DEVELOPING A FIDELITY MEASURE FOR

DUAL DIAGNOSIS CAPABILITY

IN ADDICTION TREATMENT

2003

Connecticut Department of Mental Health and Addiction Services

New Hampshire Dartmouth Psychiatric Research Center

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EXECUTIVE SUMMARY

This report describes a Stage II study of the State of Connecticut's addiction treatment programs. The goal is to assess and foster our capability to treat persons with co-occurring substance use and psychiatric disorders. Stage I involved a survey of 456 agency providers. The surveys provided a useful description of the workforce, their estimates of prevalence, treatment practices, attitudes, training needs and perceived barriers and resources to treat co-occurring disorders. These findings served as a platform for this Stage II study, which features a more objective method to determine the dual diagnosis capability of addiction treatment programs. Drawing upon the technology of fidelity, the measurement of program adherence to evidence-based practices, we developed a scale to assess dual diagnosis capability. The American Society of Addiction Medicine (ASAM, 2001) provides the field with useful guidelines for dual diagnosis capable services: Addiction Only Services (AOS), Dual Diagnosis Capable (DDC), or Dual Diagnosis Enhanced (DDE). However, there are presently no operational definitions or existing fidelity measures for addiction treatment programs.

In Stage II, we constructed a fidelity scale based upon a literature review, the CT provider survey results, and information gathered from the State of Connecticut Department of Mental Health and Addiction Services (DMHAS) leadership, the DMHAS Co-occurring disorders subcommittee, and from national leaders in fidelity scale development. We developed a draft version of the scale, consisting of 54 items, 7 sub-scales, an Overall Score, and a categorization of a program as AOS, DDC or DDE. The fidelity measure is completed based upon data gathered during a half-day site visit to an addiction treatment program.

With the assistance of DMHAS we recruited 18 programs from across the state of CT to participate in the field test. 7 programs, representing a range in levels of care and hypothesized dual diagnosis capability, were assessed. This report presents their fidelity scale data in a de-identified format.

The programs' scores ranged from AOS to DDC. Only one program rated as AOS, 3 programs were lodged between AOS and DDC, and 3 programs were on the threshold between DDC and DDE. The site visit and feedback, and the criteria from this scale were used to provide guidance for each program to attain increased dual diagnosis capability.

The findings from this Stage II study have resulted in a refined version of the fidelity measure: the Dual Diagnosis Capability in Addiction Treatment (DDCAT) scale. For Stage III, the DDCAT can be used on an expanded basis to: articulate the range of services across the state, define practical guidelines for treatment providers to increase their dual diagnosis capability, suggest specific foci for training, and potentially be linked with financial and clinical outcome data.

Stage III advances the systematic and practical improvement of care for persons with co-occurring disorders in addiction treatment programs.

BACKGROUND

In 2002, we completed a Stage I study of addiction treatment practices with co-occurring disorders in the State of Connecticut. The method involved the survey of addiction treatment providers across the state. 48 programs participated, with 456 individual agency directors, clinical supervisors, and clinicians responding. We hypothesized that this approach would provide a more accurate picture of current practices, attitudes, perceived resources and barriers for change with respect to co-occurring disorders. This could then serve as an empirical and rational basis or platform from which to develop consensus about system change and enhancement strategies. The findings were summarized in a report to the Department of Mental Health and Addiction Services (DMHAS) submitted in December 2002.

A major finding from the survey data was the utility of the American Society of Addiction Medicine Patient Placement Criteria - Second Edition Revised (ASAM-PPC-2R) taxonomy of dual diagnosis capability. Respondents were asked to identify their program on this taxonomy: AOS, DDC, and DDE. This categorization proved highly predictive of response patterns on: prevalence estimates, assessment and treatment practices, attitudes, identified training needs, and perceptions about resources and barriers to working more effectively with persons suffering from co-occurring disorders.

Because findings from survey data are limited by potential self-report bias, the next logical step should capitalize on the Stage I study, and further examine the utility of the ASAM-PPC-2R taxonomy. A Stage II study should more objectively determine dual diagnosis program capability using the ASAM-PPC-2R model. Fidelity measures provide us with a potentially useful method. Fidelity measures have been used to assess community-based programs on implementation of evidence-based practices in the mental health service system. Fidelity scales are developed based on the research evidence for the practice, expert consensus about aspects of program implementation, and a developmental process of piloting successive versions. Once developed, fidelity measures can assess both adherence and competence in the structure and delivery of treatment services. They can also be associated with outcomes.

