Co-Occurring Disorders
Integrated Dual Disorders Treatment (IDDT) Toolkit

Evidence-Based Practices: Shaping Mental Health Services Toward Recovery

This document is part of an evidence-based practice implementation resource kit developed through a contract (no. 280-00-8049) from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) and a grant from The Robert Wood Johnson Foundation (RWJF), and support from the West Family Foundation. These materials are in draft form for use in a pilot study.

CO-OCCURRING DISORDERS: INTEGRATED DUAL DISORDERS TREATMENT

Integrated Dual Diagnosis Treatment is for people who have co-occurring disorders, mental illness and a substance abuse addiction. This treatment approach helps people recover by offering both mental health and substance abuse services at the same time and in one setting.

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USER'S GUIDE

ACKNOWLEDGMENTS

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FOREWORD

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) is a proud sponsor of this implementation resource kit for integrated treatment of dual disorders. As the federal agency responsible for promoting the quality, availability, and accessibility of services for people with mental illness, CMHS is responsible for identifying treatments for mental illness that work. The materials in this resource kit document the evidence for the effectiveness of integrated treatment of dual disorders and provide detailed information to help communities to implement the practice in real world settings. During development of the implementation resource kit, we placed special emphasis on 1) strengthening the consensus-building process, 2) expanding the involvement of consumers and families, 3) including practical orientation to issues involving service organization and financing, and 4) insisting on paying careful attention to issues of ethnic and cultural sensitivity and overall cultural competence. We are well pleased with the result.

Many other organizations contributed to developing this implementation resource kit. This broad coalition of researchers, providers, administrators, policy makers, consumers and family members, gives the resource kit its strength and vitality. We are especially appreciative of the support provided by The Robert Wood Johnson Foundation that sponsored the early stages of the Project, when evidence-based integrated treatment of dual disorders was identified as a practice ready for widespread implementation. We agreed. Substance abuse is the most common and clinically significant comorbid disorder among adults with serious mental illnesses. Research and clinical experience have yielded four basic and consistent findings regarding co-occurring psychiatric and substance use disorders: 1) about 50 percent of people with serious mental disorders are affected by substance abuse; 2) dual disorders are associated with increased rates of relapse, violence, incarceration, homelessness, and serious infections such as HIV and hepatitis; 3) most mental health providers are not trained to deliver substance abuse treatment interventions; and 4) the parallel, but separate, mental health and substance abuse treatment systems that are common in the United States deliver fragmented and ineffective care for individuals with dual disorders.

This implementation resource kit reflects the current state-of-the-art concerning evidence-based integrated dual disorders services. It addresses both the "key ingredients" of the clinical model and many practical considerations essential for successful implementation. It also describes the need for each community to adapt the model to its particular needs and characteristics. Careful attention to unique community needs, coupled with fidelity to the key ingredients of the practice, equals successful implementation. The closer the kit user comes to following the implementation resource kit guidance, the more likely the practice will yield good results for consumers.

As mental health services research and evaluation progress, CMHS hopes to support the development of implementation resource kits for additional evidence-

based practices, and to refine this and other previously-developed resource kits to take new evidence into account. Indeed, evaluation of planned pilot projects for implementing this resource kit and associated implementation strategies will tell us much about how to make improvements in future versions. We hope that this and other evidence-based practice implementation resource kits will be helpful to communities across the nation as they strive to provide the most effective services possible for persons suffering from mental illness.

INTRODUCTION

Welcome to the Integrated Dual Disorders Treatment implementation resource kit. It has been produced by the Implementing Evidence-Based Practices Project as part of an effort to promote treatment practices in community mental health service settings that are known to be effective in supporting the recovery of adults with severe mental illnesses. The goal: to improve the lives of consumers by increasing the availability of effective mental health services.

The User's Guide begins by providing general information about the Implementing Evidence-Based Practices Project, including the goals and values of the project. This is followed by descriptions of the materials contained in the resource kit and their proposed role in the implementation process. The basic structure of an implementation plan is outlined. Specific suggestions for implementing the practice of integrated dual disorders treatment are presented in the Implementation Tips documents. This guide also contains a list of annotated references on integrated dual disorders treatment and a special populations appendix which provides a review of the literature addressing the range of populations for which this practice has demonstrated efficacy or effectiveness.

If you have any questions or comments about these materials or the implementation process, please contact Kristine Knoll at the NH-Dartmouth Psychiatric Research (e-mail address: Kristine.M.Knoll@Dartmouth.EDU). We look forward to supporting your efforts to improve services to people with severe mental illness. Also, please share your experience in using these materials. Feedback from users will help refine and improve future versions of these implementation materials.

BACKGROUND

What are "evidence-based practices"?

Evidence-based practices are services for people with severe mental illness (consumers) that have demonstrated positive outcomes in multiple research studies.

Over the past 15 years, researchers in mental health service systems have gathered extensive data to support the effectiveness of several psychosocial and pharmacological treatments. In 1998, the Robert Wood Johnson Foundation convened a consensus panel of researchers, clinicians, administrators, consumers, and family advocates to discuss the research and to determine

which practices currently demonstrated a strong evidence base. This project is an offshoot of these efforts.

The six evidence-based practices:
Six practices were identified as currently demonstrating a strong evidence base:

- standardized pharmacological treatment
- illness management and recovery skills
- supported employment
- family psychoeducation
- assertive community treatment
- integrated dual disorders treatment (substance use and mental illness)

Other evidence-based practices for the treatment of persons with severe mental illnesses are being identified and will be promoted as the research evolves. This project is only a beginning attempt to establish models and procedures. This list of identified practices is not intended to be complete or exclusive. There should be many evidence-based practices in the future. Some promising practices being researched currently include peer support programming, supported housing, trauma services, and treatment for people with borderline personality disorder.

What is an implementation resource kit?
An implementation resource kit is a set of materials-written documents, videotapes, PowerPoint presentations, and a website-that support implementation of a particular treatment practice.

Specific materials in this resource kit have been developed for each of the key stakeholder groups involved in the implementation effort:

- consumers of mental health services
- family members and other supporters
- practitioners and clinical supervisors
- program leaders of mental health programs
- public mental health authorities

Research has shown that providing practice guidelines to practitioners alone does not change practice. Change is most likely to occur and be sustained if all the major stakeholders in the mental health system are engaged and involved in the process of change. Therefore the materials and guidelines in this implementation resource kit are geared toward five different stakeholder groups. The materials for each specific stakeholder group were either written by representatives of that group or in close collaboration with them.

The resource kit materials are also designed to address three stages of change:

- engaging and motivating for change (why do it)
- developing skills and supports to implement change (how to do it)
- sustaining the change (how to maintain and extend the gains)

What is an implementation package?
An implementation package is a set of implementation materials (the resource kit) combined with complementary training and consultation that support implementation of the evidence-based practice. The resource kit materials are designed to be most effective when used with consultative and training services. As part of the Implementing Evidence-Based Practices Project, EBP implementation centers are being established in various states across the country to provide consultation and training (see www.mentalhealthpractices.org).

How was this implementation resource kit developed?
A team made up of multiple stakeholders developed each resource kit: researchers, clinicians, program managers and administrators, consumers, and family members. Documents oriented toward specific stakeholder groups were either written by the stakeholders or in close collaboration with them. A consensus panel, also comprised of multiple stakeholders, reviewed the materials developed for all of the six implementation resource kits to ensure consistency of presentation and attention to the various perspectives of the different constituencies.

For more information
For a more detailed discussion of the project and the implementation strategies, refer to the enclosed *Psychiatric Services* articles:

Drake RE, Goldman HH, Leff HS, et al: Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services* 52:179-182, 2001.

Torrey WC, Drake RE, Dixon L, et al: Implementing evidence-based practices for persons with severe mental illnesses. *Psychiatric Services* 52:45-50, 2001.

PROJECT PHILOSPHY AND VALUES

The project rests on two philosophical tenets:
First, mental health services for people with severe mental illnesses should have the goal of helping people to develop high-quality, satisfying functional lives. That is, services should aim not just at helping consumers stay out of the hospital and reducing or stabilizing symptoms, but also at helping them to pursue their own personal recovery process. People want services that help them to manage their illnesses and to move ahead with their lives.

Second, consumers and their families have a right to information about effective treatments, and in areas where evidence-based practices exist, consumers and family members have a right to access effective services.

Evidence-based practices are not intended to be exclusive, mandatory, or rigid. Rather, they imply self-knowledge, self-determination, choice, individualization, and recovery.

Defining recovery
There have been many efforts to define the recovery philosophy. The Consumer Advisory Panel for the Implementing Evidence-Based Practices Project drafted the following brief statement. The principles of recovery that informed the development of the implementation resource kit materials are:

- hope
- personal responsibility
- education
- self-advocacy
- support

The cessation of symptoms is not necessarily equal to recovery. Each person develops their own definition of recovery, which many view as a process rather than a destination.

It is important to know what is meant by "support." While the support of others is a valuable element in recovery, it does not include solving problems for another person or giving advice.

Empowerment is another critical component to recovery. A person becomes dis-empowered when choices are made for them, even when well-meaning supporters do it. Disempowerment also occurs when assumptions or judgments are made concerning an individual and their choices.

Recovery is most easily achievable when a person and those around them recognize the individual as a whole and complete person regardless of symptoms. One of the most valuable things a person can do for someone with psychiatric symptoms is to listen.

For more information

Copeland, Mary Ellen. *Wellness Recovery Action Plan*. 1997. Peach Press.
Ralph, Ruth O. *Review of Recovery Literature: A Synthesis of a Sample of Recovery Literature 2000*. Report produced for NASMHPD/National Technical Assistance Center for State Mental Health Planning.

COMPONENTS OF THE INTEGRATED DUAL DISORDERS TREATMENT RESOURCE KIT

Implementation Resource Kit

The following describes the purpose and content of the individual resource kit materials. This section is followed by a description of the use of these materials in the implementation process.

Implementation Resource Kit User's Guide

This document describes the implementation resource kit and how to use it. It includes annotated references for the particular evidence-based practice.

www.mentalhealthpractices.org

This website contains basic information about each of the six evidence-based practices. It includes references and links to other relevant websites. Information for consumers and family members is available in Spanish.

Information for Stakeholders (five documents)

These documents describe the evidence-based practice and highlight features of the practice most pertinent to the particular stakeholder being addressed. These are engagement pieces that address the question: why should I, as consumer, family member, practitioner, program leader, or administrator be interested in this practice? The documents for consumers and family members are available in Spanish-language versions.

Statement on Cultural Competence

This document addresses the need for practitioners and policymakers to integrate the design and delivery of the evidence-based practices within a culturally responsive context.

Workbook

The workbook is designed as a primer for practitioners regarding skills needed to provide the evidence-based practice. It emphasizes the knowledge and skill practitioners need in order to provide an effective intervention, one with high fidelity to the model. It is designed for use in training or supervisory settings.

Implementation Tips for Mental Health Program Leaders

This document provides practical guidance for agency program leaders on how to implement the evidence-based practice in a community mental health setting.

It includes strategies for building consensus in organizations preparing for change and tips on how to develop policies and procedures to support the practice.

Client Outcome Measures
Using outcome measures to evaluate and track consumer gains and program success is critical for effective implementation of an evidence-based practice. Simple outcomes are identified that can be monitored as part of routine clinical practice. The tracking of outcome measures is used as a feedback mechanism for clinicians, supervisors, and administrators.

Fidelity Scale
Research indicates that the quality of implementation of the practice-adherence to principles of the model-strongly influences outcomes. The fidelity scale enables mental health program leaders to evaluate their program in comparison to the recommended principles.

Additional Implementation Materials
PowerPoint presentations are available to supplement the Integrated Dual Disorders Treatment resource kit materials. Contact the West Institute at the New Hampshire-Dartmouth Psychiatric Research Center (603-271-5747).

HOW TO USE THE RESOURCE KIT MATERIALS: AN IMPLEMENTATION PLAN

Effective implementation of evidence-based practices is best achieved by using the materials with a structured complementary consultative and training program. As part of this project, a number of evidence-based practices implementation centers have been established throughout the country. For more information on these centers, go to www.mentalhealthpractices.org.
A brief description of a basic implementation plan that includes these supports is provided below. See the *Implementation Tips for Mental Health Programs Leaders and Implementation Tips for Public Mental Health Authorities* for more detailed suggestions regarding the implementation of Integrated Dual Disorders Treatment.

Consensus building
Build support for change

- identify key stakeholders
- provide information to all stakeholders
- develop consensus regarding a vision for the practice at your agency
- convey a vision and a commitment to all stakeholders

Enthusiasm for the implementation of the evidence-based practice can be generated by communicating how the practice benefits consumers and family members.

Use implementation resource materials:

- Distribute information materials to the key stakeholder groups.
- Hold informational meetings with key stakeholder groups. Have opinion leaders within the different stakeholder groups co-host these meetings. Include a viewing of the introductory videotape. An introductory PowerPoint presentation can be used to structure the informational meeting.

Developing an implementation plan
An action plan

- identify an agency implementation leader
- establish an implementation steering team that includes representatives from all stakeholder groups
- secure a consultant from an EBP implementation institute
- develop an implementation plan

Responsibilities of the implementation leader and implementation steering team include identifying and utilizing personnel, resources, and processes (administrative support and system changes) needed to support the evidence-based practice; an assessment of training needs; and development of an implementation timeline.

Consultants from EBP implementation centers can work with public mental health authorities and program leaders to inform them about the practice, to evaluate an agency's or system's commitment to change, and to assess current realities of financial incentives, staffing, and structure.

By developing partnerships with community organizations including peer support programs, consumer and family advocacy groups, police, homeless shelters, food banks, department of vocational rehabilitation, and others depending on the specific practice, the implementation leader and the implementation steering team can most effectively develop support for the practice. These groups may contribute to the development of an implementation plan.

Use of implementation resource materials:

- *Implementation Tips for Public Mental Health Authorities* is designed for individuals at the municipal, county, or state mental health authority.
- *Implementation Tips for Mental Health Program Leaders* is designed to be shared with the individuals in an agency that make and carry out decisions about the local resources and processes. This includes people who have responsibility for program management, training, policy development, program standards, data management, and funding.

Enacting the implementation

Making it happen

- involve agency personnel at all levels to support the implementation
- host a "kick-off" training where all stakeholders receive information about the practice
- host a comprehensive skills training for agency personnel who will be providing the practice
- arrange opportunities to visit programs that have successfully implemented the practice
- work with an implementation center for off-site support for the practice
- review current agency outcome measures relative to the practice and modify outcome data to monitor the practice. Learn how to make use of outcome measures in clinical practice and supervision
- work with a consultant/trainer to learn how to use the fidelity scale to identify strengths and weaknesses in the implementation effort

Trainers can work with the agency to offer an initial or "kickoff" training for all stakeholders. The trainer can then provide comprehensive skills training for those personnel within the agency who will be providing the practice. The trainers may

offer to visit the program at least one day per month for the first six months, then one day every other month for the next six months, for ongoing training, consultation, supervision as needed by the program. The trainer may also be available on a weekly basis for phone consultation.
Use of implementation resource materials:

Many agencies find it useful for the implementation leader and agency staff to familiarize themselves with the structure and processes of the practice by visiting an existing program. Before a site visit, the implementation leader and clinical supervisor(s) should review:

- Information for Practitioners and Clinical Supervisors
- Information for Mental Health Program Leaders
- Implementation Tips for Mental Health Program Leaders
- Workbook for Practitioners and Clinical Supervisors

Materials that support training and clinical supervision

- Workbook for Practitioners and Clinical Supervisors
- Practice demonstration videotapes
- PowerPoint training presentation (available from the West Institute)

Trainers may also serve as consultants to the administrators of the program. This includes demonstrating the usefulness of outcomes data as a clinical feedback tool. See *Monitoring Client Outcomes*.

Monitoring and evaluation

Sustaining change: How to maintain and extend the gains

- establish a mechanism for continuous feedback regarding how the practice is being provided in an agency
- publicize outcome improvements from the practice
- use fidelity scales to monitor the practice implementation

Monitoring and evaluation occur in several ways. First, the use of consultants to provide side-by-side, ongoing consultation during the first one to two years of the program is very helpful. Consultants who are experienced in the practice can recognize problems and recommend changes to address them.

Use of implementation resource materials

It is useful for programs to become comfortable early on with the measures that will be used for monitoring and evaluating the delivery of the practice: outcome measures and the fidelity scale. The information collected can be used not only to identify areas that are problematic, but also to identify areas of excellence. See *General Organizational Index*. Feedback from these measures may be used to promote and strengthen clinical and programmatic effectiveness.

A WORD ABOUT TERMINOLOGY

Terms used in the Implementation Resource Kit materials
The materials were developed by people from a variety of backgrounds and perspectives. During development, it became evident that many different terms are used to describe the key stakeholders. For the sake of clarity and consistency, in most instances common terms are used to identify these groups throughout the implementation resource kits. In some situations more precise, or alternative, terminology is used. For instance, in the Supported Employment implementation resource kit, the term 'employment specialist' is often used rather than "practitioner."

Consumers, clients, people who have experienced psychiatric symptoms
These terms refer to persons who are living with severe mental illness and who use professional mental health services-the consumers of mental health services. The term 'consumer' is most frequently employed in the resource kit materials. In the Integrated Dual Disorders Treatment workbook and in the outcome measures document, the term 'client' is used. The Illness Management and Recovery resource kit uses the term 'people who have experienced psychiatric symptoms'.

Family and other supporters
This terminology refers to families and other people who provide support to a consumer, and recognizes that many consumers have key supporters who are not family members.

Practitioners and clinical supervisors
The term practitioner refers to the people who deliver the evidence-based practice. This is used instead of clinician, case manager, nurse, psychiatrist, therapist, etc. except when referring to a specific kind of role (e.g., the employment specialist in supported employment, or the prescriber in medication management). The term clinical supervisor is used to distinguish between an administrative supervisor and the person supervising the clinical work of the practitioner.

Mental health program leaders
This term is used to describe the person at the mental health provider organization who is trying to put the practice into effect. This term is used instead of program supervisor, operations director, program manager, or program administrator. The term is used because it makes it clear that this person's job is to lead with the support of the agency's administration.

Public mental health authorities
This term is used to describe the people who determine the regulations and funding structures of the public mental health system. We recognize that evidence-based practices are also implemented and overseen in the private sector.

PHASES OF THE IMPLEMENTING EVIDENCE-BASED PRACTICES PROJECT

The Implementing Evidence-Based Practices Project was planned to take place in three phases over a five to six year period, as described below.

Phase I: Development of the Implementation Resource Kits-Fall 2000 to Summer 2002

During Phase I the core principles and critical elements of each of the six evidence-based practices were identified and guidelines for their implementation developed. This resulted in the development of a comprehensive implementation plan-production of implementation resource kits and development of a structured program of training and consultation-to facilitate the adoption of evidence-based practices in routine clinical settings.

Phase II: Pilot Testing the Implementation Resource Kits-Summer 2002 to Summer 2005

Phase II entails a multi-state demonstration of implementation using the resource kit materials in conjunction with a structured program of consultation and training. The goals are (1) to demonstrate that evidence-based practices can be successfully implemented in routine practice settings; (2) to improve the implementation resource kits including the recommendations for consultation and training support based on information gathered from pilot experiences; and (3) to learn more about the range of variables that facilitate or impede implementation in routine treatment settings.

Phase III: National Demonstration-starting in 2006

Phase III is designed to be a broad implementation effort in which the modified implementation resource kits will be made available throughout the United States. Research will focus on both evaluating the success of implementing evidence-based practices and their effects on client outcomes.

ANNOTATED BIBLIOGRAPHY FOR INTEGRATED DUAL DISORDERS TREATMENT

Practice Manuals

Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (expected publication date: Spring, 2003). *Integrated Treatment for Dual Disorders: Effective Intervention for Severe Mental Illness and Substance Abuse*. New York: Guilford Publications.

- Comprehensive clinical guide for the treatment of dual disorders from which some of the material in the implementation resource kit is drawn.

- Information on assessment, including forms and instruments, is provided.
- Ancillary treatment strategies described, such as residential and other housing approaches, involuntary intervention, vocational rehabilitation, and psychopharmacology.
- Detailed guidelines and vignettes provided. Individual (including case management, motivational interviewing, and cognitive behavioral counseling), group (including persuasion, active treatment, social skills training, and self-help groups), and family (including individual family and multiple-family group) approaches are described.
- Educational handouts covering different topics on mental illness, substance abuse, and their interactions are provided which can be duplicated for education with clients and family members.

Watkins, T. R., Lewellen, A., & Barrett, M. C. (2001). *Dual Diagnosis: An Integrated Approach to Treatment*. Thousand Oaks, CA: Sage Publications.

- Discusses strategies for integrating substance abuse treatment with care for mental illness.
- Separate chapters address different psychiatric disorders, including schizophrenia, bipolar disorder, depression, anxiety disorders, and severe personality disorders.

Ries, Richard and Consensus Panel (1994). *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse*; Treatment Improvement Protocol (TIP) Series 9: DHHS Publication No. (SMA) 94-2078.

- Provides practical information about the treatment of patients with dual disorders.
- Separate chapters on treatment systems, linkages for mental health and substance abuse treatment, mood disorders, anxiety disorders, personality disorders, psychotic disorders and pharmacologic management.

Research and Conceptual Background

Reviews of the literature

Drake, R. E., Mercer-McFadden, C., Mueser, K. T., McHugo, G. J., & Bond, G. R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin*, 24, 589-608.

- Comprehensive review of research on integrated treatment for dual disorders
- Review covers a wide range of research, including early demonstration programs in establishing the feasibility of integrated treatment in community support service settings

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

- Update on research on integrated treatment of dual disorders

Mueser, K. T., & Kavanagh, D. (2001). Treating comorbidity of alcohol problems and psychiatric disorder. In N. Heather, T. J. Peters, & T. R. Stockwell (Eds.), *Handbook of Alcohol Dependence and Related Problems* (pp. 627-647). Chichester, England: John Wiley & Sons.

- Provides an updated review of the epidemiology of dual disorders
- Describes integrated treatment approaches for dual disorders, with specific recommendations for different types of psychiatric disorders, including schizophrenia, bipolar disorder, depression and anxiety disorders

Mueser, K., Drake, R., & Wallach, M. (1998). Dual diagnosis: A review of etiological theories. *Addictive Behaviors*, 23, 717-734.

- Reviews the research literature on different theories accounting for the high rate of substance abuse in persons with severe mental illness
- Challenges the prevailing hypothesis of high rates of substance abuse and severe mental illness could be explained by "self-medication" of distressful symptoms
- Marshals evidence suggesting that some excess comorbidity is due to increased biological sensitivity to the effects of drugs and alcohol in persons with severe mental illness

Drake, R. E., & Brunette, M. F. (1998). Complications of severe mental illness related to alcohol and other drug use disorders. In M. Galanter (Ed.), *Recent Developments in Alcoholism* (Vol. XIV, Consequences of Alcoholism, pp. 285-299). New York: Plenum Publishing Company.

- Summarizes research on the effects of alcohol and drug abuse on the course of severe mental illness

Selected research articles

Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S., Moring, J., O'Brien, R., Schofield, N., & McGovern, J. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *American Journal of Psychiatry*, 158, 1706-1713.

- Describes a randomized control trial of an integrated treatment for dual disorders, including motivational interviewing, cognitive behavioral counseling, and family intervention with services as usual.
- Excellent outcomes were found for the integrated program, including substance abuse, relapse and rehospitalization.

Drake, R. E., McHugo, G. J., Clark, R. E., Teague, G. B., Xie, H., Miles, K., & Ackerson, T. H. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *American Journal of Orthopsychiatry*, 68, 201-215.

- Describes large randomized controlled trial comparing two different case management approaches for the delivery of integrated dual disorder services: assertive community treatment versus standard case management.

- Following three years of treatment, positive outcomes were found for both approaches to integrated treatment, with assertive community treatment showing modest advantages over standard case management.

Principles of Integrated Treatment for Dual Disorders

Mueser, K. T., Drake, R. E., & Noordsy, D. L. (1998). Integrated mental health and substance abuse treatment for severe psychiatric disorders. *Practical Psychiatry and Behavioral Health*, 4, 129-139.

