

Recommended Guidelines for Adult Full Service Partnerships Serving Adults, Older Adults and Transition Age Youth With Co-occurring Disorders

April 2007

These guidelines were identified by developing a crosswalk of 1) the Mental Health Services Act (MHSA), 2) the Community Supports and Services (CSS) requirements of the MHSA, fidelity elements of the National SAMHSA Resource Manuals on 3) Integrated Dual Disorders Treatment (IDDT) and 4) Assertive Community Treatment (ACT) programs and 5) the critical elements of the AB 2034 programs. The cross walk was reviewed by an advisory panel of California practitioners in dual diagnosis convened under the auspices of COJAC and by staff representatives from the counties and programs that implemented IDDT programs under the CA DMH SAMHSA grant for training and evaluation of IDDT evaluation. These guidelines were presented to the COJAC in February 2007 and recommendations of that group were incorporated into the guidelines.

Team Approach

- One Team with one service plan for one person
- Each team includes Personal Service Coordinators (PSCs), Dual Disorders Specialists with 2+ years experience, psychiatrist, nurse, specialists in housing and employment
- Caseload Size: 10 – 15 clients per staff
- Each client has an identified individual or team Personal Service Coordinator (PSC)

Integrated Approach

- Integrated Assessment
- Integrated Service Plan
- Integrated Crisis Plan
- Promotes self care

Service Delivery Policies and Philosophy

- The “whatever it takes” philosophy is clearly understood and articulated by leaders, staff, clients, family members and in written materials
- There are no time limits to services, available at any time, no waiting lists
- The program is culturally competent, e.g., understands and utilizes the strengths of culture in service delivery, knows the resources and practices of client’s ethnic/cultural community
- The services use a harm reduction approach

Service Components

- Team has 24/7 availability to respond to individual, significant others, landlords, law enforcement, others
- Program has demonstrated strategies and policies for in situ and engagement outreach
- There is flexible funding to provide basic needs, wrap around services, e.g., housing and housing subsidies, food, transportation and “just in time” tools for engagement
- There is regular ongoing assistance to support person’s service plan as needed (from 7 days/week to 1/month)
- Personal Service Coordinators or team works with families as part of the service team when approved by client
- Prescribing for psychiatric medications is based on evidence
- Medications are not withheld due to use of other substances
- There is a formal process to identify differential interventions for specific clients

Community Collaboration

- Ready access to housing and other community resources
- Coordination with other agencies and community resources
- Promote and support participation in community self help groups

Outcome Monitoring

- Clear objectives
- Real time client outcome data
- Review outcome data in staff individual and group supervision on a regular basis

Training and Supervision

- All team members participate in specialized dual recovery training initially and at least annually thereafter
- Staff are trained in and practice motivational interviewing
- Staff are trained in and practice stage-wise treatment
- Staff are trained in and practice group dual recovery treatment
- All team members receive regular ongoing group or individual supervision in dual recovery treatment, including review of client outcomes