DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT (DDCAT) *VERSION 3.2*

RATING SCALE COVER SHEET

Program Identification

Date: _____ **Rater(s):** _____ **Time Spent (Hours):** _____

Agency Name: _____

Program Name: _____

Address: _____ **Zip Code:** _____

Contact Person: 1) _____**; 2)** _____

Telephone: _____**; FAX:** _____**; Email:** _____

State: _____ **Region:** _____ **Program ID:** _____ **Time Period:** ____ **(1= Baseline; 2 = 1st-follow-up; 3= 2nd follow-up; 4= 4th follow-up; etc)**

Program Characteristics

Payments received (program):
_____ Self-pay
_____ Private health insurance
_____ Medicaid
_____ Medicare
_____ State financed insurance
_____ Military insurance

Other funding sources:
_____ Other public funds
_____ Other funds

Primary focus of agency:
_____ Addiction treatment services
_____ Mental health services
_____ Mix of addiction & MH services
_____ General health services
_____ Hospital

Size of Program:
_____ # of admissions/last fiscal year
_____ Capacity (highest # servable)
_____ Average length of stay (in days)
_____ Planned length of stay (in days)
_____ # of unduplicated clients/year

Agency type:
_____ Private
_____ Public
_____ Non-Profit
_____ For-Profit
_____ Government operated
_____ Veterans Health Admin.

Level of care:
ASAM-PPC-2R (Addiction):
_____ I. Outpatient
_____ II. IOP/Partial Hospital
_____ III. Residential/Inpatient
_____ IV. Medically Managed Intensive Inpatient (Hospital)
_____ OMT: Opioid Maintenance
_____ D: Detoxification
Mental Health:
_____ Outpatient
_____ Partial hospital/Day program
_____ Inpatient

Exclusive program/Admission criteria requirement:
_____ Adolescents
_____ Co-occurring MH & SUDs disorders
_____ HIV/AIDs
_____ Gay & Lesbian
_____ Seniors/Elders
_____ Pregnant/post-partum
_____ Women
_____ Residential setting for patients & their children
_____ Men
_____ DUI/DWI
_____ Criminal justice clients
_____ Adult General

DDCAT assessment sources

_____ Chart Review: _____ Agency brochure review: _____ Program manual review; _____ Team meeting observation;
_____ Supervision observation: _____ Observe group/individual session: _____ Interview with Program Director:
_____ Interview with Clinicians: _____ Interview with clients (#: ____); _____ Interview with other service providers; _____ Site tour.

Total # of sources used: _____

DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT PROGRAMS (DDCAT) *VERSION 3.2*

RATING SCALE

	1 AOS	2	3 DDC	4	5 DDE
I. PROGRAM STRUCTURE					
IA. Primary focus of agency as stated in the mission statement (If program has mission, consider program mission)	Addiction Only		Primary focus is addiction, co-occurring disorders are treated		Primary focus on persons with co-occurring disorders.
IB. Organizational certification & licensure.	Permits only addiction treatment	Has no actual barrier, but staff report there to be certification or licensure barriers.	Has no barrier to providing mental health treatment or treating co-occurring disorders within the context of addiction treatment		Is certified and/or licensed to provide both
IC. Coordination and collaboration with mental health services.	No document of formal coordination or collaboration. Meets the SAMHSA definition of minimal Coordination.	Vague, undocumented, or informal relationship with MH agencies, or consulting with a staff member from that agency. Meets the SAMHSA definition of Consultation.	Formalized and documented coordination or collaboration with mental health agency. Meets the SAMHSA definition of Collaboration.	Formalized coordination & collaboration, and the availability of case management staff, or staff exchange programs (variably used) Meets the SAMHSA definition of Collaboration and has some informal components consistent with Integration.	Most services are integrated within the existing program, or routine use of case management staff or staff exchange programs. Meets the SAMHSA definition of Integration.
ID. Financial incentives.	Can only bill for addiction treatments or for persons with substance use disorders.	Could bill for either service type if substance use disorder is primary, but staff report there to be barriers. –OR- Partial reimbursement for MH services available	Can bill for either service type, however, substance use disorder must be primary.		Can bill for addiction or mental health treatments, or the combination and/or integration.
	1	**2**	**3**	**4**	**5**