- Summarizes the fundamental ingredients of effective integrated dual disorder programs, including comprehensiveness, assertive outreach, assertive and protective living environment, motivation based intervention, and long-term perspective.
- Provides an explanation of the stages of treatment (engagement, persuasion, active treatment, relapse prevention), which serve to guide clinicians in selecting interventions appropriate for our clients level of motivation to address substance use problems.

Carey, K. B. (1996). Substance use reduction in the context of outpatient psychiatric treatment: A collaborative, motivational, harm reduction approach. *Community Mental Health Journal*, 32, 291-306.

- Describes conceptual foundation to a treatment approach based on motivational enhancement and the reduction of harmful consequences of substance abuse.

Minkoff, K. (1989). An integrated treatment model for dual diagnosis of psychosis and addiction. *Hospital and Community Psychiatry*, 40, 1031-1036.

- Describes essential ingredients for an integrated service system for the treatment of severe mental illness and substance use disorders.

Ziedonis, D., & Fisher, W. (1996). Motivation-based assessment and treatment of substance abuse in patients with schizophrenia. *Directions in Psychiatry*, 16, 1-7.

- Provides overview of motivation-based approach to assessment and treatment of dual disorders.

Historical context for Integrated Treatment for Dual Disorders

Ridgely, M. S., Goldman, H. H., & Willenbring, M. (1990). Barriers to the care of persons with dual diagnoses: Organizational and financing issues. *Schizophrenia Bulletin*, 16, 123-132.

Ridgely, M. S., Osher, F. C., Goldman, H. H., & Talbott, J. A. (1987). Executive summary: Chronic mentally ill young adults with substance abuse problems: A review of research, treatment, and training issues. Baltimore: Mental Health Services Research Center, University of Maryland School of Medicine.

- These two publications summarize problems with traditional approaches to dual disorders, including administrative, clinical, and philosophical barriers to accessing intervention for both disorders.

Polcin, D. L. (1992). Issues in the treatment of dual diagnosis clients who have chronic mental illness. *Professional Psychology: Research and Practice*, 23, 30-37.

- Describes obstacles in traditional treatment approaches to effective intervention for dual disorders.

Kushner, M. G., & Mueser, K. T. (1993). Psychiatric co-morbidity with alcohol use disorders. *Eighth Special Report to the U.S. Congress on Alcohol and Health* (Vol. NIH Pub. No. 94-3699, pp. 37-59). Rockville, MD: U.S. Department of Health and Human Services.

- Early comprehensive review of the epidemiology, correlates, and outcome of dual disorders.
- Summarizes research on the negative effects of psychiatric comorbidity on the course and outcome of treatment for substance abuse.

Consumer and Family Perspectives

Ethnographic and first person reports

Alverson, H., Alverson, M., & Drake, R. E. (2000). An ethnographic study of the longitudinal course of substance abuse among people with severe mental illness. *Community Mental Health Journal*, 36, 557-569.

Alverson, H., Alverson, M., & Drake, R.E. Social patterns of substance use among people with dual diagnoses. Mental Health Services Research, 3(1), 3-14, 2001.

Fox, L. (1999). Missing out on motherhood. *Psychiatric Services*, 50, 193-194.
Green, V.L. The resurrection and the life. American Journal of Orthopsychiatry, 66(1), 12-16, 1996.

Family perspectives

Clark, R. E. (2001). Family support and substance use outcomes for persons with mental illness and substance use disorders. *Schizophrenia Bulletin*, 27, 93-101.

- Describes family members financial and time contributions to helping a relative with dual disorders, and the relationship between family assistance and improved outcomes.

Schwab, B., Clark, R. E., & Drake, R. E. (1991). An ethnographic note on clients as parents. *Psychosocial Rehabilitation Journal*, 15(2), 95-99.

- Describes challenges faced by clients with dual disorders who are parents.

Practice Issues

Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (expected publication date: Spring, 2003). *Integrated Treatment for Dual Disorders: Effective Intervention for Severe Mental Illness and Substance Abuse*. New York: Guilford Publications.

- See description of book under Practice Manuals section.
- This book has chapters covering the specific topics listed below.

Assessment and treatment planning

Carey, K. B., & Correia, C. J. (1998). Severe mental illness and addictions: Assessment considerations. *Addictive Behaviors*, 23, 735-748.

- Discusses common issues faced by clinicians in assessing substance abuse in persons with severe mental illness, and provides solutions to those problems.

Connors, G. J., Donovan, D. M., & DiClemente, C. C. (2001). *Substance Abuse Treatment and the Stages of Change*. New York: Guilford Publications.

- A helpful book on treatment planning based on clients' motivation to change their addictive behavior.

Donovan, D. D. and Alan Marlatt, G. A (Eds.) New York: Guilford Publications, (1988). *Assessment of Addictive Behaviors*.

- The introductory chapter on assessment of addictive behaviors is outstanding.
- This book also contains many chapters on specific drugs and approaches that are quite good.

Drake, R. E., Rosenberg, S. D., & Mueser, K. T. (1996). Assessing substance use disorder in persons with severe mental illness. In R. E. Drake & K. T. Mueser (Eds.), *New Directions for Mental Health Services* (Vol. 70, pp. 3-17). San Francisco: Jossey-Bass.

- Describes many of the obstacles to accurate assessment of substance abuse in persons with dual disorders and strategies for overcoming these obstacles.

McHugo, G. J., Drake, R. E., Burton, H. L., & Ackerson, T. H. (1995). A scale for assessing the stage of substance abuse treatment in persons with severe mental illness. *Journal of Nervous and Mental Disease*, 183, 762-767.

- Contains information regarding the assessment of stages of treatment for persons with dual disorders.

Mueser, K. T., Drake, R. E., Clark, R. E., McHugo, G. J., Mercer-McFadden, C., & Ackerson, T. (1995). *Toolkit for Evaluating Substance Abuse in Persons with Severe Mental Illness*. Cambridge, MA: Evaluation Center at HSRI.

- Summarizes the Substance Abuse Treatment Scale for assessing clients' stage of treatment, and provides psychometric data on this scale.
- Describes three clinician-administered scales for clients with dual disorders, including the Alcohol Use Scale, the Drug Use Scale, and the Substance Abuse Treatment Scale.

- Includes software that contains the scales.
- Information provided on training clinicians on the use of the scales, establishing and maintaining reliability, and validity.

Noordsy, D. L., McQuade, D. V., & Mueser, K. T. (2002). Assessment considerations. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 159-180). Chichester, England: John Wiley & Sons.

- Describes principles of assessment of substance abuse in persons with severe mental illness.
- Explicates four steps of assessment: identification, classification, functional assessment and analysis, and treatment planning.
- Specific methods for linking assessment to treatment are described.

Rosenberg, S. D., Drake, R. E., Wolford, G. L., Mueser, K. T., Oxman, T. E., Vidaver, R. M., Carrieri, K. L., & Luckoor, R. (1998). The Dartmouth Assessment of Lifestyle Instrument (DALI): A substance use disorder screen for people with severe mental illness. *American Journal of Psychiatry*, 155, 232-238.

- Describes brief screening instrument (DALI) for identifying substance abuse in persons with severe mental illness.
- Presents data showing that DALI outperforms other screening instruments in persons with dual disorders.

Engagement

Rapp, C. A. (1998). The Strengths Model: Case Management with People Suffering from Severe and Persistent Mental Illness. New York: Oxford University Press.

- Excellent book that describes the engagement process in persons with severe mental illness.
- Very helpful for anyone attempting to engage dual disorder clients in a treatment relationship.

Stages of treatment and motivational enhancement

Carey, K. B., Purnine, D. M., Maisto, S. A., Carey, M. P., & Barnes, K. L. (1999). Decisional balance regarding substance use among persons with schizophrenia. *Community Mental Health Journal*, 35, 289-299.

- Describes use of decisional balance approach to helping persons with dual disorders weigh the advantages and disadvantages of continued substance abuse versus sobriety.

Miller, W. R., & Rollnick, S. (2002). M*otivational Interviewing: Preparing People for Change*. (Second ed.). New York: Guilford Publications.

- An outstanding book, a "classic" in the addiction field, about stages of change and recovery from substance abuse.
- An excellent place to start; mandatory reading for all clinicians working with clients with dual disorders.

Osher, F. C., & Kofoed, L. L. (1989). Treatment of patients with psychiatric and psychoactive substance use disorders. *Hospital and Community Psychiatry*, 40, 1025-1030.

- Introduces and describes the concept of stages of treatment (engagement, persuasion, active treatment, relapse prevention) that help clinicians gear treatment interventions to clients' individual motivational states.

Rollnick, S. and others. (1999). *Health Behavior Change: A Guide for Practitioners*. Churchill Livingston.

- Another helpful reference on the stages of change and recovery from substance abuse.
- Describes substance abuse counseling and relapse prevention counseling.

D'Zurilla, T. and Nezu, A. (1999), *Problem Solving Therapy (Second Edition)*. New York: Springer.

- To learn more about problem solving therapy, which can be applied to substance abuse and/or mental illness problems in clients with dual disorders.

Graham, H., Copello, A., Birchwood, M. J., Orford, J., McGovern, D., Maslin, J., & Georgiou, G. (2002). Cognitive-behavioral integrated approach for psychosis and problem substance use. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 181-206). Chichester, England: John Wiley & Sons.

- Describes cognitive-behavioral approach to treating substance abuse in persons with severe mental illness.
- Includes numerous useful clinical examples.

Marlatt, G. A., & Gordan, G. R. (1985). Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors. New York: Guilford Publications.

- Describes principles of substance abuse relapse prevention.
- Written originally for work with the substance abuse population.
- Much of the book applies to persons with severe mental illness who have achieved sobriety and are motivated to prevent relapses of their substance abuse.

Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating Alcohol Dependence*. New York: Guilford Publications.

- An excellent book on cognitive-behavioral treatment of substance abuse.
- Offers a simple introduction to basic techniques that are effective with dual disorder clients in the active treatment stage.

Group treatment for dual disorders

Bellack, A. S., & DiClemente, C. C. (1999). Treating substance abuse among patients with schizophrenia. *Psychiatric Services*, 50, 75-79.

- Describes social skills training approach to dual disorders treatment.

Bellack, A. S., Mueser, K. T., Gingerich, S., & Agresta, J. (1997). Social Skills Training for Schizophrenia: A Step-By-Step Guide. New York: Guilford Publications.

- Addresses how to conduct social skills training groups for persons with severe mental illness.
- Specific curriculum provided (steps of skills) for helping clients refuse substances and deal with substance abuse situations.

Mueser, K. T., & Noordsy, D. L. (1996). Group treatment for dually diagnosed clients. In R. E. Drake & K. T. Mueser (Eds.), Dual Diagnosis of Major Mental Illness and Substance Abuse Disorder II: Recent Research and Clinical Implications. New Directions for Mental Health Services (Vol. 70, pp. 33-51). San Francisco: Jossey-Bass.

- Describes four different types of group interventions for dual disorders, including educational, stage-wise (persuasion and active treatment), social skills training, and self-help groups.
- Brief clinical vignettes used to illustrate different group treatment methods.

Noordsy, D. L., Schwab, B., Fox, L., & Drake, R. E. (1996). The role of self-help programs in the rehabilitation of persons with severe mental illness and substance use disorders. *Community Mental Health Journal*, pp. 71-81.

- Summarizes difficulties and solutions associated with using self-help groups, such as Alcoholics Anonymous, for persons with dual disorders.

Roberts, L. J., Shaner, A., & Eckman, T. A. (1999). *Overcoming Addictions: Skills Training for People with Schizophrenia*. New York: W.W. Norton.

- Manual for providing social skills training to clients with dual disorders.

Weiss, R. D., Greenfield, S. F., & O'Leary, G. (2002). Relapse prevention for patients with bipolar and substance use disorders. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 207-226). Chichester, England: John Wiley & Sons.

- Describes group intervention program for bipolar disorder and substance abuse.
- Useful clinical examples provided illustrating group treatment methods.

Self-help

Alcoholics Anonymous (1990). *The AA Group: Where It All Begins (rev.)*. New York: Alcoholics Anonymous.

- Alcoholics Anonymous (AA) is the largest self-help organization for addiction.

- This book describes its history, traditions, and approach to recovery from addiction, base on the "12-Steps" of AA.

Hamilton, T., & Sample, P. (1994). The Twelve Steps and Dual Recovery: A Framework of Recovery for Those of Us with Addiction and an Emotional or Psychiatric Illness. Center City, MN: Hazeldon.

- Explains 12-Step approach to self-help substance abuse treatment in persons with a mental illness.

The Dual Disorder Recovery Book (1993) Hazelden, Center City, Minnesota, 1993.

- Discussion of 12-step self-help approach to recovery for persons with dual disorders.

Trimpey, J. (1996). Rational Recovery: The New Cure for Substance Addiction. New York: Pocket Books.

- Discussion of 12-step self-help approach to recovery for persons with dual disorders. Trimpey, J. (1996). Rational Recovery: The New Cure for Substance Addiction. New York: Pocket Books.
- Rational Recovery (RR) is a self-help alternative to 12-Step approaches (such as Alcoholics Anonymous).
- RR is less spirituality oriented, and more focused on helping clients take control over their lives through accepting personal responsibility to themselves and others.

Vaillant, G. E. (1995). *Natural History of Alcoholism Revisite*d. Cambridge, MA: Harvard University Press.

- Offers a brilliant analysis of natural pathways to recovery and explains how self-help and treatment can enhance the process.

Family treatment

Barrowclough, C. (2002). Family intervention for substance misuse in psychosis. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 227-243). Chichester: John Wiley & Sons.

- Describes family intervention approach for dual disorders.

McFarlane, W. R. (2002). Multifamily Groups in the Treatment of Severe Psychiatric Disorders. New York: Guilford Publications.

- Provides detailed guidance on formation and running of multi-family groups for persons with severe mental illness and their families.
- Similar groups have been run for persons with dual disorders and their families (see Mueser & Fox, 2002, next reading).

Mueser, K. T., & Fox, L. (2002). A family intervention program for dual disorders. *Community Mental Health Journal*, 38, 253-270.

- Describes family intervention program for dual disorders that includes single-family sessions and multiple-family group sessions.
- Presents pilot data from study of family program.

Mueser, K. T., & Gingerich, S. L. (in press). *Coping with Schizophrenia: A Guide for Families (Second Edition)*. New York: Guilford Publications.
- Among many helpful books on family interventions, we recommend this book that is written for families.
- Includes a chapter on how family members can help a relative with a dual disorder.

Mueser, K. T., & Glynn, S. M. (1999). *Behavioral Family Therapy for Psychiatric Disorders (Second Edition)*. Oakland, CA: New Harbinger Publications.
- Treatment manual for clinicians that describes family intervention model for severe mental illness, including strategies for addressing substance abuse in clients with dual disorders.
- Includes educational handouts on different psychiatric disorders, medications, and the interactions between mental illness and substance abuse.

Psychopharmacological treatment

Day, E., Georgiou, G., & Crome, I. (2002). Pharmacological management of substance misuse in psychosis. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 259-280). Chichester, England: John Wiley & Sons.
- Detailed chapter that describes pharmacological management of substance use disorders, including stimulants, opioids, other drugs and alcohol.

Drake, R. E., Xie, H., McHugo, G. J., & Green, A. I. (2000). The effects of clozapine on alcohol and drug use disorders among schizophrenic patients. *Schizophrenia Bulletin*, 26, 441-449.
- Summarizes positive effects of clozapine on alcoholism outcomes in persons with schizophrenia.

Green, A. I., Zimmet, S. V., Strous, R. D., & Schildkraut, J. J. (1999). Clozapine for comorbid substance use disorder and schizophrenia: Do patients with schizophrenia have a reward-deficiency syndrome that can be ameliorated by clozapine? *Harvard Review of Psychiatry*, 6, 287-296.
- Theoretical paper in which authors suggest that the neurobiology of schizophrenia makes persons with this disorder more susceptible to substance abuse, and more likely to benefit from clozapine.

Mueser, K. T., & Lewis, S. (2000). Treatment of substance misuse in schizophrenia. In P. Buckley & J. Waddington (Eds.), *Schizophrenia and Mood Disorders: The New Drug Therapies in Clinical Practice* (pp. 286-296). Oxford: Butterworth & Heinemann.
- Brief chapter that includes recommendations for pharmacological treatment of clients with dual disorders.

Mueser, K. T., Noordsy, D. L., Fox, L., & Wolfe, R. (in press). Disulfiram treatment for alcoholism in severe mental illness. *American Journal on the Addictions*.

- Quantitatively describes positive long-term outcomes of 30 persons with severe mental illness and alcoholism treated with disulfiram (Antabuse).

Infectious diseases

Bartlett, J. and others (1998). *Guide to Living with HIV Infection*. Baltimore: John Hopkins U. Press.

- Coping with HIV and hepatitis.

Eversen G. and Weinberg, H. L (1999). *Living with Hepatitis C*. Hatherleigh.

- Coping with HIV and hepatitis.

Razzano, L. (2002). Issues in comorbidity and HIV/AIDS. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 332-346). Chichester, England: John Wiley & Sons.

- Practical chapter on the nature of HIV/AIDS in persons with dual disorders and treatment approaches.

Implementation, Administration, and Cost

Implementation and administrative issues

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

- Covers issues related to the implementation and dissemination of integrated programs for dual disorders.

Fox, T., Fox, L., & Drake, R. E. (1992). Developing a statewide service system for people with co-occurring severe mental illness and substance use disorders. *Innovations and Research*, 1(4), 9-13.

- Describes the development of integrated dual disorder services in the state of New Hampshire.

Torrey WC, Drake RE, Cohen M, et al. "The Challenge of Implementing and Sustaining Integrated Dual Disorders Treatment Programs" *Community Mental Health Journal* (in press 2002).

State and local administrative perspectives

Fox, T., & Shumway, D. (1995). Human resource development. In A. F. Lehman & L. Dixon (Eds.), *Double Jeopardy: Chronic Mental Illness and Substance Abuse* (pp. 265-276). New York: Harwood Academic Publishers.

- Describes how to cultivate clinicians and administrators in developing integrated programs for dual disorders.

Mercer-McFadden, C., Drake, R. E., Clark, R. E., Verven, N., Noordsy, D. L., & Fox, T. S. (1998). *Substance Abuse Treatment for People with Severe Mental Disorders: A Program Manager's Guide*. Concord, NH: New Hampshire-Dartmouth Psychiatric Research Center.

- Useful guide for program managers and anyone else with administrative responsibility for establishing and maintaining high quality integrated programs for dual disorders.

Financing and cost-effectiveness of integrated dual disorders treatment

Clark, R. E., Teague, G. B., Ricketts, S. K., Bush, P. W., Xie, H., McGuire, T. G., Drake, R. E., McHugo, G. J., Keller, A. M., & Zubkoff, M. (1998). Cost-effectiveness of assertive community treatment versus standard case management for persons with co-occurring severe mental illness and substance use disorders. *Health Services Research*, 33, 1285-1307.

- Describes cost-effectiveness analysis of study comparing assertive community treatment (ACT) with standard case management for dual disorders.

Clark, R. E., Ricketts, S. K., & McHugo, G. J. (1999). Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. *Psychiatric Services*, 50, 641-647.

- Addresses cost of legal system involvement in persons with dual disorders.

Dickey, B., & Azeni, H. (1996). Persons with dual diagnoses of substance abuse and major mental illness: Their excess costs of psychiatric care. *American Journal of Public Health*, 86, 973-977.

- Documents the high cost of standard (non-integrated) treatment approaches to substance abuse in persons with severe mental illness.

Fidelity measures for integrated dual disorders treatment

Jerrell, J. M., & Ridgely, M. S. (1999). Impact of robustness of program implementation on outcomes of clients in dual diagnosis programs. *Psychiatric Services*, 50, 109-112.

- Documents that better substance abuse outcomes in persons with dual disorders are associated with higher program fidelity to integrated treatment model.

McHugo, G. J., Drake, R. E., Teague, G. B., & Xie, H. (1999). Fidelity to assertive community treatment and client outcomes in the New Hampshire dual disorders study. *Psychiatric Services*, 50, 818-824.

- Shows that clients in assertive community treatment (ACT) programs that implemented dual disorders treatment with high fidelity to the integrated treatment model had better substance abuse outcomes than low fidelity programs.

SPECIAL POPULATIONS APPENDIX

A review of the literature addressing the range of populations for which the skills/strategies of integrated dual disorders treatment has demonstrated efficacy or effectiveness, including factors such as age, race, ethnicity, gender, institutional setting, sexual orientation, and geographic location.

Research on integrated treatment for dual disorders has focused mainly on the development and evaluation of comprehensive programs that incorporate the core ingredients of assertive outreach, motivation-based intervention (including stages of treatment), comprehensiveness, and a long-term perspective (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998b; Ley & Jeffery, 2002). While the general findings across the different studies provide support for the effectiveness of integrated services (Drake et al., 2001), only limited research has directly examined the question of whether integrated treatment is more effective for some clients than others. As a result, the evidence base for judging the differential effectiveness of integrated treatment for different subgroups of clients is quite limited at this point.

Despite the limited data available, research on integrated treatment for dual disorders has included clients with a wide range of different backgrounds. With respect to age, while there is a tendency for clients with dual disorders to be younger, all research on the topic includes a wide range of ages, with most clients between 18 and 55 (Barrowclough et al., 2001; Carmichael et al., 1998; Drake et al., 1998a; Drake, Yovetich, Bebout, Harris, & McHugo, 1997; Godley, Hoewing-Roberson, & Godley, 1994; Jerrell & Ridgely, 1995). Similarly, all these studies included both males and females, with males making up the majority of participants, consistent with the higher prevalence of substance abuse in men than women (Mueser, Yarnold, & Bellack, 1992; Mueser et al., 2000). Special issues have been identified related to the unique needs of women with dual disorders (Brunette & Drake, 1998; Brunette & Drake, 1997; Gearon & Bellack, 1999), but there is no evidence suggesting that women with dual disorders benefit less from integrated treatment.

Race or ethnicity have varied across the different studies, with most studies including a majority of Caucasian clients but also including some African American clients (Carmichael et al., 1998; Drake et al., 1998a; Godley et al., 1994; Jerrell & Ridgely, 1995). One study included only African American clients and reported very positive results from integrated treatment (Drake et al., 1997). A large, randomized controlled trial comparing the assertive community treatment approach with standard case management for integrated treatment of dual disorders in an inner-city, homeless population has recently been concluded and results are expected soon (Mueser, Essock, Drake, Wolfe, & Frisman, 2001). This study included predominantly African American clients, but some Caucasian and Latino clients also participated. More work is needed to evaluate the effectiveness of integrated dual disorders treatment for Latino clients.

The majority of studies of integrated treatment for dual disorders have been conducted on an outpatient basis, with positive results (Barrowclough et al.,

2001; Carmichael et al., 1998; Drake et al., 1998a; Drake et al., 1997; Godley et al., 1994; Jerrell & Ridgely, 1995). Less research has examined the effectiveness of integrated treatment provided in inpatient, residential, or intensive day treatment programs. Most of the studies examining short-term residential or intensive day treatment (3-6 months) programs suffer from high dropout rates (Blankertz & Cnaan, 1994; Burnam et al., 1995; Penn & Brooks, 1999; Rehav et al., 1995). One longer-term residential program, integrated into the community with a gradual transition from the residence into the community, found very positive long-term outcomes (Brunette, Drake, Woods, & Hartnett, 2001). Shorter-term integrated inpatient treatment for dual disorders may have an important role to play in stabilizing clients, engaging them in treatment, providing education about mental illness and substance abuse interactions, and motivating them to work on their substance abuse problems (Franco, Galanter, Castaneda, & Patterson, 1995; Rosenthal, 2002). Research is needed to evaluate the effectiveness of programs such as these when they are provided in a coordinated fashion with integrated outpatient treatment for dual disorders.

Research studies on integrated treatment programs for dual disorders have included significant numbers of clients with housing instability and homelessness (Carmichael et al., 1998; Drake et al., 1998a; Drake et al., 1997; Meisler, Blankertz, Santos, & McKay, 1997). The evidence from these studies indicates that integrated treatment is effective at improving both substance abuse and housing outcomes. Presumably, the outreach component of integrated treatment is critical to successful outcomes in work with this challenging population. Geographically, research on integrated treatment for dual disorders has been conducted in a variety of places. Several studies of treatment have been done in large urban areas (e.g., Washington, DC, Austin, Texas) (Carmichael et al., 1998; Drake et al., 1997; Jerrell & Ridgely, 1995), with two studies in more rural settings (Drake et al., 1998a; Godley et al., 1994). One study of integrated treatment for dual disorders was conducted in Manchester, England (Barrowclough et al., 2001). All of these studies have reported positive effects of integrated treatment, suggesting that the treatment principles are robust across a variety of geographical settings.