In this project, a fidelity scale will be developed to assess addiction treatment programs as AOS, DDC or DDE. The methodology will involve on site field observations of programs by persons trained in the use of the fidelity measure. This offers a more objective advantage over the provider self-report format. Fidelity assessments can be used for these purposes: 1) Program self-evaluation and guidance for an internal change process; 2) DMHAS facilitation of a strategic change process toward regional or statewide organization of services for persons with co-occurring disorders; and/or 3) Creating financial incentives for dual diagnosis program services.

These strategies should be considered as Stage III options.

SPECIFIC AIM AND OBJECTIVES

Aim: To improve and sustain the capability of the State of Connecticut's addiction treatment programs to assess and treat persons with co-occurring substance use and other psychiatric disorders.

Objective 1: To develop objective measures (fidelity scale) of addiction treatment program capability to assess and treat clients with co-occurring substance use and other psychiatric disorders, based upon the ASAM-PPC-2R taxonomy of: Addiction Only Services (AOS), Dual Diagnosis Capable (DDC), and Dual Diagnosis Enhanced (DDE).

Objective 2: To pilot the fidelity scale on a sample of addiction treatment programs in the State of Connecticut, and refine the instrument based upon the findings and data, feedback from providers, and leadership consensus about Stage III strategies.

METHOD

Instrument Development

We constructed the fidelity measure based upon the ASAM-PPC-2R manual guidelines (See Appendix)(ASAM, 2001). Although no psychometrically sound measures to assess dual diagnosis capability in addiction treatment are presently available, we reviewed the scientific literature for additional content and criteria (Minkoff & Cline, 2001; Minkoff et al, 2003; Stilen & Baehni, 2002). We then involved faculty from the New Hampshire-Dartmouth Psychiatric Research Center with expertise in fidelity scale construction (Robert E. Drake, William Torrey, and Kristine Knoll). They provided feedback and suggestions on the measure's framework, criteria and the assessment process. A preliminary draft version of the fidelity scale was then presented to the State of Connecticut DMHAS leadership and the Co-occurring Disorders Committee. A pilot version was constructed, consisting of 54 items and seven scales: Program Structure, Program Ambiance, Clinical Process: Assessment, Clinical Process: Treatment; Treatment Outcome, Staffing, and Training. An Overall Score for Dual Diagnosis Capability could be generated, as well as a categorization of the program as AOS, DDC or DDE.

Agency Recruitment and Selection

Volunteer agencies were sought and a recruitment letter was developed (See Appendix). The letter was mailed to all DMHAS funded or contracted programs. 18 programs volunteered to participate in a site visit and review with the preliminary fidelity measure. From these 18 volunteer programs, 7 were selected based upon range in levels of care, geographic distribution, environment (urban, rural) and hypothesized differences in dual diagnosis capability. Both the Dartmouth Committee for the Protection of Human Subjects and the State of Connecticut DMHAS Institutional Review Board, Office of Quality Management & Improvement approved the project and an "Information Sheet for Participants" (See Appendix).

Procedure

Agencies were site visited during the week of July 21 to July 25, 2003. Half-day visits at each agency were conducted. The characteristics of these agencies are presented in Table 1.0 below.

Table 1.0: Dual Diagnosis Capability in Addiction Treatment Programs Fidelity Scale (DDCAT) Development Phase: Characteristics of Programs by ASAM-PPC-2R Level of Care

Program	Level I Outpatient	Level II Intensive Outpatient/ Partial Hospitalization	Level III Residential/ Inpatient	Level IV Medically Managed Intensive Inpatient
1	I.1		III.5	
2	I.1 OMT	II.1 OMT		
3			III.7; III.8	IV-2D
4	I.1	II.1	III.1; III.7	
5	I.1	II.1	III.1; III.5	
6	I.1			
7	I.1; I.3 OMT	II.1; II.D	III.5; III.7D OMT	

Each site visit was arranged to gather information to complete the pilot fidelity measure. The following sources of information were used:

- Chart review
- Agency brochure review
- Program manual review
- Team meeting observation
- Clinical supervision observation
- Group or individual clinical session observation
- Interview with Program Director
- Interview with Clinicians
- Interview with Clients
- Interview with other service providers

The sources of data available and used for each site visit were documented, since not all sources were used at all sites.

