REVISED IDDT FIDELITY SCALE

In attempting to apply the GOI and Fidelity Scale (November 27, 2002 version) we encountered a number of conceptual problems and problems with the anchors of the scales. We also have compared these versions of the scale with the fidelity scale in the book by Mueser and colleagues and found what appear to us to be significant omissions or changes. To some extent, these reflect the SAMHSA effort to make the GOI applicable to all six evidence-based practices; but the result for IDDT is a watering down of criteria. This version of the Fidelity scale does three things:

- It substitutes the Mueser and colleagues scale items when they are available and seem more appropriate (e.g., regarding having integrated treatment plans).

- It attempts to resolve conceptual lack of clarity, e.g. as to whether "comprehensive services" must be offered in the system or by the agency itself, or what to do when the same intervention appears in two different fidelity criteria.

- It substitutes "qualitative" anchors for quantitative anchors for items in which the quantitative anchors seem that they would be too difficult to rate reliably.

We do not think that the revisions here modify the principles behind the notion of fidelity.

We approach this revision with some temerity, noting however, that the Mueser et al. and National EBP versions of the Fidelity Scale differ significantly and both are designed by the same experts at the New Hampshire Psychiatric Institute; neither has empirical verification. Also, although the National EBP version relies much more heavily on "quantitative" anchors, the Indiana investigator Gary Bond says in response to a draft of our modified scale, "I like the way you have moved toward qualitative ratings of IDDT, that's actually how we do it in practice, the % was a mistake." Bond also says: "I would make some changes to the version we are using in the National EBP Project, and add back in some items that were in the Mueser version. I think insisting on a small organizational unit (a team) and a small caseload size are 2 elements that should be part of the scale." We also have permission from our liaison at SAMHSA to make changes. Discussion at a June 2004 National EBP meeting did not identify strong reasons for sticking with the earlier scale or for states not to modify. States implementing IDDT will continue to be in discussion about the fidelity scale. And we hope that empirical research on its validity will be funded soon.

New scale items or changed anchors appear in blue. When all stakeholders have had a chance for input a new complete version will be assembled and also sent for feedback to national experts

We initially proposed revising the assessment and treatment planning items in the GOI, but have ended up leaving the GOI as it is and adding new integrated assessment and treatment planning items to the fidelity scale.

This is the version of the fidelity scale we are using in our baseline evaluations.

FIDELITY SCALE REVISIONS

NEW ITEMS ON INTEGRATED ASSESSMENT AND TREATMENT PLANNING

a. Assessment. An "integrated assessment" is added, but is scored in the fidelity scale. It is below. This specific formulation is by Marc Bono, California's lead trainer, but it is similar to the version in Mueser et al.

Item	1	2	3	4	5
Integrated assessment of DD clients	One disorder assessed with specific symptoms, course of illness and diagnosis clarified.	Two disorders assessed with specific symptoms, course of illness and diagnosis clarified in one disorder.	Two disorders assessed with specific symptoms, course of illness and diagnosis clarified in both disorders	Two disorders assessed with specific symptoms, course of illness and diagnosis clarified in both disorders with some discussion of the relationship between disorders.	Two disorders assessed with specific symptoms, course of illness and diagnosis clarified in both disorders with an initial case formulation developed based on the relationship between these disorders.

b. This version of integrated treatment planning is based on Mueser et al but modified by Marc Bono. The Integrated Crisis Plan is directly from Muser et al.

Item	1	2	3	4	5
Integrated treatment plan	A case formulation based on a comprehensive assessment including the payoff matrix is developed and informs the treatment plan in <25% of plans	A case formulation based on a comprehensive assessment including the payoff matrix is developed and informs the treatment plan in 25% to 50% of plans	A case formulation based on a comprehensive assessment including the payoff matrix is developed and informs the treatment plan in 50% to 75% of plans	A case formulation based on a comprehensive assessment including the payoff matrix is developed and informs the treatment plan in 75% to 100% of plans	A case formulation based on a comprehensive assessment including the payoff matrix is developed and informs the treatment plan in 100% of plans
Integrated crisis plan.	Fewer than 25% of DD clients have a written crisis plan (for either disorder)	25-79% have a written crisis plan for at least one disorder	Crisis plan present for 80%, but plan targets both SA and MI in <25% of charts	Crisis plan present for 80%, and plan targets both SA and MI in 25% - 75% of charts	Crisis plan present for 80%, and plan targets both SA and MI in >75% of charts

1. Multi-disciplinary team. Principle stays the same. Rating changes from quantitative to qualitative.

NEW ANCHORS	1	2	3	4	5
1a1Multidisciplinary Team Quality. Rate a) Number of disciplines, b) frequency of meeting, c) degree of integration (e.g. single chart vs separate records, all staff housed together vs. spread out)	Traditional outpatient or brokered CM model; no team	Minimal implementation of Multi discipline. team (2 or three disciplines, low frequency of meeting, little integration)	Partial implementation of Multi discipline team (all three criteria are better than in "2" or one criterion done very well but others not)	Nearly full implementation of Multi Discipline team (all three criteria met to large degree)	Full implementation of Multi discipline team with Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health; treatment team meetings daily; highly integrated.