	AOS		DDC		DDE
II. PROGRAM MILIEU					
IIA. Routine expectation of and welcome to treatment for both disorders	Expects substance use disorders only, refer or deflect persons with mental health disorders or symptoms.	Documented to expect substance use disorders only (e.g. admission criteria, target population), but have informal procedure to allow some persons with mental health problems to be admitted.	Expect substance use disorders, and, with documentation, accepts mental health disorders by routine and if mild and relatively stable.	Program formally defined like DDC but clinicians and program informally expects and treats both disorders, <u>not</u> well documented.	Clinicians and program expect and treat both disorders, well documented.
IIB. Display and distribution of literature and patient educational materials.	Addiction or peer support (e.g. AA) only	Available for both disorders but not routinely offered or formally available.	Available for both mental health & substance use disorders, but distribution is less for mental health problems.	Available for both mental health & substance use disorders with equivalent distribution.	Available for the interaction between both mental health and substance use disorders.
	1	**2**	**3**	**4**	**5**

	AOS		DDC		DDE
III. CLINICAL PROCESS: ASSESSMENT					
IIIA. Routine screening methods for psychiatric symptoms	Pre-admission screening based on patient self-report. Decision based on clinician inference from patient presentation or by history.	Pre-admission screening for symptom & treatment history, current medications, suicide/homicide history prior to admission.	Routine set of standard interview questions for MH using generic framework, e.g. ASAM-PPC (Dimension III) or "Biopsychosocial" data collection.	Screen for mental health problems using standardized or formal instruments with established psychometric properties.	Standardized or formal instruments for both mental health and substance use disorders with established psychometric properties.
IIIB. Routine assessment if screened positive for psychiatric symptoms	Ongoing monitoring for appropriateness or exclusion from program	More detailed biopsychosocial assessment, mental status exam, each clinician driven	Formal mental health assessment, if necessary, typically occurs.	Increased capacity to access follow-up mental health assessments, although not standardized or routine.	Standardized or formal integrated assessment is routine in all cases.
IIIC. Psychiatric and substance use diagnoses made and documented.	Psychiatric diagnoses are not made or recorded	Mental health diagnostic impressions made and recorded variably.	Mental health diagnosis variably recorded in chart.	Mental health diagnosis more frequently recorded but inconsistently	Standard & routine mental health diagnoses consistently made.
IIID. Psychiatric and substance use history reflected in medical record.	Collection of substance use disorder history only.	Standard form collects substance use disorder history only. Mental health history collected inconsistently.	Routine documentation of both mental health and substance use disorder history in record in narrative section.	Specific section in recorded dedicated to history and chronology of course of both disorders.	Specific section in record devoted to history and chronology of course of both disorders and the interaction between them is examined temporally.
IIIE. Program acceptance based on psychiatric symptom acuity: low, moderate, high.	Admits persons with no to low acuity.		Admits persons in program with low to moderate acuity, but who are primarily stable.		Admits persons in program with moderate to high acuity, including those unstable in their psychiatric condition.
IIIF. Program acceptance based on severity of persistence and disability: low, moderate, high.	Admits persons in program with no to low severity of persistence of disability		Admits persons in program with low to moderate severity.		Admits persons in program with moderate to high severity
IIIG. Stage-wise assessment	Not assessed or documented.	Assessed & documented variably by individual clinician	Clinician assessed and routinely documented, focused on substance use disorders motivation	Formal measure used and routinely documented but focusing on substance use disorders motivation only.	Formal measure used and routinely documented, focus on both substance use and mental health motivation.
	1	**2**	**3**	**4**	**5**

	AOS		DDC		DDE
IV. CLINICAL PROCESS: TREATMENT					
IVA. Treatment plans.	Address addiction only (Mental health not listed)	Variable by individual clinician	Substance use disorders addressed as primary, mental health as secondary	Systematic focus in available but variably used.	Address both as primary, both listed in plan consistently.
IVB. Assess and monitor interactive courses of both disorders.	No attention or documentation of progress with mental health problems	Variable reports of progress on mental health problems by individual clinicians.	Clinical focus in narrative (treatment plan or progress note) on mental health problem change	Systematic focus is available but variably used.	Clear, detailed, and systematic focus on change in both substance use and mental health disorders.
IVC. Procedures for psychiatric emergencies and crisis management.	No guidelines conveyed in any manner.	Verbally conveyed in-house guidelines.	Documented guidelines: Referral or collaborations (to local mental health agency or E/R)		Routine capability, or a process to ascertain risk with ongoing use of substances; Maintain in program unless commitment is warranted
IVD. Stage-wise treatment	Not assessed or explicit in treatment plan.	Stage or motivation documented variably by individual clinician in treatment plan.	Stage or motivation routinely incorporated into individualized plan, but no specific stage-wise treatments.	Stage or motivation routinely incorporated into individualized plan, and general awareness of adjusting treatments by individual stage of readiness on substance use motivation only.	Stage or motivation routinely incorporated into individualized plan, and formally prescribed and delivered stage-wise treatments for both substance use and mental health issues.
IVE. Policies and procedures for medication evaluation, management, monitoring and compliance.	Patients on meds routinely not accepted. No capacities to monitor, guide or provide psychotropic medications during treatment.	Certain types of meds are not acceptable. Or must have own supply for entire treatment episode. Some capacity to monitor psychotropic medications.	Present, coordinated medication policies. Some access to prescriber for psychotropic medications and policies to guide the prescribing within the program is provided. Monitoring of the medication is largely provided by the prescriber.	Clear standards and routine for medicating provider who is also a staff member. Regular access to prescriber and guidelines for prescribing in place. The prescriber might more regularly consult with other staff regarding medication plan and recruit other staff to assist with medication monitoring	Clear standards and routine for medicating provider who is also a staff member and present on treatment teams or administration. Full access to prescriber with appropriate prescribing guidelines in place. As a treatment team member, the prescriber informs the team about the medication plan and the entire team can assist with monitoring.
	1	**2**	**3**	**4**	**5**