Ratings were made at the completion of each visit. Summary report letters were mailed to each of the agency directors or their designate a week after the visit. The feedback letters did not report scores but summarized in narrative form the findings and recommendations

from the site visit. Categories of ASAM-PPC-2R dual diagnosis program capability were noted in the feedback letters, with a particular focus on what criteria could be addressed to achieve the next level of capability. These letters can be obtained at the discretion of the individual agency director. For this Stage II study, individual programs are de-identified, and the results are presented below with confidential program codes.

RESULTS

Within the course of the site visits, adequate information was obtained to make judgments on the pilot version (Version 1.0) of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) fidelity scale. For the present study, only one rater was used.

The results of the fidelity scale ratings are presented in Table 2.0 below.

Profiles across the seven scales of the DDCAT reflect consistency in capability overall, however, obvious strengths and weaknesses can be noted. For example, Program #3 scored significantly lower on Training than on all other scales. This information may suggest to the agency the development of a more systematic and documented staff training plan.

Table 2.0: Results of DDCAT Pilot Study: Program scale scores (number of items in parentheses), Overall Score and Category

Program	Program Structure (5)	Program Milieu (2)	Clinical Process: Assessment (7)	Clinical Process: Treatment (23)	Treatment Outcome (6)	Staffing (8)	Training (3)	Overall Score	DDCAT Category
1	2.2	2.5	2.1	2.5	2.5	2.9	3.0	2.52	AOS/DDC
2	3.0	4.0	4.4	3.4	3.8	3.6	3.4	3.66	DDC/DDE
3	3.8	4.0	4.4	3.9	3.8	4.7	2.0	3.80	DDC/DDE
4	2.2	1.5	2.3	2.0	2.0	1.7	2.0	1.96	AOS
5	2.8	1.5	2.6	2.4	2.8	1.5	2.0	2.23	AOS/DDC
6	4.0	3.0	3.3	3.4	4.2	4.3	4.3	3.79	DDC/DDE
7	2.8	2.0	2.7	2.4	2.5	3.0	3.0	2.63	AOS/DDC
Average	2.9	2.6	3.1	2.8	3.0	3.1	2.8	2.94	AOS/DDC

Scores reflect anchors and corresponding DDCAT categories:
1 - AOS; 3 - DDC; 5 - DDE

Likewise, Program #5 can identify areas of suggested development (Program Ambiance, Staffing and Training) which could enhance its services toward Dual Diagnosis Capable. At present, the DDCAT categories do not force a program into one of the three ASAM-PPC-2R options, but instead provide five categories (adding AOS/DDC and DDC/DDE) to capture these intermediate placements. The translation from the Overall Score to the

corresponding DDCAT Category is as follows: AOS = 1.0 - 1.99; AOS/DDC = 2.0 - 2.99; DDC = 3.0 - 3.49; DDC/DDE = 3.5 - 4.49; and, DDE = 4.5 - 5.00

One test of the validity of the DDCAT categorization is the relationship or correspondence between the hypothetically more objective fidelity scale rating with the self-reported survey ratings obtained from agency directors, clinical supervisors and clinicians in Stage I. Table 3.0 presents this comparison below.

Table 3.0: Results of DDCAT Pilot Study Category compared with Connecticut Addiction Treatment Provider Survey ratings of program dual diagnosis capability

Program	DDCAT Category	% Rated as AOS	% Rated as DDC	% Rated as DDE
1	AOS/DDC	22.2	66.6*	11.1
2	DDC/DDE	13.0	69.6*	17.4
3	DDC/DDE	0	47.0	52.9*
4	AOS	12.5	68.7*	18.7
5	AOS/DDC	0	100.0*	0
6	DDC/DDE	11.1	55.5*	33.3
7	AOS/DDC	39.5	72.1*	4.7
Total Survey Sample (n = 456)		18.4	60.0*	21.4

*Simple majority of respondents.

