Adapted COD/IDDT Model

Readiness Assessment & Action Planning Guide

(4/20/2011)

TREATMENT ELEMENTS GUIDELINES

T-1a. Multidisciplinary Team

Definition: All clients targeted for COD/IDDT receive care from a multidisciplinary team. A multi-disciplinary team consists of, in addition to a DD clinician, two or more of the following: a physician, a nurse, a case manager, or providers of ancillary rehabilitation services.

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 COD/IDDT programs coordinate the efforts of all available disciplines, and all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative manner.

EVALUATION QUESTIONS:

a. ***Do you currently operate out of a team model, and if so, which disciplines/roles are represented?***

b. ***Does the team meet together regularly (daily?, weekly?, ?), and if so, which members participate, and at what frequency?***

c. ***Do team meetings include identification of consumer stages, and discussion of strategies for matching intervention attempts to known stage of change/treatment?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-1b. Integrated Substance Abuse Specialist

Definition: A substance abuse specialist who has at least 2 years of experience works collaboratively with the treatment team. The experience can be in a variety of settings,

preferably working with clients with a dual disorder, but any substance abuse treatment experience will qualify for rating this item.

Rationale: Having an experienced substance abuse specialist integrated into the treatment team is essential for ensuring a sustained focus on substance use.

EVALUATION QUESTIONS:

a. ***Is there co-occurring addictions knowledge and treatment experience represented on the team, and if so, by whom, and what pertinent background do they have?***

b. ***Do the individuals with SA specialization/knowledge/experience regularly participate in and/or are regularly available to consult re: assessments, treatment planning, team meeting discussions?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-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.

Rationale: Research suggests that modifications in maladaptive behavior occur most effectively when stages of treatment are taken into account.

EVALUATION QUESTIONS:

a. ***If currently reflected, how is staging represented in the Screening instrument/process currently utilized?***

b. ***If currently reflected, how is staging represented in the Initial Assessment instrument/process currently utilized?***

c. ***If currently reflected, how is staging represented in the Treatment Planning instrument/process currently utilized?***

d. If currently reflected, how is staging represented in the Progress Note documentation/process currently utilized?

e. If currently reflected, how is staging represented in the Periodic Review &/or Annual Assessment update instruments/processes currently utilized?

f. If currently reflected, how is staging considered in your current Team meetings &/or Clinical Supervision discussions?

g. If currently reflected, how are different stages addressed differently with regard to individual and/or group treatment interventions?

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-3. Access for IDDT Clients to Comprehensive DD Services

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

- ***Residential service***: Supervised residential services that accept clients targeted for COD/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. *COD/IDDT clients who are not abstinent are not excluded.*

- ***Family psycho-education***: A collaborative relationship between the treatment team and family (or significant others) that includes basic psycho-education about mental illness 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 psycho-education, 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 COD/IDDT philosophy and stages of treatment/recovery. For example, housing program encompasses motivational approaches for clients who are in the engagement or persuasion stages.

Rationale: Individuals with dual disorders 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 COD/IDDT programs must be comprehensive because the recovery process occurs longitudinally in the context of making many life changes.

EVALUATION QUESTIONS:

a. ***Do dually diagnosed consumers who may still be struggling with achieving sustainable abstinence, have access to services/supports/resources in the following areas, and if so, what exactly do they have accessible to them?***

   - ***Housing services, supports, resources?***
   - ***Educational/Vocational services, supports, resources?***
   - ***Psychoeducational services, supports, resources?***
   - ***Intensive case management (ICM, ACT, etc) services, supports, resources, esp at times of crisis/high need?***
   - ***Illness management and recovery services, supports, resources?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-4. Time-Unlimited Services

Definition: Clients with dual disorders are treated on a long-term basis with intensity modified according to need and degree of recovery. Services are available on a time-unlimited basis

Rationale: The evidence suggests that both mental health and substance use 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.

EVALUATION QUESTIONS:

a. ***What are the practices/protocols for discharging COD clients from services when they no-show for scheduled appointments, or seem to "drop out" of being engaged in receiving your services? (e.g., Length of time without contact, Outreach & engagement efforts prior to case closing, etc.)***

b. ***Once formally discharged, what are the criteria for re-engaging into active services? (How user-friendly/lengthy is this process? Does it differ depending on how long someone has been out of services?)***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-5. Outreach

Definition: For all COD/IDDT clients, but especially those in the *engagement* stage, the COD/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 COD/IDDT tend to drop out of treatment due to the chaos in their lives, low motivation, cognitive impairment, and hopelessness. Effective COD/IDDT programs use assertive outreach to keep the clients engaged.