1.a. Integrated substance abuse specialist(s() or expertise. Rename: Integrated Dual Diagnosis Specialist. Key is availability of dual diagnosis specialists not SA without MH experience. The anchors are problematic because they assume only one SA/DD specialist, while specialized programs may have most or all staff who have this background (2 years with SA or DD program). We have changed anchor to reflect this, adding multiple specialists to #5 and making #4 the old #5.

NEW ANCHORS	1	2	3	4	5
1b1. Integrated Substance Abuse Specialist: Quality	IDDT clients are referred to a separate substance abuse department within or outside the agency (e.g., referred to drug and alcohol staff)	A substance abuse specialist serves as a consultant to treatment team; does not attend meetings; is not involved in treatment planning	A substance abuse or DD 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	A DD 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	The team consists of multiple DD specialists with 2 years experience, fully integrated. They attend all team meetings; are involved in treatment planning for IDDT clients; model IDDT skills and train other staff in IDDT

2. Stage-wise interventions. Principle does not change, but qualitative anchors substitute for quantitative.[1]

	1	2	3	4	5
2a. Stage-Wise: Rate on up-to date rating of stage for each client, the presence of all four stages in the program, and a full-range of interventions appropriate to each stage. Judge by staff interviews, SATS ratings, charts.	Program does not use stages of treatment at all	Minimal use of stages (no ratings, or not up to date, truncated or fuzzy stages, lack of interventions for each stage)	Moderate use of stages (at least one element well implemented but not all three); or some staff use and others do not	Consistent use of stages but at least one of the criteria not implemented fully	A full range of interventions is available for all four stages and each client has a written up-to-date rating of current stage in treatment plan and is consistently reflected in progress notes

3. Access to comprehensive services. There are a number of problems with this criterion.

- Several components are lumped together, e.g., a) whether the service is even offered and b) how easy it is to get into it (Mueser adds time, saying access within 2 months), and c), how many actually use the service. However, it is clear that aside from the basic DD services, one must take into account individual client need for at least some of the services (eg. ACT, family services). But should everyone get illness management?

- There are other issues. a) Do the programs have to be "built in" or can they be across town with access by referral? This says offered by the service provider, but is that realistic or necessarily better? Does it mean "on-site"? b) Are the five types of programs really equivalent (as suggested in the anchors)? What does it mean to say there is access to an ACT team? It would most likely mean leaving the current team to access it. So this appears to be a "system" rather than a "program" resource. Is supported employment the same?

- ACT is not relevant because if clients access ACT they leave the IDDT program.

- Family psychoeducation is not relevant because it is covered in a separate principle.

- We considered two possible approaches. A) The ratings for supported employment and illness management would be combined. Illness management is conceptualized as a specific programmatic intervention, not ad hoc interventions by clinicians on the team. If occurring at the agency, supported employment requires integration onto the team an employment

[1] Indiana rater says: I rate this item based on several sources of evidence: what is my impression of staff's familiarity and use of SATS? Does it enter into team meeting conversation, my discussion with individual staff? Next, do I see gross inconsistencies in where clients are at and the treatment that is recommended or implemented—I also get this from more informal observations of team meeting conversation and files (do assessment goals make sense given client's stage?). Another problem that I often encounter is a team that has a great deal of variation in staff's IDDT-related skills. So, for one team, half of the staff may be o.k.-good with stage-wise interventions and the other half are poor. If that is the case, I may estimate the number of interventions that are consistent with stages to be less than 50%. Certainly not an exact science, but aim to eliminate possible ratings based on the collective information.

specialist. B) The other approach measures whether related services that are identified in the treatment plan are actually accessed in a timely way.

- We have ended up with the second approach. As valuable as SE and IMR are, they are not part of the research base for this model, and are not available in any of our programs.

- However, residential/housing services has been given its own principle since it is so important and does apply to all programs. Mueser et al have a separate chapter on this.

