDDT have a clear link between Stage of Treatment and stage specific intervention used even when substance abuse is not directly discussed.   |
| Yes | Sometimes | No | Every progress notes states the next steps for the following meeting (goal oriented and solution focused).  |
| Yes | Sometimes | No | Progress notes reflect hope-inducing language (e.g. belief in the person to achieve the goal, curious and creative response to goal achievement, no language placing blame upon the client or sarcasm being used, continual efforts to explore meaningful goals for the person, etc.) |

Comments

Client: Joe Schmoe

Time: 1:30 – 2:30 pm (60 minutes)

Goal: “Have enough energy to do the things I enjoy, instead of feeling depressed.”

IDDT Stage:   3  

Poor

- CM took Joe to the grocery store, as he had run out of food. CM helped Joe comparison shop for bargains so that he can live within his budget. CM and Joe also went to an apartment complex to fill out an application. Joe was concerned that he might not have the money for a deposit. Joe was initially quiet and withdrawn, but opened up a little while talking to CM. He admitted that he'd been drinking daily since his last meeting with CM and hasn't been feeling well. Joe seemed happier by the time CM took Joe home. *(Example of poorly written note.)*

Fair

- CM and Joe went together to purchase food and to pick up an apartment application. Joe was quiet at first, stating that he's still depressed and not sleeping well. He said that he drinks 8 – 10 beers in the evening, which makes him sleepy, but he's still tired when he wakes up in the morning. Joe also complained that, in addition to being tired, he was more depressed. CM helped Joe see that his drinking is interfering with his sleep and mood. *(An improvement over the above note, but still just reporting facts, no specifics about the stage-appropriate intervention. CM doesn't demonstrate a working knowledge of the skills/tools to use with a client in this stage.)*

Good

- CM and Joe met and discussed his mental health and substance use. Joe reported feeling depressed and tired, not sleeping well. CM used motivational interviewing to help develop discrepancy between Joe's goal of improving his mood (and feeling energetic enough to visit his grandkids, go bowling and take walks) and how his drinking makes him feel the next day. Joe stated, “I think my medication is the problem, but I know the beer doesn't help.” CM explored how the beer is less than helpful and Joe was able to list several reasons. Joe agreed to work on a Payoff Matrix at our next meeting, and CM helped Joe take care of his grocery shopping and in obtaining a housing application. *(Quality note which focuses on the client's goal, along with the challenges client is facing, while describing a specific use of skills and next steps.)*

## **Quality Enhancement of Personnel Core Competencies and Job Descriptions**

The core competencies give a detailed description of IDDT stage specific treatment skills for IDDT staff. The sample job descriptions are intended as guide to direct the hiring of IDDT staff to ensure sustained IDDT practice.

### **IDDT Job Skills and Descriptions**

It is difficult to accurately assess the progress of our staff without a set of discrete behavioral descriptors for each IDDT skill. The following list of core IDDT skill competencies is intended to guide both the practitioner and supervisor in evaluating skill development and can be used with both new and experienced staff.

The sample job descriptions offer ideas on how to develop IDDT position specific job descriptions. Good job descriptions are another way to ensure that as supervisors we are evaluating IDDT practice and not just general job duties.

## Integrated Dual Disorders Core Competencies

IDD T Competency Area	Specific Skills	Self or Supervisor Rating
A. Stage-wise Treatment		Low 1 High 5
1. Utilize Stages of Tx. to develop appropriate interventions	<ul style="list-style-type: none"> <li>• Accurate use of Substance Abuse Treatment Scale</li> <li>• Understands and can verbalize the goal of each stage.</li> <li>• Tx. Plans demonstrate interventions consistent with the client's stage of tx. (e.g., not requiring abstinence in persuasion stages, focus is on client's goals and how Dual Dx. affects them)</li> <li>• Offers informed treatment recommendations during group supervision.</li> <li>• Document individual intervention(s) detailing how the intervention was implemented, intended goal of intervention, outcome of intervention, and plan for future intervention(s) based on result.</li> </ul>	1 2 3 4 5
B. Assessment		
1. Uses appropriate assessment skills to gain relevant information about client's dual disorder, as well as to increase client's awareness of impact of the dual disorders.	<ul style="list-style-type: none"> <li>• Completes Longitudinal Assessments with appropriate specificity and linking interactions between mental health and substance abuse.</li> <li>• Uses Contextual Assessment to understand global trends in mental health/substance abuse behaviors, as well as exploring specific events.</li> <li>• Demonstrates consistent assessment of client functioning on an ongoing basis.</li> </ul>	1 2 3 4 5

## Integrated Dual Disorders Core Competencies

Integrated Dual Disorders Core Competencies		
C. Engagement		
<p>1. Demonstrates ability to effectively build rapport and trust and ability to relate to a wide variety of people.</p>	<ul style="list-style-type: none"> <li>• Projects warmth and interest when speaking with clients.</li> <li>• Changes their engagement style depending on the nature of the person they are working with.</li> <li>• Tolerant of different levels of readiness to engage for clients.</li> <li>• Effective use of self-disclosure and sharing of common interests with clients.</li> <li>• Reports by clients that they have a positive working relationship with their case manager.</li> </ul>	<p>1 2 3 4 5</p>
<p>2. Demonstrates ability to assertively outreach clients who are difficult to engage.</p>	<ul style="list-style-type: none"> <li>• Uses multiple strategies for engaging including phone calls, home visits, writing letters, and/or contacting family members (with release).</li> <li>• Contacts clients multiple times per month.</li> <li>• Is not quick to want to close out clients who do not engage immediately.</li> </ul>	<p>1 2 3 4 5</p>
<p>3. Demonstrates ability to self-reflect on personal barriers to engagement with clients as well as empathize with factors related to client's difficulty with engagement.</p>	<ul style="list-style-type: none"> <li>• Asks for feedback from supervisor or co-workers during group supervision on how they can more effectively engage with specific clients</li> </ul>	<p>1 2 3 4 5</p>

## Integrated Dual Disorders Core Competencies

D. Persuasion stage interventions		
1. Demonstrate the spirit/values of Motivational Interviewing	<ul style="list-style-type: none"> <li>• Makes effort to avoid judgmental language.</li> <li>• Able to adopt client's point of view.</li> <li>• Describes and demonstrates work with clients as collaborative rather than prescriptive.</li> <li>• Demonstrates respect for client's ability/right to self-determination.</li> <li>•</li> </ul>	1 2 3 4 5
2. Demonstrates competent use of Motivational Interviewing skills.	<ul style="list-style-type: none"> <li>• Use of open-ended questions</li> <li>• Use of affirmations to validate client's experience, progress and insight.</li> <li>• Demonstrates ability to form reflective statements (simple, amplified, and double-sided)</li> <li>• Use of summary statements to help keep conversation on track, to transition between topics, and to link together ideas that have been elicited during the conversation.</li> <li>• Utilizes basic motivational tools (e.g., importance/confidence ruler, payoff matrix, values card sort)</li> </ul>	1 2 3 4 5
3. Demonstrates ability to use Motivational Interviewing skills and tools to elicit change talk.	<ul style="list-style-type: none"> <li>• Listens empathically</li> <li>• Does not directly oppose client's resistance; instead uses resistance as a resource to further understand client's motivations.</li> <li>• Uses all skills and tools to develop discrepancy between client's own goals and current behavior (without aggressive confrontation).</li> <li>• Supports client's self-efficacy to increase confidence to make a change.</li> </ul>	1 2 3 4 5

## Integrated Dual Disorders Core Competencies

Integrated Dual Disorders Core Competencies		
E. Active Stage interventions		
1. Demonstrates ability to use cognitive-behavioral techniques to develop more adaptive perceptions and behaviors.	<ul style="list-style-type: none"> <li>Assists client in examining the interaction between thoughts/emotions/behaviors.</li> <li>Assist client to adapt cognitive-behavioral responses by increasing client awareness of thoughts, increasing client skills in reframing thoughts, and following up on client's use of reframing skills in everyday life.</li> </ul>	1 2 3 4 5
2. Demonstrates ability to develop Relapse Prevention Plan	<ul style="list-style-type: none"> <li>Thoroughly explore client's triggers and consequences of substance use/mental health relapse.</li> <li>Use the above information to develop a specific and thorough plan to cope with cues/triggers/cravings/symptoms using a variety of strategies and supports</li> </ul>	1 2 3 4 5
3. Demonstrates ability to assist client in developing a healthy, recovery-oriented lifestyle.	<p>Development and expansion of positive support system, including family, social supports, self-help resources, community offerings, job and/or education opportunities.</p> <p>Makes appropriate referrals to additional services (e.g., treatment groups, self-help groups, individual treatment, supported employment)</p>	1 2 3 4 5



### Integrated Dual Disorders Core Competencies

4. Assess and ameliorate maladaptive life skills.	<ul style="list-style-type: none"> <li>• Explores client interests and resources to develop appropriate leisure skills.</li> <li>• Demonstrates and transfers skills for relaxation/stress management.</li> <li>• Educates and role-plays with client regarding social skills (e.g., effective communication, assertiveness, problem-solving)</li> </ul>	1 2 3 4 5
F. Relapse Prevention/Recovery skills		
I. Demonstrates collaboration with client to ensure continued recovery from substance abuse and mental illness.	<ul style="list-style-type: none"> <li>• Revisit and revise Relapse Prevention Plan as needed.</li> <li>• Attitude toward relapse is non-judgmental and seeks to use relapse as a learning opportunity.</li> <li>• Seeks ways to help client become interdependent with community and work toward graduated disengagement from case management services.</li> </ul>	1 2 3 4 5
G. Family Psychoeducation on Dual Disorders		
I. Demonstrates an understanding of/ ability to engage family in the recovery process	<ul style="list-style-type: none"> <li>• Able to describe how involving family (as determined by the client) benefits the client's recovery.</li> <li>• Able to provide family with education about dual disorders and integrated treatment.</li> <li>• Able to assist family in developing coping skills to optimize client's recovery.</li> </ul>	1 2 3 4 5
H. Dual Diagnosis Group Treatment		
I. Demonstrates and communicates the importance of stage-wise group DD treatment.	<p>Able to explore and expand client's motivation for group treatment.            Demonstrates ability to remove barriers to accessing group treatment.            Acts in a support capacity to assist client in successfully engaging in/and maintaining group treatment.            Documentation shows clients participating in stage-appropriate groups or ongoing efforts to engage in groups.</p>	1 2 3 4 5

## **Training checklist for new IDDT case managers**

### **In first week of employment**

- Read Mueser, Drake, and Noordsy article on IDDT
- Read IDDT Stagewise Treatment Assessment and Interventions handout
- Read Squires and Moyers paper on Motivational Interviewing
- Read Sciacca article, “Removing Barriers: Dual Diagnosis Treatment and Motivational Interviewing”
- Watch Motivational Interviewing training tape B
- Shadow IDDT case managers at least 5 hours
- Attend Dual Diagnosis groups

### **In second week of employment**

- Watch Motivational Interviewing training tapes, C and D.
- Read IDDT text Part I: Basics
- Read IDDT text Part II: The Assessment Process
- Shadow IDDT case managers at least 5 hours
- Read IDDT text Part III: Individual Approaches
- Attend each Dual Diagnosis

### **In third week of employment**

- Read IDDT text Part IV: Group Interventions
- Read IDDT text Part V: Working with Families
- Watch Motivational Interviewing training tape F

## Guidelines for IDDT Case Manager Job Description

In addition to the usual, agency-specific case manager job description elements, the job description of the IDDT case manager should also contain the following.

1. Help the client to understand symptoms of their mental illness and substance abuse and how they impact each other.
2. Learn IDDT skills and use them with IDDT clients.
3. Participate in statewide and local agency training to increase knowledge and proficiency in IDDT principles and skills.
4. Participate regularly in case presentations in team supervision and meet with supervisor regularly to assess skill level, and use and monitor effectiveness of interventions with individual clients.
5. Understand the Stages of Treatment and use it to guide treatment planning and interventions.
6. Be familiar with and proficient in use of IDDT tools.
7. Be aware of clients' long-term needs, aspirations, and values to help develop intrinsic motivation for helpful change.
8. Work closely with other service providers to coordinate treatment in line with IDDT principles and practices.
9. Document interventions clearly using IDDT-specific language.

The purpose of these guidelines is to help the IDDT case manager understand that he/she is not doing "case management as usual", but rather, is engaging with clients with a higher level of clinical sophistication and skillfulness. IDDT is not an "add on" to usual service provision but a specific way of thinking about and interacting with clients based on their current readiness for change.

The key principle behind IDDT is that substance abuse issues are not reserved to substance abuse counselors only. The case manager needs to be able to effectively address substance abuse issues using skills appropriate to the stage that the client is in.

## Sample Integrated Dual Diagnosis Treatment Case Manager Job Description

- A. Responsibilities and Duties: The primary responsibility of the Integrated Dual Diagnosis Treatment CPST Case Manager will be to provide goal directed supports and solution-focused interventions consistent with the IDDT model. CPST case management is a face to face intervention with consumers present; however family or other collaterals may also be involved. The majority of the contacts must occur in the community locations where the person lives, works, attends school and or socializes. Specific duties include:
1. To help clients to understand the symptoms of their mental illness and their substance abuse diagnosis and to minimize the effect of those symptoms in the all the significant areas of their lives.
  2. Assist clients in learning and practicing IDDT model-specific skills that contribute to their recovery as specified in the treatment plan.
  3. Provide supportive counseling, solutions focused interventions; behavioral analysis and other IDDT model-specific interventions to increase clients ability to function in all life domains.
  4. Providing outreach and crisis intervention services to clients and prospective clients to enable timely access to those services appropriate and necessary for crisis stabilization with the purpose of diverting the client from hospitalization and allowing the client to maintain independent living;
  5. Complete strength assessment with client and identify strategies or treatment options associated with the consumer's mental illness and substance abuse diagnosis with the goal of minimizing the negative effects of mental illness symptoms or associated environmental stressors.
  6. Develop individualized crisis plan with client and review during treatment plan review time.
  7. Coordinate all client services with other providers, family and community collaterals primarily with the client consulting in the process. Extensive collateral contacts will be referred to Targeted Case management Services..
  8. Delivering reimbursable hours of service compliant with established standards;
  9. Completing all paperwork associated with the financial, clinical, legal, or regulatory management of the case or the Center's operations in a timely and accurate manner;
  10. Participating in public information and public relations activities, serve as a community liaison and advocate for mental health and the Bert Nash Center;
  11. Providing assistance with the evolution of an effective, efficient preventative program of services; and
  12. Additional responsibilities that may be assigned as circumstances warrant.
- B. Accountability: The CPST Case Manager will be directly accountable to the CSS Team Leader or his/her designee. The CSS Team Leader or his/her designee will, no less than annually, complete an evaluation in compliance with personnel policies.