References

Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S., Moring, J., O'Brien, R., Schofield, N., & McGovern, J. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *American Journal of Psychiatry*, 158, 1706-1713.

Blankertz, L. E., & Cnaan, R. A. (1994). Assessing the impact of two residential programs for dually diagnosed homeless individuals. Social Service Review, 68, 536-560. Brunette, M., & Drake, R. E. (1998). Gender differences in homeless persons with schizophrenia and substance abuse. *Community Mental Health Journal*, 34, 627-642.

Brunette, M. F., & Drake, R. E. (1997). Gender differences in patients with schizophrenia and substance abuse. *Comprehensive Psychiatry*, 38, 109-116.
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, 526-528.

Burnam, M. A., Morton, S. C., McGlynn, E. A., Peterson, L. P., Stecher, B. M., Hayes, C., & Vaccaro, J. V. (1995). An experimental evaluation of residential and nonresidential treatment for dually diagnosed homeless adults. *Journal of Addictive Diseases*, 14, 111-134.

Carmichael, D., Tackett-Gibson, M., O'Dell, L., Jayasuria, B., Jordan, J., & Menon, R. (1998). *Texas Dual Diagnosis Project Evaluation Report 1997-1998*. College Station, TX: Public Policy Research Institute/Texas A&M University.

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

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Franco, H., Galanter, M., Castaneda, R., & Patterson, J. (1995). Combining behavioral and self-help approaches in the inpatient management of dually diagnosed patients. *Journal of Substance Abuse Treatment*, 12, 227-232.

Gearon, J. S., & Bellack, A. S. (1999). Women with schizophrenia and co-occurring substance use disorders: An increased risk for violent victimization and HIV. *Community Mental Health Journal*, 35, 401-419.

Godley, S. H., Hoewing-Roberson, R., & Godley, M. D. (1994). *Final MISA Report*. Bloomington, IL: Lighthouse Institute.

Jerrell, J. M., & Ridgely, M. S. (1995). Comparative effectiveness of three approaches to serving people with severe mental illness and substance use disorders. *Journal of Nervous and Mental Disease*, 183, 566-576.

Ley, A., & Jeffery. (2002). Cochrane review of treatment outcome studies and its implications for future developments. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), Substance Misuse in Psychosis: *A Handbook of Approaches to Treatment and Service Delivery* (pp. 349-365). Chichester, England: John Wiley & Sons.

Meisler, N., Blankertz, L., Santos, A. B., & McKay, C. (1997). Impact of assertive community treatment on homeless persons with co-occurring severe psychiatric and substance disorders. *Community Mental Health Journal*, 33, 113-122.

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Information

INFORMATION FOR CONSUMERS

Dual disorders refers to the presence of both a severe mental illness and a substance use disorder. Integrated dual disorders treatment has been shown to work effectively for consumers with both disorders. In this treatment model, one clinician or treatment team provides both mental health and substance abuse treatment services.

Recovery from mental illness and substance use
As people with mental illnesses, we are also prone to develop problems with alcohol and drug use. We tend to use drugs and alcohol for the same reasons that people without a mental illness do, but we are often more sensitive to the negative effects of alcohol and drugs.

The result is that one of every two individuals with severe mental illness has the additional problem of substance use disorder, (which means abuse or dependence related to alcohol or other drugs).

There is good news.
Most of us with dual disorders can achieve recovery. And our lives are much better when we are in recovery. Building a satisfying and meaningful life without drugs or alcohol requires time, support, education, courage, and learning new skills.

How can people with dual disorders achieve recovery from both mental illness and substance abuse?

- Most people with dual disorders are able to achieve recovery. The chance of recovery improves when people receive integrated dual disorders treatment, which means combined mental health and substance abuse treatment from the same clinician or treatment team.
- Relapses do happen, but most people are able to recover from relapses relatively quickly and get back to where they were before they relapsed.
- Families and clinicians cannot force people to give up alcohol and drugs. Family and other supporters can help by providing support and hope, but recovery must be a person's own choice. It may take a long time for some people to achieve recovery.
- People with dual disorders can learn from peers who are in recovery. Some may benefit from self-help groups like Alcoholics Anonymous, Narcotics Anonymous, and Dual Recovery Anonymous. It is a matter of personal preference.

What is integrated dual disorders treatment?
Integrated Dual Disorders Treatment occurs when a person receives combined treatment for mental illness and substance use from the same clinician or treatment team.

It helps people develop hope, knowledge, skills, and the support they need to manage their problems and to pursue meaningful life goals.

You will know if you are receiving integrated treatment because your clinician or treatment team will do several things at the same time, including:

- *Help you think about the role that alcohol and other drugs play in your life.* This should be done confidentially, without any negative consequences. People feel free to discuss these issues when the discussion is confidential, nonjudgmental, and not tied to legal consequences.
- *Offer you a chance to learn more about alcohol and drugs*, to learn about how they interact with mental illnesses and with medications, and to discuss your own use of alcohol and drugs.
- *Help you become involved with supported employment and other services* that may help your process of recovery.
- *Help you identify and develop your own recovery goals*. If you decide that your use of alcohol or drugs may be a problem, a counselor trained in integrated dual disorders treatment can help you identify and develop your own recovery goals. This process includes learning about steps toward recovery from both illnesses.
- *Provide special counseling specifically designed for people with dual disorders*. If you decide that your use of alcohol or drugs may be a problem, a trained counselor can provide special counseling specifically designed for people with dual disorders. This can be done individually, with a group of peers, with your family, or with a combination of these.

If you are a person with dual disorders, participating in integrated dual disorders treatment is extremely important.
Effective treatment will help reduce the risk for many additional problems, such as increased symptoms of a mental illness, hospitalizations, financial problems, family problems, homelessness, suicide, violence, sexual and physical victimization, incarceration, serious medical illnesses, such as HIV and hepatitis B and C, and sometimes even early death.

What can you, as a consumer with dual disorders, do?

- Get more information and support about what having dual disorders means and how it affects your recovery process.
- Do everything you can to build a positive life for yourself without alcohol and drugs. For most people recovery includes meaningful activities, like a

job, friendships with people who do not use alcohol or drugs, a safe place to live, and enjoying leisure activities that are fun and relaxing. This all takes time. Don't give up.

- If you are having trouble with your mental illness as well as with substance abuse, it is important to talk with mental health professionals about how to get your symptoms under better control, and how to improve your recovery process.

For more information

Information about integrated dual disorders treatment, as well as other evidence-based practices for the treatment of mental illness in the community, can be found at www.mentalhealthpractices.org.

INFORMACIÓN PARA LOS CONSUMIDORES

Disturbios duales se refiere a la presencia tanto de una enfermedad mental severa como de abuso de substancia. El tratamiento integrado de disturbios duales ha demostrado que funciona efectivamente en los consumidores que sufren de ambos disturbios. En este modelo de tratamiento, un terapéuta o un equipo de tratamiento provee servicios de tratamiento para la salud mental y para el abuso de substancias.

La recuperación de la enfermedad mental y el uso de substancias
Debido a que somos personas con enfermedades mentales, también estamos inclinados a desarrollar problemas de alcohol y de uso de drogas. De la misma manera en que la gente sin enfermedades mentales tiende a usar drogas y alcohol, nosotros también tendemos a su uso, pero frecuentemente somos mas sensibles a los efectos negativos del alcohol y de las drogas.

El resultado es que de cada dos individuos con enfermedades mentales severas uno tiene el problema adicional del uso de substancias, (lo cual significa abuso o dependencia relacionada al alcohol y otras drogas).

Hay buenas noticias.
La mayoría de nosotros con el disturbio dual puede lograr una recuperación. Y nuestras vidas son mucho mejores cuando nos estamos recuperando. Construir una vida satisfactoria y significativa sin drogas o sin alcohol requiere tiempo, apoyo, educación, valor, y el aprendizaje de nuevas habilidades.

¿Cómo pueden las personas con el disturbio dual alcanzar la recuperación tanto de la enfermedad mental como del abuso de substancias?

- La mayoría de las personas con el disturbio dual son capaces de alcanzar la recuperación. La oportunidad de recuperación mejora cuando la persona recibe el tratamiento integrado de distubios duales, es decir, tratamiento combinado para la salud mental y el abuso de substancias del mismo terapéuta y equipo de tratamiento.
- Las recaídas ocurren, pero la mayoría de las personas son capaces de recuperarse de las recaídas con relativa rapidez y regresan a lo que eran antes de la recaída.
- Las familias y los profesionales de la medicina no pueden forzar a las personas a que dejen el alcohol y las drogas. La familia y otros grupos de ayuda pueden proveer apoyo y esperanza, pero la recuperación tiene que ser algo que la misma persona escoje. Puede que le tome mucho tiempo a la persona para que alcance la recuperación.
- Las personas con disturbios duales pueden aprender de sus compañeros que se están recuperando. Algunos pueden beneficiarse de grupos de auto-ayuda como los Alcólicos Anónimos, Narcóticos Anónimos, y Grupo de Recuperación Dual Anónimo. Se trata de una preferencia personal.

¿Qué es el tratamiento integrado de disturbios duales?
El tratamiento integrado de disturbios duales ocurre cuando una persona recibe tratamiento combinado tanto para la enfermedad mental como para el uso de substancias del mismo terapéuta o equipo de tratamiento.

Ayuda a las personas a desarrollar esperanza, sabiduría, habilidades, y el apoyo que ellos necesitan para enfrentar sus problemas y para procurar metas significativas en la vida.

Sabrá si usted está recibiendo el tratamiento integrado porque su terapéuta o equipo de tratamiento hará varias cosas al mismo tiempo, incluyendo:

- *Ayudarle a pensar sobre el papel que el alcohol y otras drogas juegan en su vida*. Esto debe hacerse confidencialmente, sin ninguna consecuencia negativa. La gente se siente libre para discutir estos temas cuando la discusión es confidencial, sin juzgar, y no ligada a consecuencias legales.
- *Le ofrece una oportunidad para aprender acerca del alcohol y las drogas*, aprender sobre como interactuan con la enfermedad mental y con las medicinas, y para discutir su propio uso del alcohol y de las drogas.
- *Ayudarle a que se involucre con el apoyo de empleo y otros servicios* que le pueda ayudar en su proceso de recuperación.
- *Le puede ayudar a identificar y a desarrollar sus propias metas para la recuperación*. Si usted acepta que su uso de alcohol o de drogas es un problema, un consejero entrenado en el tratamiento integrado de los disturbios duales le puede ayudar a identificar y desarrollar sus propias metas para la recuperación. Este proceso incluye el aprender sobre los pasos para la recuperación de ambas enfermedades.
- *Proveer consejo especial específicamente diseñado para las personas con los disturbios duales*. Si usted acepta que su uso de alcohol o drogas es un problema, un consejero entrenado puede proveerle consejo especial diseñado para la gente con los disturbios duales. Esto se puede hacer individualmente, con grupos de compañeros, o con una combinación de estos.

Si usted es una persona que tiene disturbios duales, el participar en el tratamiento integrado de disturbios duales es extremadamente importante.
El tratamiento efectivo le ayudará a reducir el riesgo de muchos problemas adicionales, tales como aumento de síntomas de una enfermedad mental, hospitalización, problemas económicos, problemas familiares, quedarse sin un hogar, suicidio, violencia, victimización sexual o física, encarcelamiento, enfermedades médicas serias, tales como el HIV y la hepatitis B y C, y algunas veces, hasta la muerte a temprana edad.

¿Qué puede usted hacer, como consumidor con disturbios duales?

- Consiga mas información y apoyo sobre lo que significa el tener disturbios duales y como afecta su proceso de recuperación.
- Haga todo lo que pueda para construir una vida positiva sin alcohol y sin drogas. Para la mayoría de las personas la recuperación incluye actividades significativas, como un trabajo, amistades con gente que no usa alcohol o drogas, un lugar seguro para vivir, y el disfrutar de tiempo de descanso con actividades que son placenteras y relajantes. Todo esto toma tiempo. No se rinda.
- Si está teniendo problemas con su enfermedad mental y con el abuso de substancias, es importante hablar con el profesional de la salud mental sobre como puede usted controlar sus síntomas, y como mejorar su proceso de recuperación.

Para mas información

Información sobre el tratamiento integrado de disturbios duales, como de otras prácticas basadas en la evidencia para el tratamiento de la enfermedad mental en la comunidad, se puede encontrar en la siguiente direccion: http://www.mentalhealthpractices.org.

INFORMATION FOR FAMILIES AND OTHER SUPPORTERS

Dual disorders refers to the presence of both a severe mental illness and a substance use disorder. Integrated dual disorders treatment is effective for both disorders. In this treatment model one clinician or treatment team provides both mental health and substance abuse treatment.

There is hope; people with dual disorders can and do recover. In fact, most people recover, and they report more satisfying lives while they are in recovery.

How does recovery from dual disorders occur?

- Recovery must be the individual's choice. People cannot be "pushed" into giving up substances. Over time they can learn to manage both their illnesses and to get on with their lives in personally meaningful ways.
- The process of recovery begins as soon as someone enters a dual disorders treatment program or becomes committed to managing their illnesses.
- Recovery takes time, hope, and courage. For most people, recovery occurs over months or years.
- People in integrated dual disorders treatment programs learn to manage two long-term illnesses and build a new meaningful life without drugs. This process requires time, support, education, courage, and skills.
- You can help. Everyone in your loved one's life can help by offering support, hope, and encouragement.

What are the facts about dual disorders?

Vulnerability is important.
People who are affected by a mental illness use drugs for the same reasons people without mental illness do, such as not having jobs, not feeling happy, and not having good skills for meeting people. In many cases, people with mental illness are more sensitive to the effects of alcohol and other drugs.

Dual disorders are common.
Study results show that one of every two individuals with severe mental illness has the additional problem of substance use disorder (abuse or dependence related to alcohol or other drugs).

Integrated dual disorders treatment works.
People with dual disorders have a much better chance of recovery from both disorders when they receive combined, or integrated mental health and substance abuse treatment from the same clinician or treatment team.

Related problems are also helped.
Effective treatment will help reduce the risk for many additional problems, such as increased symptoms, hospitalizations, financial problems, family problems, homelessness, suicide, violence, sexual and physical victimization, incarceration, serious medical illnesses, such as HIV and hepatitis B and C, and early death.

Self-help may also be useful.
Self-help groups, such as Alcoholics Anonymous or Double Trouble, are valuable to some people; it may be added to integrated dual disorders treatment, especially when the person has started on a path of recovery. Self-help groups such as Al-Anon, can be valuable to family members.

What does integrated dual disorders treatment include?
Integrated treatment involves a number of elements. Your loved one should receive each of the following services through the dual disorders program:

- case management, outreach, and other needed services such as help with housing, money management, or relationships
- special counseling and groups specifically designed for people with dual disorders
- education regarding medications and other steps to recovery from both illnesses
- help in understanding the effects of substance abuse on their lives
- supported employment services
- information and supports for family members and loved ones

What can family members and significant others do?

- Get support for yourself. Join a family support group and attend self-help groups.
- Support your loved one's efforts in their recovery process.
- Be clear that you care about your loved one, but that you can set limits around disruptive behaviors.
- Understand that relapse is part of the recovery process.
- Recognize that your loved one's self -esteem and understanding about the effects of substance use will improve with the recovery process.
- Have patience. Dual recovery may take months or years.
- Listen. Be positive. Do not criticize.
- Get information for yourself. The more you know, the more you will understand recovery and the more helpful you can be.
- Use your information and personal experience to advocate for dual disorders treatment.
- Work with your loved one's dual disorders team. Your loved one's recovery process may benefit from your hopeful support.

For more information

Information about integrated dual disorders treatment, as well as other evidence-based practices for the treatment of mental illness in the community, can also be found at www.mentalhealthpractices.org.

INFORMACIÓN PARA LAS FAMILIAS Y OTROS GRUPOS DE APOYO

Disturbios duales se refiere a la presencia tanto de una enfermedad mental severa como la del abuso de substancias. El tratamiento integrado de disturbios duales funciona para ambos. En este modelo de tratamiento un terapéuta o un equipo de tratamiento provee ambos servicios de tratamiento para la salud mental y el abuso de substancias.

Hay esperanza; las personas con disturbios duales pueden, y sí se recuperan. De hecho, la mayoría de las personas se recuperan, y ellos reportan vidas mas satisfactorias mientras están en el proceso de recuperación.

¿Cómo ocurre la recuperación de los disturbios duales?

- La recuperación tiene que ser algo que la persona escoge. No se puede "presionar" a la persona a que deje el uso de substancias. Después de un tiempo la persona puede aprender a controlar ambas enfermedades y seguir adelante con su vida personal de una manera significativa.
- El proceso de la recuperación comienza tan pronto la persona entra a un programa de tratamiento de disturbios duales o cuando la persona se compromete a controlar sus enfermedades.
- La recuperación toma tiempo, esperanza y valor. Para la mayoría de las personas, la recuperación ocurre en meses o años.
- Las personas en programas de tratamiento integrado de disturbios duales aprenden a manejar dos enfermedades de larga duración y a construir una vida significativa sin drogas. Este proceso requiere tiempo, apoyo, valor y destreza.
- Usted puede ayudar. Todas las personas en la vida de su ser querido pueden ayudar al ofreciendo apoyo, esperanza, y aliento.

¿Cuáles son los datos actuales sobre los disturbios duales?

La vulnerabilidad es importante.
Las personas que son afectadas por una enfermedad mental usan drogas por las mismas razones que tienen las personas sin enfermedades mentales, como el no tener un trabajo, el no sentirse felíz, el no tener habilidades para conocer a la gente. En muchos casos, las personas con enfermedades mentales son mas sensibles a los efectos del alcohol y a las drogas.

Los disturbios duales son comunes.
Los resultados de estudios demuestran que de cada dos personas con enfermedades mentales severas una tiene el problema adicional del uso de substancias (abuso o dependencia relacionada al alcohol o a las drogas).

El tratamiento integrado de disturbios duales funciona.
Las personas con disturbios duales tienen una mejor oportunidad de recuperarse de ambos disturbios cuando reciben un tratamiento combinado o integrado de salud mental y de abuso de substancias de un mismo terapéuta o equipo de tratamiento.

Problemas relacionados con la enfermedad también son asistidos.
Un tratamiento efectivo ayudará a reducir el riesgo de muchos de los problemas adicionales, tales como un aumento de síntomas, hospitalizaciones, problemas financieros, problemas familiares, el quedarse sin hogar, suicidio, violencia, victimización sexual y física, encarcelación, enfermedades médicas serias, tales como el HIV y hepatitis B y C, y hasta una muerte temprana.

La Auto-ayuda también puede ser beneficiosa.
Los grupos de auto-ayuda, tales como Alcohólicos Anónimos o Trastornos Duales, son valiosos para algunas personas; puede ser añadido al tratamiento integrado de disturbios duales, especialmente cuando la persona ha comenzado el camino hacia la recuperación. Los grupos de auto-ayuda, tales como Al-Anon, pueden ser valiosos para los miembros de la familia.

¿Qué incluye el tratamiento integrado de disturbios duales?
El tratamieto integrado incluye un número de elementos. Por medio del programa de disturbios duales, su ser querido deberá recibir cada uno de los siguientes servicios:

- Manejo del caso, alcance externo, y otros servicios necesarios tales como ayuda con la vivienda, el manejo del dinero, o relaciones sociales.
- Consejo especial y grupos específicamente diseñados para la gente con disturbios duales
- Educación sobre las medicinas y otros pasos necesarios para la recuperación de ambas enfermedades
- Ayudar a comprender los efectos que tiene en sus vidas el abuso de substancias
- Servicios de apoyo de empleo
- Información y apoyo para los miembros de la familia y sus seres queridos

¿Qué pueden hacer los miembros de la familia y otros seres queridos?

- Obtenga apoyo por si mismo. Unase a un grupo de apoyo familiar y asista a grupos de auto-ayuda.
- Apoye los esfuerzos de su ser querido en el proceso la recuperación. Sé claro en que se interesa su ser querido, pero que puede establecer límites en caso de comportamientos con trastornos.
- Comprenda que la recaída es parte del proceso de la recuperación.

- Reconozca que la auto-estima de su ser querido y su comprensión sobre los efectos del uso de substancias mejorarán durante el proceso de la recuperación.
- Tenga paciencia. La recuperación dual puede que tome meses o años.
- Escuche. Sea positivo. No critique.
- Obtenga información para usted mismo(a). Mientras mas sepa, mas comprenderá sobre la recuperación y asi podrá ser de mejor ayuda.
- Use su información y experiencia personal para abogar por el tratamiento de disturbios duales.
- Trabaje con el equipo de disturbios duales de su ser querido. El proceso de recuperación de su ser querido se puede beneficiar con su apoyo esperanzador.

Para mas información

Información sobre el tratamiento integrado de disturbios duales, como de otras prácticas basadas en la evidencia para el tratamiento de enfermedades mentales en la comunidad, también pueden ser encontrados en la red de internet en la siguiente dirección: http://www.mentalhealthpractices.org.

Information for Practitioners and Clinical Supervisors

What is meant by "dual disorders"?
This refers to the presence of both a severe mental illness and substance use disorder.

What is effective treatment?
Integrated dual disorders treatment has been shown to work effectively for both disorders. People with dual disorders have a better chance of recovery from both disorders when their mental health practitioners provide combined mental health and substance abuse treatments.

Why is information about integrated treatment for dual disorders important to mental health practitioners?

Dual disorders are common.
More than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs).

Dual disorders lead to poor outcomes.
People with dual disorders are at high risk for many additional problems such as symptomatic relapses, hospitalizations, financial problems, family problems, homelessness, suicide, violence, sexual and physical victimization, incarceration, serious medical illnesses, such as HIV and hepatitis B and C, and early death.

Referral to separate substance abuse services is not effective treatment.
Sending people with dual disorders to substance abuse treatment programs or to self-help groups such as AA, without offering substance abuse treatment in the mental health setting, is not an effective approach.

What are the basic components of integrated dual disorders treatment?
Providing effective integrated dual disorders treatment involves the following:

Knowledge about alcohol and drug use, as well as mental illnesses
Clinicians know the effects of alcohol and drugs and their interactions with mental illness.

Integrated services
Clinicians provide services for both mental illness and substance use at the same time.

Stage-wise treatment
People go through a process over time to recover and different services are helpful at different stages of recovery.

Assessment
Consumers collaborate with clinicians to develop an individualized treatment plan for both substance use disorder and mental illness.

Motivational treatment
Clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery. This is important for consumers who are demoralized and not ready for substance abuse treatment.

Substance abuse counseling
Substance abuse counseling helps people with dual disorders to develop the skills and find the supports needed to pursue recovery from substance use disorder.

How does one get effective training and information?
Learning dual disorders treatment skills requires knowledge, training, supervision, and practice.

Order an Integrated Dual Disorders Treatment Implementation Resource Kit.
This provides you information, training materials, annotated bibliography, and references to other training resources.

Explore implementation and training centers.
Since practitioners learn in different ways, implementation and training centers offer readings, workbooks, training videos, courses, job shadowing, supervision, and consultation.

Learn from consumers.
Many consumers will be in recovery from their substance abuse. Ask them what their recovery process was like, and what treatments were helpful. Read consumer writings about the dual disorder recovery process.

Attend AA, Al-Anon, or other self-help group meetings.
Many self-help meetings are open to nonmembers. You can learn about the process of recovery by attending these meetings.

Identify or hire an expert for your team.
One experienced team member can help others learn about integrated dual disorders treatment.

Visit an integrated dual disorders treatment team.
Arrange to visit and job shadow a program with a team that has experience providing integrated dual disorders treatment. Check the www.mentalhealthpractices.org website for a listing of available sites nationwide.

Co-lead a dual disorders group.
One way to learn skills while you are helping people work on their recovery process is to co-lead a group with an experienced dual disorders clinician.