	1	2	3	4	5
3a. Access to related services identified in the client treatment plan	None of the charts reviewed showed consideration of need for related services such as employment, illness management, or intensive case management	Some mention of related services in individual treatment plan, but few related services were actually accessed by the clients	More related services identified in the treatment plan and they were usually actually accessed by the clients	Multiple related services identified. All related services i were accessed, but not necessarily within 2 months	Multiple related services identified. All related services identified in treatment plan were accessed within 2 months
3b. **Access to residential/housing services for DD clients** ➢ Housing specialist(s) ➢ Wet-damp-dry housing	No housing specialist available in county or program; limited or inadequate wet, damp, dry housing for DD clients	Housing specialist(s) in county but not program; limited or inadequate wet, damp, dry housing for DD clients	Housing specialist(s) in program; limited or inadequate wet, damp, dry housing for DD clients	Housing specialist(s) in program; full range of wet, damp, dry housing for DD clients	Housing specialist(s) in program; full range of wet, damp, dry housing for DD clients; residential program affiliated with program

4. Time unlimited services. There are a number of conceptual difficulties as well as the practical limitations inherent in a state with very modest funding.

   - Ohio gives the services as "examples," not saying that these are the 5 that must be provided forever. But we have limited to DD services, not ACT etc. We have used Mueser's statement combined with Ohio's.

   - Is "graduation" ok? What about 12 week groups, say, but you can repeat as long as want? What if you "graduate" from the program after some period of time in relapse prevention but can come back in if you fall off the wagon? New definition resolves these issues.

NEW ANCHORS	1	2	3	4	5
Long-Term Services. Goal is that no specific time limits are place on dual-disorder services and there is no pressure for clients to move out of these services. Clients with DD are treated on a time unlimited basis with intensity modified according to need and degree of recovery. Clients are not terminated due to change in reimbursement eligibility.	Overall program has a time limit.	Program as a whole has no time limit but some of the services, such as particular groups are time limited.	Neither program nor individual services have time limits or utilization limits per se, but some services are only offered some of the time.	No time limits; services available at any time; but waiting lists exist.	No time limits; services available at any time; no waiting lists.

5. Outreach. Problems include:

- Terminology is somewhat confusing. Is this the "in situ" services of an ACT model? If so, where does legal aid fit in? Or for all these services are we just talking about a staff member who will help access the services in a practical way?

- "In situ" services is really quite different from services that "reach out" to persons who are not yet fully engaged or services that are aimed at preventing drop outs (reaching out to those who miss appointments)—what we term engagement services. Note we do not expect programs to do outreach in a third sense, that is go out to emergency rooms, jails, etc. to identify and attempt to recruit persons who are not yet official clients of the program. We have specified *in situ* and engagement separately in the qualitative anchors.

- In our experience staff perceive much more in situ activities than are reflected in charts. So independent verification is important; hence quantitative measures from the chart.

NEW ANCHORS	1	2	3	4	5
Outreach [2] • In situ aid for housing,	Program is passive in recruitment	Program makes initial attempts to	Program staff frequently	Program staff frequently attempt BOTH	Policy, supervision, and charting requirements

[2] Indiana rater says: I think this item is getting at whether the team is using outreach interventions AND how planful are the outreach attempts. For instance, one team does plenty of outreach, which is often focused on case management duties (bring in for med appt, monitor meds and sxs, accompany client to soc security appt or court appt). But, this team has demonstrated very poor planning efforts to use outreach as a tool to engage clients. I think I feel that what is done with clients in the engagement phase---stage wise treatments, such as motivational interviewing, outreach to develop rapport and help keep in treatment-- is what really separates IDDT model from other models. I think when I rate this item I may be giving more attention to what is being done with the engagement phase folks.

medical, court and legal • Outreach to engage clients initially and re-engage if stop attending	and re-engagement; almost never uses in situ outreach mechanisms.	engage but generally focuses efforts on most motivated clients; little or no in situ engagement	attempt in situ OR engagement outreach, but not both.	in situ and engagement outreach (but it is not formally supported in policy, supervision and charting requirements).	encourage in situ and engagement outreach. Over half the charts show evidence it has occurred when appropriate (e.g. when attendance is poor or a client has dropped out or if a client has court appearances).

The section in Mueser et al. called Providing Practical Help and Benefits, starting on page 96, is a clear statement of the "in situ" component. The "engagement" component is less clearly laid out in the book, but can be inferred from the following questions in the protocol:

- 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?

6. Motivational interventions. Problems:

- What does "for whom motivational interventions are indicated" mean? Is this linked to stage of treatment? Or are there any clients for whom it is NOT indicated?
- Mueser specifies "individual motivational interviewing." Do we want to specify this?
- The anchors mix qualitative and quantitative in a way not easily rated. In addition it is difficult to rate clinician's understanding of motivational interviewing (and we do not interview all clinicians as part of a site review).
- We have ended up (below) going with a quantitative measure of evidence in the charts that motivational techniques are being used, and a qualitative measure in addition based on training.[3]

NEW ANCHORS	1	2	3	4	5
• **6. Motivational Interventions: Quantity** Clinicians who treat IDDT	≤20% of client charts reflect motivational interviewing	21%- 40% of client charts reflect motivational	41%- 60% of client charts reflect motivational	61%- 79% of client charts reflect more than one type	≥80% of client charts reflect more than one type of