EVALUATION QUESTIONS:

(Part of this focus area may have some overlap with the T-4:Time-unlimited Service domain)

a. ***When consumers stop "showing up" for site-based services, what outreach efforts (if any) are made to find folks / determine service need status / re-engage? (attempted home visits? phone calls? letters? other?)***

b. ***Are all COD/IDDT services and practical assistance support only delivered onsite, or are any regularly available at other locations throughout the community (including, but not limited to consumers' place of residence)?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-6. Motivational Interventions

Definition: All interactions with dually disordered clients are based on motivational interviewing principles that include:

- *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 COD/IDDT who are unmotivated can be readily identified and effectively helped with motivational interventions.

EVALUATION QUESTIONS:

a. ***Are attempts at utilizing Motivational Interviewing strategies reflected in the language used during team meetings, and found in Assessment, Treatment Planning, and Progress Note documentation?***

b. ***What Motivational Interviewing/Enhancement training have staff already had? (with details re: what dates, how long, what instructors, etc.)***

c. Are the discussions which take place during team meetings re: consumers logged or documented in any way? If so, are attempts at utilizing Motivational Interviewing strategies reflected in the team meeting log?

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-7. Substance Abuse Counseling

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 COD/IDDT programs provide some form of counseling that promotes cognitive-behavioral skills at this stage.

EVALUATION QUESTIONS:

a. Do COD/IDDT consumers have available options for receiving addictions counseling, in any of the following forms? (individual therapy, facilitated group therapy, family therapy, 12-Step programs, etc.) If so, which ones, what services are available, and how are each accessed?

b. ***Addictions counseling is understood to address the following, and is understood to be distinct from "treatment as usual"/garden-variety/generic mental health counseling:***
   - *managing triggers & consequences of using*
   - *relapse education, prevention, and response strategies*
   - *refusal skills & problem-solving skills to manage high-risk potential using situations*
   - *challenging core beliefs about using*
   - *coping skills, distress tolerance, and social skills training to strengthen dual recovery efforts*

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-8. Group DD Treatment

Definition: All clients targeted for COD/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.

EVALUATION QUESTIONS:

a. ***What are the current staff-facilitated treatment groups available for duallly disordered consumers? (days, times, lengths of group, general topic focus)***

b. ***Are groups offered to meet the dual recovery/treatment needs of consumers at various stages of change/treatment? If so which groups are targeted for which consumer cohorts?***

c. ***Which staff facilitate which groups? Are groups ever co-facilitated, and if so, with what combination of staff?***

d. ***What is the process for connecting a consumer with one of these groups?***

e. What are the protocols for dis-including someone in one of these groups?

f. What is your practice re: someone coming to group under the influence? re: inappropriate other behaviors acted out in group?

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-9. Family Psychoeducation on Dual Disorders

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 dual disorders 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 mental illness, and family psychoeducation that can be a powerful approach for improving substance abuse outcomes in clients with co-occurring mental illnesses. 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.

EVALUATION QUESTIONS:

a. Do dually disordered consumers' family-of-origin, or family-of-choice members have information and/or supportive resources available to them to assist in understanding and/or supporting their loved one, and to be optimally aligned with effective recovery for their loved one?

b. Are there educational handouts on various substances of abuse and various COD topics available for family/support network members on an as-needed/as-requested basis?

c. Are there any educational / informational / orientation groups available for family members to gain knowledge / skills to best understand and support their loved one's dual disorders and dual recovery needs?

d. Do consumers who may still be struggling with their co-occurring addiction (and their family/support network members) have access to any formal EBP Family Psychoeducation groups offered by the agency?

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

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

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), SMART Recovery, Double Trouble or Dual Recovery Anonymous.

Rationale: Although pressuring reluctant clients to participate in self-help groups is contraindicated, social contacts with other members of self-help groups play an important role in the recovery of clients targeted for COD/IDDT who are motivated to achieve or maintain abstinence.

