DUAL DIAGNOSIS CAPABILITY IN MENTAL HEALTH TREATMENT (DDCMHT) *VERSION 3.2*

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RATING SCALE COVER SHEET

Program Identification

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

Agency Name: _____

Program Name: _____

Address: _____

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: _____

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RATING SCALE

	1 **MHOS**	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)	Mental Health Only		Primary focus is mental health, co-occurring disorders are treated		Primary focus on persons with co-occurring disorders.
IB. Organizational certification & licensure.	Permits only mental health treatment	Has no actual barrier, but staff report there to be certification or licensure barriers.	Has no barrier to providing addiction treatment or treating co-occurring disorders within the context of mental health treatment		Is certified and/or licensed to provide both
IC. Coordination and collaboration with addiction services.	No document of formal coordination or collaboration. Meets the SAMHSA definition of minimal Coordination.	Vague, undocumented, or informal relationship with addiction agencies, or consulting with a staff member from that agency. Meets the SAMHSA definition of Consultation.	Formalized and documented coordination or collaboration with addiction 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 mental health treatments or for persons with mental health disorders.	Could bill for either service type if mental health disorder is primary, but staff report there to be barriers. – OR- Partial reimbursement for addiction services available	Can bill for either service type, however, mental health disorder must be primary.		Can bill for addiction or mental health treatments, or the combination and/or integration.

	1 **MHOS**	2	3 **DDC**	4	5 **DDE**
II. PROGRAM MILIEU					
IIA. Routine expectation of and welcome to treatment for both disorders	Expect mental health disorders only, refer or deflect persons with substance use disorders or symptoms.	Documented to expect mental health disorders only (e.g. admission criteria, target population), but have informal procedure to allow some persons with substance use disorders to be admitted.	Expect mental health disorders, and, with documentation, accepts substance use 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.	Mental health only	Available for both disorders but not routinely offered or formally available.	Available for both mental health and substance use disorders but distribution is less for substance use disorders.	Available for both mental health & substance use disorders with equivalent distribution.	Available for the interaction between both mental health and substance use disorders.

	1 MHOS	2	3 DDC	4	5 DDE
III. CLINICAL PROCESS: ASSESSMENT					
IIIA. Routine screening methods for substance use	Pre-admission screening based on patient self-report. Decision based on clinician inference from patient presentation or history.	Pre-admission screening for substance use & treatment history prior to admission.	Routine set of standard interview questions for substance use using generic framework (e.g. ASAM-PPC Dim. I & V, LOCUS Dim. III) or "Biopsychosocial" data collection.	Screen for substance use 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 substance use	Ongoing monitoring for appropriateness or exclusion from program	More detailed biopsychosocial assessment, history of substance use and treatments, each clinician driven.	Increased capacity to access (not necessarily in-house) substance use assessments, although not standardized or routine.	Formal substance use assessment, if necessary, typically occurs (in-house).	Standardized or formal integrated assessment is routine in all cases.
IIIC. Psychiatric and substance use diagnoses made and documented.	Substance use disorder diagnoses are not made or recorded	Substance use disorder diagnostic impressions made and recorded variably.	Substance use disorder diagnosis variably recorded in chart (i.e., less than 40% of the time).	Substance use disorder diagnosis more frequently recorded but inconsistently (i.e., more than 40% but less than 90% of the time).	Standard & routine substance use disorder diagnoses consistently made.
IIID. Psychiatric and substance use history reflected in medical record.	Collection of mental health history only.	Standard form collects mental health history only. Substance use disorder history collected inconsistently.	Routine documentation of both mental health and substance use disorder history in record in narrative section.	Specific section in record 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 substance use disorder 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 substance use disorder.
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 mental health motivation for treatment	Formal measure used and routinely documented but focusing on mental health motivation for treatment only.	Formal measure used and routinely documented, focus on both substance use and mental health motivation for treatment.

	1 MHOS	2	3 DDC	4	5 DDE
IV. CLINICAL PROCESS: TREATMENT					
IVA. Treatment plans.	Address mental health only (addiction not listed)	Variable by individual clinician	Mental health disorders addressed as primary, substance use disorders as secondary	Systematic focus is available but variably used.	Address both as primary, both listed in plan consistently.
IVB. Assess and monitor interactive courses of both disorders.	No attention to or documentation of progress with substance use disorders	Variable reports of progress on substance use disorders by individual clinicians.	Clinical focus in narrative (treatment plan or progress note) on substance use disorder 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 intoxicated/high clients, relapse, withdrawal, or active users.	No guidelines conveyed in any manner.	Verbally conveyed in-house guidelines.	Documented guidelines: Referral or collaborations (to local substance abuse treatment agency, detox, or E/R)		Routine capability, or a process to ascertain risk with ongoing psychiatric symptoms: Maintain in program unless alternative placement (i.e., detox, commitment) based on acute risk 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 mental health motivation for treatment 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.