[3] Indiana rater says: I think sometimes it is easier to look for information that would suggest that they DON'T understand/use motivational interviewing and rate accordingly. Also, I have focused on a sample of clients who are rated as being in the engagement phase and combed through their notes and asked staff questions regarding interventions used. Lastly, I've asked the program leader to give me his/her impression of each staff members' understanding an use of MI.

clients use strategies.	approach (ie goals discrepancies, pay-off matrix);	interviewing approach (ie goals discrepancies, pay-off matrix);	interviewing approach (ie goals discrepancies, pay-off matrix)	of motivational interviewing approach (ie goals discrepancies , pay-off matrix, reframing etc,)	motivational interviewing approach (ie goals discrepancies, pay-off matrix, reframing etc,)
• Motivational Interviewing Qualitative	No record of training on MI within past year	Training on MI within past year but not all staff have attended	Training for all staff on MI within past year	Training for all staff on MI within past year and staff interviews reflect use of MI	Multiple trainings for all staff on MI within past year and staff interviews reflect use of MI

7. Substance abuse counseling.

Problems:[4]

1. The qualitative part of the rating talks about "basic substance abuse counseling principles" but the list of principles/interventions above goes far beyond that (including CBT, for example). Shouldn't the qualitative focus not on the number of clinicians who understand the basic but the range (from basic to very comprehensive) of SA counseling interventions available? Also, since clients can get the SA counseling from a 12 step group (that might not be part of the program), the staff knowledge may not be critical. And again, knowing basic substance abuse counseling principles really should be part of the multidisciplinary team with specialist(s) and the training criterion.

2. The quantitative part of the rating seems unnecessary as it should be covered by the unlimited access to services and stagewise treatment planning.

3. Mueser et al. specify individual CBT. Below we have not done so, but could. The difference between this and the Mueser scale on the actual treatment raises questions about what treatment is really part of "the model?" Is it CBT as in the book and Mueser? If SA counseling occurs in groups are we to count it in both SA counseling and DD group?

4. The set of proposed anchors is from Marc Bono, lead trainer, and focuses on providing both MH and SA counseling *and* the extent to which this is done in an integrated fashion. A choice or combination is needed here.

NEW ANCHORS	**1**	**2**	**3**	**4**	**5**

[4] Indiana rater says: I think some clarification of this item would be helpful--- are we more concerned about the percentage of clients receiving SA counseling OR the competency of team to provide such services? I seem to put more emphasis on the former, but not to the exclusion of the latter.

7. Dual Diagnosis Counseling: Clients who are in the *action* stage or *relapse prevention* stage receive dual diagnosis counseling that integrates substance abuse and mental health issues • Relapse Prevention Skills MH/SA • Problem solving skills • Coping Skills and social skills training • Challenging clients beliefs about substance abuse and mental illness • Drug and alcohol refusal skills	DDX counseling is not routinely provide	Mental Health or Substance Abuse Counseling is provided by referral in a parallel or sequential model	Mental Health or Substance Abuse Counseling is provide by the agency in specialized SA and or MH individual and/or group services	Mental Health *and* Substance Abuse Counseling is provide by the agency in specialized integrated individual and/or group services	Mental Health *and* Substance Abuse Counseling is provide by the agency in an integrated fashion *throughout all aspects of programming* as well as in specialized integrated individual and/or group

8. Group dual diagnosis treatment. Problems.

- Only a quantitative criterion is given in Indiana version. Qualitative issues such as variety of types of group, level of group (introductory vs. advanced), specificity of group to client's stage of tx are omitted.

- In one program we visited, there was a lack of distinction between different types of groups. That is, staff said the existing groups provided all content: DD counseling, mental health therapy, SA therapy. However, in the Mueser fidelity scale. Education, persuasion, Active Treatment, Combined Persuasion and Active Treatment, Social Skills Training and Relapse Prevention are all listed and scoring is based on the number of different types of group.

- Mueser et al. have two domains here, not one: Integrated group DD treatment. And "Group Treatment." The latter includes six types of group: Education, persuasion, active treatment, combined active treatment and persuasion, social skills training, relapse prevention. I have used the two items from Mueser plus the original participation item.

- CA chose to keep original based on Indiana assertion that it was easy to rate plus one focusing on extent of integration. There does not seem to be evidence that one type of group is better than others or that multiple groups are to be preferred.