Get supervision.
The proven way that clinicians acquire new skills is by working with people with dual disorders and discussing their work with an experienced supervisor. If you cannot get supervision in your agency, you may be able to obtain off-site supervision or consultation through a training center.

For more information
Information about integrated dual disorders treatment, as well as other evidence-based practices for the treatment of mental illness in the community, can be found at www.mentalhealthpractices.org.

INFORMATION FOR MENTAL HEALTH PROGRAM LEADERS

Why are dual disorders important?

Dual disorders are common.
More than half of the adults with severe mental illness in public mental health systems are further impaired by co-occurring substance use disorders (abuse or dependence related to alcohol or other drugs).

Consumers with dual disorders are at high risk.
Risks include hospitalization, overdose, victimization, violence, legal problems, homelessness, HIV infection, and hepatitis.

Poor treatment for dual disorders is expensive.
Mental health systems spend most of their resources on a small percentage of individuals with difficult problems, often consumers with dual disorders. Mental health services for these consumers cost, on average, nearly twice as much as for clients with single disorders.

Integrated dual disorders treatment works.
Consumers with dual disorders have high rates of recovery when provided integrated dual disorders treatment, which means combining mental health and substance abuse treatments within the same team or program. Integrated treatment leads to dual recovery and reduces costs. Effective treatment is good public policy.

What is integrated dual disorders treatment?

Integration
Integrated dual disorders treatment differs from traditional approaches in several ways. The most important is integration of mental health and substance abuse treatments. One practitioner or one team in one agency provides both mental health and substance abuse treatments so that the consumer does not get lost, excluded, or confused going back and forth between two different programs.

Blending
Integrated dual disorders treatments also blend mental health and substance abuse treatments. For example, substance abuse treatments focus more on motivating people with two severe disorders to pursue abstinence, and mental health treatments are modified in light of the consumer's vulnerability to psychoactive substances.

Other features

- **Stage-wise treatment**. People go through a process over time to recover, and different services are helpful at different stages of recovery.
- **Assessment**. Consumers collaborate with clinicians to develop an individualized treatment plan for both substance use disorder and mental illness.
- **Motivational treatment**. Clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery. This is important for consumers who are demoralized and not ready for substance abuse treatment.
- **Substance abuse counseling**. Substance abuse counseling helps people with dual disorders to develop the skills and find the supports needed to pursue recovery from substance use disorder.

What can mental health program leaders do?

Appoint a dual disorders program leader.
Implementation of a major program change requires that one person oversee planning, implementation, training, internal and external coordination, record keeping, and other sustaining activities.

Involve all stakeholders.
All stakeholders (consumers, families, clinicians, supervisors, program leaders, and policymakers) should be involved in planning, implementing, and sustaining an integrated service system for people with dual disorders.

Develop clinical skills.
Mental health practitioners often have not been trained to assess and treat substance abuse. Implementing an integrated dual disorders treatment program requires training staff to acquire new skills; it does not mean that additional staff must be hired.

There are four basic skills that all clinicians need:

- knowledge regarding substances of abuse and how they affect mental illness,
- substance abuse assessment skills,
- motivational interviewing skills, and
- substance abuse counseling skills.

Use established strategies for systems change.
Implementation of evidence-based practices entails a significant system change. Use well-known strategies, standardized models, and consultants.

Where can I get more information?

Integrated Dual Disorders Implementation Resource Kit.
See the *Tips for Mental Health Program Leaders*. This document identifies specific strategies, recommendations for reading, consultants, and implementation centers.

Contact national organizations.
We recommend the Center for Mental Health Services, at the Substance Abuse and Mental Health Services Administration (www.samhsa.gov), and the National Association of State Mental Health Program Directors Research Institute, Inc. (http://nri.rdmc.org).

Visit our website.
Information about integrated dual disorders treatment, as well as other evidence-based practices for the treatment of mental illness in the community, can be found at www.mentalhealthpractices.org.

IMPLEMENTATION

IMPLEMENTATION TIPS FOR MENTAL HEALTH PROGRAM LEADERS

This document is designed to help mental health program leaders who are planning to implement Integrated Dual Disorders Treatment at their clinical sites. Over the years, different leaders have used a variety of strategies to put integrated treatment into action. This document presents ideas gathered from mental health program leaders who have successfully implemented this treatment practice. Integrated Dual Disorders Treatment is the provision of mental health and substance use treatment services from the same clinician or treatment team.

Leadership

The implementation of Integrated Dual Disorders Treatment is most effective when one person leads the effort. This individual must have the backing of senior administrators and the respect of direct treatment staff.
A client-centered approach to management that encourages leaders to focus on clearly articulated client-centered goals and to use consumer outcome data to guide ongoing management decisions is recommended. Progress and success are measured by consumer outcomes (in this case people who are making demonstrable progress in recovering from substance use disorder) rather than by process measures such as hours of therapy.

Phases of Change

The process of implementing integrated dual disorders treatment can be divided into three phases:

- building a consensus for change,
- making the change, and
- sustaining the change.

Other mental health program leaders have found the following strategies helpful at each phase.

Building a Consensus for Change

Vision

It is important for the chief executive officer of your agency to articulate the vision for Integrated Dual Disorders Treatment throughout the agency, with all stakeholders, and to the public.

Concept of Recovery

Help everyone to conceptualize Integrated Dual Disorders Treatment within the larger context of recovery. People with severe mental illness and substance use disorder need to learn to manage both disorders in order to pursue their own goals and have a good quality of life.

Involvement
Involve key leaders from different stakeholder groups early in the planning process: consumer leaders, family leaders, team leaders, clinical leaders, and program leaders.

Discussion
Organize meetings and retreats for education, discussion, and planning the implementation. Educate clinicians and team leaders about studies that demonstrate the effectiveness of Integrated Dual Disorders Treatment. Be certain to discuss the common arguments for and against Integrated Dual Disorders Treatment.

Speakers
Bring in speakers who will inspire the staff, consumers and family members. Speakers should have credibility based on clinical experience; understand the relevant issues; endorse recovery-centered values; and work well with families and consumers. Connect your clinicians with people who have similar roles at programs with established Integrated Dual Disorders Treatment. Case managers like to hear from case managers providing this treatment, nurses from nurses, and so on. Similarly, consumers who are in recovery from dual disorders and their families can give testimony about their experiences and answer questions about treatment. This strategy is most effective when used with all stakeholders.

Consultants
In order to help anticipate and address the changes that will occur as a result of implementing Integrated Dual Disorders Treatment, it is useful to engage the services of a consultant or an evidence-based practices implementation center.

Making the Change

Goal
The process of care, from intake forms to program reviews, should be aligned so that the natural behavior for clinicians is to provide high-fidelity Integrated Dual Disorders Treatment.

Time frame
It generally takes about a year for staff to feel comfortable and confident providing Integrated Dual Disorders Treatment, but the time frame can vary considerably.

Competence
Every staff member needs to know the fundamentals of Integrated Dual Disorders Treatment:

- information about alcohol and drugs of abuse, and interactions with mental illness,

- assessment of substance use,
- motivational interviewing, and
- substance abuse counseling.

Additionally, staff members need to be aware of the supports available from a consumer's family or other supporters, and have a recovery orientation towards their work. All practitioners can learn these skills.

Staff size
A program does not need more staff to provide Integrated Dual Disorders Treatment; the current staff members simply need to learn and develop new skills.

Organization
Staff should optimally work in teams for the sake of clinical work, training, supervision, support, and morale. If each team contains at least one clinician with substance abuse treatment experience, staff can cross-train each other in the normal course of working together.

Training
Initial training can be accomplished through a series of didactics and discussions. Resource kit materials are designed to facilitate this process. It also helps if clinicians can visit a functioning Integrated Dual Disorders Treatment program. Remember that these experiences just begin the process of training.

Supervision
Clinicians learn new skills by doing their work in the context of good supervision. Supervision with an expert or with a group of peers should occur weekly.

Clinical team meetings
Substance abuse should be addressed in all team meetings, whether the topic is assessment, treatment planning, or case review.

Equipment
Mental health programs that implement Integrated Dual Disorders Treatments will increase the amount of substance abuse laboratory screening. Your program will need to explore the cheapest and most efficient ways of doing this. Many programs acquire their own testing equipment.

Paperwork
Assessments, treatment plans, and progress notes must address Integrated Dual Disorders Treatments. Substance abuse must be a standard item on all forms.

Outcomes tracking
People tend to recover from substance abuse in stages: engagement, persuasion, active treatment, and relapse prevention. The Stage of Substance

Abuse Treatment scale (see Appendix) can be used for monitoring individual and programmatic outcomes. This data is also useful for client-centered supervision.

Policies and procedures
Program leaders must review and revise all relevant policies and procedures to be sure that they support Integrated Dual Disorders Treatment implementation. Policies and procedures should include assessing and understanding what family and other supports are available for the consumer. The policies and procedures of other services, including housing, Supported Employment, Assertive Community Treatment, forensic liaisons, and other programs must be examined to work effectively with the Integrated Dual Disorders Treatment program.

Sustaining the change

Provide data
Provide all staff with outcome statistics (Stage of Substance Abuse Treatment) for the agency, and individual staff with outcomes for their clients on a regular basis. Line graphs show trends especially well. Some agencies prominently post relevant outcome statistics. This clearly reinforces the consumer-centered outcome goal of Integrated Dual Disorders Treatment.

Recognize staff
Visibly acknowledge staff who have made Integrated Dual Disorders Treatment a success in your program, for example, with banquets to celebrate Integrated Dual Disorders Treatment achievements. Celebrations are particularly helpful when all stakeholders attend.

Celebrate success
Find ways to share consumer success stories among staff, consumers, and family members when appropriate. Devote meetings to good news. This could include feedback and anecdotes from consumers, families, and employers.

Involve stakeholders
Consumers in recovery and their families should be involved in active roles as the program develops. For example, recovering consumers can become group leaders, case managers, assistants, and advisers. Family members can similarly contribute in many ways.

Provide supervision
Clinicians use new skills when they are addressed within the context of good supervision. Individual and team supervision structures are critical in reinforcing the use of new skills and helping staff to continually learn and develop Integrated Dual Disorders Treatment skills.

Review organizational policies and procedures
Over time programs are sustained by structural mechanisms, such as financing,

regulations, training and supervision, roles and responsibilities, record keeping, involvement of all stakeholders, and program reviews, rather than by charismatic individuals, or champions. As your Integrated Dual Disorders Treatment program develops, review all of these mechanisms regularly.

STATEMENT ON CULTURAL COMPETENCE

- What is culture, and how does it affect care?
- Why cultural competence?
- What is cultural competence?
- How is cultural competence related to evidence-based practices?
- How can cultural competence be put into practice?
- Case studies of cultural competence
    - Vignette 1-Dual Diagnosis
    - Vignette 2, Assertive Community Treatment
    - Vignette 3-Supported Employment
    - Vignette 4- Medication Management
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    - Vignette 6- Family Psychoeducation
- Selected Resources on Cultural Competence
- Resources for Mental Health Authorities
- Resources for Mental Health Administrators
- Resources for Program Leaders
- Instruments for Program Leaders to Assess Cultural Competence
- Resources for Practitioners
- Scales for Practitioners to Recognize Cultural Identity

Cultural competence is about adapting mental health care to meet the needs of consumers from diverse cultures. One key aim is to improve their access to care. Others are to build trust and to promote their engagement and retention in care. Above all, cultural competence aims to improve the quality of care and to help consumers recover quicker and better. Its broader societal purpose is to reduce or eliminate mental health disparities affecting disenfranchised groups.
This statement on cultural competence lays out ways for programs to tailor their evidence-based practices to the cultures they serve. It is meant as a guide, rather than a set of fidelity measures. The statement begins with the basics: what is culture, how does it affect care, what is cultural competence, and why is it important. It then gives examples of how cultural competence is translated into practice.

What is culture, and how does it affect care?
A culture is broadly defined as a common heritage or set of beliefs, norms, and values shared by a group of people. People who are placed, either by census categories, or through self-identification, into the same racial or ethnic group are often assumed to share the same culture; however, not all members grouped together in a given category will share the same culture. There is great diversity within each of these broad categories and individuals may identify with a given racial or ethnic culture to varying degrees. Others may identify with multiple

cultures, including those associated with their religion, profession, sexual orientation, region, or disability status.

Culture is dynamic. It changes continually and is influenced both by people's beliefs and the demands of their environment. Immigrants from different parts of the world arrive in the United States with their own culture but gradually begin to adapt and develop new, hybrid cultures that allow them to function within the dominant culture. This process is referred to as acculturation. Even groups that have been in the United States for many generations may share beliefs and practices that maintain influences from multiple cultures. This complexity necessitates an individualized approach to understanding culture and cultural identity in the context of mental health services.

The culture someone comes from influences many aspects of care, starting with whether the person thinks care is needed or not. Culture influences what concerns that person brings to the clinical setting, what language is used to express those concerns, and what coping styles are adopted. Culture affects family structure, living arrangements, and how much support someone receives in time of difficulties.

Culture also influences patterns of help—seeking whether someone starts with a primary care doctor, a mental health program, or goes to a minister, spiritual advisor, or community elder. Finally, culture affects how much stigma someone attaches to mental health problems, and how much trust is placed in the hands of providers.

It's easy to think of culture as only belonging to consumers without realizing how it also applies to providers and administrators. Their professional culture influences how they organize and deliver care. Some cultural influences are more obvious than others, like the manner in which clinicians ask questions or interact with consumers. Less obvious but equally important are what hours a clinic has, the importance the staff attaches to reaching out to family members and community leaders, and the respect they accord to the culture of each consumer entering their doors.

Knowing how culture influences so many aspects of mental health care underscores the importance of adapting programs to respond to, and be respectful of, the diversity of the surrounding community.

Why cultural competence?

For decades, many mental health programs neglected the growing diversity around them. Often, people from non-majority cultures found programs off-putting and hard to access. They avoided getting care, stopped looking for care, or, if they managed to find care, they dropped out. The result was troubling disparities: many minority groups faced lower access to care, lower use of care,

and poorer quality of care. Altogether, those disparities translated into millions of people suffering needless disability from mental illness.

Disparities are most apparent for racial and ethnic minority groups such as African Americans, American Indians and Alaska Natives, Asian Americans, Hispanic Americans, and Native Hawaiians and other Pacific Islanders. But disparities also affect many other groups, such as women and men, children and older adults, people from rural areas, and people with different sexual orientations, or with physical or developmental disabilities.

Starting in the late 1980's, the mental health profession responded with a new approach to care called "cultural competence." Cultural competence was originally defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.

What is cultural competence?

Cultural competence is an approach to delivering mental health services grounded in the assumption that services are more effective when they are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. The Surgeon General defined cultural competence in the most general terms as "the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values." In most cases, the term cultural competence refers to sets of guiding principles, developed to increase the ability of mental health providers, agencies, or systems to meet the needs of diverse communities, including racial and ethnic minorities.

While consumers, families, providers, policymakers, and administrators have long acknowledged the intrinsic value of cultural competence, insufficient research has been dedicated to identifying its key ingredients. Therefore, the field still struggles to define, operationalize, and measure cultural competence. The word "competence" is somewhat misleading. Competence usually implies a set of criteria on which to evaluate a program. But this is not yet true for cultural competence, which is still under-researched. The term "competence," in this context, means that the responsibility to tailor care to different cultural groups belongs to the system, not to the consumer. Every provider or administrator involved in delivering care from mental health authorities down to clinical supervisors and practitioners bears responsibility for trying to make their programs accessible, appropriate, appealing, and effective for the diverse communities that they serve. Many do it naturally.

How is cultural competence related to evidence-based practices?
Evidence-based practices are for every consumer who enters care, regardless of what culture they come from, according to the Surgeon General[1]. But programs often need to make adjustments to evidence-based practices in order to make them accessible and effective for cultural groups that differ in language or behavior from the original study populations. The adjustments should facilitate, rather than interfere with, a program's ability to implement evidence-based practices using the fidelity measures in this toolkit.

In a nutshell, to deliver culturally competent evidence-based practices means tailoring either the practice itself or the context in which the practice is delivered to the unique communities served by a mental health program.

In time, there may be specific fidelity measures used to assess a program's cultural competence. But this is not the case now. The concept of cultural competence is too new and the evidence base is too small. While the evidence is being collected, programs can and should take the initiative to tailor evidence-based practices to each of the cultural groups they serve, like translating their information brochures into the languages often used in their communities. Others steps are featured in the next section.

Many providers ask, how can we know if evidence-based practices apply to a particular ethnic, racial, or cultural group if the research supporting those practices was done on a very different population? The answer is that we will not know for sure until we try; but the limited research that does exist, suggests that evidence-based practices, with minor modifications or not, work well across cultures. Furthermore, because evidence-based practices represent the highest quality of care currently available, it is a matter of fairness and prudence to provide them to all people who may need them. Yet the question remains, how can we do this effectively?

How can cultural competence be put into practice?
All programs are encouraged to be more culturally competent, even though research has not yet generated a set of evidence-based practices to achieve cultural competence.

A variety of straightforward steps can be taken to make programs more responsive to the people they serve. The steps might apply to all facets of a program and need not be restricted to the evidence-based practice covered by this toolkit. The following steps are meant to be illustrative, not prescriptive:

- Understand the racial, ethnic, and cultural demographics of the population served
- Become most familiar with one or two of the groups most commonly encountered

- Create a cultural competence advisory committee consisting of consumers, family and community organizations
- Translate your forms and brochures
- Offer to match a consumer with a practitioner of a similar background
- Have access to trained mental health interpreters
- Ask each client about their cultural background and identity
- Incorporate cultural awareness into the assessment and treatment of each consumer
- Tap into natural networks of support, such as the extended family and community groups representing the culture of a consumer
- Reach out to religious and spiritual organizations to encourage referrals or as another network of support
- Offer training to staff in culturally responsive communication or interviewing skills
- Understand that some behaviors considered in one culture to be signs of psychopathology are acceptable in a different culture
- Be aware that a consumer from another culture may hold different beliefs about causes and treatment of illness

Cultural competence is also important for planners and for mental health authorities. Here are a few examples of the ways a public mental health authority or program administrators can become more culturally competent.

- Designate someone with part-time or full-time responsibility for improving and monitoring cultural competence
- Create a strategic plan to incorporate cultural competence into programs throughout a system
- Establish an advisory committee that includes representatives of all the major racial, ethnic, and cultural groups being served
- Address barriers to care (cultural, linguistic, geographic or economic)
- Provide staffing that reflects the composition of the community being served
- Conduct regular organizational self-assessments of cultural competence
- Collect and analyze data to examine disparities in services
- Designate specific resources for cultural competence training
- Include cultural competence in quality assurance and quality improvement activities and projects

Case studies of cultural competence

Vignette 1-Dual Diagnosis

Kevin is a 40 year-old African-American homeless man in Chicago who, for a decade, has cycled between jail, street, and shelter. At the shelter, he refuses getting help for what the staff believe is a longstanding combination of untreated schizophrenia and alcoholism. He becomes so drunk one night that he walks in front of a car and becomes seriously injured. While in the hospital, he is treated

for his injuries, as well as placed on anti-psychotic medications after the psychiatrists diagnose him with schizophrenia.

At the time of hospital discharge, Kevin is referred to an outpatient program for individuals with dual diagnoses. Realizing that Kevin needs aggressive treatment to avoid re-spiraling into homelessness, the head of the treatment team recommends concurrent treatment of the alcoholism and the schizophrenia. The team leader is an African American psychiatrist who has an appreciation for the years of alienation, discrimination, and victimization that Kevin describes as having contributed to his dual disorders. The clinician works hard to develop a trusting relationship. He works with the treatment team to ensure that, in addition to mental health and drug abuse treatment, Kevin receives social skills training and a safe place to live. When Kevin is well enough, and while he continues to receive group counseling for his dual disorders, one of his first steps toward recovery is to reconnect with his elderly mother who had not heard from him in ten years.

Vignette 2, Assertive Community Treatment

A minister in Baltimore contacts the city's ACT Program with an unusual concern: one of his congregants disclosed to him that another member of the congregation, an older woman from Jamaica, was beating her adult daughter for "acting crazy all the time." The Jamaican mother may even be locking her adult daughter in the basement, according to the congregant.

One year before, the ACT team's social worker had reached out to local ministers to tell them about the program. The ACT team had realized that better communication and referrals were needed. Stronger connections across organizations would improve chances for recovery by enhancing social support and adherence to treatment. Some of the consumers believed that treatment was counter to their religion.

The ACT social worker managed to obtain a court order to allow authorities to enter the Jamaican mother's home. They discovered the traumatized 25-year old daughter locked in the basement, actively psychotic, and bearing marks of physical abuse. The ACT team diagnosed the daughter with schizophrenia and managed to find a group home for her. The team arranged for an intense combination of medications, individual and group therapy, including trauma care and social skills training. Through links to the church and the community, the ACT social worker helped the daughter to get clothing and spiritual support. The social worker discovered that the mother's ethnic group from Jamaica believed that her daughter's craziness was a sign of possession by the devil—the belief system behind her abuse. After all criminal charges were dropped, the social worker reached out to the mother to educate her about schizophrenia and to set the stage for the daughter's eventual return to her mother's household.

Vignette 3-Supported Employment
Jing is a bilingual vocational worker at a mental health program in San Francisco. By informally surveying her caseload, she estimates that about 30 percent of her clients are Asian. But they come from vastly different backgrounds, ranging from Taiwan to Cambodia, with vastly different educational backgrounds. One of her clients with bipolar disorder is a recent immigrant from China. He has a high school education, but speaks Mandarin and very little English. Fluent in Mandarin, Jing is able to conduct a careful assessment of the client's job skills and a rapid, individualized job search. Because Jing is part of the treatment team, she's aware that the client has progressed to the point of being ready for full-time employment.

Jing identifies several import-export businesses in the area with monolingual Mandarin-speaking employees. She secures a position, but it pays less than one the client would qualify for if he spoke English. Jing succeeds in persuading the client to take the position while at the same time recommending a quick-immersion night program in English as a Second Language. Jing provides follow-along job support during the next few months. When the client's English is better, Jing searches for and manages to find a higher paying job for him. She stays in touch to be sure he can adjust to the greater demands of the new position, while continuing to receive treatment for his bipolar disorder.

Vignette 4- Medication Management
A primary care doctor at a rural Indian Health Service clinic tentatively diagnoses John, a 65-year old American Indian man, with a severe depression. But he is unsure whether he might have bipolar disorder. John had relied on a native healer for years but he had become so debilitated and despondent in recent weeks that his family drove him on the 4-hour trip to the doctor from their frontier area of South Dakota.

Upon examination, the primary care doctor discovers numerous medical conditions, including diabetes and hypertension, which had gone untreated. Uncertain of the diagnosis of John's psychiatric illness, and the potential for interactions with the other medications he wishes to prescribe, the doctor arranges for a psychiatric consultation via telehealth.

Through video and other telecommunications equipment, John is interviewed by a psychiatrist 500 miles away at an Indian Health Service Facility. The psychiatrist is able to assess John's appearance and body language. Having been advised by a cultural competence advisory committee, the psychiatrist knew how and what types of questions to ask John about his use of native healers and herbal remedies. She also is part of a program experienced in medication algorithms for mental disorders. She arrives at a diagnosis of bipolar disorder and recommends a medication regimen that would not interact with the diabetes and hypertension medications. Because of John's older age, she recommends extremely low doses of the psychiatric medications. But she

recognizes that the longer length of time for the antidepressants to take effect in older people (8 weeks rather than 4), combined with the lower dose, might leave John vulnerable to suicide. She suggests that the doctor work to establish communication with John's native healer to monitor John carefully and to avoid giving him certain herbal therapies that might interfere with his medications.

Vignette 5- Illness Management and Recovery Skills

Lupita, a 17-year old high school senior, arrived in a San Antonio emergency room after a suicide attempt. The psychiatrist on call happened to be the same one who had diagnosed Lupita's bipolar disorder a year ago. He thought that she had been taking her medications properly, but blood tests now revealed no traces of lithium or antidepressant.