Overall, the correspondence between the DDCAT Category and the provider self-ratings is remarkable. Only one program (#4) self rates at primarily DDC when the fidelity scale places it as AOS. Interestingly, Programs #2 and #6 are closer to DDE than they perceive. This comparison offers support for the validity of the DDCAT as a measure of program dual diagnosis capability.

The experience from the site visits and these data have resulted in a refined version of the DDCAT (Version 2.0)(See Appendix). The DDCAT 2.0 has reduced the number of items by 11 (43 items total), and has clearer anchor points for scoring. Although further refinements and reductions are necessary, including a manual for the training of new raters, the DDCAT 2.0 is warranted for a Stage III application.

CONCLUSIONS

This initiative's overarching aim is to improve and sustain the capability of the State of Connecticut's addiction treatment programs to effectively assess and treat persons with co-occurring substance use and other psychiatric disorders.

Our first specific objective for this project was to develop a measure (fidelity scale) of addiction treatment program capability to assess and treat clients with co-occurring substance use and other psychiatric disorders, based upon the ASAM-PPC-2R taxonomy of: Addiction Only Services (AOS), Dual Diagnosis Capable (DDC), and Dual Diagnosis Enhanced (DDE). After a thorough review of the scientific literature, and in collaboration with DMHAS leadership, the DMHAS Co-occurring Disorders Committee and New Hampshire Dartmouth Psychiatric Research Center faculty, we developed a draft instrument to field test with addiction treatment programs.

As proposed in our second objective, we pilot tested the fidelity scale with addiction treatment programs (7) in the State of Connecticut. Data from these programs depicted a range from AOS to DDC/DDE program capability. The fidelity scale method seems to generate useful data, and the feedback to programs appears valuable in evaluating and guiding the development of their services to persons with co-occurring disorders. Based upon these data, as well as feedback from providers and researchers, we have further refined the Dual Diagnosis Capability in Addiction Treatment (DDCAT) fidelity measure (See Appendix).

Many important questions remain about the instrument and methodology. Of primary importance is the assumption that increasing dual diagnosis capability in addiction treatment programs is associated with improved client outcomes: reduced or no substance use, reduced psychiatric problems and improved treatment retention. Although there is evidence to support this assumption (problem service matching research findings), it is not specific to the operational definitions contained and measured in the DDCAT. Further research must test and/or establish the link between the DDCAT criteria and client outcomes. Only then can it accurately be deemed a measure of fidelity to an evidence-based practice. At present, it is measure of fidelity to the ASAM-PPC-2R conceptual model and operational definitions constructed by dual diagnosis experts. Nonetheless, there is no other measure presently available to offer pragmatic or empirical guidelines for addiction treatment programs to serve persons with co-occurring substance use and psychiatric disorders.

The DDCAT measure and methodology is a work-in-progress. At 43 items, the instrument still requires further reduction, simplification, and more definitive anchors for ratings. Methods for training raters need to be established, and a corresponding manual developed. The procedure for obtaining the data during the course of the site visit requires more study and standardization. These endeavors are consistent with the early and middle developmental stages of a fidelity scale.

RECOMMENDATIONS

1. As outlined in the original proposal, Stage III of this project implements the refined version of the fidelity measure on a statewide basis. In advance of this implementation, two activities are required. First, additional psychometric fine-tuning of the DDCAT is necessary, and would be based upon the feedback gathered from this report and a review by fidelity construction experts (Drake & Torrey at Dartmouth; and Gary Bond at the University of Indiana). Second, new site reviewers would require training in the use of the DDCAT, and their inter-rater and trained-to-criteria levels established. Additional agencies might be assessed for this purpose, and an even further refined and more parsimonious version of the DDCAT would be the result (3.0). In addition, scores on the independent rater version of the DDCAT could be compared with agency self-assessment on the measure. This would be a Stage II Phase II study to complete Stage II: reliability and validity testing, training of new raters, and additional agencies sampled further refine the DDCAT for broader application.