NEW ANCHORS	1	2	3	4	5
8. Group DD Treatment: 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**
Integrated group treatment for DD. DD clients are offered group treatment specifically designed to address both mental health and substance abuse problems	No groups are offered for DD clients	Groups are offered for only one of the two disorders	Separate groups are offered but not integration of the disorders in the groups	Separate groups for each disorder, but some integration occurs in the groups	Integrated groups where both disorders are the focus of treatment

9. Family education and support.[5]

- Problems: As noted above, staff at all programs assured us that they worked with all families if they were available. However, staff received no training and there was no specialized program regarding successful family interventions. Hence the need for a qualitative measure, as below. We reference the available evidence-based *programs* for families of DD clients at the top end of the scale. Criteria 4 and 5 do not necessitate use by IDDT raters of a family intervention fidelity scale. They simply requires that the program itself has a clear idea of the elements of the family intervention it is attempting to implement.

- "Psychoeducation" as a term, though widespread is unnecessary jargon. No other type of education specifies the content (whatever "psycho" might be) in its description.

[5] Indiana rater says: It can be difficult to tease out how formal or informal is the "family psychoeducation." I can be pretty lenient when considering information on this item. I usually ask the team (or PL) to indicate which clients' families are in contact with the team and this number provides a ceiling. Then, I keep an eye out for information that suggests the content of such contacts (progress notes) and WHO initiates them (e.g. one ACT team was in contact with quite a few families, but these families were primarily initiating the contacts, which suggests the team was doing more case management and crisis management instead of proactively providing support and education).

NEW ANCHORS	1	2	3	4	5
Family education and support	No identification of families or significant others for each client; or no outreach to families provided	Minimum outreach to families provided: • Materials on DD offered or sent • Consultation with families around treatment decisions	Moderate outreach: materials, consultation, some specific intervention, i.e. support group, coping skills training group.	Partial implementation of an evidence-based family intervention for DD.[6] Reviewers will look for evidence program is using an *explicit* evidence-based model	Full implementation of an evidence-based family intervention for DD. Reviewers will look for evidence program is using an *explicit* evidence-based model.

10. Participation in self-help groups.

Problems:

1. This is another area where the quantitative seems difficult. With a sample of 10 charts and a requirement that applies to different stages making the quantitative judgment would not be reliable. However, Indiana rater says: Straightforward. Get percentage of clients in appropriate stages attending self-help group (try to distill who seems to be going regularly and how much assistance does staff provide clients in attending self-help groups). On the basis of this have put back in but also retained the version suggested by Marc Bono.

2. Mueser suggests: Clients are routinely referred to self-help groups; clinicians frequently attend these groups with clients, and agency has liaison. However, our Project Leader Vicki Smith and Marc Bono both rejected the *specific* criterion of attending groups with the client.

3. We have used anchors provided by Marc Bono, Lead Trainer, who focuses on both referrals and staff knowledge and activity in utilizing self-help groups.

[6] Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S. W., Moring, J., O'Brien, R., et al. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *Am J Psychiatry, 158*(10), 1706-1713.
Mueser, K. (2002). A Family Intervention Program for Dual Disorders. *Community Mental Health Journal, 38*(3), 253-270.

NEW ANCHORS	1	2	3	4	5
10. Participation in Alcohol & Drug Self-Help Groups: Clients in the *action* stage or *relapse prevention* 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
Proactive Self Help Groups & Liaison • Staff have a working knowledge of the Self Help Groups they refer to • Staff attend self help groups with clients • Staff help clients to prepare and/or adjust to self help groups (Mock Groups, in-house groups, Self help Prep Groups, Individual Counseling, etc)	No referral of dual-disorder clients in action or relapse prevention stages to self-help in community or at agency	Occasional referral of dual-disorder clients in action or relapse prevention stages to self-help in community or at agency	Routine referral but staff do not have a working knowledge of the self help programs	Routine referral and staff has a working knowledge of the self help programs	Routine referral and staff has a working knowledge of the self help programs and take proactive steps to assist clients in utilizing this resource including such things as mock groups or attending with the client

11. Pharmacological treatment

Problems:

1. The use of clozapine, naltrexone, disulfiram and other medications with DD clients is not sufficiently established to make it a requirement for high scoring; we do want to be sure that psychiatrists are aware of what literature exists and consider the use of these medications. There are favorable reports about other medications than those listed here, including olanzapine.[7]

[7] Berk, M., Brook, S., & Trandafir, A. I. (1999). A comparison of olanzapine with haloperidol in cannabis-induced psychotic disorder: a double-blind randomized controlled trial. *Int Clin Psychopharmacol, 14*(3), 177-180; Conley, R. R., Kelly, D. L., & Gale, E. A. (1998). Olanzapine response in treatment-refractory schizophrenic patients with a history of substance abuse. *Schizophrenia Research, 33*(1-2), 95-101; Hutchison, K. E., Rutter, M. C., Niaura, R., Swift, R. M., Pickworth, W. B., & Sobik, L. (2004). Olanzapine attenuates cue-elicited craving for tobacco. *Psychopharmacology*; Littrell, K. H., Petty, R. G., Hilligoss, N. M., Peabody, C. D., & Johnson, C. G. (2001). Olanzapine treatment for patients with schizophrenia and substance abuse. *J Subst Abuse Treat, 21*(4), 217-221.