## Integrated Dual Diagnosis Specialist

The Evidence-based Best Practice (EBP) known as the Integrated Dual Diagnosis Treatment (IDDT) model calls for an Integrated Substance Abuse Specialist as part of the multi-disciplinary team serving clients with dual diagnoses. This person is often an approved Substance Abuse Counselor and/or a Qualified Mental Health Practitioner (QMHP). The purpose of this position is to provide stage-appropriate substance abuse counseling to dually-diagnosed clients on an individual basis, provide clinical direction to the IDDT team, and to assist in provision of ongoing training opportunities/skills building to members of the IDDT team.

Examined more closely, certain essential elements of this position become evident. The Integrated Substance Abuse Specialist must be:

1. **Fully integrated into the IDDT team.** It is expected that the Specialist will attend all team meetings, consult on cases, and keep the team on-task as far as using stage-appropriate suggestions and interventions.
2. **Dedicated to implementing the model with high fidelity.** The Specialist is on the front lines of guiding team philosophy and practice. The Specialist sets the tone of using the model with high-fidelity in order to provide the best possible outcomes for clients. Without dedication to this purpose, the specialist can—knowingly or unwittingly—undermine the process and draw focus away from those values and skills which best serve the clients.
3. **Skilled in IDDT Interventions.** The Specialist will be doing hands-on work with dually-diagnosed clients. While this position is usually available to provide substance abuse counseling to clients in the Active and Relapse Preventions stages, they will assuredly come into contact with clients in earlier stages, as well. Additionally, the Specialist must be sufficiently skilled to model the interventions to IDDT team members. While the agency is responsible for setting up a training protocol for new hires and ongoing skills refreshers, the Specialist must be proficient in IDDT skills in order to provide ongoing skills training to IDDT clinicians.

Conversely, consideration of this position provides indications to what would be inappropriate utilization of the Specialist. The Specialist is not:

1. **A replacement for a fully-trained IDDT team.** Successful implementation of the EBP requires that all team members be fully-trained in the IDDT model. The Specialist is an important adjunct, but this position cannot substitute for a trained IDDT team.
2. **Solely responsible for Active and Relapse Prevention stage interventions.** The Specialist has the requisite skill to provide individual substance abuse
3. counseling, but Case Managers and other clinicians are also expected to use stage-appropriate interventions when helping dually-diagnosed clients in these (and all) stages.

As sites work to improve fidelity to the model and provide the best possible services to dually-diagnosed clients, the position of Integrated Substance Abuse Specialist will be a vital part of the IDDT team. We hope you have found this brief guide to be of use.

## Guidelines for IDDT Supervisor Job Description

In addition to the usual, agency-specific elements of a supervisor's job description the following should be noted.

The job of IDDT supervisor falls into three main categories: training, monitoring and assessment of case manager interventions, and coaching case managers toward greater skillfulness in interventions.

1. Understand the IDDT model's principles and skills.
2. Be proficient in the use of these skills.
3. Train case managers and other service providers in these skills in formal, didactic trainings as well as in informal coaching interactions.
4. Meet with team on a weekly basis for supervision that focuses on formal case management clinical presentations.
5. Insure that the tone of the team meeting is positive and respectful toward clients while still validating case manager's difficulties.
6. Meet regularly with case managers and other service providers for individual supervision.
7. Assess case managers' understanding and skill level and help them to assess their own understanding and skills.
8. Insure that client progress is being monitored and that non-responders to treatment are being flagged for further supervision and evaluation.
9. Work to change structure of agency procedures, paperwork, etc. to increase effectiveness of IDDT implementation.
10. Set aside time to regularly accompany case managers to assess and coach them (field mentoring).

Agency administration needs to have a clear understanding of the time commitments that are needed for supervisory effectiveness. The supervisor's schedule will need to be structured around IDDT-specific tasks.

## Information Management

Information management is critical for a supervisor to be able to monitor how well the program is doing and make adjustments to improve program performance. There are two areas for supervisors to pay attention to:

1. Fidelity Implementation
2. Outcomes

The following pages consist of tools that will help the IDDT supervisor track fidelity implementation and outcomes.



## What Is Needed For A Fidelity Review

1. IDDT Fidelity Scale and Protocol
2. GOI Fidelity Scale and Protocol (if time permits)
3. Number of SPMI clients in CSS program
4. Number of dually diagnosed clients
5. Number of clients in each stage
6. Number of clients in dual diagnosis groups
7. Number of client in Action Stages and beyond in community self-help groups
8. Number of clients in the active or relapse prevention stages individual active stage counseling
9. Chart review form
10. Interview times with team, med provider(s), substance abuse specialist, and a group of clients (if time permits)
11. Time to review charts and fill out chart review form
12. If IDDT is implemented on multiple teams complete IDDT fidelity review for each team

## IDDT Fidelity Items Requiring Counts from Center Site

1. Total number of clients targeted for IDDT services \_\_\_\_\_

2. Number of dual diagnosis clients for each stage of treatment

Pre-engagement	_____
Engagement	_____
Early Persuasion	_____
Late Persuasion	_____
Early Active	_____
Late Active	_____
Relapse Prevention	_____
Maintenance Recovery	_____

3. Number of clients in the *action stage* or *relapse prevention stage* (stages 5 – 7) receiving individual substance abuse counseling (from a provider trained in IDDT).

\_\_\_\_\_

4. Number clients targeted for IDDT attending **group treatment** specifically designed to address both mental health and substance abuse problems. These groups could be persuasion, active treatment, or family.

\_\_\_\_\_

5. Number of IDDT clients in *active treatment stage* or *beyond* (stages 5-8) regularly attending **self-help groups** in community.

\_\_\_\_\_

6. Has your Intake Assessment changed since your previous fidelity review? \_\_\_\_ (If yes, please provide reviewers with a copy of the new assessment.)

Is this assessment re-administered at least once annually? \_\_\_\_\_

7. Does the agency or CSS program conduct a standardized screen (e.g., CAGE-AID, DALI, etc.) for all clients new to the agency/program in order to identify those who are eligible for IDDT?

\_\_\_\_\_

If yes, what screening instrument is used? \_\_\_\_\_

## IDDT Certification Criteria

Item Grouping	Passing	Exemplary
<p><b>Structure</b> (Items 1A, 1B, 3, 4, 13)</p> <p><b>1a. Multidisciplinary Team:</b> Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health treatment team</p> <p><b>1b. Integrated Substance Abuse Specialist:</b> Substance abuse specialist works collaboratively with the treatment team, modeling IDDT skills and training other staff in IDDT</p> <p><b>3. Access for IDDT Clients to Comprehensive DD Services</b></p> <ul style="list-style-type: none"> <li>• Residential services</li> <li>• Supported employment</li> <li>• Family psychoeducation</li> <li>• Illness management</li> <li>• ACT or ICM</li> </ul> <p><b>4. Time-Unlimited Services</b></p> <ul style="list-style-type: none"> <li>• Substance abuse counseling</li> <li>• Residential services</li> <li>• Supported employment</li> <li>• Family psychoeducation</li> <li>• Illness management</li> <li>• ACT or ICM</li> </ul> <p><b>13. Secondary Interventions for Substance Abuse Treatment Non-Responders:</b> Program has a protocol for identifying substance abuse treatment non-responders and offers individualized secondary interventions, such as:</p> <ul style="list-style-type: none"> <li>• Clozapine/naltrexone/disulfiram</li> <li>• Long-term residential care</li> <li>• Trauma treatment</li> <li>• Intensive family intervention</li> <li>• Intensive monitoring</li> </ul>	3.5	4.5

Item Grouping	Passing	Exemplary
<p><b>Case Intervention Features</b> (Items 2, 5, 6, 7, 12)</p> <p><b>2. Stage-Wise Interventions:</b> Treatment consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention)</p> <p><b>5. Outreach:</b> Program demonstrates consistently well-thought-out strategies and uses outreach to community whenever appropriate:</p> <ul style="list-style-type: none"> <li>• Housing assistance</li> <li>• Medical care</li> <li>• Crisis management</li> <li>• Legal aid</li> </ul> <p><b>6. Motivational Interventions:</b> Clinicians who treat IDDT clients use strategies such as:</p> <ul style="list-style-type: none"> <li>• Express empathy</li> <li>• Develop discrepancy between goals and continued use</li> <li>• Avoid argumentation</li> <li>• Roll with resistance</li> <li>• nstill self-efficacy and hope</li> </ul> <p><b>7. Substance Abuse Counseling:</b> Clients who are in the <i>action</i> stage or <i>relapse prevention</i> stage receive substance abuse counseling that include:</p> <ul style="list-style-type: none"> <li>• Teaching how to manage cues to use and consequences to use</li> <li>• Teaching relapse prevention strategies</li> <li>• Drug and alcohol refusal skills training</li> <li>• Problem-solving skills training to avoid high-risk situations</li> <li>• Challenging clients' beliefs about substance abuse</li> <li>• Coping skills and social skills training</li> </ul> <p><b>12. Interventions to Promote Health:</b> Examples include:</p> <ul style="list-style-type: none"> <li>• Teaching how to avoid infectious diseases</li> <li>• Supporting attempts to reduce substance use</li> <li>• Helping clients avoid high-risk situations and victimization</li> <li>• Securing safe housing</li> <li>• Encouraging clients to pursue work, medical care, diet, &amp; exercise</li> </ul>	3.5	4.0

Item Grouping	Passing	Exemplary
<p><b>Auxiliary Services</b> (Items 8, 9, 10, 11)</p> <p><b>8. Group DD Treatment:</b> DD clients are offered group treatment specifically designed to address both mental health and substance abuse problems</p> <p><b>9. Family Psychoeducation on DD:</b> Clinicians provide family members (or significant others):</p> <ul style="list-style-type: none"> <li>• Education about DD</li> <li>• Coping skills training</li> <li>• Collaboration with the treatment team Support</li> </ul> <p><b>10. Participation in Alcohol &amp; Drug Self-Help Groups:</b> Clients in the <i>action</i> stage or <i>relapse prevention</i> stage attend self-help programs in the community</p> <p><b>11. Pharmacological Treatment:</b> Prescribers for IDDT clients:</p> <ul style="list-style-type: none"> <li>-Prescribe psychiatric medications despite active substance use</li> <li>-work closely with team/client</li> <li>-focus on increasing adherence</li> <li>-avoid benzodiazepines and other addictive substances</li> <li>-use clozapine, naltrexone, disulfiram</li> </ul>	2.5	3.0

## Integrated Dual Disorders Treatment Fidelity Scale

This document is intended to help guide you in administering the Integrated Dual Disorders Treatment (IDDT) Fidelity Scale. In this document you will find the following:

- 1) **Introduction:** The introduction gives an IDDT overview and a who/what/how of the scale. There is also a checklist of suggested activities for before, during, and after the fidelity assessment that should lead to the collection of higher quality data, more positive interactions with respondents, and a more efficient data collection process.
- 2) **Protocol:** The protocol explains how to rate each item. In particular, it provides:
  - a) A *definition* and *rationale* for each fidelity item. These items have been derived from comprehensive, evidence-based literature.
  - b) A list of *data sources* most appropriate for each fidelity item (e.g., chart review, program leader interview, team meeting observation). When appropriate, a set of *probe questions* is provided to help you elicit the critical information needed to score the fidelity item. These probe questions were specifically generated to help you collect information from respondents that is free from bias such as social desirability.
  - c) *Decision rules* will facilitate the correct scoring of each item. As you collect information from various sources, these rules will help you determine the specific rating to give for each item.
- 3) **Cover sheet:** This is a record form for background information on the study site. The data are not used in determining fidelity, but to provide important information for classifying programs, such as size and duration of program, type of parent organization, and community characteristics.
- 4) **Checklist for multiple sources:** The checklist is to be used to assess if each of the multiple sources provides evidence for the presence of critical ingredients specified in each item.
- 5) **Score sheet:** The score sheet provides instructions for scoring, including how to handle missing data, and identifies cut-off scores for full, moderate, and inadequate implementation.

## Integrated Dual Disorders Treatment Fidelity Scale: Introduction

Substance abuse is a common and devastating disorder among persons with severe mental illness (SMI). Dual disorders (DD), which denotes the co-occurrence of substance use disorder and SMI, occur in about 50% of individuals with SMI (Regier et al., 1990) and is associated with a variety of negative outcomes, including higher rates of relapse, violence, hospitalization, homelessness, and incarceration (Drake et al., 2001). Integrated dual disorder treatment (IDDT) is an evidence-based practice that has been found to be effective in the recovery process for clients with DD. In IDDT, the same clinicians or teams of clinicians, working in one setting, provide mental health and substance abuse interventions in a coordinated fashion. As an evidence-based psychiatric rehabilitation practice, IDDT aims to help the client learn to manage both illnesses so that he/she can pursue meaningful life goals. The critical ingredients of IDDT include assertive outreach, motivational interventions, and a comprehensive, long-term, staged and individualized approach to recovery.

Overview of the scale. The IDDT Fidelity Scale contains 13 program-specific items that have been developed to measure the adequacy of implementation of IDDT programs. Each item on the scale is rated on a 5-point rating scale ranging from 1 (Not implemented) to 5 (Fully implemented). The standards used for establishing the anchors for the fully implemented ratings were determined through a variety of expert sources as well as empirical research.

What is rated. The scale is rated on current behavior and activities, not planned or intended behavior. For example, in order to get full credit for Item 3 (Access for IDDT Clients to Comprehensive DD Services), it is not enough that the agency is planning future changes in this area.

Unit of analysis. The scale is appropriate for organizations that are serving clients with SMI and for assessing adherence to evidence-based practices at the *agency/clinic level*, rather than at the level of a specific clinician. However, separate ratings may be completed for a specialty team in addition to the *agency/clinic level*.

How the rating is done. The fidelity assessment is done in person at the program site, following a prearranged schedule. The fidelity assessment requires a minimum of 4 hours to complete, although a longer period of assessment will offer more opportunity to collect information and hence should result in a more valid assessment. The data collection procedures include chart review, observation of team meeting or supervision, observation of one or more group or counseling sessions, and semi-structured interviews with the program leader, the medication prescriber(s), the clinicians providing the services, and clients.