EVALUATION QUESTIONS:

a. Are there known meetings of any of the various peer-led self-help groups in the surrounding community, with meeting listings available to share with consumers needing referral?

b. If a "mainstream" 12-Step group not specifically intended for dually disordered individuals (AA, NA, CA), is it known whether there are certain area meetings that are friendlier/more warm and welcoming to dually disordered consumers, and/or whether there are those which are not?

c. Are there active dual-focused meetings in the local community, of dual-focus AA, dual-focus NA, or Dual Recovery Anonymous, or ?

d. Are there active contacts in each of the peer-led community self-help fellowships who may be called upon to assist in bridging consumers to local community-based meetings?

e. ***Do staff know of groups (Al-anon, Nar-anon, CODA, etc.) available for family members to gain perspective / support to best understand and manage their relationship (especially re: healthy detachment, enabling/codependence) with their dually disordered loved one in a way that best supports recovery for all?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-11. Pharmacological Treatment

Definition: Physicians, Physician's Assistants or Nurse Practitioners prescribing medications are trained in dual disorders treatment and work with the client and the COD/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, represented in the evaluation questions below:

Rationale: Research indicates that psychotropic medications are effective in the treatment of mental illness, including clients who have active substance abuse problems. Access to such medications including antipsychotics, mood stabilizers, and antidepressants is critical to effective treatment of mentally ill clients.

EVALUATION QUESTIONS:

a. ***Do prescribers (Psychiatrists, Nurse Practitioners) prescribe psychiatric medications despite currently active substance use/abuse?***

b. ***Do prescribers work closely with the team and dually disordered consumer? How exactly (and at what frequency) does the prescriber participate/interact with the other members of the treatment team?***

c. ***Do prescribers focus on increasing adherence, that is, do they encourage dually disordered consumers to fully engage and participate in all COD treatment elements, including but not limited to pharmacological interventions?***

d. Do prescribers avoid the prescription of benzodiazepines or other potentially addictive medications to dually disordered consumers? If not, what clinical rationale/prescribing practice guidelines govern their prescription of potentially addictive psychotropic medications?

e. Do prescribers utilize medications to assist dually disordered individuals with managing cravings to use/relapse, as one element of COD treatment? Do prescribers utilize clozapine, naltrexone, disulfiram, and/or suboxone as pharmacological interventions? If not, why not? (there may be administrative, cost or other systems issues involved here, including what medications are permitted for use with which populations – please note whether formularies are in use that include these medications; please also note whether medication samples &/or Patient Assistance Programs are known and used on behalf of consumers with the Drug Companies providing these medications.)

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-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 avoid 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 dual disorders are at higher risk than the general population for the detrimental effects of substance abuse described above.

EVALUATION QUESTIONS:

a. ***What "harm reduction" efforts are part of addressing the co-occurring addiction behaviors and risks of consumers who are ambivalent about committing to abstinence-based treatment?***

b. ***What psychoeducation or support services are offered to improve consumers' physical health status (nutrition, exercise, STDs, etc.), which includes addressing the role played by substance involvement?***

c. ***What psychoeducation, available resources or other support services are offered to address consumers' social needs in ways that don't involve using or "using buddies"?***

d. ***What psychoeducation, available resources or support services are offered to improve consumers' housing status, legal status, employment or financial status, which includes addressing the role played by substance involvement?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

T-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 COD/IDDT services. 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 dually disordered clients respond well to basic COD/IDDT services, 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.

EVALUATION QUESTIONS:

a. ***How are "non-responders" defined, and identified in your service-providing program for dually disordered individuals?***

b. ***What process is currently in place (if any) to review and adjust the service plan for such individuals?***

c. ***What additional resources/interventions are on the menu of options for consideration re: adjusting the service plan to be more effective? How are each of these menu options accessed – involved process and timeframe?***
   - ***Co-occurring trauma treatment/interventions?***
   - ***Family/support network outreach & collaboration efforts?***
   - ***Use of pharmacological agents?***

d. ***What contingency management strategies have been developed and are available, involving the strategic leveraging of externally motivating elements related to access to money (rep payeeships, etc.), legal consequences (probation, parole conditions, etc.), access to housing (lease conditions, etc.)***
   - ***If alcohol or drug-testing is an available service/practice, what triggers it and how is it utilized in service-planning for dually disordered consumers?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-1. Program Philosophy

Definition: The program is committed to a clearly articulated philosophy consistent with COD/IDDT evidence-based practices, based on the following 5 sources:

- Program leader
- Senior staff (e.g., executive director, psychiatrists)
- Practitioners providing COD/IDDT services
- Clients and/or family members
- Written materials (e.g., brochures) or other media

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

EVALUATION QUESTIONS:

d. Are there currently brochures, other service literature, or other information sources that describe available COD services and how to access them? Are consumers and family members/natural supports aware of this information or how to access it if/when needed?

e. Do agency staff know about COD services, and how to make referrals if needed?

f. Does the agency's Board know of COD services (or the need for COD services) and support their development/implementation?

g. Is upper-level leadership (Executive Director, Clinical Director, Medical Director) involved and supportive? How do you know?

h. Do current policies reflect/support COD-informed practices/procedures that are different from "PAU" (policies as usual)?