The psychiatrist tried to communicate with Lupita's anxious parents waiting in the visitor area, only to learn that they spoke only Spanish and no English. She had mistakenly assumed that because Lupita, a second generation Mexican American, was highly acculturated, so were her parents. She contacted the hospital's bilingual social worker who discovered that the parents felt powerless for months as they watched their daughter sink into a severe depression, all the while lacking the motivation to take her medications. The social worker, whose family had similarly emigrated from a rural region of Mexico, knew to gently ask the parents if they could read and understand the dosage directions for Lupita's medication. Finding that the parents had limited literacy in both English and Spanish helped the psychiatrist and social worker to tailor a treatment program that would not depend on the written word. Seeing the parents as essential to Lupita's recovery and knowing she lived at home, the psychiatrist encouraged the parents, through the interpreter, to accompany their daughter to an illness management and recovery program. The hospital had organized programs for Spanish-speaking families because Latinos are a majority group in San Antonio. During the weekly sessions, the social worker translated for the family and helped them with scheduling Lupita's psychiatric visits and to apportion the correct combination of pills in a daily pill container. Understanding that the family had no phone, the social worker worked with them to find a close neighbor who might allow them use of the phone to relay messages from her and to contact her if Lupita stopped taking her medications.

Vignette 6- Family Psychoeducation

When Kawelo lost his job as an electrician, his therapist asked Kawelo if he had a family elder who knew of community elders familiar with traditional Hawaiian healing practices for personal and family problems. The therapist knew that Native Hawaiians, in times of difficulties, rely on their elders, traditional healer, family, and/or teacher to provide them with wisdom and cultural practices to resolve problems. One such practice is *ho`oponopono*, which is a traditional cultural process for maintaining harmonious relationships among families through structured discussion of conflicts. *Ho`oponopono* is also used by individuals for personal healing and/or guidance in troubled times.

Kawelo's therapist recognized the importance of tapping into this community support and suggested that his family seek out ho`oponopono. The therapist contacted the family and elders to arrange a meeting concerning Kawelo's problems with depression, for which he needed both medication and counseling. At the group meeting the therapist further explained that Kawelo was so ill hat he lacked the motivation to receive treatment, and that his condition was so serious that he may be at risk for suicide. The therapist asked the elders how the group could help to encourage Kawelo to stick with his treatment and how they could watch Kawelo for suicidal signs. After lengthy deliberations, the family decided that one way to help Kawelo was to participate in ho'oponopono to understand the types of problems that he is experiencing and identify how the family could help him heal himself. Some members of the family also agreed to participate in a bi-weekly family psychoeducation group held at the community mental health center to learn more about his mental illness, coping skills and strategies, and pharmacological and psychosocial treatments. Through family psychoeducation the family would participate in structured sessions using a variety of educational formats. Because an important level of healing in Native Hawaiian culture involves sharing feelings and positive and negative emotions, in an open, safe, and controlled environment, the family's participation in a combination of ho'oponopono and family psychoeducation was ideal.

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Selected Resources on Cultural Competence
The resources listed below are for consumers and families, mental health authorities, administrators, program leaders and practitioners. They may be useful for all stakeholders in mental health services.

National Resources for Consumers and Families
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
National Mental Health Information Center
(800) 789-2497
mentalhealth.samhsa.gov

First Nations Behavioral Health Confederacy
(406) 732-4240 Montana
(505) 275-3801 Albuquerque, NM
pauletterunningwolf@hotmail.com

National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
1-800-950-NAMI (6264)
Fax: (703) 524-9094
TTY: (703) 516-7227
www.nami.org

National Asian American Pacific Islander Mental Health Association
1215 19th St. Suite A
Denver, Colorado 80202
(303) 298-7910
Fax: (303) 298-8081
www.naapimha.org

National Institute of Mental Health (NIMH)
Office of Communications
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
(866) 615-NIMH (6464)
Fax: (301) 443-4279
TTY: (301) 443-8431
www.nimh.nih.gov

National Latino Behavioral Health Association
PO Box 387
506 Welch, Unit B
Berthoud, CO 80513
(970) 532-7210
Fax: (970) 532-7209
www.nlbha.org

National Leadership Council on African American Behavioral Health
6904 Tulane Drive
Austin, Texas
(512) 929-0142
Fax: (512) 471-9600
tkjohnson@mail.utexas.edu

National Mental Health Association
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
(800) 969-NMHA
Fax: (703) 684-5968

TDD: (800) 433-5959
www.nmha.org

Resources for Mental Health Authorities

Aponte, C., Mason, J. "A Demonstration Project of Cultural Competence Self-Assessment of 26 Agencies" in M. Roizner, *A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations*(Boston: Judge Baker Children's Center, 1996) 72-73.

California Mental Health Ethnic Services Managers with the Managed Care Committee. *Cultural Competency Goals, Strategies and Standards for Minority Health Care to Ethnic Clients* (Sacramento: California Mental Health Directors' Association, 1995).

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. *Cultural Competence Standards in Managed Mental Health Care Services: Four Underserved/ Underrepresentd Racial/Ethnic Groups* (2000). This is the final report from four working groups: African Americans, Asian Americans, and Pacific Islanders, Latinos, and Native Americans. It contains a series of standards for culturally competent mental health care and a plan for implementation. The report does not represent the official positions of the U.S. Department of Health and Human Services. A glossary is included. Information and recommendations are provided on the following:

- guiding principles
- overall system standards and implementation guidelines
- clinical standards and implementation guidelines
- provider competencies

Dillenberg, J., Carbone, C.P. *Cultural Competency in the Administration and Delivery of Behavioral Health Services* (Phoenix: Arizona Department of Health Services, 1995).

Knisley, M.B. *Culturally Sensitive Language: Community Certification Standards* (Columbus, OH: Ohio Department of Mental Health, 1990).

National Implementation Research Network. *Consensus Statement on Evidence-Based Programs and Cultural Competence* (Tampa, FL:Louis de la Parte Florida Mental Health Institute, 2003).

New York State Office of Mental Health. *Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs* (Albany, NY: New York State Office of Mental Health, 1998).

New York State Office of Mental Health. *Final Report: Cultural and Linguistic Competency Standards* (Albany, NY: New York State Office of Mental Health, 1998).

Pettigrew, G.M. *Plan for Culturally Competent Specialty Mental Health Services* (Sacramento, CA: California Mental health Planning Council, 1997).

Phillips, D., Leff, H.S., Kaniasty, E., Carter, M., Paret, M., Conley, T., Sharma, M.P. *Culture, Race and Ethnicity (C/R/E) in Performance Measurement: A Compendium of Resources; Version 1*. (Cambridge, MA: Evaluation Center@HSRI, Human Services Research Institute, 1999).

Siegel, C., Davis-Chambers, E., Haugland, G., Bank, R., Aponte, C., McCombs, H. "Performance Measures of Cultural Competency in Mental Health Organizations." *Administration and Policy in Mental Health* 28(2000): 91-106.

U.S. Department of Health and Human Services. *Consumer Mental Health Report Card. Final Report: Task Force on a Consumer-Oriented Mental Health Report Card* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996).

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General* (Washington, DC: U.S. Department of Health and Human Services, 1999).

Western Interstate Commission for Higher Education (WICHE) Mental Health Program and the Evaluation Center@HSRI (Human Services Research Institute). *Notes from a Roundtable on Conceptualizing and Measuring Cultural Competence* (WICHE, Mental Health Program and the Evaluation Center at Human Services Research Institute, 1999).

WICHE. *Cultural Competence Standards in Managed Mental Health Care for Four Underserved/ Underrepresented Racial/Ethnic Groups* (Boulder, CO: WICHE Publications, 1997).

Resources for Mental Health Administrators

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Mental Health Services
1 Choke Cherry Road Room 6-1057
Rockville, MD 20850
ph. 240-276-1310
ph. 1-800-789-2647
w. mentalhealth.samhsa.gov

Lopez, L., Jackson, V.H. "Cultural Competency in Managed Behavioral Healthcare: An Overview" in V.H. Jackson, L. Lopez (Eds) *Cultural Competency*

in Managed Behavioral Healthcare (Providence, RI: Manisses Communications Group, Inc., 1999).

National Alliance of Multi-ethnic Behavioral Health Associations
Howard University, School of Social Work
601 Howard Place N.W.
Washington, DC 20059
(202) 806-4727
misaacs@howard.edu

National Center for Cultural Competence
Georgetown University Center
for Child and Human Development
3307 M Street, NW
Suite 401
Washington, D.C. 20007
(202) 687-5387
TTY (202) 687-5503
cultural@georgetown.edu

The Evaluation Center@HSRI
2336 Massachusetts Avenue
Cambridge, MA 02140
(617) 876-0426
http://tecathsri.org/

Western Interstate Commission for Higher Education (WICHE)
Mental Health Program
P.O. Box 9752
Boulder, CO 80301-9752

Resources for Program Leaders

Barrio, C. "The Cultural Relevance of Community Support Programs." *Psychiatric Services* 51 (2000): 879-874.

Issacs, M.R., Benjamin, M.P. *Toward a Culturally Competent System of Care: Programs Which Utilize Culturally Competent Principles* (Washington, DC: Georgetown University Child Development Center, 1991).

Leong, F. "Delivering and Evaluating Mental Health Services for Asian Americans." in *Report of the Roundtable on Multicultural Issues in Mental Health Services Evaluation* (Tucson, AZ: The Evaluation Center, Human Services Research Institute, 1998).

Musser-Granski, J., Carrillo, D.F. "The Use of Bilingual, Bicultural Paraprofessionals in Mental Health Services: Issues for Hiring, Training, and Supervision" *Community Mental Health Journal* 33 (1997): 51-60.

National Institute of Mental Health (NIMH) www.nimh.nih.gov
Phillips, D. et al. *Culture, Race and Ethnicity (C/R/E) in Performance Measurement: A Compendium of Resources; Version 1* (Cambridge, MA: Evaluation Center, Human Services Research Institute, 1999).

Organizational names, contact names, websites, e-mail addresses and mailing addresses are included. This publication has extensive lists of resources, standards, and selected readings. Information is provided on such topics as: training, language, service satisfaction and dissatisfaction, stakeholder involvement, social environments, community outreach, service planning, access and delivery, recruitment and retention, data collection and analysis, assessment, impact of practitioner identity, indigenous practitioners/services, attitudes, needs assessment, and additional readings on translated versions of instruments. Readings are included on African Americans, Hispanics/Latinos, Native Americans, and Asian Americans and Pacific Islanders. The compendium contains the following sections for diverse cultural, racial and ethnic groups:

- standards for behavioral health competence
- behavioral health disorder prevalence and service utilization
- measures of identity
- behavioral health diagnostic, assessment and outcomes measures
- instruments to assess behavioral health service competence

Ponterotto, J.G., Alexander, C.M. "Assessing the Multicultural Competence of Counselors and Clinicians" in L.A. Suzuki, P.J. Meller, J.G. Ponterotto (Eds.) *Handbook of Multicultural Assessment: Clinical, Psychological, and Educational Applications* (San Francisco: Jossey-Bass, 1996) 651-672.

Tirado, M.D. *Tools for Monitoring Cultural Competence in Health Care* (San Francisco: Latino Coalition for a Healthy California, 1996).

U.S. Surgeon General. *Mental Health: A Report of the Surgeon General* (Washington, DC: U.S. Department of Health and Human Services, 1999).

U.S. Surgeon General. *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General* (Washington, DC: U.S. Department of Health and Human Services, 2001).

Instruments for Program Leaders to Assess Cultural Competence
Cross-Cultural Counseling Inventory (CCCI).
LaFromboise, Coleman, and Hernandez (1991).

- Observer rates 20 items.

- Measures counseling effectiveness.

Multicultural Counseling Awareness Scale (MCAS).
Ponterotto, Reiger, Barrett, and Sparks (1994).

- Self-report of 45 items.
- Assesses cultural awareness, knowledge and skills.

Multicultural Counseling Inventory (MCI).
Sodowski, Taffe, Gutkin, and Wise (1994).

- Self-report of 43 items.
- Assesses awareness, knowledge, skills, and relations.

Resources for Practitioners

Aguirre-Molina M., Molina C.W., Zambrana R.E. (Eds.) *Health Issues in the Latino Community* (San Francisco, CA: John Wiley & Sons, Inc., 2001).

Alvidrez, J. "Ethnic Variations in Mental Health Attitudes and Service Among Low Income African American, Latina, and European American Young Women." *Community Mental Health Journal* 35 (1999): 515-530.
American Medical Association, Council on Scientific Affairs, Ad Hoc Committee on Health Literacy. *Health Literacy: Report of the Council on Scientific Affairs* (JAMA, Dec. 6, 1995): 1677- 1682.

Aranda, M.P. "Culture Friendly Services for Latino Elders." *Generations* 14 (1990): 55-57.

Atkinson, D., Morten, G., Sue, D. *Counseling American Minorities* (Dubuque, IA: Wm. C. Brown, 1983).

Atkinson, D.R., Gim, R.H. "Asian-American Cultural Identity and Attitudes towards Mental Health Services" *Journal of Counseling Psychology* 36 (1989): 209-213.

Baldwin, J.A., Bell, Y. "The African Self-Consciousness Scale: An Afrocentric Personality Questionnaire" *The Western Journal of Black Studies* 9 (1985): 61-68.

Bauer, H., Rodriguez, M.A., Quiroga, S., Szkupinkski, S., Flores-Ortiz, Y.G. "Barriers to Health Care for Abused Latina and Asian Immigrants" *Journal of Health Care for the Poor and Underserved* 11 (2000): 33-44.

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Scales for Practitioners to Recognize Cultural Identity
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INTEGRATED DUAL DISORDERS TREATMENT FIDELITY SCALE

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

Introduction
The introduction gives an IDDT overview and a who/what/how of the scale. There is also a checklist of suggested activities for before, during, and after the fidelity assessment that should lead to the collection of higher quality data, more positive interactions with respondents, and a more efficient data collection process.

Protocol
The protocol explains how to rate each item. In particular, it provides:

- *A definition and rationale* for each fidelity item. These items have been derived from comprehensive, evidence-based literature.
- A list of *data sources* most appropriate for each fidelity item (e.g., chart review, program leader interview, team meeting observation). When appropriate, a set of probe questions is provided to help you elicit the critical information needed to score the fidelity item. These probe questions were specifically generated to help you collect information from respondents that is free from bias such as social desirability.
- *Decision rules* will facilitate the correct scoring of each item. As you collect information from various sources, these rules will help you determine the specific rating to give for each item.

Cover sheet
This is a record form for background information on the study site. The data are not used in determining fidelity, but to provide important information for classifying programs, such as size and duration of program, type of parent organization, and community characteristics.

Checklist for multiple sources
The checklist is to be used to assess if each of the multiple sources provides evidence for the presence of critical ingredients specified in each item.

Score sheet
The score sheet provides instructions for scoring, including how to handle missing data, and identifies cut-off scores for full, moderate, and inadequate implementation.

Protocol: Item Definitions and Scoring

Overview

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

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- 1a. Multidisciplinary Team
- 1b. Integrated Substance Abuse Specialist
- 2. Stage-Wise Interventions
- 3. Access for IDDT Clients to Comprehensive DD Services
- 4. Time-Unlimited Services
- 5. Outreach
- 6. Motivational Interventions
- 7. Substance Abuse Counseling
- 8. Group DD Treatment
- 9. Family Psychoeducation on DD
- 10. Participation in Alcohol & Drug Self-Help Groups
- 11. Pharmacological Treatment:
- 12. Interventions to Promote Health:
- 13. Secondary Interventions for Substance Abuse Treatment Non-Responders:

1a. Multidisciplinary Team

Definition

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

Rationale

Although a major focus of treatment is the elimination or reduction of substance abuse, this goal is more effectively met when other domains of functioning in

which clients are typically impaired are also addressed. Competent IDDT programs coordinate all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative manner.

Sources of Information

a) Program leader interview

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

b) Clinician interview

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

c) Employment specialist and residential staff interview

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

d) Client interview

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

Item Response Coding

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

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

1b. Integrated Substance Abuse Specialist
Note: Code both 1a and 1b

Definition
A substance abuse specialist who has at least 2 years of experience works collaboratively with the treatment team. The experience can be in a variety of settings, preferably working with clients with a dual disorder, but any substance abuse treatment experience will qualify for rating this item.

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

a) Program leader interview

- *How often does the substance abuse counselor attend team meetings?*
- *How often does the substance abuse counselor attend team meetings?*
- *Is the substance abuse specialist considered a member of the team? How so? Do they carry a caseload?*
- *Are they involved in treatment planning for IDDT clients?*
- *Do you talk to him/her a lot?*

b) Clinician interview

- *Ask similar questions as asked of program leader*

c) Substance abuse specialist interview

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

d) Chart Review

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

2. Stage-Wise Interventions

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

- *Engagement*: Forming a trusting working alliance/relationship.
- *Motivation*: Helping the engaged client develop the motivation to participate in recovery-oriented interventions.
- *Action*: Helping the motivated client acquire skills and supports for managing illnesses and pursuing goals.
- *Relapse Prevention*: Helping clients in stable remission develop and use strategies for maintaining recovery.

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

Sources of Information:

a) Program leader interview

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

b) Clinician interview

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

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

c) Team meeting/supervision observation

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

d) Observation of group or counseling sessions

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

e) Chart review (especially treatment plan)

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

Item Response Coding

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

3. Access for IDDT Clients to Comprehensive DD Services

Definition

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

- ***Residential service:*** Supervised residential services that accept clients targeted for IDDT, including supported housing (i.e., outreach for housing purposes to clients living independently) and residential programs with on-site residential staff. Exclude short-term residential services (i.e., a month or less).
- ***Supported employment:*** Vocational program that stresses competitive employment in integrated community settings and provides ongoing support. IDDT clients who are not abstinent are not excluded.
- ***Family psychoeducation:*** A collaborative relationship between the treatment team and family (or significant others) that includes basic psychoeducation about SMI and its management, social support and empathy, interventions targeted to reducing tension and stress in the family as well as improving functioning in all family members.
- ***Illness management and recovery:*** Systematic provision of necessary knowledge and skills through psychoeducation, behavioral tailoring, coping skills training and a cognitive-behavioral approach, to help clients

learn to manage their illness, find their own goals for recovery, and make informed decisions about their treatment.

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

Ancillary services are consistent with IDDT philosophy and stages of treatment/recovery. For example, housing program encompasses approaches for clients who are in engagement and motivation stages of recovery.

Rationale

Individuals with DD have a wide range of needs, such as developing a capacity for independent living, obtaining employment or some other meaningful activity, improving the quality of their family and social relationships, and managing anxiety and other negative moods. Competent IDDT programs must be comprehensive because the recovery process occurs longitudinally in the context of making many life changes.

Sources of Information

a) Program leader interview

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

b) Clinician interview

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

c) Rehabilitation service provider interview

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

d) Chart review (especially treatment plan)

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

Item Response Coding

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

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

4. Time-Unlimited Services

Definition

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

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

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

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

Rationale

The evidence suggests that both disorders tend to be chronic and severe. A

time-unlimited service that meets individual client's needs is believed to be the most effective strategy for this population.

Sources of Information

a) Program leader interview

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

b) Clinician interview

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

c) Employment specialists and residential program case manager interview

- Inquire whether these services are time-limited.

d) Chart review (especially treatment plan)

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

Item Response Coding

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

5. Outreach

Definition

For all IDDT clients, but especially those in the *engagement* stage, the IDDT program provides assertive outreach, characterized by some combination of meetings and practical assistance (e.g., housing assistance, medical care, crisis management, legal aid, etc.) in their natural living environments as a means of developing trust and a working alliance. Other clients continue to receive outreach as needed.

Rationale

Many clients targeted for IDDT tend to drop out of treatment due to the chaos in their lives, low motivation, cognitive impairment, and hopelessness. Effective IDDT programs use assertive outreach to keep the clients engaged.

Sources of Information

a) Program leader interview

- *Do you have a policy about closing out people who don't show up for treatment?*
- *Often clients targeted for IDDT drop out of treatment. How do you engage or re-engage such clients? What kind of strategies do you use to develop a working alliance with your clients?*
- *How do you engage clients targeted for IDDT that are homeless?*
- *How does a client reach you in a time of crisis?*
- *Probe further to determine types/frequency of services provided outside the office.*

b) Clinician interview

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

c) Client interview

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

d) Chart review (especially treatment plan)

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

Item Response Coding

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

6. Motivational Interventions

Definition

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

- Expressing empathy
- Developing discrepancy between goals and continued use
- Avoiding argumentation
- Rolling with resistance
- Instilling self-efficacy and hope

Rationale

Motivational interviewing involves helping the client identify his/her own goals and to recognize, through a systematic examination of the individual's ambivalence, that not managing one's illnesses interferes with attaining those

goals. Research has demonstrated that clients targeted for IDDT who are unmotivated can be readily identified and effectively helped with motivational interventions.

Sources of Information

a) Program leader interview

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

b) Clinician interview

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

c) Team meeting/supervision observation

- Listen for discussion of motivational interventions.

d) Observation of group or counseling sessions

- Listen for discussion of motivational interventions.

e) Chart review (especially treatment plan)

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

f) Client interview

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

Item Response Coding

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

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

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

- Teaching how to manage cues to use and consequences of use,
- Teaching relapse prevention strategies,
- Teaching drug and alcohol refusal skills
- Problem-solving skills training to avoid high-risk situations,
- Challenging clients' beliefs about substance use; and
- Coping skills and social skills training to deal with symptoms or negative mood states related to substance abuse (e.g., relaxation training, teaching sleep hygiene, cognitive-behavioral therapy for depression or anxiety, coping strategies for hallucinations).

The counseling may take different forms and formats, such as individual, group (including 12-Step programs), or family therapy or a combination.

Rationale
Once clients are motivated to manage their own illnesses, they need to develop skills and supports to control symptoms and to pursue an abstinent lifestyle. Effective IDDT programs provide some form of counseling that promotes cognitive-behavioral skills at this stage.

Sources of Information

a) Program leader interview

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

b) Clinician interview

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

c) Chart review

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

d) Observation of group or counseling sessions

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

Item Response Coding

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

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

8. Group DD Treatment

Definition

All clients targeted for IDDT are offered a group treatment specifically designed to address both mental health and substance abuse problems, and approximately two-thirds are engaged regularly (e.g., at least weekly) in some type of group treatment. Groups could be family, persuasion, dual recovery, etc.

Rationale

Research indicates that better outcomes are achieved when group treatment is integrated to address both disorders. Additionally, the group format is an ideal setting for clients to share experiences, support, and coping strategies.

Sources of Information

a) Program leader interview

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

b) Clinician interview

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

c) Chart review

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

d) Observation of group counseling session

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

e) Client interview

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

Item Response Coding

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

9. Family Psychoeducation on DD

Definition

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

Rationale

Research has shown that social support plays a critical role in reducing relapse

and hospitalization in persons with SMI, and family psychoeducation that can be a powerful approach for improving substance abuse outcomes in clients with SMI. However, the decision to involve significant others is the client's choice. Clinicians should discuss with the client the benefits of family treatment, and respect his/her decision about whether and in what way to involve them.

Sources of Information

a) Program leader interview

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

b) Clinician interview

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

c) Client interview

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

d) Chart review

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

Item Response Coding

% **families receiving psychoeducation = B/A x 100**

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

10. Participation in Alcohol & Drug Self-Help Groups

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

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

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

Sources of Information
a) Program leader interview

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

b) Clinician interview

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

c) Chart review

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

Item Response Coding

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

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

11. Pharmacological Treatment:

Definition

Physicians or nurses prescribing medications are trained in DD treatment and work with the client and the IDDT team to increase medication adherence, to decrease the use of potentially addictive medications such as benzodiazepines, and to offer medications such as clozapine, disulfiram, or naltrexone that may help to reduce addictive behavior. Five specific indicators are considered. Do prescribers:

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

Rationale

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

Sources of Information

a) Clinician interview

- *Are psychotropic medications prescribed to clients with active substance abuse problems? How many active clients are currently taking psychotropic medication?*
- *Have any IDDT clients been prescribed benzodiazepines?*
- *Have any IDDT clients been prescribed clozapine to reduce addiction?*
- *Have any IDDT clients been prescribed antabuse, disulfiram, or naltrexone?*

- *How often do you contact your clients' prescriber?*
- *What kind of strategies do you use for clients who do not take medications as prescribed?*

b) Medication prescriber interview

- *Are there certain restrictions, in terms of specific types of substances abused or specific mental illnesses, in which psychotropic medications are not to be prescribed? Please give some examples.*
- *How do you approach DD clients pharmacologically, as opposed to psychiatric patients who do not have a drug/alcohol problem?*
- *How often do you contact your patients' DD clinician?*
- Probe for the presence or absence of the 5 indicators listed in the definition.

c) Chart review

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

Item Response Coding

If all 5 strategies are used, the item would be coded as a 5.