2. Both in the Stage I provider survey and in the Stage II dual diagnosis capability fidelity scale development study several important levels of training need emerged. There appears to be a distinct training need for: 1) Basic information and skills with co-occurring disorders; 2) Advanced information and therapeutic techniques for co-occurring disorders; and 3) Psychotropic medications in addiction treatment. These trainings should be appropriately matched to level of clinician need, and not mixed. Otherwise inefficient use of resources in staff and trainer time will result. Basic skills would include information on prevalence, simple screening and triage. In addition, exercises on attitudes and negative bias must be offered at the Basic level. The Advanced level would consist of complex differential diagnosis, and a organized presentation of the disparate evidence for specific treatments for common co-occurring disorders in addiction treatment settings: Mood, anxiety, and Axis II disorders. Finally, clinical guidelines for the appropriate response to common psychotropic medications found in clients and prescribed for clients in addiction treatment: anti-depressants, anxiolytics, mood stabilizers, narcotics, sleep medications, pain medicines, and medications for ADHD/ADD.

3. With the guidance of DMHAS leadership and the Co-occurring Disorder Committee, a strategic plan for statewide assessment of program dual-diagnosis capability should be undertaken. Prior to these assessments, agency leaders and stakeholder groups (e.g. CT Addiction Treatment Providers Association) can convene and be presented with the DDCAT and rating criteria. In addition, all agencies can receive the DDCAT and rating criteria to self-assess. These exercises will stimulate requests for guidance and technical assistance to enhance services within certain criteria (e.g. “What are recommended screening instruments?”). The capacity to respond to these inquiries must be anticipated and developed.

4. Statewide assessments can be performed within a timeline and framework determined by DMHAS. A timeline factor may be the number of raters who are trained in the DDCAT methodology. A framework factor may be the strategy of approach or "roll-out." This may initially involve a solicitation for volunteers, and then evolve to a more definitive plan for program assessment by region, modality, level of care, or type of funding.

5. Data obtained from the DDCAT can be linked to MIS and client outcome databases. This advances our understanding of the implications of dual diagnosis capability.

6. The information gathered from the DDCAT can be used for several purposes, and serves to guide processes, already underway, more empirically and systematically:

    - Agency leaders can use the DDCAT criteria and scales as pragmatic guidelines to enhance their services, staffing and training plan. Some of these enhancements involve additional costs (e.g. physician coverage), some do not (e.g. implementing reliable screening measures).
    - Agencies can use the actual DDCAT score and review process as an "objective" report card, and with the assistance of outside observers, use the information as constructive feedback about ways to improve services.
    - DMHAS can use the DDCAT data for system and regional assessment of the scope and capability of services available to the people of Connecticut. This information can guide statewide planning for services, for training, and for contractual and funding incentives for service provision (e.g. paying a provider more for DDE services, less for AOS services).

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FOR FURTHER INFORMATION:

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APPENDIX

I. American Society of Addiction Medicine Patient Placement - Second Edition Revised. Taxonomy for program dual diagnosis capability

II. Study recruitment letter to agencies from Thomas Kirk, Jr., Ph.D., Commissioner, State of Connecticut Department of Mental Health & Addiction Services

III. Information Sheet for Study Participants

IV. Dual Diagnosis Capability in Addiction Treatment (DDCAT) Version 2.0

ASAM-PPC-2R CO-OCCURRING DISORDER PROGRAM TYPOLOGY

ADDICTION-ONLY SERVICE (AOS)

Services directed solely at the treatment of addictive disorders. Such services are not directed at co-occurring mental disorders: for example, an AOS program typically would not accept an individual who needs psychotropic medications, and mental health issues generally would not be addressed in treatment planning or content. (p.359*).

Programs that either by choice or for lack of resources, cannot accommodate clients who have psychiatric illnesses that require ongoing treatment, however stable the illness and however well-functioning the client. (From Co-Occurring Disorders Survey Questionnaire).

DUAL DIAGNOSIS CAPABLE (DDC)

Treatment programs that address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning. Such programs have arrangements in place for coordination and collaboration with mental health services. They also can provide psychopharmacologic monitoring and psychological assessment and consultation, either on site or through coordinated consultation with off site providers. Program staff are able to address the interaction between mental and substance-related disorders and their effect on the patient's readiness to change-as well as relapse and recovery environment issues-through individual and group program content. Nevertheless, the primary focus of DDC programs is the treatment of substance-related disorders. (p.362*).

