APPENDIX 2: THE CALIFORNIA FIDELITY SCALE AND GENERAL ORGANIZATIONAL INDEX[1]

General Organizational Index

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G1. Program Philosophy. 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, 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
***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

1 The GOI is essentially unchanged from the version promulgated by SAMHSA. The Fidelity Scale changes in the California version are indicated by being in blue. A summary of the rationale behind each change is available by request.

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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, Comprehensi ve-ness	Pervasive deficiencies in one of the following: Standardization, Quality of assessments, Timeliness, Comprehensive-ness	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 individualize d 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 individualize d 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 individualize d 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 individualize d services meeting the goals of the EBP	>80% of clients served by EBP receive individualized services meeting the goals of the EBP
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*
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: (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 1 of: (1) Comprehensive & 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*
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
G13. Practice Is Integrated into Daily Work. Practitioners receive credit for and are expected to: ·Participate in IDDT training provided by CIMH or the agency ·Prepare for IDDT case presentations using IDDT tools and concepts ·Document IDDT work in charts (e.g. outreach, proactive 12 step work, stage-based treatment) ·Attend IDDT supervision weekly (group and/or individual) .Attend client-centered treatment team meetings or consult regularly with other treatment providers regarding DD cases	All practitioners receive credit for or are expected to perform only 1 item OR There is no integration of the practice	All practitioners receive credit for or are expected to perform only 2 items	All practitioners receive credit for or are expected to perform only 3 items	All practitioners receive credit for or are expected to perform 4 items	All practitioners receive credit for or are expected to perform all 5 items
G14. EBP Coordinator/Program Leader. An EBP coordinator is	There is no identified Coordinator/ Program Leader.	Only 1-2 of the necessary criteria are met for this position	3-4 of the necessary criteria are met for this	5-6 of the necessary criteria are met for this	Time is designated and protected for this position

designated with a specific portion of time (at least 10%) and given the EBP related job responsibilities:			position	position **OR** This position is split between 2 people who carry out all functions	**AND** all 7 duties are conducted or overseen by this person

Fidelity Scale

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Integrated assessment of DD clients	One disorder assessed with specific symptoms, course of illness and diagnosis clarified.	Two disorders assessed with specific symptoms, course of illness and diagnosis clarified in one disorder.	Two disorders assessed with specific symptoms, course of illness and diagnosis clarified in both disorders	Two disorders assessed with specific symptoms, course of illness and diagnosis clarified in both disorders with some discussion of the relationship between disorders.	Two disorders assessed with specific symptoms, course of illness and diagnosis clarified in both disorders with an initial case formulation developed based on the relationship between these disorders.
Integrated treatment plan	A case formulation based on a comprehensive assessment including the payoff matrix is developed and informs the treatment plan in <25% of plans	A case formulation based on a comprehensive assessment including the payoff matrix is developed and informs the treatment plan in 25% to 50% of plans	A case formulation based on a comprehensive assessment including the payoff matrix is developed and informs the treatment plan in 50% to 75% of plans	A case formulation based on a comprehensive assessment including the payoff matrix is developed and informs the treatment plan in 75% to 100% of plans	A case formulation based on a comprehensive assessment including the payoff matrix is developed and informs the treatment plan in 100% of plans
Multidisciplinary Team Quality. Rate a) Number of disciplines, b) frequency of meeting, c) degree of integration (e.g. single chart vs. separate records, all staff housed together vs. spread out)	Traditional outpatient or brokered CM model; no team	Minimal implementation of Multi discipline. team (2 or three disciplines, low frequency of meeting, little integration)	Partial implementation of Multi discipline team (all three criteria are better than in "2" or one criterion done very well but others not)	Nearly full implementation of Multi Discipline team (all three criteria met to large degree)	Full implementation of Multi discipline team with Case managers, psychiatrist, nurses, residential staff, and vocational specialists work collaboratively on mental health; treatment team meetings daily; highly integrated.