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-2. Eligibility/Client Identification

Definition:

For COD/IDDT implemented in a mental health center or substance abuse treatment 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 COD/IDDT practice.

For COD/IDDT implemented in a regional service area (in Michigan, PIHP or CA catchment area): All clients within the jurisdiction of the service area are screened using standardized tools or admission criteria that are consistent with the COD/IDDT.

- The *target population* refers to all adults with 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 providing COD/IDDT services.** If the target population is served in discrete programs (e.g., case management, residential, day treatment, etc.), then ordinarily all adults are included in this definition.
- *The intent is to identify any and all for who could benefit from COD/IDDT services.* Screening and Assessment tools sensitive to both mental health and substance use disorders are recommended.
- Screening typically occurs at program admission, but for a program that is newly adopting COD/IDDT services, there should be a plan for systematically reviewing clients already active in services.

Rationale: Accurate identification of clients who would benefit most from COD/IDDT services requires routine review for eligibility, based on criteria consistent with COD/IDDT treatment.

EVALUATION QUESTIONS:

a. If all clients were screened, what percent would, reasonably, be found to have co-occurring mental health and substance use disorders?

b. How does your organization identify those clients with co-occurring mental health and substance use disorders (including Substance Abuse and Substance Dependence)? If using an electronic health record, is there a report available that lists all consumers with diagnoses in both mental heath and substance use disorder domains?

c. How is eligibility determined for access to COD &/or IDDT services?

d. Do the screening instruments currently in use have appropriate sensitivity for "screening in" individuals with co-occurring mental health and

substance use disorders? (Please send a copy of the Screening Instrument that is used)

e. Is the screening administered by staff with training/knowledge/experience in co-occurring addictions?

f. How many referral pathways are there into your organization's services, and are the screening steps standardized across different "front doors"?

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-3. Penetration

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

$$\frac{\text{\# of clients receiving COD/IDDT services}}{\text{\# of clients eligible for COD/IDDT services}}$$

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

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

EVALUATION QUESTIONS:

a. Of all of the clients identified with co-occurring mental health and substance use disorders, how many have access to any COD treatment services?

b. Of all of the clients identified with co-occurring mental health and substance use disorders, how many have access to higher-intensity IDDT team treatment services?

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-4. Assessment

Definition: All COD/IDDT 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, non-informative 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 bio-psychosocial 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.

EVALUATION QUESTIONS:

a. Does the Initial Assessment tool/process currently in use have appropriate sensitivity for identifying the diagnoses and recovery needs of individuals with co-occurring mental health and substance use disorders? (Please send a copy of the Assessment Instrument that is used)

b. Is the Assessment administered in a standardized manner across the agency by staff with training/knowledge/experience in co-occurring addictions?

c. Does the Assessment instrument capture sufficiently broad/comprehensive and sufficiently detailed/individualized information necessary to inform a personalized treatment plan?

d. How frequently are Assessments administered / re-administered?

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-5. Individualized Treatment Plan

Definition: For all COD/IDDT clients, there is an explicit, individualized treatment plan (even if it is not called this) related to COD recovery that is consistent with the 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 COD/IDDT treatment 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.

EVALUATION QUESTIONS:

a. Are the treatment plans for dually disordered clients different in any way than those for singly diagnosed mental health or substance abuse clients? Are the treatment plans for dually disordered clients sufficiently individualized to meet each of their unique recovery needs?

b. How frequently are treatment plans reviewed for potential adjustment? What (if anything) triggers a Periodic Review at a frequency higher than annually?

c. Does each client diagnosed with co-occurring mental health and substance use disorders have one or more goals on their treatment plan addressing some aspect of dual recovery?

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-6. Individualized Treatment

Definition: All COD/IDDT clients receive individualized treatment meeting the recovery goals of integrated dual disorders treatment. "*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: 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.)

Rationale: The key to the success of COD/IDDT is implementing a plan that is individualized and meets the goals for integrated dual recovery for each client.

EVALUATION QUESTIONS:

a. Are there different types and levels of intensity of treatment interventions available on the organization's array of co-occurring disorder services?

b. Are the treatment interventions / services matched to each individual's dual recovery needs?

c. Are the treatment interventions / services for one dually diagnosed consumer different than for others? Is this reflected not only in the treatment plans, but also in the progress note documentation and/or treatment team meeting log as well?

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-7. Training

Definition: All new practitioners receive standardized training in COD/IDDT (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.