We recommend that interviews with clinicians be done in a group format (the same applies to interviews with clients). If the program has 5 or fewer DD clinicians, it is desirable to interview all of them. If the program has more than 5 DD clinicians, attempts should be made to interview at least 5 of them. In terms of clients targeted for IDDT, we recommend interviewing 3 clients, ideally individuals who have received IDDT for at least one year.

For some items that require chart review for rating, the fidelity assessment involves the examination of 10 charts of IDDT clients. The ideal is that charts are randomly selected. We suggest that you ask the program's contact person to select 20 charts prior to your site visit, and then randomly select and review 10 of those charts during your visit.

Coding of many items requires both understanding on the part of clinicians and application of that understanding. If clinicians generally do not understand the concepts, then score as 1. If they understand parts of the concept and if they apply the understanding consistently, score as 3. To score 5, there needs to be consistent evidence that the concepts are applied consistently for 80% or more of clients, as documented across different sources of evidence.

Who does the ratings. Fidelity assessments can be made by both external groups as well as by the organization implementing IDDT. Both types of assessment are recommended. We will focus on fidelity assessments made by independent assessors. Fidelity assessments should be administered by individuals who have experience and training in interviewing and data collection procedures (including chart reviews). In addition, raters need to have an understanding of the nature and critical ingredients of IDDT. We recommend that all fidelity assessments be conducted by at least two raters.

Missing data: Missing data can occur for many reasons. One might be a failure on the assessor's part to collect the necessary information. This scale is designed to be fully completed, with no missing data on any items. Consequently, fidelity assessors should not leave any item uncoded because of insufficient information. Rather, the assessors should follow up with phone calls, emails, or additional visits to ensure completeness of the assessment. It is critical that raters record detailed notes of responses given by the interviewees.

Another reason that data might be missing is that the rating scale does not fit the organization's approach to services to this population. For example, the item of stage-wise treatment is rated on the basis of the percentage of clients receiving stage-wise services. However, if the clinicians in a program do not have an understanding of stage-wise interventions and therefore do not use this framework, then the proper scoring on this item is 1. It is not missing. We anticipate that many new programs will receive low fidelity ratings on many items for which the program has not yet formulated a policy.

## References

Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, *52*(4), 469-476.

Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study. *Jama*, *264*(19), 2511-2518.



## IDDT Fidelity Assessor Checklist

### Before the Fidelity Site Visit:

*Review the sample cover sheet.* This sheet is useful for organizing your fidelity assessment, identifying where the specific assessment was completed, along with general descriptive information about the site. You may need to tailor this sheet to your specific needs (e.g., unique data sources, purposes for the fidelity assessment).

*Create a timeline for the fidelity assessment.* Fidelity assessments require careful coordination of efforts and good communication, particularly if there are multiple assessors. For instance, the timeline might include a note to make reminder calls to the program site to confirm interview dates and times.

*Establish a contact person at the program.* You should have one key person who arranges your visit and communicates beforehand the purpose and scope of your assessment. Typically this will be the IDDT program director or coordinator. Exercise common courtesy in scheduling well in advance, respecting the competing time demands on clinicians, etc.

*Identify program staff with whom you will need to meet during your fidelity visit.* Work with the program contact person to arrange a schedule of interviews for the day of your visit with case managers, substance abuse specialists, rehabilitation services providers (i.e., vocational staff, relevant PHP staff), therapists, psychiatrist or medication prescriber, etc. Again, scheduling your fidelity visit well in advance will more likely enable you to meet with all necessary staff members.

*Establish a shared understanding with the site being assessed.* It is essential that the fidelity assessment team communicates to the programs the goals of the fidelity assessment. Assessors should also inform program staff about who will see the report, whether the program site will receive this information, and exactly what information will be provided. The most successful fidelity assessments are those in which there is a shared goal among the assessors and the program site to understand how the program is progressing according to evidence based principles. If administrators or line staff fear that they will lose funding or look bad if they don't score well, then the accuracy of the data may be compromised.

*Indicate what you will need from respondents during your fidelity visit.* In addition to the purpose of the assessment, briefly describe what information you will need, who you will need to speak with, and how long each interview or visit will take to complete. The site visit is likely to go the most smoothly if the contact person could, where available, assemble the following information prior to your site visit:

- A copy of agency brochure
- A copy of IDDT Program Mission Statement
- Roster of IDDT staff (roles, FTEs)
- A copy of the substance use screening instrument used by the agency
- A copy of the standardized DD assessment instrument used by the program
- Total number of clients served by the agency
- Number of active clients receiving DD services
- Number of clients served in the previous year

- Number of clients who dropped out of the program in the previous year
- Number of active clients receiving specific DD services (e.g., substance abuse counseling, DD group counseling, family interventions)
- Number of active clients receiving additional rehabilitation services from the agency
- Number of active clients who attend a self-help group in the community
- Weekly schedule for counseling services
- Clinician training curriculum and schedule
- List of process and/or outcome variables
- Quality assurance data

*Inform that you will need to observe at least one team meeting (or supervision meeting) and at least one group or counseling session during your visit. This is an important factor in determining when you should schedule your assessment visit to the program.*

*Alert your contact person that you will need to sample 10 charts. It is preferable from a time efficiency standpoint that the charts be drawn beforehand, using a random selection procedure. Obviously, a program can falsify the system by hand picking charts and/or updating them right before the visit. If there is a shared understanding that the goal is to better understand how a program is implementing services, this is less likely to occur.*

#### During Your Fidelity Site Visit:

*Tailor terminology used in the interview to the site. For example, if the site uses the term consumer for client, use that term. If case managers are referred to as clinicians, use that terminology. Every agency has specific job titles for particular staff roles. By adopting the local terminology, the assessor will improve communication.*

*During the interview, record all the important names and numbers (e.g., numbers of clinicians, active clients, clients served in the preceding year, etc.)*

*If discrepancies between sources occur, query the program leader to get a better sense of the program's performance in a particular area. The most common discrepancy is likely to occur when the interview with program leader gives a more idealistic picture of the program's functioning than do the chart and observational data. For example, on Item 5 (Outreach), the clinicians may report that they often spend their time working in the community, while the chart review may show that client contact takes place largely in the office. To understand and resolve this discrepancy, the assessor may go back to the clinicians and say something like, "Our chart review shows client contact is office-based the majority of the time. Since you had reported you often provided outreach services in the community, we wanted your help to understand the difference."*

*Before you leave, check for missing data.*

#### After Your Fidelity Site Visit:

*The same day of the site visit, both assessors should independently rate the fidelity scale. Within 24 hours the assessors should then compare their ratings and resolve any disagreements. Come up with a consensus rating for each item.*

Sometimes assessors have collected different data or have interpreted the response differently during the interview. Within a week of the fidelity assessment (ideally, the next day or two), the fidelity assessors should follow up with contact to the program leader to clarify any item for which there is a lack of consensus. This is also the time to *follow up on any missing data*.

Tally the item scores and determine which level of implementation was achieved (See Score Sheet).

## IDDT Fidelity Scale Protocol: Item Definitions and Scoring

### Overview:

The IDDT fidelity assessment evaluates services provided to a targeted group of clients with DD and the clinicians who are responsible for their mental health and substance abuse treatment. *The fidelity assessment focuses on whomever the program leader designated as the target population.* (The organization may have a much larger number of clients who are candidates for the IDDT, but that is a question of penetration, not fidelity.) At the outset of the fidelity assessment, in fact even before the day of the fidelity visit, the fidelity assessors should make clear which clients are the IDDT clients and which staff are designated as IDDT staff. For a new program that has not yet adopted IDDT, some of the questions will be unclear, because the program is not organized consistently with IDDT. *If a program is hard to rate on an item because the philosophical assumptions differ from the premises of the model (e.g., they are not following a stagewise approach to treatment), the site will get a low rating on items related to these concepts, rather than a “not applicable” rating.*

### 1a. Multidisciplinary Team

Definition: All clients targeted for IDDT receive care from a multidisciplinary team. A multidisciplinary team consists of two or more of the following: a physician, a nurse, a case manager, or providers of ancillary rehabilitation services described in Item 3.

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.

### Sources of Information:

#### a) Program leader interview

- *Thinking about your IDDT clients, who provides their mental health case management? Describe these services.*
- *Do these clinicians have team meetings? How often? Who is present?*
- *Are nurses, residential staff, employment specialists, and substance abuse counselors involved in joint planning? What about the client’s psychiatrist?*
- *How much contact do case managers have with other team members in a typical week?*

#### b) Clinician interview

- Ask similar questions as asked of program leader, regarding clients on their caseload.

#### c) Employment specialist and residential staff interview

- *How often do you attend treatment team meetings with DD clients’ case managers? Are you consulted regarding treatment decisions? Do case managers help with housing/employment?*

#### d) Client interview

- Do you also receive employment [housing, family, illness management, or ACT/ICM] services from this agency? [If yes] Does your DD clinician have contact with your employment specialist [housing specialist, family counselor, case manager] regularly so that they are on the same page in helping you?
- Were there any other services you wanted, but were not available?

#### Item Response Coding:

First determine if the agency's mental health case managers, and rehabilitation service providers, and other professional staff work together as a team, as manifested by regular contacts and collaborative treatment planning. If this is generally not true, for example, if the substance abuse counselor attends a treatment team meeting less than once every two weeks, then this item should be scored lower. If the treatment approach is mostly parallel or brokered (different clinicians working in different buildings or different parts of the same building but not meeting together on a regular basis), score this as 1. If the treatment approach is a mix between parallel and multidisciplinary (e.g., nurse and substance abuse counselor present at weekly treatment team meetings, but other key rehabilitation staff are not), score as 3.

If the organization embraces a multidisciplinary approach, but it is inconsistently applied, then it may be more appropriate to determine the percentage of clients receiving multidisciplinary services, using team rosters as the primary data source, and determining whether the activities are documented in the charts.

#### **1b. Integrated Substance Abuse Specialist**

Note: Code both 1a and 1b

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.

#### a) Program leader interview

- How often does the substance abuse counselor attend team meetings?
- How often does the substance abuse counselor have contact with the client's CM in a typical week?
- Is the substance abuse specialist considered a member of the team? How so? Do they carry a caseload?
- Are they involved in treatment planning for IDDT clients?
- Do you talk to him/her a lot?

## b) Clinician interview

- Ask similar questions as asked of program leader

## c) Substance abuse specialist interview

- *Do you attend team meetings? How often?*
- *What is your role with regard to the CM/Treatment team? (If there's contact with the team, probe for whether a member, supervisor, consulting or any combination.)*
- *How many IDDT clients do you see? What is your role for them? (Probe for CM, assessment, treatment planning, groups, individual, etc.)*

## d) Chart Review

- Check for Substance abuse specialist involvement in treatment planning
- Check for individual and group sessions conducted by the SA specialist for IDDT clients

## 2. Stage-Wise Interventions

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

- *Engagement:* Forming a trusting working alliance/relationship.
- *Motivation:* Helping the engaged client develop the motivation to participate in recovery-oriented interventions.
- *Action:* Helping the motivated client acquire skills and supports for managing illnesses and pursuing goals.
- *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 is taken into account.

### Sources of Information:

#### a) Program leader interview

- *What is the treatment model used to treat clients with substance abuse problems?*
- *Do you refer clients to AA? What about detox programs?*
- *How do you deal with clients who appear unwilling to change? (Probe for whether confrontation is used)*
- *Do you see the goal as abstinence? (Probe if this is a short- vs. long-term goal)*
- *How does your team view abstinence versus reduction of use?*
- *What kind of relapse prevention skills do you teach? Do you teach relapse prevention skills to clients who are actively using drugs/alcohol?*
- *Has the organization ever offered training on stages of treatment [change]?*

## b) Clinician interview

- *Are you familiar with a stage-wise approach to substance use treatment? [if yes] What stages are defined in the approach your program uses?*
- If the clinicians say they do use stage-wise model, ask them to go through caseload and identify the stage each client is in. Try to get an idea of what the clinician is trying to accomplish with each client (i.e., are they trying to get someone in the engagement stage to attend AA/NA or are they building rapport and providing support?). The goal is to identify how many active clients currently fit in each of the four stages. **Items 7 and 10** will need these numbers!

*Note: Labeling of stages is not as critical as intention and actual practice.*

## c) Team meeting/supervision observation

- Listen for discussion of interventions based on stages of treatment [change].

## d) Observation of group or counseling sessions

- Listen for interventions based on stages of treatment [change].

## e) Chart review (especially treatment plan)

- Examine 10 charts for documentation of stage-wise treatment. Count the number of charts for which treatment matches stage.

Item Response Coding: Coding of this item requires both understanding on the part of clinicians and application of that understanding. If clinicians generally do not understand the concepts, then score as 1. If they understand parts of the concept (for example, if they differentiate between engagement and action), and if they apply the understanding consistently (e.g., different goals for clients in these two stages), score as 3. To score 5 on this item, there needs to be consistent evidence that the stage-wise concepts are applied consistently for 80% or more of clients, as documented across different sources of evidence.

## 3. Access for IDDT Clients to Comprehensive DD Services

Definition: To address a range of needs of clients targeted for IDDT, agency offers the following five ancillary rehabilitation services (for a service to be considered available, it must both exist and be *accessible* within 2 months of referral by clients targeted for IDDT who need the service):

- ***Residential service.*** Supervised residential services that accept clients targeted for IDDT, 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).
- ***Supported employment.*** Vocational program that stresses competitive employment in integrated community settings and provides ongoing support. *IDDT clients who are not abstinent are not excluded.*

- **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.
- **Illness management and recovery:** 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.
- **Assertive community treatment (ACT) or intensive case management (ICM):** A multidisciplinary team (client-to-clinician ratios of 15:1 or lower) with at least 50% of client contact occurring in the community and 24-hour access.

Ancillary services are consistent with IDDT philosophy and stages of treatment/recovery.

For example, 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.

#### Sources of Information:

##### a) Program leader interview

- Does your agency provide residential [vocational, family psychoeducation, illness management and recovery, or ACT/ICM] services? [If yes] Probe for specifics of each service area, e.g., *What kind of residential services? How long is your residential service? What do you mean by supported housing?*
- Please describe the referral process to these services. *What is the waiting period for clients targeted for IDDT to obtain these services after the referral is made?*
- Are clients targeted for IDDT eligible for these services? *What are the admission criteria?* Probe and listen for exclusion criteria (e.g., *The state vocational rehabilitation agency won't let us take clients with DD into VR until they have been sober for 6 months.*)
- Request a copy of agency brochure, if available, and look for description of available rehabilitation services.