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

Stage-Wise: Rate on up-to date rating of stage for each client, the presence of all four stages in the program, and a full-range of interventions appropriate to each stage. Judge by staff interviews, SATS ratings, charts.	Program does not use stages of treatment at all	Minimal use of stages (no ratings, or not up to date, truncated or fuzzy stages, lack of interventions for each stage)	Moderate use of stages (at least one element well implemented but not all three); or some staff use and others do not	Consistent use of stages but at least one of the criteria not implemented fully	A full range of interventions is available for all four stages and each client has a written up-to-date rating of current stage in treatment plan and is consistently reflected in progress notes
Access to related services identified in the client treatment plan	None of the charts reviewed showed consideration of need for related services such as employment, illness management, or intensive case management	Some mention of related services in individual treatment plan, but few related services were actually accessed by the clients	More related services identified in the treatment plan and they were usually actually accessed by the clients	Multiple related services identified. All related services were accessed, but not necessarily within 2 months	Multiple related services identified. All related services identified in treatment plan were accessed within 2 months
Access to residential housing ➢ Housing specialist(s) ➢ Wet-damp-dry housing ➢ Affiliated residential	No housing specialist available in county or program; limited or inadequate wet, damp, dry housing for DD	Housing specialist(s) in county but not program; limited or inadequate wet, damp, dry housing for DD clients	Housing specialist(s) in program; limited or inadequate wet, damp, dry housing for DD clients	Housing specialist(s) in program; full range of wet, damp, dry housing for DD clients	Housing specialist(s) in program; full range of wet, damp, dry housing for DD clients; residential program affiliated with program

program	clients				

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

Outreach • In situ aid for housing, medical, court and legal • Outreach to engage clients initially and re-engage if stop attending	Program is passive in recruitment and re-engagement; almost never uses in situ outreach mechanisms.	Program makes initial attempts to engage but generally focuses efforts on most motivated clients; little or no in situ engagement	Program staff frequently attempt in situ OR engagement outreach, but not both.	Program staff frequently attempt BOTH in situ and engagement outreach (but it is not formally supported in policy, supervision and charting requirements).	Policy, supervision, and charting requirements encourage in situ and engagement outreach. Over half the charts show evidence it has occurred when appropriate (e.g. when attendance is poor or a client has dropped out or if a client has court appearances).
Motivational Interventions I: Quantity 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.	≤20% of client charts reflect motivational more than one type of motivational interviewing approach (ie goals discrepancies, pay-off matrix, reframing etc,)	21%- 40% of client charts reflect more than one type of motivational interviewing approach (ie goals discrepancies, pay-off matrix, reframing etc,)	41%- 60% of client charts reflect more than one type of motivational interviewing approach (ie goals discrepancies, pay-off matrix, reframing etc,)	61%- 79% of client charts reflect more than one type of motivational interviewing approach (ie goals discrepancies, pay-off matrix, reframing etc,)	≥80% of client charts reflect more than one type of motivational interviewing approach (ie goals discrepancies, pay-off matrix, reframing, etc)
Motivational Interviewing Qualitative II	No record of training on MI within past year or use of MI	Training on MI within past year but not all staff have	Training for all staff on MI within past year and	Training for all staff on MI within past year and staff	Multiple trainings for all staff on MI within past year and staff

		attended and little if any use of MI	staff interviews reflect inconsistent use of MI	interviews reflect consistent use of MI	interviews reflect consistent use of MI

Dual Diagnosis Counseling: Clients who are in the *action* stage or *relapse prevention* stage receive dual diagnosis counseling that integrates substance abuse and mental health issues • Relapse Prevention Skills MH/SA • Problem solving skills • Coping Skills and social skills training • Challenging clients beliefs about substance abuse and mental illness • Drug and alcohol refusal skills	DDX counseling is not routinely provide	Mental Health or Substance Abuse Counseling is provided by referral in a parallel or sequential model	Mental Health or Substance Abuse Counseling is provide by the agency in specialized SA and or MH individual and/or group services	Mental Health *and* Substance Abuse Counseling is provide by the agency in specialized integrated individual and/or group services	Mental Health *and* Substance Abuse Counseling is provide by the agency in an integrated fashion *throughout all aspects of programming* as well as in specialized integrated individual and/or group
Integrated group treatment for DD. DD clients are offered group treatment specifically designed to address both mental health and substance abuse problems	No groups are offered for DD clients	Groups are offered for only one of the two disorders	Separate groups are offered but not integration of the disorders in the groups	Separate groups for each disorder, but some integration occurs in the groups	Integrated groups where both disorders are the focus of treatment
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