2. One considerations was suggested by Marc Bono but is not in the revised rating below: "physicians are trained specifically in differential diagnosis of SA/MH problems." Assessing training is too difficult for this kind of review.

NEW ANCHORS	1	2	3	4	5
11. Pharmacological Treatment: Prescribers for IDDT clients: • Prescribe psychiatric medications despite active substance use • Work closely with team/client • Focus on increasing adherence • Avoid benzodiazepines and other addictive substances • ~~Use~~ Consider clozapine, naltrexone, disulfiram or other medications with some evidence base for use with DD	All clients do not have ready access to psychiatric evaluation and treatment.	Clients have access to psychiatric evaluation and treatment but medications may be withheld for those with concurrent substance abuse; OR prescription of medications with abuse potential (e.g. benzodiazepines) is not controlled	Clients have access to psychiatric evaluation and treatment, medications are not withheld, and medications with abuse potential are controlled; but prescribers have virtually no contact with treatment team and make no apparent efforts to increase adherence	Clients have access to psychiatric evaluation and treatment, medications are not withheld, and medications with abuse potential are controlled; and prescribers have extensive contact with the treatment team and make apparent efforts to increase adherence	In addition to criteria in #4, prescribers actively consider naltrexone, disulfiram, clozapine, & other medications having some evidence base for use with persons with dual disorders.

12. Interventions to prevent health-related and other negative consequences of dual disorders

Problems: This is another "quantitative" measure that is better done qualitatively.[8] Ohio uses the reduction of negative consequences and distinguishes at the high end between individual interventions and programs such as needle exchange. We have done this too in the belief that offering group and programmatic opportunities shows greater program commitment and client access to such modalities. Group interventions do not substitute for individual interventions. We have made a point of including nicotine reduction, even though it is not specifically a part of Mueser et al. The "protocol" has a good list of interventions that are both health-related and concern other domains of life, e.g., teaching clients to avoid victimization. Prevention/harm reduction should be tied to specific behaviors: e.g., HIV prevention (bleaching needles, not sharing needles, needle exchange, condom use), other STD prevention (minimize high-risk sexual behaviors), violence prevention (DV groups, trauma survivors, etc.), cancer prevention (smoking cessation, diet and nutrition, early/periodic screenings).

[8] Indiana rater says: I rate this item based on the extent to which such services (interventions to promote health) are systematically offered and how skilled are *all* staff on team (i.e. not just nurse or PL) in talking about such issues. I also keep an eye out for related goals on treatment plan. Too difficult to quantify the number of clients receiving such services.

NEW ANCHORS	1	2	3	4	5
Interventions to promote health and reduce the health-related and other negative consequences of substance use (including nicotine)	No explicit programmatic support for promoting health or reducing negative consequences of DD	Program support for general health interventions such as diet and exercise but not for reducing the negative consequences of DD	Program support for general health interventions and for reducing negative consequences of DD but interventions not used consistently (as documented in charts, protocols, and staff interviews)	Program support for general health interventions and for reducing negative consequences of DD but only individually (no programmatic interventions such as trauma groups, smoking cessation groups, and needle exchange)	Program supports reduction of negative consequences of DD *and* interventions are used *consistently* including programmatic interventions such as trauma groups, smoking cessation groups, and needle exchange)

Nicotine is a powerful addiction with more than 50% of the cigarettes smoked in this country being consumed by people diagnosed with mental illnesses. More than 90% of clients diagnosed with a co-occurring severe mental illness and substance use disorder smoke. It is a very neglected area in dual recovery but should definitely be considered incorporated in COD work.. Also, the physical consequences of alcohol/drug use, especially in combination with psychiatric disorders, are very significant. Reducing physical health-related consequences is an important element in harm reduction.[9]

