IDDT Fidelity Action Planning Guidelines

1a. Multidisciplinary Team

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

Rationale: Although a major focus of treatment is the elimination or reduction of substance abuse, this goal is more effectively met when other domains of functioning in which clients are typically impaired are also addressed. Competent IDDT programs coordinate all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative manner.

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

2. Who is responsible for this next step?

3. When will we accomplish this next step?

1b. Integrated Substance Abuse Specialist

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

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

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

2. Who is responsible for this next step?

3. When will we accomplish this next step

2. Stage-Wise Interventions

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

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

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

2. Who is responsible for this next step?

3. When will we accomplish this next step?

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 psycho-education***: A collaborative relationship between the treatment team and family (or significant others) that includes basic psycho-education 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 psycho-education, behavioral tailoring, coping skills training and a cognitive-behavioral approach, to help clients learn to manage their illness, find their own goals for recovery, and make informed decisions about their treatment.
- ***Assertive community treatment (ACT)*** or ***intensive case management (ICM)***: A multidisciplinary team (client-to-clinician ratios of 15:1 or lower) with at least 50% of client contact occurring in the community and 24-hour access.

Ancillary services are consistent with 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.

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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. Services are available on a time-unlimited basis

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.

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3. When will we accomplish this next step?

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.

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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.

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7. Substance Abuse Counseling

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

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

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

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

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2. Who is responsible for this next step?

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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.

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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.

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10. Participation in Alcohol & Drug Self-Help Groups

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

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11. <u>Pharmacological Treatment:</u>

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

Do prescribers:

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

<u>Rationale</u>: 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.

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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.

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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.

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