EVALUATION QUESTIONS:

a. ***Please list your IDDT team members and/or COD service-providing practitioners, along with the specific COD-related training they have each received over the past 2 years, and by whom. (This may include overview training on the IDDT model, and/or training pertinent to various Treatment domains, such as Stage-matched interventions, Motivational Interviewing, COD Group facilitation, etc.)***

b. ***If your organization has a standardized COD training plan or curriculum that is utilized with new hires, please provide a copy of that for review, along with a description of the experience/credentials of instructors/trainers.***

c. ***In what practice focus areas do you offer regular refresher training for existing trained staff, and at what frequency? Who provides the refresher training?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-8. Supervision

Definition: COD/IDDT service 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 COD/IDDT recovery and its application to *specific client situations.*

Administrative meetings and meetings that are not specifically devoted to COD/IDDT do not fit the criteria for this item. The *client-specific* 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.

EVALUATION QUESTIONS:

a. ***Do IDDT team members and/or COD service-providing practitioners receive regular supervision that addresses clinical/treatment aspects of co-occurring service delivery for particular clients? If so, who provides the supervision, what are their experience/training qualifications, and what is the frequency with which it is regularly provided?***

b. ***Is the Supervision one-on-one, or in a larger group?***

c. ***Are supervision sessions logged or documented in some manner?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-9. Process Monitoring

Definition: Supervisors/program leaders monitor the process of implementing COD/IDDT services 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 COD/IDDT services 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 known, effective models of delivering COD/IDDT services.

EVALUATION QUESTIONS:

a. ***Are there any efforts currently made to monitor the development and implementation of COD services? If so, what form does this take, and how frequently does this occur?***

b. ***If a structured approach is used (COMPASS/CO-FIT, MIFAST IDDT Fidelity Review, etc) do the results inform subsequent action-planning to further IDDT/COD service implementation? Are organizational action plans documented and available for review?***

c. ***How does the organization know that progress has been made re: the development and implementation of IDDT/COD services?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-10. Outcome Monitoring

Definition: Supervisors/program leaders monitor the outcomes of COD/IDDT clients every 3 months and share the data with COD/IDDT 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.

EVALUATION QUESTIONS:

a. ***Are any treatment outcomes being measured and monitored? If so, which ones, and how frequently?***

b. ***Are the results fed back to clinicians? To consumers? If so, in what manner and how frequently?***

c. ***Are any existing treatment outcome monitoring efforts embedded in the electronic health record, or are they gathered manually? Whose role is it to aggregate and/or view & analyze, and/or communicate the findings of existing outcome monitoring?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-11. Quality Assurance (QA)

Definition: The agency's QA Committee has an explicit plan to review COD/IDDT service development or components of such development every 6 months. The steering committee for COD/IDDT may serve this function. Good QA committees help the agency in important decisions, such as penetration goals, placement of COD/IDDT services within the agency, hiring/staffing needs, etc.

QA committees also help guide and sustain the implementation by reviewing fidelity to known, effective ways of providing COD/IDDT services, making recommendations for improvement, advocating/promoting COD/IDDT services within the agency and in the community, and deciding on and keeping track of key outcomes relevant to COD/IDDT services.

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.

EVALUATION QUESTIONS:

a. ***Does the organization have a Quality Improvement / Quality Assurance type of oversight group for clinical services? What is it called, who sits on this group, and how frequently does it meet?***

b. ***Is the development and implementation of COD/IDDT services a regular agenda item for this group? How frequently is there meaningful discussion supporting the advance of COD/IDDT services, including recommendations for improvement, advocating for needed resources, promotion of the involved services within the organization and community, or tracking of key outcomes?***

c. ***Are these discussions captured in meeting minutes?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?

O-12. Client Choice Regarding Service Provision

Definition: All clients receiving COD/IDDT services are offered a reasonable range of choices consistent with COD/IDDT treatment; 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 a comprehensive COD/IDDT service array.

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:

o Integrated Dual Disorders Treatment
- *Group or individual interventions*
- *Frequency of DD treatment*
- *Specific self-management goals*

Rationale: A major premise of COD/IDDT treatment 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.

EVALUATION QUESTIONS:

a. ***Does the organization offer a reasonable range of available and accessible options to consumers, within the existing array of COD/IDDT treatment services?***

- ***For example, are both individual and group interventions available?***
- ***Can the frequency of treatment contacts vary to fit the level of treatment need?***
- ***Are harm reduction goals an option for those consumers not yet ready for immediate total abstinence?***

NEXT STEPS:

1. What are the next steps towards achieving this standard?

2. Who is responsible for this next step?

3. When will we accomplish this next step?