	AOS		DDC		DDE
IV. CLINICAL PROCESS: TREATMENT (cont)					
IVF. Specialized interventions with mental health content.	Not addressed in program content	Based on judgment by individual clinician; Irregular penetration into routine services	In program format as generalized intervention, e.g. stress management); More regular penetration into routine services. Routine clinician adaptation of an evidence-based addiction treatment (e.g. MI, CBT, TSF)	Some specialized interventions by specifically trained clinicians in addition to routine generalized interventions.	Routine MH symptom management groups; Individual therapies focused on specific disorders; Systematic adaptation of an evidence-based addiction treatment (e.g. MI, CBT, TSF).
IVG. Education about psychiatric disorder & its treatment, and interaction with substance use & its treatment.	No	Variably	Present in generic format and content, and delivered in individual and/or group formats.		Present specific content for specific disorder co-morbidities, and delivered in individual and/or group formats.
IVH. Family education and support.	For alcohol or drug problems only	Variably or by individual clinical judgment	MH issues regularly but informally incorporated into family education or support sessions. Available as needed.	Generic group on site for families on substance use and mental issues, variably offered. Structured group with more routine accessibility	Routine and systematic co-occurring disorder family group integrated into standard program format. Accessed by the majority of families with co-occurring disorder family member
IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment.	None used to facilitate either use of addiction or mental health peer support	Used variably by or infrequently by individual clinicians, for individual patients, mostly for facilitation of addiction peer support groups	Present, generic format on site, but no specific or intentional facilitation based on mental health problems. More routine facilitation of traditional addiction peer support groups (e.g. AA, NA)	Present but variable facilitation to peer support groups targeting specific mental health issues, either to traditional peer support groups or those specific to both (e.g. DRA, DTR, etc).	Routine & specific to need of co-occurring persons, special programs on site, routinely targeted to specific issues, either to traditional peer support groups or those specific to both (e.g. DRA).
IVJ. Availability of peer recovery supports for patients with CODs.	Not present, or if present not recommended.	Off site, recommended variably	Present, off site and facilitated with contact persons or informal matching with peer supports in the community, some co-occurring focus.	Present, off site, integrated into plan, and routinely documented with co-occurring focus.	Present, on site, facilitated and integrated into program (e.g. alumni groups); Routinely used and documented with co-occurring focus.
	1	**2**	**3**	**4**	**5**

	AOS		DDC		DDE
V. CONTINUITY OF CARE					
VA. Co-occurring disorder addressed in discharge planning process.	Not addressed	Variably addressed by individual clinicians.	Co-occurring disorder systematically addressed as secondary in planning process for off site referral.		Both disorders seen as primary, and plans made and insured, on site, or by arrangement - off site, at least 80% of the time.
VB. Capacity to maintain treatment continuity.	No mechanism for managing ongoing care of mental health needs when addiction treatment program is completed.	No formal protocol to manage mental health needs once program is completed, but some individual clinicians may provide extended care until appropriate linkage takes place; Variable documentation	No formal protocol to manage mental health needs once program is completed, but when indicated, most individual clinicians provide extended care until appropriate linkage takes place; Routine documentation	Formal protocol to manage mental health needs indefinitely, but variable documented evidence that this is routinely practiced, typically within the same program or agency.	Formal protocol to manage mental health needs indefinitely and consistent documented evidence that this is routinely practiced, typically within the same program or agency.
VC. Focus on ongoing recovery issues for both disorders.	No	Individual clinician determined.	Routine focus is on recovery from addiction, mental health issues are viewed as potential relapse issues only.		Routine focus on addiction recovery and mental health illness management and recovery, both seen as primary and ongoing.
VD. Facilitation of peer support groups for co-occurring disorders is documented and a focus in discharge planning, and connections are insured to community peer recovery support groups.	No	Rarely, but addressed by individual clinicians	Yes, variable, but not routine or systematic, focus on co-occurring disorders peer support community connection (engagement in meetings or functions off-site)		Yes, routine and systematic, at least 80% of the time with focus on co-occurring disorders peer support community connection (engagement in meetings or functions off-site).
VE. Sufficient supply and compliance plan for medications is documented.	No medications in plan.		Yes, 30-day or supply to next appointment off-site.		Maintains medication management in program with provider.
	1	**2**	**3**	**4**	**5**