Programs that have a primary focus on the treatment of substance-related disorders, but are also capable of treating clients who have relatively stable diagnostic or subdiagnostic co-occurring mental health problems related to an emotional, behavioral or cognitive disorder. (From COD Survey Questionnaire).

DUAL DIAGNOSIS ENHANCED (DDE)

Treatment programs that incorporate policies, procedures, assessments, treatment and discharge planning processes that accommodate patients who have co-occurring mental and substance-related disorders. Mental health symptom management groups are incorporated into addiction treatment. Motivational enhancement therapies specifically designed for those with co-occurring mental and substance-related disorders are more likely to be available (particularly in outpatient settings) and, ideally, there is close collaboration or integration with a mental health program that provides crisis back-up services and access to mental health case management and continuing care. In contrast to DDC services, DDE services place their primary focus on the integration of services for mental and substance-related disorders in their staffing, services an program content. (p.362).

Programs that are designed to treat clients who have more unstable or disabling co-occurring mental disorders in addition to their substance-related disorders. (From COD Survey Questionnaire).

* American Society of Addiction Medicine. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders. Second Edition-Revised. Chevy Chase MD: American Society of Addiction Medicine.

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

A Healthcare Service Agency

To: Addiction Treatment Providers

From: Thomas A. Kirk, Ph.D., Commissioner
Kenneth M. Marcus, M.D., Medical Director
Paul J. DiLeo, Director of Community Services and Hospitals

Date: May 1, 2003

Re: **Co-occurring disorders Initiative: Addiction treatment capability**

At the national, state and local levels, our field has become increasingly cognizant of the prevalence of co-occurring substance use and psychiatric disorders among clients in both our addiction treatment and mental health service systems. Over the past year, we have launched several new initiatives, in effort to enhance and expand access and the quality of services provided to persons with dual-disorders.

On the addiction treatment side, we completed a Phase I project last year giving us an objective overview of the current practices, attitudes, perceived resources, barriers and training needs. This was accomplished at the direction of Dr. Mark McGovern of the Department of Psychiatry at Dartmouth Medical School. 456 providers across the state completed detailed surveys about co-occurring disorders. These findings were published in a summary report you have been issued (if not summary reports are available from Sam Segal, DMHAS). Individual agency reports have recently been assembled and distributed to each of you for your own self-examination.

Many interesting findings emerged from the survey data, including the potential value of the American Society of Addiction Medicine Patient Placement Criteria - Second Edition Revised (ASAM-PPC-2R) system for categorizing addiction programs: Addiction Only, Dual-Diagnosis Capable, or Dual-Diagnosis Enhanced. Again with the help of Dr. McGovern and the New Hampshire Dartmouth Psychiatric Research Center, DMHAS is interested in articulating the clinical, resource and administrative ingredients that support or inhibit a program's dual diagnosis capability.

Over the next several months, Dr. McGovern will be conducting Phase II of the co-occurring disorders in addiction treatment initiative. In this phase, he intends to visit treatment programs, meet with agency directors and clinical staff, observe clinical staff or treatment team meetings, review program policy and procedure manuals and de-identified clinical records. The goal of these visits, which should take 2 to 3 hours per agency, is to more objectively identify program factors that support capability to assess and treat clients with co-occurring disorders.

We are hopeful that your agency will consider volunteering for such a visit, and would encourage you to do so. It would enable you to contribute to the development of our understanding of what it takes to operate a program capable of effectively responding to clients with co-occurring disorders. It would also enable you to receive some objective feedback and insight about your agency, and develop some awareness of items you may already have in place or may need to develop in order to increase your capability.

At this phase, we are looking for voluntary participation from our agencies. All information will be confidential, and assembled and analyzed by the NH-Dartmouth Research Center group with this in mind. Neither the decision to participate nor the information provided would affect your status with DMHAS in any way.

If you are interested in participating, we advise you to contact either Sam Segal or Lauren Siembab at DMHAS, or contact the NH-Dartmouth Psychiatric Research Center project coordinator directly (Bonnie Wrisley: 603-271-5819, or Bonnie.R.Wrisley@Dartmouth.edu). Please do so by June 1, 2003.

We are grateful for your support of the Co-Occurring Disorders Initiative, which we hope will continue to place the State of Connecticut on the forefront of this nationally important matter.