##### b) Clinician interview

- Ask similar questions as for program leader. Then follow up by going through caseload and determine which services each IDDT client is currently receiving. Probe for reasons why client is not receiving a relevant service, e.g., supported employment. **In order to document access to a service, a minimum requirement is at least one IDDT client must currently be receiving that service.**



c) Rehabilitation service provider interview

- Interview rehabilitation service provider, either by phone or in person, to confirm whether they accept clients who have drug/alcohol problem.
- Probe for the service provider's philosophy regarding DD clients.

d) Chart review (especially treatment plan)

- Look for documentation of referrals made to the 5 services.

Item Response Coding: Evaluate the availability of each of the services above. To count as available, the service must be offered by the organization AND clients with IDDT must have genuine access to the service if they need it. *In order to document access to a service, a minimum requirement is at least one IDDT client must currently be receiving that service.* If a service is not currently being used by any clients or so restricted that IDDT clients rarely receive it, then that service is counted as unavailable.

If multiple sources confirm that all 5 services are available to clients targeted for IDDT, the item would be coded as a 5.

#### 4. Time-Unlimited Services

Definition: Clients with DD are treated on a long-term basis with intensity modified according to need and degree of recovery. The following services are available on a time-unlimited basis:

- Substance abuse counseling
- Residential service
- Supported employment
- Family psychoeducation
- Illness management and recovery
- ACT or ICM

Notes:

1. Score this item for available services only. For example, if the site has residential services and ACT, but not the other services, then evaluate if these two services are time-unlimited or not. If both are time-unlimited, then the site receives full credit for this item, even though the other services are not available (which is rated on preceding item).

This item refers to the program policy regarding time limits or graduation— *program initiated time limits*. The next item refers to clients who are hard to engage or who drop out.

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.

### Sources of Information:

#### a) Program leader interview

- Are there any time limits for the provision of DD treatment in your agency? [If yes] How long? How do you determine the duration of support clients receive?
- Do you graduate clients from IDDT after they have completed a certain number of sessions or groups?
- Which of your DD treatment services are given on a time-unlimited basis?
- Are clients funded for a particular period of time, for example, to receive substance abuse or employment services?

#### b) Clinician interview

- Ask the same questions as for program leader.
- Have you had anyone who graduated from IDDT in the last 6 months? [If yes] Please describe the circumstances.

#### c) Employment specialists and residential program case manager interview

- Inquire whether these services are time-limited.

#### d) Chart review (especially treatment plan)

- Examine length of time in services and reasons for termination.

Item Response Coding: If 80% or more of DD treatment services *that an agency does provide* are provided on a long-term basis, the item would be coded as a 5. (If an agency does not provide a service at all, then this is coded under Item 3).

## 5. Outreach

Definition: For all IDDT clients, but especially those in the *engagement* stage, the IDDT program provides assertive outreach, characterized by some combination of meetings and practical assistance (e.g., housing assistance, 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 targeted for IDDT 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.

### Sources of Information:

#### a) Program leader interview

- Do you have a policy about closing out people who don't show up for treatment?
- Often clients targeted for IDDT drop out of treatment. How do you engage or re-engage such clients? What kind of strategies do you use to develop a working alliance with your clients?
- How do you engage clients targeted for IDDT that are homeless?

- *How does a client reach you in a time of crisis?*
- Probe further to determine types/frequency of services provided outside the office.

b) Clinician interview

- Ask similar questions as for program leader. Also ask about several clients who were hardest to engage and what the clinicians did.

c) Client interview

- *Have you ever received services/support from your DD clinician [employment specialist, housing specialist] outside of the office, e.g., in your home, in the park, or at work? [If yes] How often?*
- *Do you feel that he/she would come out to wherever you are to help you when you are in trouble and need help urgently?*

d) Chart review (especially treatment plan)

- Examine length of time in services and reasons for termination.

Item Response Coding: If program demonstrates consistently well-thought-out strategies and uses street outreach whenever appropriate, code as 5.

## 6. Motivational Interventions

Definition: All interactions with DD clients are based on motivational interviewing that includes:

- *Expressing empathy*
- *Developing discrepancy between goals and continued use*
- *Avoiding argumentation*
- *Rolling with resistance*
- *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 targeted for IDDT who are unmotivated can be readily identified and effectively helped with motivational interventions.

Sources of Information:

a) Program leader interview

- *Are you familiar with the concept of motivational interviewing [interventions]? [If yes] How do you understand the concept? Could you give us examples of motivational interventions?*
- *Has the agency ever offered training on motivational interventions?*
- *How do you instill self-confidence and hope in your clients?*

## b) Clinician interview

- Ask similar questions as for program leader. Also, go through a review of a couple of clients who might benefit from motivational strategies and query how the clinician would respond.

## c) Team meeting/supervision observation

- Listen for discussion of motivational interventions.

## d) Observation of group or counseling sessions

- Listen for discussion of motivational interventions.

## e) Chart review (especially treatment plan)

- Examining 10 charts, look for documentation of motivational interventions.

## f) Client interview

- *Do you like the DD clinicians? Do you have a good relationship? Was there a time when it wasn't a good relationship?*
- *Do the DD clinicians help to identify your goals*
- *Do they help you focus on your goals?*
- *Are the DD clinicians good listeners? Do they do a good job in making you feel hopeful, capable, and confident?*
- *Do the DD clinicians keep you motivated to cut back/stay clean? How do they keep you motivated?*

Item Response Coding: Coding of this item requires both understanding on the part of clinicians and application of that understanding. If clinicians generally do not understand the concepts, then score as 1. If they understand parts of the concept, and if they apply the understanding consistently, score as 3. To score 5 on this item, there needs to be consistent evidence that the concepts are applied consistently for 80% or more of clients for whom motivational interventions are indicated, as documented across different sources of evidence.

## 7. Substance Abuse Counseling

Note: Rating this item requires that the caseload be previously assessed according to stage (in Item 2). If the program has not formally assessed their caseload, then estimate number of clients who are in these stages (after briefly defining).

Definition: Clients who are in the *action* stage or *relapse prevention* stage receive substance abuse counseling aimed at:

- Teaching how to manage cues to use and consequences of use
- Teaching relapse prevention strategies
- Teaching drug and alcohol refusal skills
- Problem-solving skills training to avoid high-risk situations

- Challenging clients' beliefs about substance use; and
- Coping skills and social 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 programs), or family therapy or a combination.

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.

Sources of Information:

a) Program leader interview

- *Could you tell me about substance abuse counseling offered in your program? Do you offer individual [group, family] substance abuse counseling? How often?*
- *Please describe the program philosophy and strategies your clinicians use.*
- Request a copy of the program's substance abuse counseling schedule and curriculum.

b) Clinician interview

- *What kind of skills do you teach in the individual [group, family] substance abuse counseling? Probe to confirm if each of the five areas listed above is addressed.*
- *Do all clients who are motivated receive some form of substance abuse counseling? [If no] Who do NOT receive substance abuse counseling? Probe if the clinicians take into account clients' motivational stage when introducing substance abuse counseling.*

c) Chart review

- Look for documentation of motivational stage and substance abuse counseling.

d) Observation of group or counseling sessions

- Listen for discussion of motivational stage. Observe techniques/topics during group and whether they are appropriate for group members' stage of treatment.

Item Response Coding: Coding of this item requires both understanding on the part of clinicians and application of that understanding. If clinicians generally do not understand the concepts, then score as 1. If they understand parts of the concept, and if they apply the understanding consistently, score as 3. To score 5 on this item, there needs to be consistent evidence that >80% of clients in *action* stage or *relapse prevention* stage receive substance abuse counseling, the item would be coded as a 5.

Note: Rating this item requires that the caseload be previously assessed according to stage (in Item 2). If the program has not formally assessed their caseload, then estimate the number of clients who are in these stages (after briefly defining).

## 8. Group DD Treatment

Definition: All clients targeted for IDDT 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 group treatment. Groups could be family, persuasion, dual recovery, etc.

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.

### Sources of Information:

#### a) Program leader interview

- *Could you tell me about the types of groups that are available to clients targeted for IDDT? How many different groups are available?*
- *Do you have groups that address both mental health and substance abuse? How many clients attend such a group regularly?*
- Request a copy of the program's group treatment schedule, if available.

#### b) Clinician interview

- *Could you tell me about the types of groups that are available to clients targeted for IDDT? How many different groups are available for clients targeted for IDDT?*
- *How do you determine which group each client should be in?*
- *Do you have groups that address both mental health and substance abuse? [If yes] Could you describe the group process of such an integrated DD group? Do all clients attend such an integrated DD group? [If no] Probe what proportion of clients regularly attends a DD group.*

#### c) Chart review

- Determine number of clients attending groups on a regular basis documented in charts.

#### d) Observation of group counseling session

- Listen for discussion of both substance use and SMI topics and how they are related

#### e) Client interview

- *Do you attend groups here? What kind of groups do you participate in?*
- *Do you attend a group that addresses both drug/alcohol use and mental health?*

Item Response Coding: If multiple sources confirm that >65% of clients targeted for IDDT regularly attend a DD group, the item would be coded as a 5.

## 9. Family Psychoeducation on DD

Definition: Where available and if the client is willing, clinicians always attempt to involve family members (or long-term social network members) to give psychoeducation about DD and coping skills to reduce stress in the family, and to promote collaboration with the treatment team.

Rationale: Research has shown that social support plays a critical role in reducing relapse and hospitalization in persons with SMI, and family psychoeducation that can be a 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 with the client the benefits of family treatment, and respect his/her decision about whether and in what way to involve them.

### Sources of Information:

#### a) Program leader interview

- *Does your program provide family psychoeducation on DD? [If yes] Can you describe how you provide family psychoeducation?*
- *How many clients in your program are in contact with family members (or significant others) on a weekly basis? (Estimates suggest about 60% of DD clients have weekly contact with their families). Of those clients, how many receive family psychoeducation?*

#### b) Clinician interview

- *Do you provide family psychoeducation on DD? [If yes] Please describe what you cover in your family psychoeducation. Probe also for frequency and format (individual vs. multifamily group session). From clinician interview and/or agency's internal record, obtain: A) Total number of active clients targeted for IDDT who are in contact with family members significant others on a weekly basis; and B) Number of active clients targeted for IDDT receiving family psychoeducation. See the 'Item Response Coding' below for computation.*
- *What happens if the client refuses to involve his/her family?*
- *What would you do if the client is willing to involve his/her family, but the family refuses to participate in family treatment? Do you attempt outreach to the families?*
- *Do you use a manual or book to guide family psychoeducation? [If yes] Request to review such a manual/guidebook.*

#### c) Client interview

- *Do your family members or friends participate in family treatment? [If yes] Was it your decision? How did the program help you to get them involved? [If no] Do you want them to be more involved in your treatment?*

d) Chart review

- Look for documentation of involvement of family or significant others.

Item Response Coding:

% families receiving *psychoeducation* =  $B/A \times 100$

If >65% of families (or significant others) receive psychoeducation on DD, the item would be coded as a 5.

## 10. Participation in Alcohol & Drug Self-Help Groups

Note: Rating this item requires that the caseload be previously assessed according to stage (in Item 2). If the program has not formally assessed their caseload, then estimate number of clients who are in these stages (after briefly defining).

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

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 targeted for IDDT who are motivated to achieve or maintain abstinence.

Sources of Information:

a) Program leader interview

- How many clients in your program are regularly attending self-help groups in the community?
- Does the agency have a designated individual who is a liaison to self-help groups in the community?

b) Clinician interview

- Do you refer your clients to self-help groups in the community such as AA, NA, Rational Recovery, Double Trouble, or Dual Recovery?
- When do you usually refer you clients to self-help groups? (The goal here is to ascertain if the clinicians take into account clients' motivational stage when referring to self-help groups.)
- Do you [or a designated liaison] ever attend self-help group meetings with clients to help them identify suitable groups?
- How many clients in your program are regularly attending self-help groups in the community?
- How do you make sure that clients follow through with the referrals?
- When we talked about the stages of treatment some time ago, you identified for us the number of clients that fit in each of the **engagement**, **persuasion**, **action**, and **relapse prevention** stages. Now, how many of the clients in the **action** and **relapse prevention** stages are currently attending self-help groups in the community?



### c) Chart review

- Look for documentation of referral to, and follow up on, self-help groups in the community (Exclude self-help groups offered within the agency).

Item Response Coding: If >65% of clients in the *active treatment* stage or *relapse prevention* stage regularly attend self-help programs in the community, the item would be coded as a 5.

Note: Rating this item requires that the caseload be previously assessed according to stage (in Item 2). If the program has not formally assessed their caseload, then estimate number of clients who are in these stages (after briefly defining).

## II. 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. Five specific indicators are considered. Do prescribers:

1. Prescribe psychiatric medications despite active substance use
2. Work closely with team/client
3. Focus on increasing adherence
4. Avoid benzodiazepines and other addictive substances
5. Use clozapine, naltrexone, disulfiram

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.

### Sources of Information:

#### a) Clinician interview

- Are psychotropic medications prescribed to clients with active substance abuse problems? How many active clients are currently taking psychotropic medication?
- Have any IDDT clients been prescribed benzodiazepines?
- Have any IDDT clients been prescribed clozapine to reduce addiction?
- Have any IDDT clients been prescribed antabuse, disulfiram, or naltrexone?
- How often do you contact your clients' prescriber?
- What kind of strategies do you use for clients who do not take medications as prescribed?

#### b) Medication prescriber interview

- Are there certain restrictions, in terms of specific types of substances abused or specific mental illnesses, in which psychotropic medications are not to be prescribed? Please give some examples.
- How do you approach DD clients pharmacologically, as opposed to psychiatric patients who do not have a drug/alcohol problem?

- *How often do you contact your patients' DD clinician?*
- Probe for the presence or absence of the 5 indicators listed in the definition.

c) **Chart review**

- Look for documentation of medication (including type, dosage, and rationale for prescription) and issues related to compliance/adherence.

Item Response Coding: If all 5 strategies are used, the item would be coded as a 5.