12. Interventions to Promote Health:

Definition

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

Rationale

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

Sources of Information

a) Program leader interview

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

b) Clinician interview

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

c) Chart review

- Look for documentation of interventions to reduce negative consequences.

d) Client interview

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

Item Response Coding

If =80% of clients receive services to promote health, the item would be coded as a 5.

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

Definition

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

Rationale

Approximately 50% of DD clients respond well to basic IDDT and will attain stable remissions of their substance use disorders within 2-3 years. All clients should be assessed regularly (at least every three months) to make sure they are

making progress toward recovery. Those who are not making progress should be reviewed by a senior clinician and considered for more intensive interventions. The idea is to use an algorithmic approach based on current knowledge and experienced clinical judgment. For example, clients who experience increased nightmares, intrusive thoughts, and anxiety leading to relapse when sober should be considered for a PTSD intervention. Clients who are not making progress and have regular family contact should be considered for an intensive family intervention. Clients who experience severe craving should be considered for monitored naltrexone. Clients who are impulsive drinkers should be considered for monitored disulfiram.

Sources of Information

a) Program leader interview

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

b) Clinician interview

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

c) Client interview

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

Item Response Coding

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

IDDT Fidelity Scale Cover Sheet

Date:_____ Rater(s):_____

Program Name:_____

Address:_____

Contact Person:_____ Title:_____

Phone:_____ Fax:_____

E-mail:_____

____ Chart review ____ Agency brochure review

____ Team meeting observation ____ Supervision observation

____ Group or counseling session observation

____ Interview with program director/coordinator

____ Interview with clinicians ____ Interview with clients

____ Interview with rehabilitation service providers (Specify:_____)

____ Interview with _____

____ Interview with _____

Number of DD clinicians: _____ Number of active clients with DD: _____

Number of clients with DD served in preceding year: _____

Date program was started: _____

IDDT Fidelity Assessor Checklist

Before the Fidelity Site Visit:

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

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

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

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

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

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

contact person could, where available, assemble the following information prior to your site visit:

- A copy of agency brochure
- A copy of IDDT Program Mission Statement
- Roster of IDDT staff (roles, FTEs)
- A copy of the substance use screening instrument used by the agency
- A copy of the standardized DD assessment instrument used by the program
- Total number of clients served by the agency
- Number of active clients receiving DD services
- Number of clients served in the previous year
- Number of clients who dropped out of the program in the previous year
- Number of active clients receiving specific DD services (e.g., substance abuse counseling, DD group counseling, family interventions)
- Number of active clients receiving additional rehabilitation services from the agency
- Number of active clients who attend a self-help group in the community
- Weekly schedule for counseling services
- Clinician training curriculum and schedule
- List of process and/or outcome variables
- Quality assurance data

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

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

During Your Fidelity Site Visit:

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

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

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

Before you leave, check for missing data.

After Your Fidelity Site Visit:

- The same day of the site visit, *both assessors should independently rate the fidelity scale*. Within 24 hours the assessors should then compare their ratings and resolve any disagreements. Come up with a consensus rating for each item.
- Sometimes assessors have collected different data or have interpreted the response differently during the interview. Within a week of the fidelity assessment (ideally, the next day or two), the fidelity assessors should follow up with contact to the program leader to clarify any item for which there is a lack of consensus. This is also the time to *follow up on any missing data*.
- Tally the item scores and determine which level of implementation was achieved (see Score Sheet).

IDDT Fidelity Scale Score Sheet

Program:_____ Date of Visit:_____

Rater 1:_____ Rater 2:_____

1a	Multidisciplinary Team			
1b	Integrated Substance Abuse Specialist			
2	Stage-Wise Interventions			
3	Access for IDDT Clients to Comprehensive DD Services			
4	Time-Unlimited Services			
5	Outreach			
6	Motivational Interventions			
7	Substance Abuse Counseling			
8	Group DD Treatment			
9	Family Psychoeducation on DD			
10	Participation in Alcohol & Drug Self-Help Groups			
11	Pharmacological Treatment			
12	Interventions to Promote Health			
13	Secondary Interventions for Substance Abuse Treatment Non-Responders			
	MEAN TOTAL SCORE:			

Integrated Dual Disorders Treatment

Integrated Dual Disorders Treatment Fidelity Scale

	1	2	3	4	5
1a. Multidisciplinary Team: Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health treatment team	< 20% of clients receive care from multidisciplinary team (i.e., most care follows a brokered CM or traditional outpatient approach)	21% - 40% of clients receive care from a multidisciplinary team	41% - 60% of clients receive care from a multidisciplinary team	61% -79% of clients receive care from a multidisciplinary team	≥80% of clients receive care from a fully multidisciplinary team with a strong emphasis on accessing a broad range of services and excellent communication between all disciplines
1b. Integrated Substance Abuse Specialist: Substance abuse specialist works collaboratively with the treatment team, modeling IDDT skills and training other staff in IDDT	No substance abuse specialist connected with agency	IDDT clients are referred to a separate substance abuse department within the agency (e.g., referred to drug and alcohol staff)	Substance abuse specialist serves as a consultant to treatment team; does not attend meetings; is not involved in treatment planning	Substance abuse specialist is assigned to the team, but is not fully integrated; attends some meetings; may be involved in treatment planning but not systematically	Substance abuse 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
2. Stage-Wise Interventions: Treatment consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention)	≤20% of interventions are consistent with client's stage of recovery	21%- 40% of interventions are consistent	41%- 60% of interventions are consistent	61% - 79% of interventions are consistent	≥80% of interventions are consistent with client's stage of recovery

	1	2	3	4	5
3. Access for IDDT Clients to Comprehensive DD Services • Residential services • Supported employment • Family psychoeducation • Illness management • ACT or ICM	Less than 2 services are provided by the service provider that IDDT clients can access	2 services are provided by the service provider and IDDT clients have genuine access to these services	3 services are provided by the service provider and IDDT clients have genuine access to these services	4 services are provided by the service provider and IDDT clients have genuine access to these services	All 5 services are provided by the service provider and IDDT clients have genuine access to these services
4. Time-Unlimited Services • Substance abuse counseling • Residential services • Supported employment • Family psychoeducation • Illness management • ACT or ICM	≤20% of available services are provided on a time-unlimited basis (e.g., clients are closed out of most services after a defined period of time)	21%- 40% of available services are provided on a time-unlimited basis	41%- 60% of available services are provided on a time-unlimited basis	61%- 79% of available services are provided on a time-unlimited basis	≥80% of available services are provided on a time-unlimited basis with intensity modified according to each client's needs

	1	2	3	4	5
5. Outreach: Program demonstrates consistently well-thought-out strategies and uses outreach to community whenever appropriate: • Housing assistance • Medical care • Crisis management • Legal aid	Program is passive in recruitment and re-engagement; almost never uses outreach mechanisms	Program makes initial attempts to engage but generally focuses efforts on most motivated clients	Program attempts outreach mechanisms only as convenient	Program usually has plan for engagement and uses most of the outreach mechanisms that are available	Program demonstrates consistently well-thought-out strategies and uses outreach whenever appropriate
6. Motivational Interventions: Clinicians who treat IDDT clients use strategies such as: • Express empathy • Develop discrepancy between goals and continued use • Avoid argumentation • Roll with resistance • Instill self-efficacy and hope	Clinicians providing IDDT treatment do not understand motivational interventions and ≤20% of interactions with clients are based on motivational approaches	Some clinicians providing IDDT treatment understand motivational interventions and 21%- 40% of interactions with clients are based on motivational approaches	Most clinicians providing IDDT treatment understand motivational interventions and 41%- 60% of interactions with clients are based on motivational approaches	All clinicians providing IDDT treatment understand motivational interventions and 61%- 79% of interactions with clients are based on motivational approaches	All clinicians providing IDDT treatment understand motivational interventions and ≥80% of interactions with clients are based on motivational approaches

	1	2	3	4	5
7. Substance Abuse Counseling: Clients who are in the *action* stage or *relapse prevention* stage receive substance abuse counseling that include: • Teaching how to manage cues to use and consequences to use • Teaching relapse prevention strategies • Drug and alcohol refusal skills training • Problem-solving skills training to avoid high-risk situations • Challenging clients' beliefs about substance abuse • Coping skills and social skills training	Clinicians providing IDDT treatment do not understand basic substance abuse counseling principles and ≤20% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	Some clinicians providing IDDT treatment understand basic substance abuse counseling principles and 21%-40% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	Most clinicians providing IDDT treatment understand basic substance abuse counseling principles and 41%-60% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	All clinicians providing IDDT treatment understand basic substance abuse counseling principles and 61% - 79% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling	All clinicians providing IDDT treatment understand basic substance abuse counseling principles and ≥80% of clients in active treatment stage or relapse prevention stage receive substance abuse counseling
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

	1	2	3	4	5
9. Family Psychoeducation on DD: Clinicians provide family members (or significant others): • Education about DD • Coping skills training • Collaboration with the treatment team • Support	<20% of families (or significant others) receive family psychoeducation on DD	20% - 34% of families (or significant others) receive family psychoeducation on DD	35% - 49% of families (or significant others) receive family psychoeducation on DD	50% - 65% of families (or significant others) receive family psychoeducation on DD	>65% of families (or significant others) receive family psychoeducation on DD
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

	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 clozapine, naltrexone, disulfiram	Prescribers have virtually no contact with treatment team and make no apparent efforts to increase adherence OR prescribers require abstinence prior to prescribing psychiatric medications	Approximately 2 of 5 strategies used, e.g., prescribers have minimal contact with treatment team; no apparent efforts to increase adherence or to decrease substance use via pharmacological management	Approximately 3 of 5 strategies used, e.g., there is little evidence that prescribers function with team/client input, but there is evidence that prescribers make efforts to increase adherence and reduce substance use	4 of 5 strategies used, e.g., prescribers typically receive some minimal input from IDDT team to maximize adherence; there is evidence that prescribers make efforts to decrease addictive meds and increase use of meds that help reduce addictive behavior	Evidence that all 5 strategies used; prescribers receive pertinent input from the treatment team regarding medication decisions and strategies to maximize adherence. No prohibitions on antipsychotic use due to substance use; offers medications known to be effective for decreasing substance use
12. Interventions to Promote Health: Examples include: • Teaching how to avoid infectious diseases • Helping clients avoid high-risk situations and victimization • Securing safe housing • Encouraging clients to pursue work, medical care, diet, & exercise	Staff offer no form of services to promote health	No structured program, staff may have some knowledge of reducing negative consequences of substance abuse but use concepts rarely	Less than half of all DD clients receive services to promote health; clinicians providing IDDT treatment use concepts unsystematically	50%- 79% of clients receive services to promote health; all clinicians providing IDDT treatment are well-versed in techniques to reduce negative consequences	≥80% of clients receive services to promote health; all clinicians providing IDDT treatment are well-versed in techniques to reduce negative consequences

	1	2	3	4	5
13. Secondary Interventions for Substance Abuse Treatment Non-Responders: Program has a protocol for identifying substance abuse treatment non-responders and offers individualized secondary interventions, such as: • Clozapine, naltrexone, disulfiram • Long-term residential care • Trauma treatment • Intensive family intervention • Intensive monitoring	≤20% of non-responders are evaluated and referred for secondary interventions OR No recognition of a need for secondary interventions for nonresponders	21%- 40% of non-responders are evaluated and referred for secondary interventions OR Secondary interventions, if available, are not systematically offered to nonresponders	Program has protocol and 41%- 60% of non-responders are evaluated and referred for secondary interventions OR No formal method for identifying nonresponders	Program has protocol for identifying nonresponders and 61%- 79% of non-responders are evaluated and referred for secondary interventions	Program has protocol for identifying nonresponders and >80% of non-responders are evaluated and referred for secondary interventions

Using Fidelity Scales for Evidence-Based Practices

What is fidelity?

Fidelity refers to the degree of implementation of an evidence-based practice (EBP). A fidelity scale measures fidelity. Such scales have been developed for each of the six EBPs included in the Implementing EBP Project (assertive community treatment, supported employment, integrated treatment for dual disorders, illness management, family psychoeducation, and medication guidelines). Each scale assesses approximately 15 to 30 critical ingredients of the EBP, based on its underlying principles and methods. The scale items provide concrete indications that the practice is being implemented as intended. For example, one item on the Supported Employment Fidelity Scale concerns "rapid job search." This item is rated as fully implemented if the consumers in a program average one month or less between admission to the supported employment program and their first job interview.

Why measure fidelity?

Several assumptions underlie the use of fidelity scales. First, a fidelity scale should adequately sample the critical ingredients of the EBP to differentiate between programs that follow the practice and those that do not. Research suggests that fidelity scales for supported employment and for assertive community treatment do accomplish this. Second, fidelity scales should be sensitive enough to detect progress in the development of a program from the start-up phase to its mature development. There is some evidence that fidelity scales achieve this goal as well. Third, high-fidelity programs are expected to have greater effectiveness than low-fidelity programs in achieving desired consumer outcomes. Several studies comparing fidelity ratings to outcomes also support this assumption.

One key use of fidelity scales is for monitoring programs over the course of their development (and even after they are fully established). Experience by implementers suggests that routine use of fidelity scales provides an objective, structured way to give feedback about program development. This is an excellent method to diagnose program weaknesses and clarify strengths for providing positive feedback on program development. Fidelity scales also provide a comparative framework for evaluating statewide trends and outliers. The strategic use of repeated evaluations of programs using fidelity scales, either on an individual program or statewide level, is based on the general principle that whatever is paid attention to is more likely to be improved.

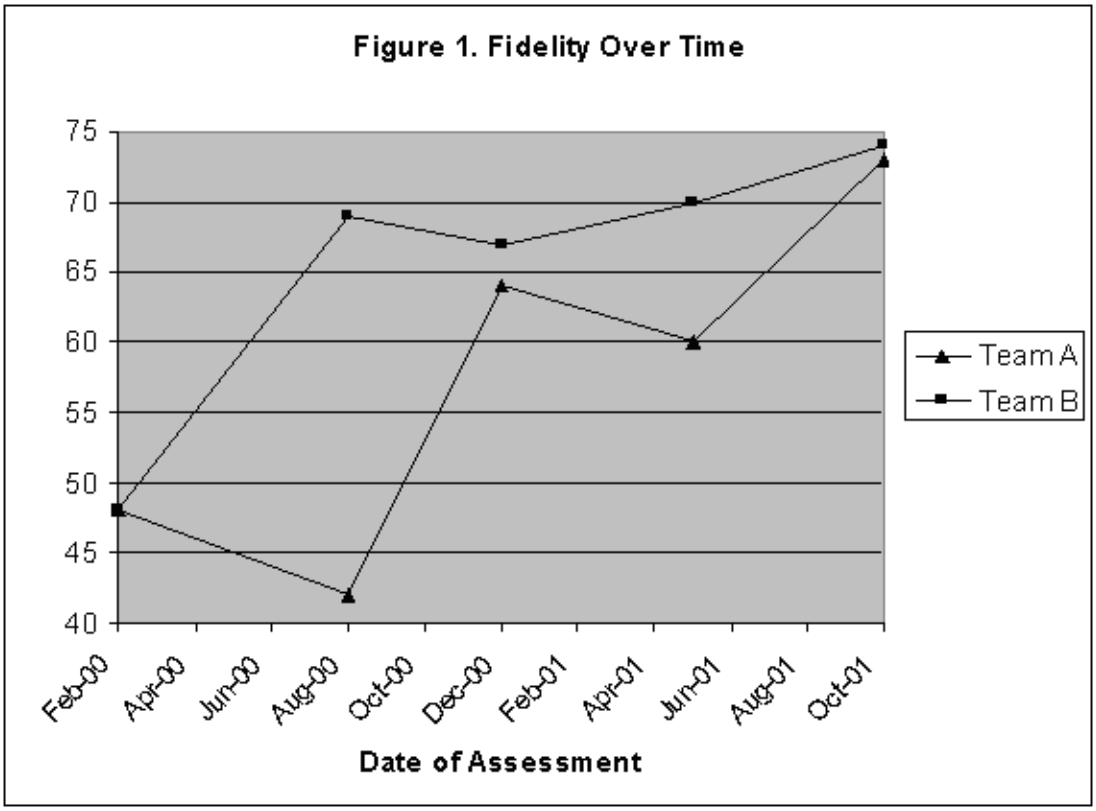
How are fidelity scales used?

In the Implementing EBP Project we have developed fidelity scales that are simple to understand. EBP items are rated on a 5-point response format, ranging from 1 equaling no implementation-to 5 equaling full implementation, with intermediate numbers representing progressively greater degrees of implementation. The response alternatives are behaviorally anchored, identifying

measurable elements of the practice. Independent evaluators using multiple sources of information make the most valid ratings. Sources of information include interviews with staff, observation of team meetings, review of charts, and intervention observations. A daylong site visit is the optimal method for acquiring this information. Interviewers should be familiar with the EBP being rated. Although we recommend outside raters, fidelity scales can also be used by program managers to conduct self-ratings. The validity of self-ratings (or any ratings, for that matter) depends on the knowledge of the person making the ratings, access to accurate information pertaining to the ratings, and the objectivity of the ratings. We encourage the use of self-ratings, with appropriate caveats regarding potential biases that could be introduced by raters invested in seeing a program "look good" or who do not fully understand the principles of the EBP. In addition to the scales developed for independent evaluators and program managers, companion fidelity measures intended for consumers and family members are under development for some EBPs.

Graphing fidelity ratings

We recommend that programs implementing an EBP graph their fidelity ratings over time, using their total fidelity score. By graphing this score, a program can see its change over time. When the program shows greater fidelity over time, this serves to reinforce their efforts. Another feature of graphing fidelity is to examine the cut-off score for "full implementation." A program can use this score as a target and measure accordingly.



USING GENERAL ORGANIZATIONAL INDEX FOR EVIDENCE-BASED PRACTICES

Overview

The *General Organizational Index* (GOI) measures a set of general operating characteristics of an organization hypothesized to be related to its overall capacity to implement and sustain any evidence-based practice. The items on the GOI were derived from clinical experience, although the research literature also supports the importance of many of these factors. The 6/26/02 draft version of this index contains 10 broad principles regarding elements such as program philosophy, training, supervision, and program monitoring. In future drafts, several items regarding cultural competency will be added. Whereas the fidelity scales are specific to each EBP, the GOI refers to operating characteristics that should be very similar across the EBPs.

The GOI is intended to be a companion assessment tool used at the same time as the EBP fidelity scale is administered. When conducting fidelity site visits, the implementation monitors should include GOI interview items (as outlined in the General Organizational Index Protocol).

The same set of 10 items is used for all 5 evidence-based practices (EBPs). One item-G2-has two alternate forms, G2A and G2B. G2A, for family psychoeducation, illness management and recovery, and supported employment, refers to information provision. G2B, for assertive community treatment and integrated dual disorders treatment, refers to screening. With the exception of item G2A/B, the wording of all the items is the same for all EBPs. However, in administering this index, the implementation monitor should tailor the language to fit with the specific practice.

Why measure general organization characteristics?

The rationale for the use of the GOI is similar to the one given for fidelity scales (See "Using Fidelity Scales"). Clinical experience suggests that agencies that generally do an excellent job in implementing a practice have the GOI elements in place within the organization. Programs scoring high on the GOI are expected to be more effective in implementing an EBP and in achieving desired outcomes. We also recommend that agencies implementing an EBP use the GOI as a self-assessment tool for monitoring programs over the course of their development (and even after they are fully established). Considerable experience by implementers has suggested that routine use of such indices provides an objective, structured way to give feedback about program development.

How is the GOI used?

The assessment philosophy for the GOI mirrors that for fidelity scales. The GOI contains simple-to-understand face-valid items that are rated on a 5-point response format, ranging from 1 equals no implementation to 5 equals full implementation, with intermediate numbers representing progressively greater

degrees of implementation. The response alternatives are behaviorally anchored, that is, they identify concrete measurable elements of the practice. Our experience is that independent evaluators using multiple sources of information make the most valid ratings. Typical sources of information include interviews with staff, observation of team meetings, review of charts, and observation of interventions. Although we recommend outside raters, the GOI can also be used by program managers to conduct self-ratings. The validity of self-ratings (or any ratings, for that matter) depends on the knowledge of the person making the ratings, access to accurate information pertaining to the ratings, and the objectivity of the ratings. We encourage the use of self-ratings, with appropriate caveats regarding potential biases that can be introduced by raters who are invested in seeing a program "look good" or who do not fully understand the principles of the General Organizational Index. In addition to the scales developed for independent evaluators and program managers, companion fidelity measures intended for consumers and family members are under development for some EBPs.

Graphing GOI
We recommend that programs implementing an EBP graph their GOI over time. See the section on fidelity scales for a related example.

- Item Definitions and Scoring
- Index Cover Sheet
- Score Sheet
- Scale

General Organizational Index (GOI)-Item Definitions and Scoring

G1. Program Philosophy

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

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

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

Sources of Information

Overview
During the course of a site visit, fidelity assessors should be alert to indicators of program philosophy consistent with or inconsistent with the EBP including

observations from casual conversations, staff and client activities, etc. Statements that suggest mis-conceptions or reservations about the practice are negative indicators, while statements that indicate enthusiasm for and understanding of the practice are positive indicators. The intent of this item is to gauge the understanding of and commitment toward the practice. It is not necessary that every element of the practice is currently in place (this is gauged by the EBP-specific fidelity scale), but rather whether all those involved are committed to implementing a high fidelity EBP.
The practitioners rated for this item **are limited to those implementing this practice**. Similarly, the clients rated are those receiving the practice.

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

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

d) Chart review

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

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

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

Item Response Coding

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

Difference between a major and minor area of discrepancy (needed to distinguish between a score of "4" and a score of "3"): An example of a minor

source of discrepancy for ACT might be larger caseload sizes (e.g., 20-1) or some brokering of services. An example of a major discrepancy would be if the team seldom made home visits or if the psychiatrist was uninvolved in the treatment team meetings.

G2. Eligibility/Client Identification

Definition

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

- The *target population* refers to all adults with severe mental illness (SMI) served by the provider agency (or service area). If the agency serves clients at multiple sites, then **assessment is limited to the site or sites that are targeted for the EBP**. If the target population is served in discrete programs (e.g., case management, residential, day treatment, etc.), then ordinarily all adults with SMI are included in this definition.
- Screening will vary according to the EBP. T*he intent is to identify any and all for who could benefit from the EBP*. For Integrated Dual Disorder Treatment and Assertive Community Treatment, the admission criteria are specified by the EBP and specific assessment tools are recommended for each. For Supported Employment, all clients are invited to receive the service because all are presumed eligible (although the program is intended for clients at the point they express interest in working). The screening for Illness Management & Recovery includes an assessment of the skills and issues addressed by this EBP. For Family Psychoeducation, the screening includes the assessment of the involvement of a family member or significant other. In every case, the program should have an explicit, systematic method for identifying the eligibility of every client.
- Screening typically occurs at program admission, but for a program that is newly adopting an EBP, there should be a plan for systematically reviewing clients already active in the program.

Rationale

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

Sources of Information

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

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

d) Chart review

- Review documentation of screening process & results.

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

Item Response Coding

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

G3. Penetration

Definition

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

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

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

Rationale

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

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

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

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

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

G4. Assessment

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

- *Standardization* refers to a reporting format that is easily interpreted and consistent across clients.
- *High quality* refers to assessments that provide concrete, specific information that differentiates between clients. If most clients are assessed

using identical words, or if the assessment consists of broad, noninformative checklists, then this would be considered low quality.
- *Comprehensive* assessments include: history and treatment of medical, psychiatric, and substance use disorders, current stages of all existing disorders, vocational history, any existing support network, and evaluation of biopsychosocial risk factors.
- *Timely* assessments are those updated at least annually.

Rationale
Comprehensive assessment/re-assessment is indispensable in identifying target domains of functioning that may need intervention, in addition to the client's progress toward recovery.