	1 MHOS	2	3 DDC	4	5 DDE
IV. CLINICAL PROCESS: TREATMENT (continued)					
IVE. Policies and procedures for evaluation, management, monitoring and compliance for/of medications for substance use disorders. This includes: (i) Medications to treat intoxication states, decrease/eliminate withdrawal symptoms, decrease reinforcing effects of abused substances, promote abstinence and prevent relapse; (ii) Policies about the use of benzodiazepines or other potentially addictive medications.	No capacities to monitor, guide or provide medications related to substance use disorders. Patients with active substance use are routinely not accepted into treatment.	Certain types of meds may be prescribed for substance use disorders and some capacity to monitor medications related to substance use. Variable by provider	Present, coordinated policies regarding medications for substance use disorders. Some types of medications are routinely available. Monitoring of the medication is largely provided by the prescriber.	Present, coordinated policies regarding medications for substance use disorders. The prescriber might more regularly consult with other staff regarding medication plan and recruit other staff to assist with medication monitoring	Present, coordinated policies regarding all types of medications for substance use disorders. There is access to a provider with these specialties on the treatment team.
IVF. Specialized interventions with addiction content.	Not addressed in program content	Based on judgment by individual clinician; Irregular penetration into routine services	In program format as generalized intervention. More regular penetration into routine services. Routine clinician adaptation of an evidence-based mental health treatment (e.g., ACT, CBT, IPT, IM&R, PSR)	Some specialized interventions by specifically trained clinicians in addition to routine generalized interventions.	Routine addiction symptom management groups; Individual therapies focused on specific disorders; Systematic adaptation of an evidence-based mental health treatment (e.g., ACT, CBT, IDDT, IPT, IM&R, PSR)
IVG. Education about substance use disorders & treatment, and interaction with mental health disorders & 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.

	1 MHOS	2	3 DDC	4	5 DDE
IV. CLINICAL PROCESS: TREATMENT (continued)					
IVH. Family education and support.	For mental health disorders only	Variably or by individual clinical judgment	Substance use 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 health 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 or infrequently by individual clinicians, for individual patients, mostly for facilitation of mental health peer support groups	Present, generic format on site, but no specific or intentional facilitation based on addiction. More routine facilitation of traditional mental health peer support groups (e.g., NAMI, Procovery)	Present but variable facilitation to peer support groups targeting specific addiction issues, either to traditional peer support groups or those specific to both (e.g. DRA, DTR).	Routine & specific to need of co-occurring, special programs on site, routinely targeted to specific issues, either to traditional peer support or groups specific to both (e.g. DRA, DTR).
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 MHOS	2	3 DDC	4	5 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 addiction needs when mental health treatment program is completed or the person is scheduled to move to another level of care.	No formal protocol to manage addiction needs once program is completed or the person is scheduled to move to another level of care, but some individual clinicians may provide extended care until appropriate linkage takes place; Variable documentation	No formal protocol to manage addiction needs once program is completed or the person is scheduled to move to another level of care, but when indicated, most individual clinicians provide extended care until appropriate linkage takes place; Routine documentation	Formal protocol to manage addiction needs indefinitely or until appropriate linkage takes place, but variable documented evidence that this is routinely practiced, typically within the same program or agency.	Formal protocol to manage addiction needs indefinitely or until appropriate linkage takes place 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 mental health disorders, addiction issues are viewed as potential relapse issues only.		Routine focus on addiction recovery and mental 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 substance abuse related medications (see IVE) is documented.	No medications in plan.	Sometimes can be provided. Variable by provider	Yes, short-term supply to next appointment off-site.		Maintains medication management in program with provider for longer-term as needed.

	1 MHOS	2	3 DDC	4	5 DDE
VI. STAFFING					
VIA. Psychiatrist or other physician or prescriber of pharmacological therapies for addiction.	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 staff with substance abuse licensure, certification, 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 substance abuse 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 MHOS	2	3 DDC	4	5 DDE
VII. TRAINING					
VIIA. Direct care staff members have basic training in prevalence, common signs & symptoms, screening and assessment for substance use 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 staff with advanced training in specialized treatment approaches, but this is not part of the program's training plan.	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:

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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** _____

DDCMHT INDEX PROGRAM CATEGORY: SCALE METHOD

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

DUAL DIAGNOSIS CAPABILITY:

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

DDCMHT INDEX PROGRAM CATEGORY: CRITERION METHOD

% CRITERIA MET FOR MHOS (# of "1" or > /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** _____