## 12. Interventions to Promote Health:

Definition: Efforts are made to promote health through encouraging clients to practice proper diet and exercise, find safe housing, and avoiding high-risk behaviors and situations. The intent is 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., chronic illnesses, sexually transmitted diseases), social effects (e.g., loss of family support, victimization), self-care and independent functioning (e.g., mental illness relapses, malnutrition, housing instability, unemployment, incarceration), and use of substances in unsafe situations (e.g., driving while intoxicated). Examples of strategies designed to reduce negative consequences include: teaching how to avoid infectious diseases; supporting clients who switch to less harmful substances; providing support to families; helping clients avoid high-risk situations for victimization; encouraging clients to pursue work, exercise, healthy diet, and non-user friends; and securing safe housing that recognizes clients' ongoing substance abuse problems.

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

### Sources of Information:

a) **Program leader interview**

- *What's your philosophy regarding treatment for individuals that continue to drink or use drugs?*
- *Do your groups or individual sessions systematically cover healthy diet, safe sex, switching to less harmful substances, avoiding victimization, etc.?*

b) **Clinician interview**

- Ask similar questions as for program leader. Review specific examples of clients currently receiving this type of services.

c) **Chart review**

- Look for documentation of interventions to reduce negative consequences.

#### **d) Client interview**

- *Does your program provide education or training addressing negative effects of drug/alcohol abuse, e.g., driving while intoxicated, unprotected sex, losing friends and family? What did you learn in those classes?*

Item Response Coding: If  $\geq 80\%$  of clients receive services to promote health, the item would be coded as a 5.

### **13. Secondary Interventions for Substance Abuse Treatment Non-Responders:**

Definition: Secondary interventions are more intensive (and expensive) interventions that are reserved for people who do not respond to basic outpatient IDDT. To meet the criterion for this item, the program has a specific plan to identify treatment non-responders, to evaluate them for secondary (i.e., more intensive) interventions, and to link them with appropriate secondary interventions. Potential secondary interventions might include special medications that require monitoring (e.g., clozapine, naltrexone, or disulfiram); more intensive psychosocial interventions (e.g., intensive family treatment, additional trauma interventions, intensive outpatient such as daily group programs, or long-term residential care); or intensive monitoring, which is usually imposed by the legal system (e.g., protective payeeship or conditional discharge).

Rationale: Approximately 50% of DD clients respond well to basic IDDT and will attain stable remissions of their substance use disorders within 2-3 years. All clients should be assessed regularly (at least every three months) to make sure they are making progress toward recovery. Those who are not making progress should be reviewed by a senior clinician and considered for more intensive interventions. The idea is to use an algorithmic approach based on current knowledge and experienced clinical judgment. For example, clients who experience increased nightmares, intrusive thoughts, and anxiety leading to relapse when sober should be considered for a PTSD intervention. Clients who are not making progress and have regular family contact should be considered for an intensive family intervention. Clients who experience severe craving should be considered for monitored naltrexone. Clients who are impulsive drinkers should be considered for monitored disulfiram.

#### Sources of Information:

##### **a) Program leader interview**

- *How do you review client progress?*
- *Do you have a way to identify specific clients who are not making progress? Do you have criteria and what are they?*
- *If clients do not make progress, what do you do?*
- Probe for secondary interventions listed in the definition.

##### **b) Clinician interview**

- Ask similar questions as for program leader. Also, ask the clinicians to give examples of the secondary interventions they have used for clients not making progress.

c) Client interview

- *Has there ever been a time when you weren't able to get/stay clean despite receiving both mental health and substance abuse treatment from this program? [If yes] Did staff here try anything new to help you or give you other options for treatment?*

Item Response Coding: If >80% of non-responders are evaluated and referred for secondary interventions, the item would be coded as a 5.

### Integrated Dual Diagnosis Treatment (IDDT) Fidelity Scale

	1	2	3	4	5
<b>Ia. Multidisciplinary Team:</b> Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health treatment team	< 20% of clients receive care from multidisciplinary team (i.e., most care follows a brokered CM or traditional outpatient approach)	21% - 40% of clients receive care from a multidisciplinary team	41% - 60% of clients receive care from a multidisciplinary team	61% - 79% of clients receive care from a multidisciplinary team	≥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
<b>Ib. Integrated Dual Diagnosis Specialist:</b> Integrated Dual Diagnosis specialist works collaboratively with the treatment team, modeling IDDT skills and training other staff in IDDT	No Integrated Dual Diagnosis specialist connected with agency	IDDT clients are referred to a separate substance abuse department within the agency (e.g., referred to drug and alcohol staff)	Integrated Dual Diagnosis specialist serves as a consultant to treatment team; does not attend meetings; is not involved in treatment planning	Integrated Dual Diagnosis specialist is assigned to the team, but is not fully integrated; attends some meetings; may be involved in treatment planning but not systematically	Integrated Dual Diagnosis specialist is a fully integrated member of the treatment team; attends all team meetings; involved in treatment planning for IDDT clients; models IDDT skills and trains other staff in IDDT
<b>2. Stage-Wise Interventions:</b> Treatment consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention)	≤20% of interventions are consistent with client's stage of recovery	21%- 40% of interventions are consistent	41%- 60% of interventions are consistent	61% - 79% of interventions are consistent	≥80% of interventions are consistent with client's stage of recovery
<b>3. Access for IDDT Clients to Comprehensive DD Services</b> <ul style="list-style-type: none"> <li>• Residential services</li> <li>• Supported employment</li> <li>• Family psychoeducation</li> <li>• Illness management</li> <li>• ACT or ICM</li> </ul>	Less than 2 services are provided by the service provider that IDDT clients can access	2 services are provided by the service provider and IDDT clients have genuine access to these services	3 services are provided by the service provider and IDDT clients have genuine access to these services	4 services are provided by the service provider and IDDT clients have genuine access to these services	All 5 services are provided by the service provider and IDDT clients have genuine access to these services

## Integrated Dual Disorders Treatment (IDDT) Fidelity Scale

	1	2	3	4	5
<p><b>4. Time-Unlimited Services</b></p> <ul style="list-style-type: none"> <li>• IDDT counseling</li> <li>• Residential services</li> <li>• Supported employment</li> <li>• Family psychoeducation</li> <li>• Illness management</li> <li>• ACT or ICM</li> </ul>	<p>≤20% of available services are provided on a time-unlimited basis (e.g., clients are closed out of most services after a defined period of time)</p>	<p>21%- 40% of available services are provided on a time-unlimited basis</p>	<p>41%- 60% of available services are provided on a time-unlimited basis</p>	<p>61%- 79% of available services are provided on a time-unlimited basis</p>	<p>≥80% of available services are provided on a time-unlimited basis with intensity modified according to each client's needs</p>
<p><b>5. Outreach:</b> Program demonstrates consistently well-thought-out strategies and uses outreach to community whenever appropriate:</p> <ul style="list-style-type: none"> <li>• Housing assistance</li> <li>• Medical care</li> <li>• Crisis management</li> <li>• Legal aid</li> </ul>	<p>Program is passive in recruitment and re-engagement; almost never uses outreach mechanisms.</p>	<p>Program makes initial attempts to engage but generally focuses efforts on most motivated clients.</p>	<p>Program attempts outreach mechanisms only as convenient.</p>	<p>Program usually has plan for engagement and uses most of the outreach mechanisms that are available.</p>	<p>Program demonstrates consistently well-thought-out strategies and uses outreach whenever appropriate.</p>
<p><b>6. Motivational Interventions:</b> Clinicians who treat IDDT clients use strategies such as:</p> <ul style="list-style-type: none"> <li>• Express empathy</li> <li>• Develop discrepancy between goals and continued use</li> <li>• Avoid argumentation</li> <li>• Roll with resistance</li> <li>• Instill self-efficacy and hope</li> </ul>	<p>Clinicians providing IDDT treatment do not understand motivational interventions and ≤20% of interactions with clients are based on motivational approaches</p>	<p>Some clinicians providing IDDT treatment understand motivational interventions and 21%- 40% of interactions with clients are based on motivational approaches</p>	<p>Most clinicians providing IDDT treatment understand motivational interventions and 41%- 60% of interactions with clients are based on motivational approaches</p>	<p>All clinicians providing IDDT treatment understand motivational interventions and 61%- 79% of interactions with clients are based on motivational approaches</p>	<p>All clinicians providing IDDT treatment understand motivational interventions and ≥80% of interactions with clients are based on motivational approaches</p>

## Integrated Dual Disorders Treatment (IDDT) Fidelity Scale

	1	2	3	4	5
<p><b>7. Active Stage Treatment Counseling:</b> Clients who are in the <i>action</i> stage or <i>relapse prevention</i> stage receive counseling that includes:</p> <ul style="list-style-type: none"> <li>• Teaching how to manage cues to use and consequences to use</li> <li>• Teaching relapse prevention strategies</li> <li>• Drug and alcohol refusal skills training</li> <li>• Problem-solving skills training to avoid high-risk situations</li> <li>• Challenging clients' beliefs about substance abuse</li> <li>• Coping skills and social skills training</li> </ul>	Clinicians providing IDDT treatment do not understand basic active stage treatment counseling principles and $\leq 20\%$ of clients in active treatment stage or relapse prevention stage receive active stage treatment counseling	Some clinicians providing IDDT treatment understand basic active stage treatment counseling principles and 21%-40% of clients in active treatment stage or relapse prevention stage receive active stage treatment counseling	Most clinicians providing IDDT treatment understand basic active stage treatment counseling principles and 41%-60% of clients in active treatment stage or relapse prevention stage receive active stage treatment counseling	All clinicians providing IDDT treatment understand basic active stage treatment counseling principles and 61% - 79% of clients in active treatment stage or relapse prevention stage receive active stage treatment counseling	All clinicians providing IDDT treatment understand basic active stage treatment counseling principles and $\geq 80\%$ of clients in active treatment stage or relapse prevention stage receive active stage treatment counseling
<b>8. Group DD Treatment:</b> DD clients are offered group treatment specifically designed to address both mental health and substance abuse problems	$<20\%$ of DD clients regularly attend a DD group	20% - 34% of DD clients regularly attend a DD group	35% - 49% of DD clients regularly attend a DD group	50% - 65% of DD clients regularly attend a DD group	$>65\%$ of DD clients regularly attend a DD group
<p><b>9. Family Psychoeducation on DD:</b> Clinicians provide family members (or significant others):</p> <ul style="list-style-type: none"> <li>• Education about DD</li> <li>• Coping skills training</li> <li>• Collaboration with the treatment team</li> <li>• Support</li> </ul>	$<20\%$ of families (or significant others) receive family psychoeducation on DD	20% - 34% of families (or significant others) receive family psychoeducation on DD	35% - 49% of families (or significant others) receive family psychoeducation on DD	50% - 65% of families (or significant others) receive family psychoeducation on DD	$>65\%$ of families (or significant others) receive family psychoeducation on DD
<b>10. Participation in Alcohol &amp; Drug Self-Help Groups:</b> Clients in the <i>action</i> stage or <i>relapse prevention</i> stage attend self-help programs in the community	$<20\%$ of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	20% - 34% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	35% - 49% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	50% - 65% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	$>65\%$ of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community

## Integrated Dual Disorders Treatment (IDDT) Fidelity Scale

	1	2	3	4	5
<p><b>II. Pharmacological Treatment:</b> Prescribers for IDDT clients:</p> <ul style="list-style-type: none"> <li>• Prescribe psychiatric medications despite active substance use</li> <li>• Work closely with team/client</li> <li>• Focus on increasing adherence</li> <li>• Avoid benzodiazepines and other addictive substances</li> <li>• Use clozapine, naltrexone, disulfiram</li> </ul>	<p>Prescribers have virtually no contact with treatment team and make no apparent efforts to increase adherence OR prescribers require abstinence prior to prescribing psychiatric medications</p>	<p>Approximately 2 of 5 strategies used, e.g., prescribers have minimal contact with treatment team; no apparent efforts to increase adherence or to decrease substance use via pharmacological management</p>	<p>Approximately 3 of 5 strategies used, e.g., there is little evidence that prescribers function with team/client input, but there is evidence that prescribers make efforts to increase adherence and reduce substance use</p>	<p>4 of 5 strategies used, e.g., prescribers typically receive some minimal input from IDDT team to maximize adherence; there is evidence that prescribers make efforts to decrease addictive meds and increase use of meds that help reduce addictive behavior</p>	<p>Evidence that all 5 strategies used; prescribers receive pertinent input from the treatment team regarding medication decisions and strategies to maximize adherence. No prohibitions on antipsychotic use due to substance use; offers medications known to be effective for decreasing substance use</p>
<p><b>12. Interventions to Promote Health:</b> Examples include:</p> <ul style="list-style-type: none"> <li>• Teaching how to avoid infectious diseases</li> <li>• Supporting attempts to reduce substance use</li> <li>• Helping clients avoid high-risk situations and victimization</li> <li>• Securing safe housing</li> <li>• Encouraging clients to pursue work, medical care, diet, &amp; exercise</li> </ul>	<p>Staff offer no form of services to promote health</p>	<p>No structured program, staff may have some knowledge of reducing negative consequences of substance abuse but use concepts rarely</p>	<p>Less than half of all DD clients receive services to promote health; clinicians providing IDDT treatment use concepts unsystematically</p>	<p>50%- 79% of clients receive services to promote health; all clinicians providing IDDT treatment are well-versed in techniques to reduce negative consequences</p>	<p>≥80% of clients receive services to promote health; all clinicians providing IDDT treatment are well-versed in techniques to reduce negative consequences</p>



### Integrated Dual Disorders Treatment (IDDT) Fidelity Scale

	1	2	3	4	5
<p><b>13. Secondary Interventions for IDDT Non-Responders:</b>            Program has a protocol for identifying IDDT non-responders and offers individualized secondary interventions, such as:</p> <ul style="list-style-type: none"> <li>• Clozapine/naltrexone/disulfiram</li> <li>• Long-term residential care</li> <li>• Trauma treatment</li> <li>• Intensive family intervention</li> <li>• Intensive monitoring</li> </ul>	<p>≤20% of non-responders are evaluated and referred for secondary interventions OR            No recognition of a need for secondary interventions for nonresponders</p>	<p>21%- 40% of non-responders are evaluated and referred for secondary interventions OR            Secondary interventions, if available, are not systematically offered to nonresponders</p>	<p>Program has protocol and 41%- 60% of non-responders are evaluated and referred for secondary interventions OR            No formal method for identifying nonresponders</p>	<p>Program has protocol for identifying nonresponders and 61%- 79% of non-responders are evaluated and referred for secondary interventions</p>	<p>Program has protocol for identifying nonresponders and &gt;80% of non-responders are evaluated and referred for secondary interventions</p>

## General Organizational Index (GOI)

### *-Item Definitions and Scoring-*

#### GI. Program Philosophy

Definition: The program is committed to a clearly articulated philosophy consistent with the *specific* evidence-based practice (EBP), based on the following 5 sources:

- Program leader
- Senior staff (e.g., executive director, psychiatrists)
- Practitioners providing EBP
- Clients and/or family members (depending on EBP focus)
- Written materials (e.g., brochures)

Rationale: In psychiatric rehabilitation programs that truly endorse EBPs, staff members at all levels embrace the program philosophy and practice it in their daily work.