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

a) Program leader interview, b) Senior staff interview and **c) Practitioner interview:**
- *"Do you give a comprehensive assessment to new clients? What are the components that you assess?"*
- Request a copy of the standardized assessment form, if available, and have the practitioners go through the form.
- *"How often do you re-assess clients?"*

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

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

G5. Individualized Treatment Plan

Definition
For all EBP clients, there is an explicit, individualized treatment plan (even if it is not called this) related to the EBP that is consistent with assessment and updated every 3 months.

"Individualized" means that goals, steps to reaching the goals, services/ interventions, and intensity of involvement are unique to this client. Plans that are the same or similar across clients are not individualized. One test is to place a

treatment plan without identifying information in front of the supervisor and see if they can identify the client.

Rationale
Core values of EBP include individualization of services and supporting clients' pursuit of their goals and progress in their recovery at their own pace. Therefore, the treatment plan needs ongoing evaluation and modification.

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

a) Chart review (treatment plan):
- **Using the same charts as examined during the EBP-specific fidelity assessment**, look for documentation of specific goal(s) and client-based goal-setting process.
- Are the treatment recommendations consistent with assessment?
- Evidence for a quarterly review (and modification)?

b) Program leader interview
- *"Please describe the process of developing a treatment plan. What are the critical components of a typical treatment plan and how are they documented?"*

c) Practitioner interview:
- When feasible, use the specific charts selected above. Ask the practitioners go over a sample treatment plan.
- *"How do you come up with client goals?"* Listen for client involvement and individualization of goals.
- *"How often do you review (or follow up on) the treatment plan?"*

d) Client interview:
- *"What are your goals in this program? How did you set these goals?"*
- *"Do you and your practitioner together review your progress toward achieving your goal(s)?"* [If yes] *"How often? Please describe the review process."*

e) Team meeting/supervision observation, if available:
- Observe how treatment plan is developed. Listen especially for discussion of assessment, client preferences, and individualization of treatment.
- Do they review treatment plans?

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

individualized but updated only every 6 months, then the item would be coded as a 3.

G6. Individualized Treatment

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

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

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

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

Sources of Information:

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

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

c) Client interview:
- *"Tell me about how this program or practitioner is helping you meet your goals."*

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

G7. Training

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

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

Sources of Information:

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

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

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

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

e) Practitioner interview:

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

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

G8. Supervision

Definition
EBP practitioners receive structured, weekly supervision from a practitioner

experienced in the particular EBP. The supervision can be either group or individual, but CANNOT be peers-only supervision without a supervisor. The supervision should be client-centered and explicitly address the EBP model and its application to *specific client situations*.
Administrative meetings and meetings that are not specifically devoted to the EBP do not fit the criteria for this item. The *client-specific* EBP supervision should be at least one hour in duration each week.

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

Sources of Information:

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

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

d) Team meeting/supervision observation, if available:

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

e) Supervision logs documenting frequency of meetings.
Item Response Coding
If >80% of practitioners receive weekly supervision, the item would be coded as a "5".

G9. Process Monitoring

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

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

Sources of Information:

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

- *"Does your program collect process data regularly?"* [If yes] Probe for specifics: frequency, who, how (using [**EBP area**] Fidelity Scale vs. other scales), etc.
- *"Does your program collect data on client service utilization and treatment attendance?"*
- *"Have the process data impacted how your services are provided? For example?"*

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

Item Response Coding

If there is evidence that standardized process monitoring occurs at least every 6 months, the item would be coded as a "5".

G10. Outcome Monitoring

Definition

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

Rationale

Systematic and regular collection of outcome data is imperative in evaluating program effectiveness. Effective programs also analyze such data to ascertain what is working and what is not working, and use the results to improve the quality of services they provide.

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

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

Sources of Information:

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

- *"Does your program have a systematic method for tracking outcome data?"* [If yes] Probe for specifics: how (computerized vs. chart only), frequency, type of outcome variables, who collects data, etc.

- *"Do you use any checklist/scale to monitor client outcome (e.g., Substance Abuse Treatment Scale)?"*
- *"What do you do with the outcome data? Do your practitioners review the data on regular basis?"* [If yes] *"How is the review done (e.g., cumulative graph)?"*
- *"Have the outcome data impacted how your services are provided? For example?"*

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

Item Response Coding

If standardized outcome monitoring occurs quarterly and results are shared with EBP Practitioners, the item would be coded as a "5".

G11. Quality Assurance (QA)

The agency's QA Committee has an explicit plan to review the EBP or components of the program every 6 months. The steering committee for the EBP can serve this function. Good QA committees help the agency in important decisions, such as penetration goals, placement of the EBP within the agency, hiring/staffing needs. QA committees also help guide and sustain the implementation by reviewing fidelity to the EBP model, making recommendations for improvement, advocating/promoting the EBP within the agency and in the community, and deciding on and keeping track of key outcomes relevant to the EBP.

Rationale

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

Sources of Information:

a) Program leader interview:

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

b) QA Committee member interview:

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

Item Response Coding

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

G12. Client Choice Regarding Service Provision
All clients receiving EBP services are offered a reasonable range of choices consistent with the EBP; the EBP practitioners consider and abide by client preferences for treatment when offering and providing services.
Choice is defined narrowly in this item to refer to services provided. This item does not address broader issues of client choice, such as choosing to engage in self-destructive behaviors.

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

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

Sample of Relevant Choices by EBP:

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

- Nature of medication support
- Nature of substance abuse treatment

Rationale
A major premise of EBP is that clients are capable of playing a vital role in the management of their illnesses and in making progress towards achieving their goals. Providers accept the responsibility of getting information to clients so that they can become more effective participants in the treatment process.

Sources of Information:

a) Program leader interview:
- *"Please tell us what your program philosophy is regarding client choice. How do you incorporate their preferences in the services you provide?"*
- *"What options are there for your services? Please give examples."*

b) Practitioner interview:
- *"What do you do when there is a disagreement between what you think is the best treatment for a client and what he/she wants?"*
- *"Please describe a time when you were unable to abide by a client's preferences."*

c) Client interview:
- *"Does the program give you options for the services you receive? Are you receiving the services you want?"*

d) Team meeting/supervision observation:
- Look for discussion of service options and client preferences.

e) Chart review (especially treatment plan):
- Look for documentation of client preferences and choices.

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

General Organizational Index Cover Sheet

Date:_____ Rater(s):_____

Program Name:_____

Address:_____

Contact Person:_____ Title:_____

Phone:_____ Fax:_____

E-mail:_____

____ Chart review ____ Agency brochure review

____ Team meeting observation ____ Supervision observation

____ Interview with Program Director/Coordinator

____ Interview with practitioners ____ Interview with clients

____ Interview with supervisors

____ Interview with rehabilitation service providers

____ Interview with _____

____ Interview with _____

# of EBP Practitioners: _____ **# of active clients served by EBP: ____**

# of clients served by EBP in preceding year:_____

# of charts reviewed:_____

Date program was started: _____

GOI Score Sheet

Program:_____

Date of Visit:_____

Informants - Name(s) and Position(s)_____

_____,
_____

		Rater 1	Rater 2	Consensus
G1	Program Philosophy			
G2	Eligibility/Client Identification			
G3	Penetration			
G4	Assessment			
G5	Individualized Treatment Plan			
G6	Individualized Treatment			
G7	Training			
G8	Supervision			
G9	Process Monitoring			
G10	Outcome Monitoring			
G11	Quality Assurance (QA)			
G12	Client Choice Regarding Service Provision			
	MEAN TOTAL SCORE:			

General Organizational Index (GOI) Scale

	1	2	3	4	5
G1. Program Philosophy. The program is committed to a clearly articulated philosophy consistent with the specific evidence-based model, based on the following 5 sources: • Program leader • Senior staff (e.g., executive director, psychiatrist) • Practitioners providing the EBP • Clients and/or families receiving EBP • Written materials (e.g., brochures)	No more than 1 of the 5 sources shows clear understanding of the program philosophy OR All sources have numerous major areas of discrepancy	2 of the 5 sources show clear understanding of the program philosophy OR All sources have several major areas of discrepancy	3 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one major area of discrepancy	4 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one or two minor areas of discrepancy	All 5 sources display a clear understanding and commitment to the program philosophy for the specific EBP

	1	2	3	4	5
***G2. Eligibility/Client Identification.** All clients with severe mental illness in the community support program, crisis clients, and institutionalized clients are screened to determine whether they qualify for the EBP using standardized tools or admission criteria consistent with the EBP. Also, the agency tracks the number of eligible clients in a systematic fashion.	≤20% of clients receive standardized screening and/or agency DOES NOT systematically track eligibility	21%-40% of clients receive standardized screening and agency systematically tracks eligibility	41%-60% of clients receive standardized screening and agency systematically tracks eligibility	61%-80% of clients receive standardized screening and agency systematically tracks eligibility	>80% of clients receive standardized screening and agency systematically tracks eligibility
***G3. Penetration.** The maximum number of eligible clients are served by the EBP, as defined by the ratio: **# clients receiving EBP** **# clients eligible for EBP**	Ratio ≤ .20	Ratio between .21 and .40	Ratio between .41 and .60	Ratio between .61 and .80	Ratio > .80

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

_____ **Total # clients in target population**

_____ **Total # clients eligible for EBP** **% eligible: ___%**

_____ **Total # clients receiving EBP** **Penetration rate: ____**

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

	1	2	3	4	5
G7. Training. All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) *within 2 months of hiring*. Existing practitioners receive annual refresher training (at least 1-day workshop or its equivalent).	≤20% of practitioners receive standardized training annually	21%-40% of practitioners receive standardized training annually	41%-60% of practitioners receive standardized training annually	61%-80% of practitioners receive standardized training annually	>80% of practitioners receive standardized training annually
G8. Supervision. EBP practitioners receive structured, weekly supervision (group or individual format) from a practitioner experienced in the particular EBP. The supervision should be client-centered and explicitly address the EBP model and its application to *specific client situations*.	≤20% of practitioners receive supervision	21% - 40% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision on an informal basis	41%-60% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision monthly	61%-80% of EBP practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision twice a month	>80% of EBP practitioners receive structured weekly supervision, focusing on specific clients, in sessions *that explicitly address the EBP model and its application*

	1	2	3	4	5
G9. Process Monitoring. Supervisors and program leaders monitor the process of implementing the EBP every 6 months and use the data to improve the program. Monitoring involves a standardized approach, e.g., use of a fidelity scale or other comprehensive set of process indicators.	No attempt at monitoring process is made	Informal process monitoring is used at least annually	Process monitoring is deficient on 2 of these 3 criteria: (1) Comprehensive & standardized; (2) Completed every 6 mos.; (3) Used to guide program improvements OR Standardized monitoring done annually only	Process monitoring is deficient on one of these three criteria: (1) Comprehensive and standardized; (2) Completed every 6 months; (3) Used to guide program improvements	Standardized comprehensive process monitoring occurs at least every 6 mos. and is used to guide program improvements
G10. Outcome Monitoring. Supervisors/program leaders monitor the outcomes for EBP clients every 3 months and share the data with EBP practitioners. Monitoring involves a standardized approach to assessing a key outcome *related to the EBP*, e.g., psychiatric admissions, substance abuse treatment scale, or employment rate.	No outcome monitoring occurs	Outcome monitoring occurs at least once a year, but results are not shared with practitioners	Standardized outcome monitoring occurs at least once a year and results are shared with practitioners	Standardized outcome monitoring occurs at least twice a year and results are shared with practitioners	Standardized outcome monitoring occurs quarterly and results are shared with EBP practitioners
G11. Quality Assurance (QA). The agency has a QA Committee or implementation steering committee with an explicit plan to review the EBP, or components of the program, every 6 months.	No review or no committee	QA committee has been formed, but no reviews have been completed	Explicit QA review occurs less than annually OR QA review is superficial	Explicit QA review occurs annually	Explicit review every 6 months by a QA group *or steering committee for the EBP*

	1	2	3	4	5
G12. Client Choice Regarding Service Provision. All clients receiving EBP services are offered choices; the EBP practitioners consider and abide by client preferences for treatment when offering and providing services.	Client-centered services are absent (or all EBP decisions are made by staff)	Few sources agree that type and frequency of EBP services reflect client choice	Half sources agree that type and frequency of EBP services reflect client choice	Most sources agree that type and frequency of EBP services reflect client choice OR Agency fully embraces client choice with one exception	All sources agree that type and frequency of EBP services reflect client choice

MONITORING CLIENT OUTCOMES

- What are client outcomes?
- Why monitor client outcomes?
- Recovery and client outcomes
- A powerful resource for program leaders
- Outcomes and evidence-based practices
- Guidelines for an evidence-based practices information system
- Using tables and graphs in reports
- Recommendations for additions to the basic evidence-based practices information system
- References
- Client Outcomes-Quarterly Report Form
- Definitions for Quarterly Report Form
- Kansas Consumer Satisfaction Survey
- Quality of Life Self-Assessment

What are client outcomes?

Client outcomes are those aspects of clients' lives that we seek to improve or to manage successfully through the delivery of mental health services. Medications help clients manage their symptoms. Supported employment programs help clients find work in the community. Dual disorders groups help clients reduce their dependence on alcohol and illicit drugs. Relapse prevention programs help clients stay out of the hospital. Some outcomes are the direct result of an intervention, such as getting a job through participation in a vocational program, whereas others are indirect, such as improvements in quality of life due to having a job. Some outcomes are concrete and observable, such as the number of days worked in a month, whereas others are subjective and private, such as satisfaction with vocational services. Every mental health service intervention, whether considered treatment or rehabilitation, has both immediate and long-term client goals. In addition, clients have goals for themselves, which they hope to attain through the receipt of mental health services. These goals translate into outcomes, and the outcomes translate into specific measures. For example, the goal of a supported employment program is community integration through employment. The outcome for clients is obtaining and holding regular jobs in the community. The outcome measure for a supported employment program may be the number of weeks that a client has worked at competitive jobs during the past quarter.

Why monitor client outcomes?

Client outcomes are the bottom-line for mental health services, like profit is in business. No successful businessperson would assume that the business was profitable just because the enterprise was producing a lot of widgets (e.g. cars, clothes) or employees were working hard. This does not mean that the owner does not need to pay attention to productivity, but rather one would not make the assumption that productivity necessarily leads to profit. In mental health, productivity measures, such as the number of counseling sessions or the number of clients served, tell us very little, if anything, about the effects of services on clients and their welfare.

This fact has led to a broad-based call for outcome monitoring. At the policy and systems level, the Government Performance and Results Act of 1993 requires that all federal agencies measure the results of their programs and restructure their management practice to improve these results. In a parallel fashion, there is a significant movement in human service management toward client outcome-based methods (Rapp & Poertner, 1992). Studies have shown that an outcome orientation of managers leads to increased service effectiveness in mental health (Gowdy & Rapp, 1989). This has led Patti (1985) to argue that effectiveness, meaning client outcomes, should be the "philosophical linchpin" of human services organizations.

Recovery and client outcomes

Recovery means more than controlling symptoms. It's about getting on with life beyond the mental health system. As Pat Deegan (1988) wrote:

The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution (p. 15).

While the goals of each individual are unique in detail, people with severe mental illness generally desire the same core outcomes that we all want:

- To live independently in a place called home
- To gain an education, whether for career enhancement or personal growth
- To have a job that enhances our income, provides a means to make a contribution, and enables us to receive recognition
- To have meaningful relationships
- To avoid the spirit-breaking experiences of hospitalization, incarceration, or substance abuse
-

If this is true, then mental health services should be focused on the most powerful methods available to help consumers achieve these outcomes. The evidence-based practice that is described in this resource kit was chosen for its ability to achieve one or more of these outcomes.

A powerful resource for program leaders

If funds are the lifeblood of an organization, then information is its intelligence. Collecting and using client outcome data can improve organizational performance. Consider the following vignette.

Participants in a partial hospitalization program sponsored by a community mental health center were consistently showing very little vocational interest or activity. Program staff began gathering data monthly on clients' vocational status and reporting this to their program consultant. He returned these data to program staff using a simple bar graph every three months. The result of gathering and using information on clients' vocational activity was evident almost immediately. Three months after instituting this monitoring

system, the percentage of the program's clients showing no interest or activity in vocational areas declined from an original 64 percent to 34 percent. Three months later this percentage decreased an additional 6 percent, so that 72 percent of program participants were now involved in some form of vocational activity.

This example shows that when information is made available, people respond to it. Peters and Waterman (1982) in their study of successful companies observed:

We are struck by the importance of available information as the basis for peer comparison. Surprisingly, this is the basic control mechanism in the excellent companies. It is not the military model at all. It is not a chain of command wherein nothing happens until the boss tells somebody to do something. General objectives and values are set forward and information is shared so widely that people know quickly whether or not the job is getting done-and who's doing it well or poorly (p. 266). They observed that the data were never used to "browbeat people with numbers" (p.267). The information alone seemed to motivate people.

What is clear from these examples is this: *The collection and feedback of information influences behavior.* Current research suggests several principles to improve organizational effectiveness:

- The role of information in an organization is to initiate action and influence organizational behavior.
- The act of collecting information (measurement) generates human energy around the activity being measured.
- To ensure that information directs human energy toward enhanced performance, data collection and feedback must be used:
    - to foster and reinforce desired behaviors;
    - to identify barriers to performance and ways to overcome them; and
    - to set goals for future performance.
- Feedback directs behavior toward performance when it provides "cues" to workers to identify clear methods for correction and when it helps workers learn from their performance.
- Feedback motivates behavior toward performance when it is used to create expectations for external and internal rewards, is linked to realistic standards for performance, and is directed toward the future versus used punitively to evaluate past performance.

Managers who are committed to enhancing client outcomes have a powerful tool. By proactively and systematically collecting and using client outcome information, managers can enhance the goal-directed performance of program staff, as well as increase their

motivation, professional learning, and sense of reward. Minimally, supervisors and managers should distribute (or post) the outcome data reports and discuss them with staff. Team meetings are usually the best time. Numbers reflective of above average or exceptional performance should trigger recognition, compliments, or other rewards. Data reflecting below average performance should provoke a search for underlying reasons and the generation of strategies that offer the promise of improving the outcome. By doing this on a regular basis the manager has begun to create a "learning organization" characterized by consistently improving client outcomes.

Outcomes and evidence-based practices

The foundation of evidence-based practices is client outcomes. The decision to implement an evidence-based practice is based on its ability to help clients achieve the highest rates of positive outcomes. Therefore, one key component of the implementation of an evidence-based practice is the careful monitoring and use of client outcome data. The problem for many mental health providers is that current data systems do not capture relevant client outcomes or are unable to produce meaningful and timely reports. Providers must find ways to develop evidence-based practices information systems that are easy to implement and to maintain.

The following material is designed to guide programs that are implementing an evidence-based practice in developing a practical and useful information system. Some programs may go their own way and develop a system anew. Other programs may adapt existing information systems to suit their needs for monitoring client outcomes. These guidelines will help programs to make such beginnings and adaptations. In addition, programs may wish to expand the evidence-based practices information systems that we describe, to build on the success they have had using a basic system or to customize a system to their needs and context. We encourage such expansion once a basic system has been implemented successfully, and we make recommendations for such enhancements at the end of this section.

We begin with advice on getting started, and then we describe a simple, yet comprehensive, system for monitoring evidence-based practice outcomes. We follow this with ideas on using tables and graphs of outcome data to improve practice and on expanding basic systems.

Guidelines for an evidence-based practices information system

Many practitioners feel overwhelmed by the demands of their jobs and cannot imagine adding the burden of collecting client outcomes. Reporting systems already exist in many mental health settings, but they are time-consuming, and they do not provide useful feedback to improve practice. Thus, resistance is likely when implementing a new system to monitor client outcomes. To overcome this resistance we recommend starting with a very simple system and making the system practical and immediately useful.

Start simply.

At the outset, the system must be simple to implement, use, and maintain. Complexity has doomed numerous well-intended attempts to collect and use client outcome data. One way

to keep it simple is to limit the amount and sources of information that it contains. Begin with a few key client outcomes and build the system around them. Collect data from practitioners, without the initial need for data collection from clients and families. Start with simple reports that tabulate results for the past quarter and show time trends, and then let experience with the system determine what additional reports are needed.

Fit the needs of practitioners.
The system must not create undue burden for practitioners, and it must provide information to them that is useful in their jobs. If possible, the system should collect already known information about clients, and it should require little time to record the data. The system should fit into the workflow of the organization, whether that means, for example, making ratings on paper or directly into a computer. It should collect information on participation in evidence-based services and on client outcomes. Program leaders and practitioners can then keep track of what services clients are using and how they are doing on key outcomes. It should produce easy-to-read and timely reports that contribute to planning and lead to action, for individual clients, for treatment teams, and for the program as a whole.

These two guidelines may lead to a system that consists of a single outcome measure that is collected regularly and used by the program leader and practitioners to monitor their progress toward stated goals for an evidence-based practice. For example, a supported employment program may decide to monitor the rate of competitive employment among those clients who have indicated a desire to work. Practitioners may be asked to indicate whether each client has worked in a competitive job during the past quarter. These data can then be tallied for the entire program to indicate the employment rate during the past quarter, which can be compared to prior quarters and can be used to develop performance goals based on client choices for the upcoming quarter.

The system suggested by these two guidelines can be implemented in a variety of ways, from paper and pencil to multi-user computer systems. Begin with whatever means you have available and expand the system from there. In the beginning, data may be collected with a simple report form, and hand-tallied summaries can be reported to practitioners. A computer with a spreadsheet program (e.g., EXCEL) makes data tabulation and graphing easier than if it is done by hand. A computerized system for data entry and report generation presents a clear advantage, and it may be the goal, but do not wait for it. Feedback does not have to come from a sophisticated computer system to be useful. It is more important that it is meaningful and frequent.

As a client outcome monitoring system develops, program leaders and practitioners will weave it into the fabric of their day-to-day routines. Its reports provide tangible evidence of the use and value of services, and they will become a basis for decision-making and supervision. At some point, the practitioners may wonder how they did their job without an information system, as they come to view it as an essential ingredient of well-implemented evidence-based practices.

Once a basic system has been implemented for a single evidence-based practice, we encourage programs to consider expanding to a comprehensive system for monitoring multiple evidence-based practices. We provide two additional guidelines for developing such a system.

Include all evidence-based practices in one system.
The system should monitor the participation of clients in all evidence-based practices. This can be as simple as recording whether clients are eligible for each practice, and in which practices they have participated during the past quarter. For those practices that are implemented, participation rates can be monitored over time, as a means of monitoring the penetration of the practices in the population of eligible clients. For those practices that are not yet implemented, the system will create incentive to do so.
Likewise, the system should monitor a core set of outcomes that apply across evidence-based practices and that are valued by clients and families, as well as by providers and policymakers. For example, keeping people with mental illness in stable community housing, rather than in institutions or homeless settings, is an agreed-upon outcome for several evidence-based practices. Consequently, keeping track of quarterly rates of hospitalization, incarceration, and homelessness will enable evaluation of the effectiveness of a range of services.

Make the data reliable and valid.
For an information system to be useful, the data must reliable and valid. That is, the data must be collected in a standardized way (reliability), and the data must measure what it is supposed to measure (validity). Thus, the outcomes must be few in number and concrete, in order for practitioners to stay focused on key outcomes, to understand them in a similar way, and to make their ratings in a consistent and error-free fashion. To enhance reliability and validity, we recommend simple ratings (e.g., Did the client hold a competitive job in this quarter?), rather than more detailed ones (e.g., How many hours during this quarter did the client work competitively?). In addition, reliability will be enhanced if the events to be reported are easy to remember, and thus we recommend collecting data at regular and short intervals, such as quarterly at the outset, and we recommend collecting data for salient events. We recommend the following outcomes:

- psychiatric or substance abuse hospitalization
- incarceration
- homelessness
- independent living
- competitive employment
- educational involvement
- stage of substance abuse treatment

These few outcomes reflect the primary goals of the evidence-based practices. Assertive community treatment, family psychoeducation, and illness management and recovery share the goal of helping clients to live independently in the community. Thus, their goal is to reduce hospitalization, incarceration, and homelessness, and to increase independent living. Supported employment and integrated dual disorders treatment have more direct

outcomes, and thus it is important to assess work/school involvement and progress toward substance abuse recovery, respectively. A Quarterly Report Form is presented at the end of this section as an example of a simple, paper-based way to collect participation and outcome data on a regular basis.