Family education and support	No identification of families or significant others for each client; or no outreach to families provided	Minimum outreach to families provided: • Materials on DD offered or sent • Consultation with families around treatment decisions	Moderate outreach: materials, consultation, some specific intervention, i.e. support group, coping skills training group.	Partial implementation of an evidence-based family intervention for DD.[2] Reviewers will look for evidence program is using an *explicit* evidence-based model	Full implementation of an evidence-based family intervention for DD. Reviewers will look for evidence program is using an *explicit* evidence-based model.
Participation in Alcohol & Drug Self-Help Groups: Clients in the *action* stage or *relapse prevention* stage attend self-help programs in the community	<20% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	20% - 34% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	35% - 49% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	50% - 65% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community	>65% of clients in the active treatment stage or relapse prevention stage attend self-help programs in the community
Proactive Self Help Groups & Liaison • Staff have a working knowledge of the Self Help Groups they refer to • Staff attend self help groups with clients • Staff help clients to prepare and/or adjust to self help groups (Mock Groups, in-house groups, Self help Prep Groups, Individual Counseling, etc)	No referral of dual-disorder clients in action or relapse prevention stages to self-help in community or at agency	Occasional referral of dual-disorder clients in action or relapse prevention stages to self-help in community or at agency	Routine referral but staff do not have a working knowledge of the self help programs	Routine referral and staff has a working knowledge of the self help programs	Routine referral and staff has a working knowledge of the self help programs and take proactive steps to assist clients in utilizing this resource including such things as mock groups or attending with the client

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

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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 • Consider clozapine, naltrexone, disulfiram or other medications with some evidence base for use with DD	All clients do not have ready access to psychiatric evaluation and treatment.	Clients have access to psychiatric evaluation and treatment but medications may be withheld for those with concurrent substance abuse; OR prescription of medications with abuse potential (e.g. benzodiazepines) is not controlled	Clients have access to psychiatric evaluation and treatment, medications are not withheld, and medications with abuse potential are controlled; but prescribers have virtually no contact with treatment team and make no apparent efforts to increase adherence	Clients have access to psychiatric evaluation and treatment, medications are not withheld, and medications with abuse potential are controlled; and prescribers have extensive contact with the treatment team and make apparent efforts to increase adherence	In addition to criteria in #4, prescribers actively consider naltrexone, disulfiram, clozapine, & other medications having some evidence base for use with persons with dual disorders.
Interventions to promote health and reduce the health-related and other negative consequences of substance use (including nicotine)	No explicit programmatic support for promoting health or reducing negative consequences of DD	Program support for general health interventions such as diet and exercise but not for reducing the negative consequences of DD	Program support for general health interventions and for reducing negative consequences of DD but interventions not used consistently (as documented in charts, protocols, and staff interviews)	Program support for general health interventions and for reducing negative consequences of DD but only individually (no programmatic interventions such as trauma groups, smoking cessation groups, and needle exchange)	Program supports reduction of negative consequences of DD *and* interventions are used including including programmatic interventions such as trauma groups, smoking cessation groups, and needle exchange)

Secondary interventions for non-responders • **Diagnosis based (including trauma)** • **Residential program** • **Criminal-justice liaison** • **Money management or payeeship** • **Contingency management** • **Outreach harm reduction approach for pre-contemplation clients** • **Medications such as clozapine that require close monitoring** • **Others if specified in tx plan**	No formal way of identifying non-responders	Formal way of identifying non-responders but no specific interventions are in treatment plans for these clients	Formal way of identifying and one to or two interventions are specified in treatment plans for these clients	Formal way of identifying and three or four interventions are specified in treatment plans for these clients	Formal way of identifying and five or more interventions are specified in treatment plans for these clients
Client-to-Clinician Ratio (excluding the psychiatrist) RECORD BUT DO NOT INCLUDE IN RATING SUMMARY	Over 50 clients per clinician	41-50 clients per clinician	31-40 clients per clinician	21-30 clients per clinician	20 or fewer clients per clinician