#### Sources of Information:

Overview: During the course of a site visit, fidelity assessors should be alert to indicators of program philosophy consistent with or inconsistent with the EBP including observations from casual conversations, staff and client activities, etc. Statements that suggest misconceptions or reservations about the practice are negative indicators, while statements that indicate enthusiasm for and understanding of the practice are positive indicators. The intent of this item is to gauge the understanding of and commitment toward the practice. It is not necessary that every element of the practice is currently in place (this is gauged by the EBP-specific fidelity scale), but rather whether all those involved are committed to implementing a high fidelity EBP.

The practitioners rated for this item are **limited to those implementing this practice**. Similarly, the clients rated are those receiving the practice.

#### a) Program leader interview, b) Senior staff interview and c) Practitioner interview:

- At the beginning of interview, have the staff briefly describe the program.
- “What are the critical ingredients or principles of your services?”
- “What is the goal of your program?”
- “How you define [EBP area]?”

#### d) Client interview:

- “What kind of services do you receive from this program?”
- Using a layperson’s language, describe to the client/family, the principles of the specific EBP area; probe if the program offers services that reflect each principle.
- “Do you feel the staff of this program competent and helpful to you in addressing your problems?”

#### e) Written material review (e.g., brochure):

- Does the site have written materials on the EBP? *If no written material, then item is rated done one scale point (i.e., lower fidelity).*
- Does the written material articulate program philosophy consistent with EBP?

Item Response Coding: The goal of this item is *not* to quiz every staff worker to determine if they can recite every critical ingredient. The goal is to gauge whether the understanding is generally accurate and not contrary to the EBP. If, for example, a senior staff member says, “most of our clients are not work ready,” then that would be a red flag for the practice of supported employment. If all sources show evidence of a clear understanding of the program philosophy, the item is coded as a “5”. For a source type that is based on more than one person (e.g., Practitioner interviews) determine the majority opinion when rating that source as endorsing or not endorsing a clear program philosophy. Note: If no written material, then count that source as being unsatisfactory.

*Difference between a major and minor area of discrepancy (needed to distinguish between a score of “4” and a score of “3”):* An example of a minor source of discrepancy for ACT might be larger caseload sizes (e.g., 20-1) or some brokering of services. An example of a major discrepancy would be if the team seldom made home visits or if the psychiatrist was uninvolved in the treatment team meetings.

## G2. Eligibility/Client Identification

### Definition:

*For EBPs implemented in a mental health center:* All clients in the community support program, crisis clients, and institutionalized clients are screened using standardized tools or admission criteria that are consistent with the EBP.

*For EBPs implemented in a service area:* All clients within the jurisdiction of the services area are screened using standardized tools or admission criteria that are consistent with the EBP. For example, in New York, county mental health administrations are responsible for identifying clients who will be served by assertive community treatment programs.

- The *target population* refers to all adults with severe mental illness (SMI) served by the provider agency (or service area). If the agency serves clients at multiple sites, then **assessment is limited to the site or sites that are targeted for the EBP**. If the target population is served in discrete programs (e.g., case management, residential, day treatment, etc.), then ordinarily all adults with SMI are included in this definition.
- Screening will vary according to the EBP. *The intent is to identify any and all for who could benefit from the EBP.* For Integrated Dual Disorder Treatment and Assertive Community Treatment, the admission criteria are specified by the EBP and specific assessment tools are recommended for each. For Supported Employment, all clients are invited to receive the service because all are presumed eligible (although the program is intended for clients at the point they express interest in working). The screening for Illness Management & Recovery includes an assessment of the skills and issues addressed by this EBP. For Family Psychoeducation, the screening includes the assessment of the

involvement of a family member or significant other. 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 an EBP, there should be a plan for systematically reviewing clients already active in the program.

Rationale: Accurate identification of clients who would benefit most from the EBP requires routine review for eligibility, based on criteria consistent with the EBP.

Sources of Information:

a) Program leader interview, b) Senior staff interview and c) Practitioner interview:

- “Describe the eligibility criteria for your program.”
- “How are clients referred to your program? How does the agency identify clients who would benefit from your program? Do all new clients receive screening for [substance abuse or SMI diagnosis]?”
- “What about crisis [or institutionalized] clients?”
- Request a copy of the screening instrument used by the agency.

d) Chart review

- Review documentation of screening process & results.

e) (Where applicable) County mental health administrators. If eligibility is determined at the service area level (e.g., the New York example), then the individuals responsible for this screening should be interviewed.

Item Response Coding: This item refers to all clients with SMI in the community support program or its equivalent at the site(s) where the EBP is being implemented; it is not limited to the clients receiving EBP services only. Calculate this percentage and record it on the fidelity rating scale in the space provided. If 100% of these clients receive standardized screening, the item would be coded as a “5.”

### G3. Penetration

Definition: *Penetration* is defined as the percentage of clients who have access to an EBP as measured against the total number of clients who could benefit from the EBP. Numerically, this proportion is defined by:

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

As in the preceding item, the numbers used in this calculation are specific to the site or sites where the EBP is being implemented.

Rationale: Surveys have repeatedly shown that persons with SMI often have a limited access to EBPs. The goal of EBP dissemination is not simply to create small exclusive programs but to make these practices easily accessible within the public mental health system.

Sources of Information:

The calculation of the penetration rate depends of the availability of the two statistics defining this rate.

- Numerator: The number receiving the service is based on a roster of names maintained by the program leader. Ideally, this total should be corroborated with service contact sheets and other supporting evidence that the identified clients are actively receiving treatment. As a practical matter, agencies have many conventions for defining “active clients” and dropouts, so that it may be difficult to standardize the definition for this item. The best estimate of the number actively receiving treatment should be used.
- Denominator: If the provider agency systematically tracks eligibility, then this number is used in the denominator. (See rules listed above in G2 to determine target population before using estimates below.) If the agency does not, then the denominator must be estimated by multiplying the total target population by the corresponding percentage based on the literature for each EBP. According to the literature, the estimates should be as follows:
  - Supported Employment – 60%
  - Integrated Dual Disorders Treatment – 40%
  - Illness Management & Recovery – 100%
  - Family Psychoeducation – 100% (some kind of significant other)
  - Assertive Community Treatment – 20%

Example for calculating denominator: Suppose you don't know how many consumers are eligible for supported employment (i.e., the community support program has not surveyed the clients to determine those who are interested). Let's say the community support program has 120 clients. Then you would estimate the denominator to be:  
 $120 \times .6 = 72$

Item Response Coding: Calculate this ratio and record it on the fidelity scale in the space provided. If the program serves >80% of eligible clients, the item would be coded as a “5”.

#### G4. Assessment

Definition: All EBP clients receive standardized, high quality, comprehensive, and timely assessments.

*Standardization* refers to a reporting format that is easily interpreted and consistent across clients.

*High quality* refers to assessments that provide concrete, specific information that differentiates between clients. If most clients are assessed using identical words, or if the assessment consists of broad, noninformative checklists, then this would be considered low quality.

*Comprehensive* assessments include: 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.

*Timely* assessments are those updated at least annually.

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.

Sources of Information:

a) Program leader interview, b) Senior staff interview and c) Practitioner interview:

- “Do you give a comprehensive assessment to new clients? What are the components that you assess?”
- Request a copy of the standardized assessment form, if available, and have the practitioners go through the form.
- “How often do you re-assess clients?”

d) Chart review:

- Look for comprehensiveness of assessment by looking at multiple completed assessments to see if they address each individual component of the comprehensive assessment each time an assessment is performed.
- Is the assessment updated at least yearly?

Item Response Coding:

If >80% of clients receive standardized, high quality, comprehensive, and timely assessments, the item would be coded as a “5”.

## G5. Individualized Treatment Plan

Definition: For all EBP clients, there is an explicit, individualized treatment plan (even if it is not called this) related to the EBP that is consistent with assessment and updated every 3 months. “Individualized” means that goals, steps to reaching the goals, services/ interventions, and intensity of involvement are unique to this client. Plans that are the same or similar across clients are not individualized. One test is to place a treatment plan without identifying information in front of the supervisor and see if they can identify the client.

Rationale: Core values of EBP 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.

Sources of Information:

*Note:* This item and the next are assessed together; i.e., follow up questions about specific treatment plans with question about the treatment.

a) Chart review (treatment plan):

- Using the same charts as examined during the EBP-specific fidelity assessment, look for documentation of specific goal(s) and client-based goal-setting process.

- Are the treatment recommendations consistent with assessment?
  - Evidence for a quarterly review (and modification)?
- b) Program leader interview
- “Please describe the process of developing a treatment plan. What are the critical components of a typical treatment plan and how are they documented?”
- c) Practitioner interview:
- When feasible, use the specific charts selected above. Ask the practitioners go over a sample treatment plan.
  - “How do you come up with client goals?” Listen for client involvement and individualization of goals.
  - “How often do you review (or follow up on) the treatment plan?”
- d) Client interview:
- “What are your goals in this program? How did you set these goals?”
  - “Do you and your practitioner together review your progress toward achieving your goal(s)?” [If yes] “How often? Please describe the review process.”
- e) Team meeting/supervision observation, if available:
- Observe how treatment plan is developed. Listen especially for discussion of assessment, client preferences, and individualization of treatment.
  - Do they review treatment plans?

Item Response Coding: If >80% of EBP clients have an explicit individualized treatment plan that is updated every 3 months, the item would be coded as a 5. IF the treatment plan is individualized but updated only every 6 months, then the item would be coded as a 3.

## G6. Individualized Treatment

Definition: All EBP clients receive individualized treatment meeting the goals of the EBP. “Individualized” treatment means that steps, strategies, services/interventions, and intensity of involvement are focused on *specific* client goals and are unique for each client. Progress notes are often a good source of what really goes on. Treatment could be highly individualized despite the presence of generic treatment plans.

An example of a low score on this item for Integrated Dual Disorders Treatment: a client in the engagement phase of recovery is assigned to a relapse prevention group and constantly told he needs to quit using, rather than using motivational interventions.

An example for a low score on this item for Assertive Community Treatment: the majority of progress notes are written by day treatment staff who see the client 3-4 days per week, while the Assertive Community Treatment team only sees the client about once per week to issue his check.

Rationale: The key to the success of an EBP is implementing a plan that is individualized and meets the goals for the EBP for each client.

Sources of Information:

a) Chart review (treatment plan):

- Using the same charts as examined during the EBP-specific fidelity assessment, examine the treatment provided. Limit the focus to a recent treatment plan related to the EBP. The assessor should judge whether an appropriate treatment occurred during the time frame indicated by the treatment plan.

b) Practitioner interview:

- When feasible, use the specific charts selected above. Ask the practitioners to go over a sample treatment plan and treatment.

c) Client interview:

- “Tell me about how this program or practitioner is helping you meet your goals.”

Item Response Coding: If >80% of EBP clients receive treatment that is consistent with the goals of the EBP, the item would be coded as a 5.

## G7. Training

Definition: All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) within 2 months of hiring. Existing practitioners receive annual refresher training (at least 1-day workshop or its equivalent).

Rationale: Practitioner training and retraining are warranted to ensure that evidence-based services are provided in a standardized manner, across practitioners and over time.

Sources of Information:

a) Program leader interview, b) Senior staff interview and c) Practitioner interview:

- “Do you provide new practitioners with systematic training for [EBP area]?” [If yes] Probe for specifics: mandatory or optional, length, frequency, content, group or individual format, who trains, in-house or outside training, etc.
- “Do Practitioners already on the team receive refresher trainings?” [If yes] Probe for specifics.

d) Review of training curriculum and schedule, if available:

- Does the curriculum appropriately cover the critical ingredients for [EBP area]?

e) Practitioner interview:

- “When you first started in this program, did you receive a systematic/formal training for [EBP area]?” [If yes] Probe for specifics: mandatory or optional, length, frequency, content, group or individual format, who trained, in-house or outside training, etc.
- “Do you receive refresher trainings?” [If yes] Probe for specifics.

Item Response Coding: If >80% of practitioners receive at least yearly, standardized training for [EBP area], the item would be coded as a “5”.



## G8. Supervision

Definition: EBP practitioners receive structured, weekly supervision from a practitioner experienced in the particular EBP. The supervision can be either group or individual, but CANNOT be peers-only supervision without a supervisor. The supervision should be client-centered and explicitly address the EBP model and its application to *specific client situations*.

Administrative meetings and meetings that are not specifically devoted to the EBP do not fit the criteria for this item. The *client-specific* EBP supervision should be at least one hour in duration each week.

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

Sources of Information:

a) Program leader interview, b) Senior staff interview and c) Practitioner interview:

- Probe for logistics of supervision: length, frequency, group size, etc.
- “Please describe what a typical supervision session looks like.”
- “How does the supervision help your work?”

d) Team meeting/supervision observation, if available:

- Listen for discussion of [EBP area] in each case reviewed.

e) Supervision logs documenting frequency of meetings.

Item Response Coding: If >80% of practitioners receive weekly supervision, the item would be coded as a “5”.

## G9. Process Monitoring

Definition: Supervisors/program leaders monitor the process of implementing the EBP every 6 months and use the data to improve the program. Process monitoring involves a standardized approach, e.g., use of a fidelity scale or other comprehensive set of process indicators. An example of a process indicator would be systematic measurement of how much time individual case managers spend in the community versus in the office. Process indicators could include items related to training or supervision. The underlying principle is that whatever is being measured is related to implementation of the EBP and is not being measured to track billing or productivity.

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

Sources of Information:

a) Program leader interview, b) Senior staff interview and c) Practitioner interview:

- “Does your program collect process data regularly?” [If yes] Probe for specifics: frequency, who, how (using [EBP area] Fidelity Scale vs. other scales), etc.
- “Does your program collect data on client service utilization and treatment attendance?”

- “Have the process data impacted how your services are provided? For example?”
- d) Review of internal reports/documentation, **if available**

Item Response Coding: If there is evidence that standardized process monitoring occurs at least every 6 months, the item would be coded as a “5”.