[9] See: Hutchison, K. E., M. C. Rutter, et al. (2004). "Olanzapine attenuates cue-elicited craving for tobacco." Psychopharmacology. RATIONALE. Recent biological conceptualizations of craving and addiction have implicated mesolimbic dopamine activity as a central feature of the process of addiction. Imaging, and pharmacological studies have supported a role for dopaminergic structures in cue-elicited craving for tobacco. OBJECTIVE. If mesolimbic dopamine activity is associated with cue-elicited craving for tobacco, a dopamine antagonist should attenuate cue-elicited craving for tobacco. Thus, the aim of the present study was to determine whether an atypical antipsychotic (olanzapine, 5 mg) decreased cue-elicited craving for tobacco.METHOD. Participants were randomly assigned to 5 days of pretreatment with olanzapine (5 mg; n=31) or were randomly assigned to 5 days of a matching placebo (n=28). Approximately 8 h after the last dose, participants were exposed to a control cue (pencil) followed by exposure to smoking cues. Participants subsequently smoked either nicotine cigarettes or de-nicotinized cigarettes.RESULTS. Olanzapine attenuated cue-elicited craving for tobacco but did not moderate the subjective effects of smoking.DISCUSSION. This study represents one of the first investigations of the effect of atypical antipsychotics on cue-elicited craving for tobacco. The results suggest that medications with similar profiles may reduce cue-elicited craving, which in turn, may partially explain recent observations that atypical antipsychotics may reduce substance use; Noordsy, D. L. and A. I. Green (2003). "Pharmacotherapy for schizophrenia and co-occurring substance use disorders." Curr Psychiatry Rep **5**(5): 340-6. Research on the optimal pharmacotherapy for people with schizophrenia and co-occurring substance use disorders remains in its infancy. This report reviews existing data and provides an update on recent research. The confluence of findings is consistent with a model of a reward dysfunction inherent in the neuropathology of schizophrenia, leading to a heightened vulnerability of people with

13. Secondary interventions for non-responders

Problems: The primary problem here is defining who is a non-responder![10] Understanding why someone is not-responding to treatment is critical and should drive further interventions/strategy—and this should be highly individualized. This is recognized in the original ratings on evaluation and referral for secondary interventions. Below we go beyond that to assume that some evidence-based secondary interventions are actually available.

1. Three of the five interventions mentioned are covered in other items (medications, residential, family interventions), leaving only trauma treatment and intensive monitoring

2. The literature suggests that DD modified therapeutic communities are effective; the literature also suggests that for persons with CJ problems, formal links with probation and the courts is effective.

3. The literature suggests that different approaches are appropriate for persons with personality disorder.[11]

4. The literature suggests that for persons still in pre-contemplation harm reduction interventions can make a significant difference.[12]

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schizophrenia to substance use disorders. Studies indicate that patients with dual disorders have difficulty tolerating conventional antipsychotics, have higher rates of medication nonadherence, and have greater impulsivity and sensation seeking. Limited evidence suggests that clozapine treatment may be associated with reduced substance abuse, with weaker evidence suggesting that other novel antipsychotics may have similar, but potentially less potent, effects. Controlled trials to test the effects of these medications are underway. A number of recent studies indicate that bupropion can facilitate reduced tobacco smoking among patients with schizophrenia. The preferential use of novel antipsychotics, a lower threshold for prescription of clozapine, the use of bupropion for smoking cessation, careful monitoring of compliance, and possible use of other medications for substance use disorders when indicated are recommended in pharmacologic management for people with co-occurring substance use disorders and schizophrenia; Sobell, L. C., M. B. Sobell, et al. (2002). "Self-change and dual recoveries among individuals with alcohol and tobacco problems: current knowledge and future directions." Alcohol Clin Exp Res **26**(12): 1936-8.

[10] Indiana rater says: With this item, I am looking for info on how they identify nonresponders (if they have a screening process at all) and then what are their intervention options. There should be several options available (i.e. they shouldn't be only relying on crisis intervention and invol hospitalization). The items listed are examples and I don't consider exclusive. I have found team leaders to be pretty frank in answering direct questions related to this item and struggle sometimes with how systematic this screening process should be.

[11] Rush, B. (2002). *BEST PRACTICES Concurrent Mental Health and Substance Use Disorders*. Ottawa: Health Canada.

[12] Rogers, S. J. and T. Ruefli (2004). "Does harm reduction programming make a difference in the lives of highly marginalized, at-risk drug users?" Harm Reduct J **1**(1): 7. Harm reduction is a controversial model for treating drug users, with little formal research available on its operation and effectiveness. In order to advance the field, we first conducted participatory research of harm reduction with 120 clients using nominal-group technique to develop culturally relevant outcomes to measure progress. Second, we conducted focus group interviews with a different group of clients to help validate the outcomes. Third, we used the outcomes in an evaluation of the largest harm reduction program in New York City, which involved a representative sample of 261 and entailed baseline, post, and six follow-up assessments. The participatory research resulted in outcomes of 10 life areas important to drug users. Evaluation results showed that program participants made positive improvements across most outcomes, with the most substantial progress made in how clients dealt with drug-use problems. Along with their participation in the program, progress in some outcomes was also associated with clients' type of drug use (i.e., stable vs. chaotic), where more stable drug use was associated with better ways of making an income and types of housing. Surprisingly, progress was not associated with the kinds or numbers of services received or the length of time in the program. This was attributed to the service delivery model of harm reduction, in which clients are less inclined to

5. The approach taken here is to give credit for having a protocol to identify non-responders and to give credit for the availability of a) diagnosis specific interventions, including personality disorder and PTSD, b) CJ-linked programs c) ready access to DD therapeutic community or other DD specific residential tx,[13] and d) outreach harm reduction approaches *and* other approaches if specified in the treatment plan.