	AOS		DDC		DDE
VI. STAFFING					
VIA. Psychiatrist or other physician or prescriber of psychotropic medications.	No formal relationship with a prescriber for this program.	Consultant or contractor off site.	Consultant or contractor on site.	Staff member, present on site for clinical matters only	Staff member, present on site for clinical, supervision, treatment team, and/or administration.
VIB. On site clinical staff members with mental health licensure (doctoral or masters level), or competency.	No formal relationship with program.	1-24% of clinical staff members.	25-33% of clinical staff members.	34-49% of clinical staff members.	50% or more of clinical staff members.
VIC. Access to mental health supervision or consultation.	No	Yes, off site by consultant, undocumented.	Yes, on site supervision provided PRN. Informal process.	Yes, on site supervision. Provided regularly. Irregular documentation.	Yes, on site, documented regular supervision sessions for clinical matters.
VID. Case review, staffing or utilization review procedures emphasize and support co-occurring disorder treatment.	No	Variable, by off site consultant, undocumented.	Yes, on site, documented as needed (PRN) and with co-occurring disorder issues.		Yes. Documented, routine and systematic coverage of co-occurring issues.
VIE. Peer/Alumni supports are available with co-occurring disorders.	No		Present, but as part of community, and routinely available to program patients, either thru informal relationships or more formal connections such as thru peer support service groups (e.g. AA hospital and institutional committees; NAMI).		Present, on site, either as paid staff, volunteers, or routinely available program "alumni".
	1	**2**	**3**	**4**	**5**

	AOS		DDC		DDE
VII. TRAINING					
VIIA. Direct care staff members have basic training in prevalence, common signs & symptoms, screening and assessment for psychiatric symptoms and disorders.	Not trained in basic skills.	Variably trained, not documented as part of systematic training plan, but encouraged by management.	Trained in basic skills per agency strategic training plan.	Trained in these skills per agency strategic training plan, and also have some advanced training in specialized treatment approaches.	Trained in these skills per agency strategic training plan, and also have staff with advanced training in specialized treatment approaches as part of plan.
VIIB. Direct care staff members are cross-trained in mental health and substance use disorders, including pharmacotherapies, and have advanced specialized training in treatment of persons with co-occurring disorders.	Not trained, or not documented.	At least 33% trained.	At least 50% trained	At least 75% are trained	At least 90% are trained.

ADDITIONAL SITE VISIT NOTES:

DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT PROGRAMS (DDCAT) *VERSION 3.2*

SCORING SUMMARY

I. Program Structure

A. _____
B. _____
C. _____
D. _____

_____

Sum Total = _____
/4 = **SCORE** _____

II. Program Milieu

A. _____
B. _____

_____

Sum Total = _____
/2 = **SCORE** _____

III. Clinical Process: Assessment

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____

_____

Sum Total = _____
/7 = **SCORE** _____

IV. Clinical Process: Treatment

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____
H. _____
I. _____
J. _____

_____

Sum Total = _____
/10 = **SCORE** _____

DDCAT INDEX PROGRAM CATEGORY: SCALE METHOD

OVERALL SCORE (Sum of Scale Scores/7): _____

DUAL DIAGNOSIS CAPABILITY:

AOS (1 - 1.99) _____
AOS/DDC (2 - 2.99) _____
DDC (3 - 3.49) _____
DDC/DDE (3.5 - 4.49) _____
DDE (4.5 - 5.0) _____

DDCAT INDEX PROGRAM CATEGORY: CRITERION METHOD

% CRITERIA MET FOR AOS (# of "1" scores/35): **100%**
% CRITERIA MET FOR DDC (# of "3 or <" scores/35): _____
% CRITERIA MET FOR DDE (# of "5" scores/35): _____

HIGHEST LEVEL OF DD CAPABILITY (80% or more): _____

V. Continuity of Care

A. _____
B. _____
C. _____
D. _____
E. _____

_____

Sum Total = _____
/5 = **SCORE** _____

VI. Staffing

A. _____
B. _____
C. _____
D. _____
E. _____

_____

Sum Total = _____
/5 = **SCORE** _____

VII. Training

A. _____
B. _____

_____

Sum Total = _____
/2 = **SCORE** _____