## G10. Outcome Monitoring

Definition: Supervisors/program leaders monitor the outcomes of EBP clients every 3 months and share the data with EBP practitioners in an effort to improve services. Outcome monitoring involves a standardized approach to assessing clients.

Rationale: Systematic and regular collection of outcome data is imperative in 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.

The key outcome indicators for each EBP are discussed in the implementation resource kits. A provisional list is as follows:

- Supported Employment – competitive employment rate
- Integrated Dual Disorders Treatment – substance use (such as the Stages of Treatment Scale)
- Illness Management & Recovery – hospitalization rates; relapse prevention plans; medication compliance rates
- Family Psychoeducation – hospitalization and family burden
- Assertive Community Treatment – hospitalization and housing

### Sources of Information:

a) Program leader interview, b) Senior staff interview and c) Practitioner interview:

- “Does your program have a systematic method for tracking outcome data?” [If yes]  
Probe for specifics: how (computerized vs. chart only), frequency, type of outcome variables, who collects data, etc.
- “Do you use any checklist/scale to monitor client outcome (e.g., Substance Abuse Treatment Scale)?”
- “What do you do with the outcome data? Do your practitioners review the data on regular basis?” [If yes] “How is the review done (e.g., cumulative graph)?”
- “Have the outcome data impacted how your services are provided? For example?”

d) Review of internal reports/documentation, **if available**

Item Response Coding: If standardized outcome monitoring occurs quarterly and results are shared with EBP Practitioners, the item would be coded as a “5”.

## G11. Quality Assurance (QA)

Definition: The agency's QA Committee has an explicit plan to review the EBP or components of the program every 6 months. The steering committee for the EBP can serve this function.

Good QA committees help the agency in important decisions, such as penetration goals, placement of the EBP within the agency, hiring/staffing needs. QA committees also help guide and sustain the implementation by reviewing fidelity to the EBP model, making recommendations for improvement, advocating/promoting the EBP within the agency and in the community, and deciding on and keeping track of key outcomes relevant to the EBP.

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

Sources of Information:

a) **Program leader interview:**

- “Does your agency have an established team/committee that is in charge of reviewing the components of your [EBP area] program?” [If yes] Probe for specifics: who, how, when, etc.

b) **QA Committee member interview:**

- “Please describe the tasks and responsibilities of the QA Committee.” Probe for specifics: purpose, who, how, when, etc.
- “How do you utilize your reviews to improve the program’s services?”

Item Response Coding: If agency has an established QA group or steering committee that reviews the EBP or components of the program every 6 months, the item would be coded as a “5”.

## G12. Client Choice Regarding Service Provision

Definition: All clients receiving EBP services are offered a reasonable range of choices consistent with the EBP; the EBP practitioners consider and abide by client preferences for treatment when offering and providing services.

Choice is defined narrowly in this item to refer to services provided. This item does not address broader issues of client choice, such as choosing to engage in self-destructive behaviors.

To score high on this item, it is not sufficient that a program offers choices. The choices must be consonant with EBP. So, for example, a program implementing supported employment would score low if the only employment choices it offered were sheltered workshops.

A *reasonable range of choices* means that EBP practitioners offer realistic options to clients rather than prescribing only one or a couple of choices or dictating a fixed sequence or prescribing conditions that a client must complete before becoming eligible for a service.

*Sample of Relevant Choices by EBP:*

- Supported Employment
  - Type of occupation
  - Type of work setting

- Schedules of work and number of hours
- Whether to disclose
- Nature of accommodations
- Type and frequency of follow-up supports
- Integrated Dual Disorders Treatment
  - Group or individual interventions
  - Frequency of DD treatment
  - Specific self-management goals
- Family Psychoeducation
  - Client readiness for involving family
  - Who to involve
  - Choice of problems/issues to work on
- Illness Management & Recovery
  - **Selection of significant others to be involved**
  - Specific self management goals
  - Nature of behavioral tailoring
  - Skills to be taught
- Assertive Community Treatment
  - **Type and location of housing**
  - Nature of health promotion
  - Nature of assistance with financial management
  - Specific goals
  - Daily living skills to be taught
  - Nature of medication support
  - Nature of substance abuse treatment

Rationale: A major premise of EBP 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.

Sources of Information:

a) Program leader interview.

- “Please tell us what your program philosophy is regarding client choice. How do you incorporate their preferences in the services you provide?”
- “What options are there for your services? Please give examples.”

b) Practitioner interview.

- “What do you do when there is a disagreement between what you think is the best treatment for a client and what he/she wants?”
- “Please describe a time when you were unable to abide by a client’s preferences.”

c) Client interview.

- “Does the program give you options for the services you receive? Are you receiving the services you want?”

d) Team meeting/supervision observation.

- Look for discussion of service options and client preferences.

e) Chart review (especially treatment plan).

- Look for documentation of client preferences and choices.

Item Response Coding: If all sources support that type and frequency of EBP services always reflect client choice, the item would be coded as a “5”. If agency embraces client choice fully, except in one area (e.g., requiring the agency to assume representative payeeships for all clients), then the item would be coded as a “4”.

### General Organizational Index (GOI)

	1	2	3	4	5
<p><b>G1. Program Philosophy.</b> The program is committed to a clearly articulated philosophy consistent with the specific evidence-based model, based on the following 5 sources:</p> <ul style="list-style-type: none"> <li>• Program leader</li> <li>• Senior staff (e.g., executive director, psychiatrist)</li> <li>• Practitioners providing the EBP</li> <li>• Clients and/or families receiving EBP</li> <li>• Written materials (e.g., brochures)</li> </ul>	<p>No more than 1 of the 5 sources shows clear understanding of the program philosophy OR All sources have numerous major areas of discrepancy</p>	<p>2 of the 5 sources show clear understanding of the program philosophy OR All sources have several major areas of discrepancy</p>	<p>3 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one major area of discrepancy</p>	<p>4 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one or two minor areas of discrepancy</p>	<p>All 5 sources display a clear understanding and commitment to the program philosophy for the specific EBP</p>
<p><b>*G2. Eligibility/Client Identification.</b> All clients with severe mental illness in the community support program, crisis clients, and institutionalized clients are screened to determine whether they qualify for the EBP using standardized tools or admission criteria consistent with the EBP. Also, the agency tracks the number of eligible clients in a systematic fashion.</p>	<p>≤20% of clients receive standardized screening and/or agency DOES NOT systematically track eligibility</p>	<p>21%-40% of clients receive standardized screening and agency systematically tracks eligibility</p>	<p>41%-60% of clients receive standardized screening and agency systematically tracks eligibility</p>	<p>61%-80% of clients receive standardized screening and agency systematically tracks eligibility</p>	<p>&gt;80% of clients receive standardized screening and agency systematically tracks eligibility</p>
<p><b>*G3. Penetration.</b> The maximum number of eligible clients are served by the EBP, as defined by the ratio:  <math display="block">\frac{\# \text{ clients receiving EBP}}{\# \text{ clients eligible for EBP}}</math></p>	<p>Ratio ≤ .20</p>	<p>Ratio between .21 and .40</p>	<p>Ratio between .41 and .60</p>	<p>Ratio between .61 and .80</p>	<p>Ratio &gt; .80</p>

\*These two items coded based on all clients with SMI at the site or sites where the EBP is being implemented; all other items refer specifically to those receiving the EBP.

\_\_\_\_\_ Total # clients in target population  
 \_\_\_\_\_ Total # clients eligible for EBP                      % eligible: \_\_\_\_\_ %  
 \_\_\_\_\_ Total # clients receiving EBP                      Penetration rate: \_\_\_\_\_

### General Organizational Index (GOI)

	1	2	3	4	5
<p><b>G4. Assessment.</b> Full standardized assessment of all clients who receive EBP services. Assessment includes history and treatment of medical/psychiatric/substance use disorders, current stages of all existing disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors.</p>	<p>Assessments are completely absent or completely non-standardized</p>	<p>Pervasive deficiencies in two of the following: Standardization, Quality of assessments, Timeliness, Comprehensive-ness</p>	<p>Pervasive deficiencies in one of the following: Standardization, Quality of assessments, Timeliness, Comprehensive-ness</p>	<p>61%-80% of clients receive standardized, high quality assessments at least annually OR Information is deficient for one or two assessment domains</p>	<p>&gt;80% of clients receive standardized, high quality assessments, the information is comprehensive across all assessment domains, and updated at least annually</p>
<p><b>G5. Individualized Treatment Plan.</b> For all EBP clients, there is an explicit, individualized treatment plan <i>related to the EBP</i> that is consistent with assessment and updated every 3 months.</p>	<p>≤ 20% of clients served by EBP have an explicit individualized treatment plan, <i>related to the EBP</i>, updated every 3 mos.</p>	<p>21%-40% of clients served by EBP have an explicit individualized treatment plan, <i>related to the EBP</i>, updated every 3 mos.</p>	<p>41%-60% of clients served by EBP have an explicit individualized treatment plan, <i>related to the EBP</i>, updated every 3 mos. OR Individualized treatment plan is updated every 6 mos. for all clients</p>	<p>61%-80% of clients served by EBP have an explicit individualized treatment plan, <i>related to the EBP</i>, updated every 3 mos.</p>	<p>&gt;80% of clients served by EBP have an explicit individualized treatment plan <i>related to the EBP</i>, updated every 3 mos.</p>
<p><b>G6. Individualized Treatment.</b> All EBP clients receive individualized treatment meeting the goals of the EBP.</p>	<p>≤ 20% of clients served by EBP receive individualized services meeting the goals of the EBP</p>	<p>21%-40% of clients served by EBP receive individualized services meeting the goals of the EBP</p>	<p>41%-60% of clients served by EBP receive individualized services meeting the goals of the EBP</p>	<p>61% - 80% of clients served by EBP receive individualized services meeting the goals of the EBP</p>	<p>&gt;80% of clients served by EBP receive individualized services meeting the goals of the EBP</p>

### General Organizational Index (GOI)

	1	2	3	4	5
<p><b>G7. Training.</b> All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) <i>within 2 months of hiring</i>. Existing practitioners receive annual refresher training (at least 1-day workshop or its equivalent).</p>	<p>≤20% of practitioners receive standardized training annually</p>	<p>21%-40% of practitioners receive standardized training annually</p>	<p>41%-60% of practitioners receive standardized training annually</p>	<p>61%-80% of practitioners receive standardized training annually</p>	<p>&gt;80% of practitioners receive standardized training annually</p>
<p><b>G8. Supervision.</b> EBP practitioners receive structured, weekly supervision (group or individual format) from a practitioner experienced in the particular EBP. The supervision should be client-centered and explicitly address the EBP model and its application to <i>specific client situations</i>.</p>	<p>≤20% of practitioners receive supervision</p>	<p>21% - 40% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision on an informal basis</p>	<p>41%-60% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision monthly</p>	<p>61%-80% of EBP practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision twice a month</p>	<p>&gt;80% of EBP practitioners receive structured weekly supervision, focusing on specific clients, in sessions <i>that explicitly address the EBP model and its application</i></p>
<p><b>G9. Process Monitoring.</b> Supervisors and program leaders monitor the process of implementing the EBP every 6 months and use the data to improve the program. Monitoring involves a standardized approach, e.g., use of a fidelity scale or other comprehensive set of process indicators.</p>	<p>No attempt at monitoring process is made</p>	<p>Informal process monitoring is used at least annually</p>	<p>Process monitoring is deficient on 2 of these 3 criteria: (1) Comprehensive &amp; standardized; (2) Completed every 6 mos.; (3) Used to guide program improvements OR Standardized monitoring done annually only</p>	<p>Process monitoring is deficient on one of these three criteria: (1) Comprehensive and standardized; (2) Completed every 6 months; (3) Used to guide program improvements</p>	<p>Standardized comprehensive process monitoring occurs at least every 6 mos. and is used to guide program improvements</p>



### General Organizational Index (GOI)

	1	2	3	4	5
<p><b>G10. Outcome Monitoring.</b> Supervisors/program leaders monitor the outcomes for EBP clients every 3 months and share the data with EBP practitioners. Monitoring involves a standardized approach to assessing a key outcome <i>related to the EBP</i>, e.g., psychiatric admissions, substance abuse treatment scale, or employment rate.</p>	No outcome monitoring occurs	Outcome monitoring occurs at least once a year, but results are not shared with practitioners	Standardized outcome monitoring occurs at least once a year and results are shared with practitioners	Standardized outcome monitoring occurs at least twice a year and results are shared with practitioners	Standardized outcome monitoring occurs quarterly and results are shared with EBP practitioners
<p><b>G11. Quality Assurance (QA).</b> The agency has a QA Committee or implementation steering committee with an explicit plan to review the EBP, or components of the program, every 6 months.</p>	No review or no committee	QA committee has been formed, but no reviews have been completed	Explicit QA review occurs less than annually OR QA review is superficial	Explicit QA review occurs annually	Explicit review every 6 months by a QA group <i>or steering committee for the EBP</i>
<p><b>G12. Client Choice Regarding Service Provision.</b> All clients receiving EBP services are offered choices; the EBP practitioners consider and abide by client preferences for treatment when offering and providing services.</p>	Client-centered services are absent (or all EBP decisions are made by staff)	Few sources agree that type and frequency of EBP services reflect client choice	Half sources agree that type and frequency of EBP services reflect client choice	Most sources agree that type and frequency of EBP services reflect client choice OR Agency fully embraces client choice with one exception	All sources agree that type and frequency of EBP services reflect client choice

## Data Collection for IDDT

Data is collected from IDDT sites on a quarterly basis. Data for the Jan. – March quarter is sent to KU in April no later than the 15<sup>th</sup> of the month; data from the April – June quarter is sent to KU in by July 15<sup>th</sup>, and so forth. Agencies keep copies for themselves that can then be updated quarterly. Agencies may choose to include client names on their own copies, but please do not send client names to KU.

Quarterly spreadsheets should be e-mailed to Bryan Knowles at the following address: [knowles@ku.edu](mailto:knowles@ku.edu).

The information needed for each client can be viewed in the sample spreadsheet included in this section of the Supervisor's Toolkit. Please read the included instructions **very carefully** in order to format the data correctly. Consistent formatting across agencies is of great importance due to the need to aggregate the data.

Reports are generated based on this data. The hope is that in the near future, KU will be able to provide movement tables for both the Stages of Treatment and AIMS outcomes (e.g., independent living, employment, etc.) which will be sent back to the agencies as well as used for research and State purposes.