NEW ANCHORS	1	2	3	4	5
Secondary interventions for non-responders. • **Diagnosis based (including trauma)** • **Residential program** • **Criminal-justice liaison** • **Money management or payeeship** • **Contingency management** • **Outreach harm reduction approach for pre-contemplation clients** • **Medications such as clozapine that require close monitoring** • **Others if specified in tx plan**	No formal way of identifying non-responders	Formal way of identifying non-responders but no specific interventions are in treatment plans for these clients	Formal way of identifying and one to or two interventions are specified in treatment plans for these clients	Formal way of identifying and three or four interventions are specified in treatment plans for these clients	Formal way of identifying and five or more interventions are specified in treatment plans for these clients

Bonita House says: The profile of our non-responders are those people who are in such an active pattern of use and "the lifestyle;" may be demonstrating a lot of anti-social behaviors, refusing to talk with anybody about their perceived psychological distress or acute psychiatric symptoms, would not consider talking about medications, have blown-out or burned out all housing resources, may have acted out physically in our own clinic or with outside providers, etc, that the above-identified approaches would not be appropriate at this point. These folks are very much in pre-contemplation and keeping them and others safe, maintaining any kind of an alliance and keeping our relationship going, reducing harm in all respects to them, is the main focus of

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associate their success with a single staff person or with a single service or intervention received than with the program as a whole.

[13] The primary citations in the literature are: Carroll, J. F., & McGinley, J. J. (1998). Managing MICA clients in a modified therapeutic community with enhanced staffing. *J Subst Abuse Treat, 15*(6), 565-577; McCoy, M. L., Devitt, T., Clay, R., Davis, K. E., Dincin, J., Pavick, D., et al. (2003). Gaining insight: who benefits from residential, integrated treatment for people with dual diagnoses? *Psychiatr Rehabil J, 27*(2), 140-150; French, M. T., Sacks, S., De Leon, G., Staines, G., & McKendrick, K. (1999). Modified therapeutic community for mentally ill chemical abusers: outcomes and costs. *Evaluation and the Health Professions, 22*(1), 60-85; Brunette, M. F., Drake, R. E., Woods, M., & Hartnett, T. (2001). A comparison of long-term and short-term residential treatment programs for dual diagnosis patients. *Psychiatric Services, 52*(4), 526-528.

treatment Though they represent the minority of clients we serve they do represent the majority of people who we would identify as non-responders, and who often draw down disproportionate amounts of staff time. The interventions above do not address this type of non-responder and the stage of change they are in. (as an aside..we would certainly like to become more effective in our interventions with them through the course of this project and we look forward to trainings that will be developed in this area.)

Mueser et al. do not discuss secondary interventions. Drake discusses some of those proposed above in his recent update review of the literature. The CHANGES dual diagnosis program uses residential treatment for non-responders, particularly for clients on probation.

The persons Terry is discussing are persons who, in our other programs, will probably not be counted as "in" the program. Bonita House, because of how clients are referred, has no option but to include them. Some of the clients Terry mentions *might* be appropriate for the criminal-justice linked interventions or for payee-based interventions or even for contingency management; they would all be appropriate for outreach-based harm reduction activities.

So there is first of all the issue of whether to include the kind of pre-contemplation clients Terry mentions as "non-responders." Secondly, if such clients are "in," there is the issue of whether for Bonita having interventions specified in the treatment plan (even if they are not programmatic as some of those listed are) is an inadequate way of dealing with this issue. The criteria above have been rewritten so that specific programs are not required but that there is still a premium on having a range of options.

14. Client to clinician ratio excluding psychiatrist

Problem: the Mueser et al standards included this criterion but it was dropped from the National EBP version—as noted in the introduction Bond thinks it should be added back in. Caseload size is in fact one of the primary factors we identify in looking at our four programs as have a large potential impact on implementation.

However, this is not a simple issue. Marc Bono has worked in programs with very low and quite high (1/100) caseloads. The high caseload does not necessarily mean the program is not going to be effective. Part of this depends on the client acuity/functioning level. We show the Mueser et al version below but are proposing for our project NOT to use it. We will keep track of caseload size and client functioning (with the Multnomah) and include these variables in analysis but not as part of the fidelity scale itself.

Mueser et al. staff rating scale (not proposed for use in California)

	1	2	3	4	5
Client-to-Clinician Ratio (excluding the psychiatrist)	Over 50 clients per clinician	41-50 clients per clinician	31-40 clients per clinician	21-30 clients per clinician	20 or fewer clients per clinician