A stand-alone computerized client outcome monitoring system has been developed for the Evidence-Based Practices Project. It follows the above guidelines closely and is available to those programs who wish to start with such a system.

Using tables and graphs in reports

The single factor that will most likely determine the success of an information system is its ability to provide useful and timely feedback to practitioners. It is all well and good to worry about what to enter into a system, but ultimately its worth is in converting data into information. For example, the data may show that twenty consumers worked in a competitive job during the past quarter, but it is more informative to know that this represents only 10 percent of the consumers in the supported employment program and only three of these were new jobs. For information to influence practice, it must be understandable and meaningful, and it must be delivered in a timely way. In addition, the monitoring system must tailor the information to suit the needs of various users and to answer the queries of each of them.

The outcome monitoring system should format data for a single client into a summary report that tracks participation in practices and outcomes over time. This report could be entered in the client's chart, and it could be the basis for a discussion with the client of treatment and rehabilitation progress and options. Further value of a monitoring system comes in producing tables and graphs that summarize the participation and outcomes of groups of clients. Below are some examples of tables and graphs that are useful when implementing and sustaining an evidence-based practice.

Quarterly summary tables

Whether for an entire program, for a specific team, or for a single practitioner's caseload, rates of participation in practices and client outcomes should be displayed for the past quarter. Such a table can address the following kinds of questions.

- How many of my clients participated in our supported employment program last quarter?
- How many of my clients worked competitively during the last quarter?
- What proportion of clients in our program for persons with severe mental illness were hospitalized last quarter?
- How did the hospitalization rate for those on assertive community treatment teams compare to the rate for clients in standard case management?
- How many clients with a substance use disorder have yet to participate in our integrated dual diagnosis treatment program?

Simple percentages or proportions, based on quarterly tallies, provide important feedback for both program management and clinical service provision.

Movement tables

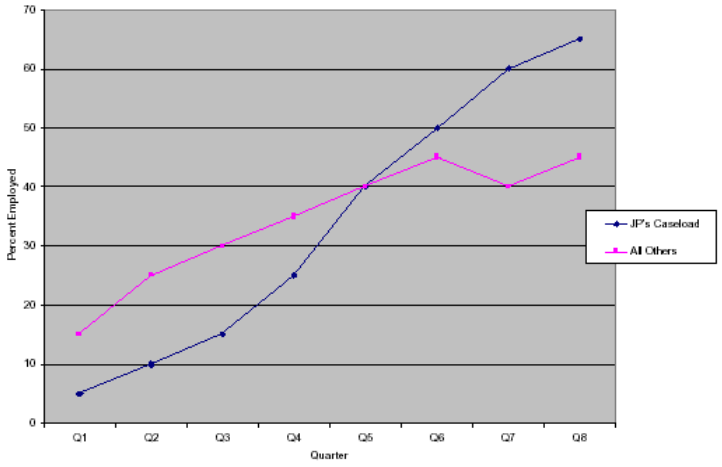
Movement tables summarize changes from the previous quarter. They are created by cross-tabulating the same variable from two successive quarters. For example, participation in the family psychoeducation program can be cross-tabulated as shown below.

		Participation during Q2	
		no	yes
Participation during Q1	no	50	20
	yes	10	40

This table indicates that, out of 120 clients overall, 50 clients did not participate in the program during either quarter (no/no), 40 participated during both quarters (yes/yes), 20 began participation during Quarter 2 (no/yes), and 10 stopped participation after Quarter 1 (yes/no). Thus, there was a net gain of 10 clients in the family psychoeducation program from Quarter 1 to Quarter 2. The same kind of table can show changes in outcomes between quarters as well. This would answer a question such as, "Were more clients working in competitive jobs during the most recent quarter, as compared to the previous quarter?" Movement tables can be prepared for various groupings of clients. For example, the net gain in competitive employment could be compared across caseloads from multiple case managers or across multiple vocational specialists.

Longitudinal plots

A longitudinal plot is an efficient and informative way to display participation or outcome data for more than two successive periods. The idea is to plot a participation or outcome variable over time, to view performance in the long term. A longitudinal plot can be for an individual, a caseload, a specific evidence-based practice, or an entire program. A single plot can also contain longitudinal data for multiple clients, caseloads, or programs, for comparison. Below is an example comparing one case manager's caseload to all other clients in a supported employment program over a two-year period.



This plot reveals that JP's clients were slower to find employment in the first year (Quarters 1-4), when compared to other clients in the program, but they made continued progress throughout year two (Quarters 5-8), whereas the rate of employment for the other clients has leveled off. Longitudinal plots are powerful feedback tools, as they permit a longer-range perspective on participation and outcome, whether for a single client or a group of clients. They enable a meaningful evaluation of the success of a program, and they provide a basis for setting goals for future performance.

Recommendations for additions to the basic evidence-based practices information system

Mental health service programs that are sophisticated in using information systems or that have been successful in implementing a start-up system may want to collect and use more information than we recommend for a basic system. For example, programs may want more detailed participation data, such as the number of group sessions attended or the number of contacts with a case manager. They may want to include additional client outcomes or to collect them in a more detailed way.

Programs may also want to collect feedback directly from consumers and family members. Recipients of services are important informants for programs seeking to improve outcomes. Programs may want to know if clients are satisfied with their services and the outcomes they have achieved. They may seek input from consumers about how to improve the services, practically and clinically. Programs may want to know if the services are helping consumers and families to achieve their goals. These are worthy ambitions, and such data have become part of many monitoring and quality improvement systems.

We did not recommend collecting data from consumers and family members as part of a basic system for monitoring client outcomes for a number of reasons. First, we recommend starting with a set of outcomes that practitioners can reported quickly and accurately. The task of collecting data from clients and families could impede progress and distract focus. Second, there are no well-validated questionnaires to assess many of the constructs that are frequently included in consumer and family surveys. Outcomes such as satisfaction, quality of life, and recovery are multifaceted and difficult to measure objectively. Third, it is hard to obtain a representative sample of respondents. Mailed surveys are often not returned. Interviews may be done with those individuals who are easy to reach and cooperative. Questions may be asked only of those who show up for routine appointments. Unless the data are collected from a representative sample, it is difficult to interpret the findings, because it is not clear to whom they generalize. Fourth, there may be better ways to get feedback from consumers than by trying to collect quantitative data from them. A program may be better off holding focus groups for consumers or families to discuss a specific evidence-based practice with the practitioners or with quality improvement personnel. Likewise, a program may learn more about consumer perceptions of services and their feelings about recovery from qualitative interviews with a small group of consumers. Fifth, quality improvement personnel may be better able and qualified to collect, analyze, and interpret data from consumers and families. A treatment team may collect informal feedback from consumers through their day-to-day contacts, but it may be

better left to others to collect systematic data. In many agencies, formal reporting systems already include client-based assessments, and it may be possible to build on these efforts rather than to duplicate them.

Yet, programs may want to collect data from the recipients of their services. If a basic outcome monitoring system has been implemented, then expanding data collection to include consumers and family members may be appropriate and feasible. Programs are encouraged to explore their options, although it is important to remain mindful of the issues discussed above. We include the *Kansas Consumer Satisfaction Survey*, and a *Quality of Life Self-Assessment* developed in New York, as examples for programs to consider.

When thinking about expanding data collection beyond the basic set of outcomes, it is important to realize that more is not necessarily better. Unless the data can be reported reliably and validly, the value of adding more data to the monitoring system is illusory. The old adage, "garbage in, garbage out," must be kept in mind when the temptation is present to expand a working system. Feedback that is based on unreliable, invalid, or unrepresentative data may be no better for a system than no feedback at all. Nevertheless, the thoughtful and gradual expansion of a working system for collecting and using client outcome can increase the value of the feedback. The litmus test is not what and how much data a program collects, but rather whether the program uses the data to inform and improve the practice.

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Client Outcomes-Quarterly Report Form

Client ID: _____	Reported by: _____
Date: _____	Quarter: _____

Indicate the client's status during the *past 3 months*. Check all that apply:

Evidence-Based Practice	**Eligible**	**Enrolled**
Integrated Dual Disorders Treatment		
Supported Employment		
Assertive Community Treatment		
Illness Management & Recovery		
Family Psychoeducation		

In the *past 3 months*, how many weeks has the client:

Held a competitive job?	
Been homeless?	
Been incarcerated?	
Been hospitalized for psychiatric reasons?	
Been hospitalized for substance use reasons?	

What has been the client's stage of substance abuse treatment during the *past 3 months*? Circle one.

N/A	Engagement	Persuasion	Active treatment	Relapse prevention

What is the client's current living arrangement? Circle one.

1. Psychiatric hospital 2. Substance use hospitalization 3. General hospital psychiatric ward 4. Nursing home or IC-MH 5.Family care home 6. Lives with relatives (heavily dependent for personal care) 7.Group home	8. Boarding house 9. Lives with relatives (but is largely independent) 10. Supervised apartment program 11. Independent living 12. Other (specify) 13. Emergency shelter 14. Homeless

What is the client's current educational status? Circle one.

1. No educational participation 2. Avocational/educational involvement 3. Pre-educational explorations 4. Working on GED 5. Working on English as second language 6. Basic educational skills	7. Attending vocational school or apprenticeship, vocational program (CNA training) or attending high school 8. Attending college-1-6 hours 9. Attending college -7 or more hours 10. Other (specify)

Definitions for Quarterly Report Form

Each person completing the form should become familiar with the definitions of the data elements in order to provide consistency among reporters.

Heading information

Client ID
The client ID that is used at your agency. This is usually a name or an identifying number. This information will only be accessible to the agency providing the service.
Reported by
The name of the person who completed the form-the case manager or other staff member from the mental health agency who have access to the desired information.

Date
The date the report was completed.

Quarter
The time frame for the reporting period. For example, January-March, April-June, July-September, October-December.

Evidence-based practice

Eligible
Does the client meet the participation criteria for a specific EBP?
For example, all persons who have a severe mental illness and a drug/alcohol diagnosis are eligible for participation in integrated dual disorders treatment. Each EBP has criteria for program participation that should be used to determine eligibility.

Enrolled
Is the client participating in a particular EBP service? Note: aggregate data about eligibility and enrollment can be used to determine the penetration of services to eligible persons served by a mental health agency.
For the following incidents, the quarterly report should record the number of weeks the client spent in the specific incident category during the 3 months of the reporting period.

Employment
In the past 3 months, how many weeks has the client held a competitive job?
Competitive employment is viewed as working in a paid position (almost always outside the mental health center) that would be open to *all* community members to apply. This would exclude persons working in sheltered workshops, transitional employment positions, or volunteering. It may include persons who are self-employed but the person must work regularly and be paid for the work.

Incidents reporting

Been homeless?
Record the number of weeks the client spent homeless during the reporting period. This refers to individuals who lack a fixed, regular, and adequate nighttime residence.

Been incarcerated?
Record the number of weeks the client spent incarcerated in jails or other criminal justice lock-ups during the reporting period.

Been hospitalized for psychiatric reasons?
Record the number of weeks the client spent hospitalized primarily for treatment of psychiatric disorder(s) during the reporting period. This includes both public and private hospitals whose primary function is the treatment of mental disorders.

Been hospitalized for substance use reasons?
Record the number of weeks the client spent hospitalized primarily for treatment of substance use disorder(s) during the reporting period. This includes those both public and private hospitals whose primary function is the treatment of substance use disorders.

Stage of substance abuse treatment

What has been the client's stage of substance abuse treatment during the past 3 months?
For those persons participating in integrated dual disorders treatment, please indicate the appropriate stage of substance abuse treatment. N/A is used for persons who do not have a substance use problem or diagnosis.

Engagement. This category includes Pre-engagement and Engagement.

- The person does not have any regular contacts with an assigned case manager, mental health counselor, or substance abuse counselor. The lack of regular contact implies lack of a working alliance.

Persuasion. This category includes Early Persuasion and Late Persuasion.

- The client has regular contacts with a counselor but has not yet reduced substance use for more than a month (early persuasion), or has reduced substance use for at least one month while discussing substance use issues or attending groups (late persuasion). Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.

Active Treatment. This category includes Early Active Treatment and Late Active Treatment.

- The client is engaged in treatment, is discussing substance use or attending a group, has reduced use for at least one month and is working toward abstinence as a goal, even though he or she may still be abusing (early active treatment). This category also includes persons engaged in treatment, who have acknowledged that

substance abuse is a problem, and have achieved abstinence but for less than 6 months (late active treatment)

Relapse Prevention. This category includes Relapse Prevention, and In Remission or Recovery.

- The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence for at least 6 months. Occasional lapses, not days of problematic use, are allowed (relapse prevention). This category also includes clients who have had no problems related to substance use for over one year and are no longer in any type of substance abuse treatment (in remission or recovery).

Residential and educational status

These data provide your agency with an ongoing record of the client's residential and educational status. Record the status that applies to the client on the last day of the reporting period.

What is the client's current living arrangement?

1. Psychiatric hospital. This includes those hospitals, both public and private, whose primary function is the treatment of mental disorders. This includes state hospitals and other freestanding psychiatric hospitals.

2. Substance use hospitalization. This includes those hospitals, both public and private, whose primary function is the treatment of substance use disorders.

3. General hospital psychiatric ward. This category includes psychiatric wards located in general medical centers that provide short-term, acute crisis care.

4. Nursing home or IC-MH. This category includes facilities that are responsible for the medical and physical care of a client and have been licensed as such by the state.

5. Family care home. This category is for situations in which a client is living in a single family dwelling with a non-relative who provides substantial care. Here (as with #8), substantial care is determined by the degree that the nonrelative(s) is responsible for the daily care of the individual. Such things as medication management, transportation, cooking, cleaning, restrictions on leaving the home, and money management are considered. The non-relative may have guardianship responsibilities. If the client is not able to do a *majority* of the daily living tasks without the aid of the caretaker, the caretaker(s) is providing substantial care.

6. Lives with relatives (heavily dependent for personal care). Here the individual client and relatives should be consulted to the degree that family members are responsible for the daily care of the individual client. An important distinction between this status and #9 is to ask, "If the family was not involved, would the person be living in a more restrictive setting?" In assessing the extent to which the members provide substantial care, such

things as taking medication, transportation, cooking, cleaning, control of leaving the home, and money management can be considered. If the client is unable to independently perform a *majority* of the daily living functions, the family member(s) is providing substantial care.

7. Group home. A group home is defined here as a residence that is run by staff who provide many functions (shopping, meal preparation, laundry, etc.) that are essential to independent living.

8. Boarding house. A boarding home is a facility that provides for a place to sleep and meals, but it is not seen as an extension of a mental health agency, nor is it staffed with mental health personnel. These facilities are largely privately run, and clients have a high degree of autonomy.

9. Lives with relatives (but is largely independent). As with status #8, an assignment to this category requires information provided by the client and family. The key consideration relates to the degree that the individual is able to perform the *majority* of tasks essential to daily living without the supervision of a family member.

10. Supervised apartment program. Here, the client is living (fairly independently) in an apartment sponsored by a mental health agency. In determining whether someone fits in this category, look at the extent to which mental health staff have control over key aspects of the living arrangements. Example characteristics of control include:

- the mental health agency signs the lease,
- the mental health agency has keys to the house or apartment,
- the mental health agency provides onsite day or evening staff coverage, or
- the mental health agency mandates client participation in certain mental health services-medication clinic, day program, etc.-in order to reside in the house or apartment. Clients only receiving case management support or financial aid are NOT included in this category; they are considered to be living independently (#11).

11. Independent living. This category describes clients who are living independently and are capable of self-care. It includes clients who live independently with case management support. This category also includes clients who are largely independent and choose to live with others for reasons not related to mental illness. They may live with friends, a spouse, or other family members.
The reasons for shared housing could include personal choice related to culture and/or financial considerations.

12. Other. This status should be clearly defined in the space provided by those completing the form.

13. Emergency shelter. This category includes temporary arrangements due to a crisis or misfortune that are not specifically related to a recurrence of the client's illness. While

many emergency shelters provide emotional support, the need for emergency shelter is due to an immediate crisis not related to the client's mental illness.
14. Homeless. This category includes individuals who lack a fixed, regular, and adequate nighttime residence.

What is the client's current educational status?

1. No educational participation.

2. Avocational/educational involvement. These are organized classes in which the client enrolls consistently and expects to take part for the purpose of life enrichment, hobbies, recreation, etc. These classes must be community based, not run by the mental health center. Classes are those that any citizen could participate in, not just persons with severe mental illness. If any of these activities involve college enrollment, use status #8 or #9.

3. Pre-educational explorations. Individuals in this status are engaged in educational activities with the specific purpose of working towards an educational goal. This includes individuals who attend a college orientation class with the goal of enrollment, meet with the financial aid office to apply for scholarships, or apply for admission for enrollment. This status also includes those persons who attend a mental health center sponsored activity focusing upon an educational goal, e.g., campus visits with a case manager to survey the location of classrooms; meetings with the case manager and college staff to secure entitlements.

4. Working on GED. This status includes people who are taking classes to obtain their GED.

5. Working on English as second language. This includes those who are taking classes in English as a second language in a community setting.

6. Basic educational skills. This includes those who are taking adult educational classes focused on basic skills such as math and reading.

7. Attending vocational school or apprenticeship, vocational program (CAN training), or attending high school. This status includes those participating in community based vocational schools; learning skills through an apprenticeship, internship, or in a practicum setting; involved in on-the-job training to acquire more advanced skills; participating in correspondence courses which lead to job certification; and young adults attending high school.

8. Attending college: 1-6 hours. This individual attends college for 6 hours or less per term. This status continues over breaks, etc., if the individual plans to continue his/her enrollment. This status suggests regular attendance by the individual. Includes correspondence, TV, or video courses for college credit.

9. Attending college: 7 or more hours. This individual attends college for more than 7 hours per term. This status continues over breaks, etc., if the individual plans to continue his/her enrollment. Regular attendance with expectations of completion of course work is essential for assignment to this status.

10. Other. This status should be clearly defined in the space provided by those completing the form.

Kansas Consumer Satisfaction Survey

Mental Health Agency: _____ County Where You Live: _____
This survey asks for your opinions about the mental health services you receive. Your feedback will be used to help improve the services that are available to you and others. No names are attached to the survey forms, so the information you provide is strictly confidential. Your answers will not be shown to staff at the agency where you receive your services.
Below are listed age, gender, and race/ethnic group categories. Please place a check mark by the categories that fit you. (Note: You may leave this section blank if you prefer not to give this information.)

Age:		**Race or Ethnic group:**
____ 16 - 25		____ American Indian or Alaskan Native
____ 26 - 35	**Gender:**	____ Asian/Pacific Islander
____ 36 - 45	____ Female	____ Black/African American
____ 46 - 55	____ Male	____ Hispanic
____ 56 - 65		____ White
____ Over 65		____ Multiple Race/Ethnicity

Some services offered by the Mental Health Center are listed below. Please make a check mark by the services that you have used:

____Case Management	____Medication Services	____Psychosocial Services
____Partial Hospital	____Vocational Services	____Attendant Care
____Educational Services	____Compeer	____Other

INSTRUCTIONS: There are no right or wrong answers. Please answer each question by CIRCLING the number of the choice which matches your opinion at the present time. (Note: The response, "Does Not Apply", means that you have not used this service or the service is not available where you live.)

Please circle the one choice that best describes your opinion for each statement.	5 Strongly Agree	4 Agree	3 In Between	2 Disagree	1 Strongly Disagree	0 Does Not Apply
1. I have good access to the program (distance, public transportation, parking, etc.)	5	4	3	2	1	0
2. As a result of the services I have received here, I deal more effectively with daily problems.	5	4	3	2	1	0

Please circle the one choice that best describes your opinion for each statement.	5 Strongly Agree	4 Agree	3 In Between	2 Disagree	1 Strongly Disagree	0 Does Not Apply
3. I believe that the staff have my best interest in mind.	5	4	3	2	1	0
4. If I am having a problem with my case manager, the program will make staff changes.	5	4	3	2	1	0
5. I am rarely lonely or bored.	5	4	3	2	1	0
6. The doctor here listens to my concerns and values my opinion.	5	4	3	2	1	0
7. The program's services and staff help me to stay out of the hospital.	5	4	3	2	1	0
8. As a result of the services I have received here, I am better able to deal with crisis.	5	4	3	2	1	0
9. I am free to make choices about my life without fear of losing the help I get from the program.	5	4	3	2	1	0
10. If I have an emergency at night or on the weekend, I am able to get help from the program.	5	4	3	2	1	0
11. Staff follow through on promises they make.	5	4	3	2	1	0
12. I can choose where I live.	5	4	3	2	1	0
13. Staff do a good job of telling me about my rights as a consumer.	5	4	3	2	1	0
14. My opinions and ideas are included in my treatment plan.	5	4	3	2	1	0

Please circle the one choice that best describes your opinion for each statement.	5 Strongly Agree	4 Agree	3 In Between	2 Disagree	1 Strongly Disagree	0 Does Not Apply
15. The staff here treat me like an adult, not a child.	5	4	3	2	1	0
16. The staff help to overcome the problems that go along with getting and keeping a job.	5	4	3	2	1	0
17. To the best of my knowledge, staff have kept my personal information confidential.	5	4	3	2	1	0
18. As a result of the services I have received here, I do better with my leisure time.	5	4	3	2	1	0
19. Overall, I am satisfied with the services I receive.	5	4	3	2	1	0
20. If I don't want the services the staff recommend, they will give me other choices.	5	4	3	2	1	0
21. The staff I work with are competent and knowledgeable.	5	4	3	2	1	0
22. Staff have helped me to maintain a home or apartment in the community.	5	4	3	2	1	0
23. I know who the consumer representative is on the Mental Health Center's Governing Board.	5	4	3	2	1	0
24. As a result of the services I have received here, I do better in social situations.	5	4	3	2	1	0
25. Staff are willing to see me as often as I feel it is necessary.	5	4	3	2	1	0

Please circle the one choice that best describes your opinion for each statement.	5 Strongly Agree	4 Agree	3 In Between	2 Disagree	1 Strongly Disagree	0 Does Not Apply
26. My doctor tries to find the medications that work best for me.	5	4	3	2	1	0

Please give us any comments you would like to make about what you like and dislike about the services you receive, and suggestions for how to make things better.

(You may attach additional pages if more space is needed for comments.)

Quality of Life Self-Assessment

This survey asks you to tell us how things are going for you these days. It should take you about 5 minutes to complete. When finished, please give the survey to your care Coordinator so that you can review the results together.

Your name (please print):_____
Your Care Coordinator's name:_____
Today's date:_____

In this section, we ask you to rate how things are going in different areas of your life. For each statement below, circle the answer that best matches your experience.

Overall, how would you rate (Circle one choice for each statement)

	0	1	2	3	Should this be on your service plan?
The place where you live (your housing).	Poor	Fair	Good	Excellent	Yes or No
The amount of money you have to buy what you need.	Poor	Fair	Good	Excellent	Yes or No
Your involvement in work, employment.	Poor	Fair	Good	Excellent	Yes or No
Your level of education.	Poor	Fair	Good	Excellent	Yes or No
Your access to transportation to get around.	Poor	Fair	Good	Excellent	Yes or No
Your social life.	Poor	Fair	Good	Excellent	Yes or No
Your participation in community activities (leisure, sports, spiritual, volunteer work).	Poor	Fair	Good	Excellent	Yes or No
Your ability to have fun and relax.	Poor	Fair	Good	Excellent	Yes or No
Your physical health.	Poor	Fair	Good	Excellent	Yes or No
Your level of independence.	Poor	Fair	Good	Excellent	Yes or No
Your ability to take care of yourself (staying healthy, eating right, avoiding danger).	Poor	Fair	Good	Excellent	Yes or No
Your self-esteem (how you feel about yourself).	Poor	Fair	Good	Excellent	Yes or No
The effect of Alcohol & other drugs on your life.	Poor	Fair	Good	Excellent	Yes or No
Your mental health symptoms.	Poor	Fair	Good	Excellent	Yes or No
Overall, how things are going in your life?	Poor	Fair	Good	Excellent	Yes or No
Is there anything else that you want on your service plan?					