This data serves some very important purposes. The first, and most important, is to ensure that clients are making progress in their recovery.

Another reason this data is crucial is to provide outcomes-based evidence for the IDDT model in Kansas. This is absolutely crucial to ensuring the State's continued support of the efforts that agencies have put into serving people with co-occurring disorders. Requests for continued and/or expanded funding for these efforts will be impossible without the supporting data.

The Office of Mental Health Research and Training is excited about the many benefits of producing outcomes data, and we appreciate your cooperation in improving services for the people we serve!

### Instructions for Completion of IDDT Data Form

Data collected on the XL spreadsheet will be updated quarterly. Due to the need to compile a great deal of data, KU will not be able to accept hard copies of updates. This form is intended to provide column-by-column instructions for completing the form electronically. Mental Health Centers may choose to save a copy of this form for their own use, but when updating and returning the form to KU, **please closely follow the instructions below**. KU will be combining data from different sites, so it will be **vitaly important** that all sites use **the same format**. When you see the phrase **FORMAT NOTE**, please pay special attention to how you enter the data.

#### **Column heading: “AIMS Alt-ID”**

Every client in AIMS is assigned an alternate ID, as the state does not track data by names. Individual centers can access names, but KU cannot. For this reason, we need the Alt-ID as a unique identifier. Mental Health Centers can certainly add the name of the client for their own records, but when updating the data for KU, **please ensure that clients’ names are not included**.

#### **Column headings for “Previous” and “Current” Stages of Tx.**

**FORMAT NOTE:** At the top of the column (“Qtr Ending: \_\_\_”) please enter the last month and current year of the quarter being reported on. Once it is filled in, an example date in the heading would look like this: “Date: Dec. 2008” **Only** put this date **in the heading** (not in the column below the heading).

As new columns are added for new quarters, please do not erase any of the old columns. It is very important that we have the data longitudinally. Additionally, having these fields will be of assistance to agencies in tracking “treatment non-responders” (item 13 of the Fidelity Scale). **FORMAT NOTE:** When entering stage, please use a number to represent the stage (i.e., **Pre-engagement = 1, Engagement = 2, Early Persuasion = 3, Persuasion = 4, Early Active = 5, Late Active = 6, Relapse Prevention = 7, and Remission/Recovery = 8**)

As data is updated, the easiest way to modify the electronic version of this form will be to add a column for the most current Stage of Treatment and to re-label the previous columns accordingly (i.e., the old “current qtr.” column would be re-labeled “last qtr.” and columns prior to that will just contain “Date: \_\_\_”). There are three simple steps to adding the new column:

1. Hold the cursor next to the **column label** for “Client is new since last report” (this is the **letter** just **above** the words “Client is new...” In the accompanying example, this is the letter “E.”) The cursor will become a black arrow pointing downward.
2. **Left click** one time to highlight that column.
3. Now **right click** (a menu appears) and choose “Insert,” which will **add a new column** to the left. The column that appears will become the new “Current Qtr. Stage of Tx.” column when you re-label the columns as mentioned above.

If a client has been closed in the current quarter, simply enter the stage of treatment at the time of discharge and add “discharged” plus the date of the discharge in the new “Current Stage of Tx.” column.

As noted above, KU will be tracking data longitudinally, so please do not erase/delete any of the columns with prior stages of treatment.

**Column heading: “Client is new since last report”**

This will be used to track new clients as they enter services. Simply place an X in this column to identify clients who came into services during the quarter you are reporting on.

**Column heading: “Does cl have SA Dx.? (Y/N)”**

This column indicates whether the client has a formal substance abuse diagnosis per the reporting Mental Health Center’s record.

**Column heading: “Agency.Team Serving Client”**

This is used to identify which team within an agency is serving a particular client and will be useful to agencies in providing outcomes to particular teams. If this information is shared with teams quarterly, it will also meet the requirement on the General Organizational Index (GOI) item #10, “Outcomes Monitoring.”

**FORMAT NOTE:** In order to sort for this data, attention to formatting is very important. Every agency is assigned a number through AIMS (e.g., Area MHC is 001, Bert Nash is 002, etc.) Every agency will be asked to assign a two-digit number to each team that is trained in IDDT and to provide a key for KU (i.e., 01= Bryan’s team, 02= Dianne’s team, 03= Grant’s team, etc...).

The reason for this is that team leaders may change over time, but the number will remain the same. **The format to identify an agency and team will look like a whole number (agency) with two decimal places (team).** Example: Bert Nash’s AIMS agency number is “002” and they may identify a team as “01= Bryan’s team.” All of the Bert Nash clients on “Bryan’s Team,” would be labeled “2.01” This is another of those processes that will take some effort at the beginning but after it is done, the number will not change unless the client is transferred to a different team.

**Column Heading: “Case Manager Serving Client”**

Please use three initials to represent the case manager serving the client. If a case manager doesn’t have a middle name, please use an “X” as the middle initial.

The final column is for KU use, and agencies do not need to fill it out.

## Tracking Outcomes Data for IDDT Sites

In discussing this topic, we came up with some questions about what AIMS can and can't do in terms of sorting data. We addressed these with Doug M. and came up with an idea that addresses three logistical problems:

1. AIMS does not track Stages of Tx., which—although not really a great outcome measure when arguing for cost-effectiveness—would be good to have.
2. Even if all clients with Dual Diagnoses are listed in AIMS, there is no way to track how long the client has been receiving (or “targeted for”) those services (e.g., cl may have been in CSS services for a while but substance use was only recently discovered to be an issue).
3. AIMS has a particular way of organizing and formatting data, which doesn't seem to allow longitudinal data to be compared side-by-side within data sets. (It's complicated, but as I understand it the regular AIMS movement tables won't let us pick and choose the clients we decide to compare.)

The system we devised uses AIMS and XL to fill in the gaps mentioned above.

- I. The first (and most time/effort intensive) step is to collect from each agency the following information:
  - a. Alt-ID of the client
  - b. Whether cl has a substance abuse Dx. (and if not, attempting to add one)
  - c. Stage of Tx.
  - d. How long the cl has been receiving IDDT services

This task would ideally be accomplished by KU staff who could go to each site (and each team at each site) to collect the information (some of which the team would have prepared ahead of time) and problem-solve around any barriers to getting accurate information. Alternatively, we could simply ask each site to submit the information via e-mail; the down-side being that data might be less accurate or incomplete.

- II. Through some complicated wizardry involving AIMS and Access, an XL list can be generated from AIMS data. Some modifications would be required:
  - a. KU staff would eliminate irrelevant Alt-ID's (those not receiving IDDT services).
  - b. The information gathered above would be added to the spreadsheet, allowing KU staff to track data for each individual and for the group over time.

- III. Using a template provided by KU staff, sites would regularly update the requested information (which they are supposed to be doing anyway).

Part of what we here at KU have been working on is developing a reader-friendly format for this information, and we hope that you will find the sample table to be just that.

A quick explanation of what you will see when look at the sample:

These movement tables compare two quarters' worth of data ( in this case, Oct-Dec 2008 vs. Jan – March, 2009). The rows labeled on the left represent Oct-Dec . The **columns** across the top represent Jan – March.

The purpose of these tables is to illustrate movement from one stage to another (either forward or backward) as well as those clients who stayed the same. The yellow cells which form a diagonal line indicate those people who **remained in the same stage** from one quarter to the next. For example, the first yellow box at the top left represents those people who were previously in Stage 1 (the row labeled 1) and were still in Stage 1 the next quarter (the **column** labeled 1). If you wanted to know how many people moved from Stage 4 (prev. quarter) to Stage 5 (most recent quarter), you would find where row 4 and column 5 intersect.

Looking at the overall table, the numbers that fall **above** that yellow line of cells are people who moved from a lower stage to a higher stage. We've colored this section green. Those numbers that fall **below** the line are those people who moved from a higher stage to a lower stage. These are colored in red/pink.

The “Movement Index” is arrived at by dividing the total number of people who moved forward (above the line) by the number of people who moved backward (below the line). A score of “1.0” would indicate that the same number of people moved forward as backward. Anything above a 1.0 is an indication that more people moved forward than backward, and (you may see where this is headed) any number lower than a 1.0 indicates that more people moved backward than moved forward. In a nutshell, the higher the Movement Index, the better.

Please share this information with the IDDT teams and consider how the data might be most useful in programmatic planning.

A sample movement table is on the next page.

	AIMS Alt-ID	Previous Qtr. Stage # Qtr Ending: Dec 07	Current Qtr. Stage # Qtr Ending: March 08	Client is new since last report (make an X)	Does cl have SA Dx.? (Y/N)	Agency.Team Serving Client	Case Manager Serving Client	(For KU Use) SA Dx. In AIMS?
1	AA	n/a	2	X	Y	2.01	BDK	
2	BB	4	5		Y	2.02	GHC	
3	CC	6	6		Y	2.01	BDK	
4	DD	2	4		N	2.03	DXA	
5	EE	4	3		Y	2.02	GHC	
6	FF	n/a	3	X	N	2.02	GHC	
7	GG	6	7		Y	2.03	DXA	

## Stages of Treatment Movement Table

		To: Quarter Ending 3/31/2009								Grand Total
		1	2	3	4	5	6	7	8	
From: Quarter Ending 12/30/08	1	1	2	3	4	5	6	7	8	0
	2	1	3	1	1	2	3	4	5	8
	3	1	2	9	4	5	1	1	2	17
	4	1	1	2	4	1	2	3	4	8
	5	1	2	3	2	5	1	2	1	14
	6	1	2	2	3	4	6	1	1	10
	7	1	2	3	4	5	1	4	5	10
	8	1	1	2	4	1	3	2	19	32
	Grand Total	0	7	17	15	7	17	10	26	99

Movement Index: 1.04



## IDDT RESOURCE LIST

### BOOKS/WORKBOOKS:

“Integrated Treatment for Dual Disorders, A guide to Effective Practice” by Kim Mueser, Douglas Noordsy, Robert Drake, Lindy Fox

[http://www.guilford.com/cgi-bin/cartscript.cgi?page=addictions/mueser.htm&cart\\_id=297937.11781](http://www.guilford.com/cgi-bin/cartscript.cgi?page=addictions/mueser.htm&cart_id=297937.11781)

“Motivational Interviewing, Preparing People for Change, Second Addition” by William Miller, Stephen Rollnick

[http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/miller2.htm&dir=pp/addictions&cart\\_id=168547.12581](http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/miller2.htm&dir=pp/addictions&cart_id=168547.12581)

“The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life” by Kim T. Mueser, Susan Gingerich

[http://www.amazon.com/Complete-Family-Guide-Schizophrenia-Helping/dp/1593852738/ref=sr\\_1\\_2/002-9574698-2397638?ie=UTF8&s=books&qid=1177453056&sr=1-2](http://www.amazon.com/Complete-Family-Guide-Schizophrenia-Helping/dp/1593852738/ref=sr_1_2/002-9574698-2397638?ie=UTF8&s=books&qid=1177453056&sr=1-2)

Overcoming Addictions: Social Skills Training for Persons with Scizophrenia" by Lisa Roberts.

[http://www.amazon.com/exec/obidos/tg/detail/-/0393702995/qid=1050066041/sr=1-26/ref=sr\\_1\\_26/104-8269934-3705565?v=glance&s=books](http://www.amazon.com/exec/obidos/tg/detail/-/0393702995/qid=1050066041/sr=1-26/ref=sr_1_26/104-8269934-3705565?v=glance&s=books)

"Dual Disorders Recovery Counseling" by Dennis Daley & Michael Thase. I've been using this one personally for a long time...

[http://www.amazon.com/exec/obidos/tg/detail/-/0830906940/qid=1050066424/sr=1-46/ref=sr\\_1\\_46/104-8269934-3705565?v=glance&s=books](http://www.amazon.com/exec/obidos/tg/detail/-/0830906940/qid=1050066424/sr=1-46/ref=sr_1_46/104-8269934-3705565?v=glance&s=books)

"Dual Diagnosis Workbook" by Dennis Daley (also recommended highly):

[http://www.amazon.com/exec/obidos/tg/detail/-/0830906665/qid=1050066359/sr=1-26/ref=sr\\_1\\_26/104-8269934-3705565?v=glance&s=books](http://www.amazon.com/exec/obidos/tg/detail/-/0830906665/qid=1050066359/sr=1-26/ref=sr_1_26/104-8269934-3705565?v=glance&s=books)

Resource for your teams...lots of handouts, exercises, and practical materials for work with our consumers...

<http://www.mckillipbasics.com/basics.html>

Co-Occurring Disorders Treatment Manual and Workbook published by the Louis de la Parte Florida Mental Health Research Institute, University of South Florida:

<http://www.fmhi.usf.edu/institute/pubs/pdf/mhlp/CDTManual.pdf>,

<http://www.fmhi.usf.edu/institute/pubs/pdf/mhlp/CDTWorkbook.pdf>

EVIDENCE BASED PRACTICES:

<http://www.mentalhealthpractices.org/fam.html>

<http://www.motivationalinterview.org/>

TOOLKITS:

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/default.asp>

ASSESSMENT INSTRUMENTS:

<http://casaa.unm.edu/inst/inst.html>

ADDITIONAL RESOURCES:

Psychotropic medication handout:

<http://www.mattc.org/media/PsychoMeds2004spreads.pdf>

Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence:

[www.ohiosamiccoe.cwru.edu](http://www.ohiosamiccoe.cwru.edu) (We recommend the Message Board...)

Resources for Co-Occurring Addiction and Personality Disorders:

<http://www.toad.net/~arcturus/dd/ddhome.htm>

Project Mainstream Syllabus: Motivational Interviewing Training:

<http://www.projectmainstream.net/catalog.cfm?dest=dir&linkon=Section&linkid=40>

Dual Recovery Anonymous: A 12 Step Program:

<http://draonline.org/>

Dr. Ken Minkoff's Service Planning Guidelines and Treatment Matching Paradigm:

<http://www.bhrm.org/guidelines/Minkoff.pdf>

University of Rhode Island Change Assessment (URICA)

<http://www.uri.edu/research/cprc/Measures/urica.htm>

Harm Reduction Coalition:

<http://www.harmreduction.org/>

Turning Knowledge into Practice: A Manual for Behavioral Health Administrators and Practitioners about Understanding and Implementing Evidence-Based Practices:

<http://www.tacinc.org/CMS/viewPage.cfm?pageId=114>

Mid Atlantic ATTC Motivational Interviewing Center of Excellence:

<http://www.mid-attc.org/mi.htm>